STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wurtland Nursing and Rehabilitation	100 Wurtland Avenue Wurtland, KY 41144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's documents and policy, the facility failed to ensure the physician was notified of a change in condition when the resident began showing signs of fluid overload. Resident (R) 117 experienced a significant weight gain of 17 pounds in 13 days, from [DATE] to [DATE], while a resident at the facility. The facility's failure to recognize and notify the physician of the resident's condition change beginning on [DATE] resulted in a delay in intervention and treatment for the resident. The resident was admitted to the hospital on [DATE] with diagnoses of fluid overload and myocardial infarction and expired at the hospital on [DATE], approximately eight hours and forty-five minutes after his arrival at the hospital. The deficient practice affected 1 of 35 residents reviewed for physician notification.Immediate Jeopardy (IJ) was identified on [DATE] and determined to exist on [DATE] in the area of 42 CFR 483.10, Resident Rights, F580 at a Scope and Severity (S/S) of a J. The facility's Administrator was notified of the IJ on [DATE].The facility provided an acceptable IJ Removal Plan on [DATE] alleging removal of the IJ on [DATE]. The State Survey Agency's survey team validated the facility's corrective action to remove the IJ prior to exit with remaining non-compliance remaining at a S/S of a D.Refer to F684 and F656The findings include: Review of the facility's policy titled, Weight Monitoring, dated [DATE], revealed staff was to weigh residents as ordered. Further review revealed staff was to notify the physician of a weight gain or loss of three pounds within one week.Closed record review of R117's admission Record revealed the facility admitted R117 on [DATE] with diagnoses including pneumonia, nontraumatic subdural hemorrhage, and primary hypertension.Review of R117's admission Note, revealed the resident weighed 252.8 pounds on [DATE].Review of R117's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight out of 15, indicating the resident was moderately cognitively impaired. Further review revealed the resident had diagnoses of atrial fibrillation and hypertension. Review of R117's Care Plan, dated [DATE], revealed interventions for nurses to weigh the resident as ordered and notify the physician of significant weight changes. Further review of the care plan revealed staff was to document abnormal findings and notify the physician.Review of the Physician's Orders for R117, dated [DATE], revealed an order for weekly weights.Review of R117's weights on the facility's document Weight Summary revealed the Director of Nursing (DON) entered the resident's weight of 259 pounds on [DATE], a gain of 6.2 pounds in four days, from admission. Further review revealed LPN1 entered the resident's weight of 267 pounds on [DATE], for a gain of 14.2 pounds in nine days, from admission. However, there was no documentation to support the provider was notified related to the 14.2-pound gain. Review of the Skilled Care Nursing Documentation, the assessment dated [DATE], revealed Licensed Practical Nurse (LPN) 1 documented R117 as having shortness of breath and/or labored breathing with exercise and while lying flat, but there was no documentation to support the physician was notified related to the resident's abnormal findings of having shortness of breath and/or labored breathing, as per the resident's care plan. Review of R117's weights on the facility's document Weight Summary (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	revealed on [DATE], LPN4 documented the resident's weight of 270 pounds, 13 days from admission, for a gain of 17.2 pounds since admission. Review of R117's Health Status Note, found in the electronic medical record (EMR), dated [DATE], revealed LPN4 notified the APRN of her assessment findings and obtained orders for a chest x-ray (related to fluid retention), labs, and intramuscular furosemide (a potent diuretic used to treat fluid retention).Review of R117's Progress Notes-View All, from [DATE] through [DATE], revealed no evidence the facility staff identified R117's weight gain as a symptom of a significant change in condition. Further review revealed no evidence that the facility staff notified the physician of a weight gain of three pounds or more after the weights were taken on [DATE], with a 6.2-pound weight gain in four days, and on [DATE] with a 14.2-pound weight gain in nine days.Review of R117's Health Status Note, dated [DATE] at 2:43 PM and written by LPN4, revealed the resident had +3 to +4 pitting edema (swelling caused by too much fluid trapped in the body's tissue) in all four extremities, as well as shortness of breath. Further review revealed the facility sent R117 to the hospital for an evaluation at the request of the resident's family member, FM1.In an interview on [DATE] at 10:00 AM, R117's family member (FM) 1 stated he visited the resident every day and noticed the resident's legs, feet, and scrotum were increasingly swollen throughout R117's stay at the facility. He further stated he expressed his concerns to staff every day, but they told him the edema was not a problem. FM1 stated he told the staff he wanted to take R117 home early in his stay because he felt staff ignored his worries about R117's edema. FM1 stated he communicated his concerns about R117's edema to LPN4 on the morning of [DATE]. Review of R117's hospital records revealed the hospital admitted R117 on [DATE] with diagnoses of acute congestive heart failure (CHF) exacerbation, fluid overload, atrial fibrillation, and myocardial infarction. Further review revealed R117 expired at the hospital at 12:25 AM on [DATE].In an interview on [DATE] at 1:42 PM, LPN1, who charted R117's weight on [DATE] stated if she noticed a significant change in a resident's weight, she would re-weigh the resident to check for accuracy, assess the resident for swelling or respiratory distress, and notify the physician. LPN1 further stated she could not recall if she notified the Advanced Practice Registered Nurse (APRN) about R117 gaining weight. She stated her practice was to always document when she notified the APRN or physician about a resident's condition. In an interview on [DATE] at 1:18 PM, the APRN stated any time a resident experienced a rapid weight gain, it was important for staff to notify the APRN or physician. He stated that a lot of things could cause weight gain, so if a resident gained weight, his practice was to order a re-weigh of the resident and instruct staff to complete an assessment of the resident to check for fluid overload. In further interview, the APRN stated staff did not notify him of any of R117's repeated weight gains until [DATE]. In an interview on [DATE] at 5:27 PM, the Medical Director, who was also R117's primary physician, stated his expectation was for staff to notify him or the APRN of significant changes in the resident's condition, including weight changes. In continued interview, the Medical Director stated he relied heavily on nurses to follow the policies and act appropriately on assessment findings. In an interview on [DATE] at 5:49 PM, the Director of Nursing (DON) stated her expectations were for staff to ensure accurate weights and to re-weigh the residents if there was a discrepancy. Further, she stated staff should notify the physician. The DON stated she could not find evidence that would suggest the facility's staff identified R117's weight gain as a symptom of a significant change in condition or notified the APRN of R117's weight gain. In an additional interview on [DATE] at 12:42 PM, with the DON, she stated she did not recall identifying R117's weight gain on [DATE] as a significant increase from his admission weight after she entered the increased weight in the electronic health record. She further stated she did not recall notifying the APRN of R117's weight gain.In an interview on [DATE] at 9:30 AM, the Administrator stated he was not clinical, but he expected staff to follow policies and notify the APRN or physician when appropriate. The Administrator further stated he could not find evidence the facility had notified the APRN or physician of R117's weight change, stating, If we missed a weight, that's on us. The facility provided an acceptable IJ Removal Plan on [DATE] alleging removal of the IJ on [DATE] which the (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	State Survey Agency survey team validated prior to exit on [DATE]. The IJ Removal Plan is as follows verbatim: Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.1. Resident number 117 was discharged on [DATE].Address how the facility will identify other residents having the potential to be affected by the same deficient practice.2. All current residents were re-weighed and reassessed for change of condition on 3.7.26 by Director of Nursing Services, Assistant Director of Nursing Services and Unit Manager with weights being reviewed for the last 6 months. All significant changes in weight resulted in nursing assessment per Director of Nursing Services, Assistant Director of Nursing services, or Unit manager with notification of physician or nurse practitioner for orders as needed. All residents were reassessed and reweighed on 3.7.26. All residents were reassessed by Director of Nursing Services, Assistant Director of Nursing Services, Unit Manager with any changes of condition reported to the Nurse Practitioner and orders given on 3.7.26.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.3. Director of Nursing Services educated by the Regional Nurse Consultant on [DATE] to review weight reports timely related to weekly Nutritional At Risk (NAR) meeting. Beginning on 3.7.26 all nurses educated by Infection Preventionist/Staff Development, Director of Nursing Services or Assistant Director of Nursing Services regarding policy on notifying the physician or nurse practitioner of all changes of conditions including weight changes with no nurse working before receiving the education, 13 of 23 currently completed. Post test given to all nurses regarding the education with expected 100% pass rate. If 100% pass rate is not achieved, re-education was given. DNS, ADNS, IPSO or unit manager will provide education until all 23 of 23 nurses completed.Education will be added to all new hire orientation for nurses. No outside nursing agencies utilized at this time.Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.4. On 3/7 /26 an ADHOC Quality Assurance Performance Improvement (QAPI) meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant, and the Medical Director. This meeting reviewed the alleged deficiency, audit tools and education for all care team members regarding notification of changes.The QAPI (Quality Assurance Performance Improvement) Committee consists of the Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Infection Preventionist/Staff Development, Human Resources Director, Business Office Manager, Therapy Manager, Social Services Director, Activities Director, and MOS Nurse.Beginning 3.8.26 Director of Nursing Services, Assistant Director of Nursing or Unit Manager will audit to ensure that all changes in condition including weight changes resulted in physician or nurse practitioner notification. Results of audit will be forwarded to the QAPI Committee for review, presented by the Director of Nursing.An Ad Hoc QAPI was completed on [DATE] with the Executive Director, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant and Medical Director. This meeting reviewed the audit tools, plan and education audits regarding notification of change in conditions.5. Completion Date [DATE]

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's documents and policies, the facility failed to develop and implement a comprehensive care plan to ensure the care plan met each of the resident's medical, nursing, mental and psychosocial needs identified on his/her comprehensive assessment for 1 of 35 residents reviewed for comprehensive care plans, Resident (R) 117.R117 gained 17 pounds in 13 days while a resident at the facility from [DATE] through [DATE], a significant weight gain with exhibited signs of edema. The resident was sent to the hospital on [DATE] and admitted with diagnoses of fluid overload and myocardial infarction (heart attack). The resident expired at the hospital on [DATE], approximately eight hours and forty-five minutes after his arrival at the hospital. The facility's failure to implement interventions from his care plan and notify the physician beginning on [DATE] resulted in a delay in intervention and treatment for the resident. Immediate Jeopardy (IJ) was identified on [DATE] and determined to exist on [DATE] in the area of 42 CFR 483.21, Comprehensive Resident Centered Care Plan, F656 at a Scope and Severity (S/S) of a J. The facility's Administrator was notified of the IJ on [DATE].The facility provided an acceptable IJ Removal Plan on [DATE] alleging removal of the IJ on [DATE]. The State Survey Agency survey team validated the facility's corrective action to remove the IJ prior to exit with remaining non-compliance remaining at a S/S of a D.See F684The findings include:Review of the facility's policy titled, Comprehensive Care Plans, dated [DATE], revealed the facility was to develop and implement a resident-specific comprehensive care plan.Review of the facility's policy titled, Weight Monitoring, dated [DATE], revealed staff was to weigh residents as ordered. Further review revealed staff was to notify the physician of a weight gain or loss of three pounds within one week.Review of R117's admission Record revealed the facility admitted R117 on [DATE] with diagnoses including pneumonia, nontraumatic subdural hemorrhage, and primary hypertension.Review of R117's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed the resident had diagnoses of atrial fibrillation and hypertension. Further review revealed the facility documented the resident had an intravenous (IV) access to receive antibiotics, however, failed to fully develop the resident's care plan which included goals and interventions for the IV. Review of R117's Care Plan, dated [DATE], revealed an intervention for nurses to weigh the resident as ordered and notify the physician of significant weight changes. Further review of the care plan revealed the facility updated the care plan on [DATE] to include the resident was at risk for cardiac dysfunction due to arrythmias and coronary artery disease. Per review of the care plan, an intervention was developed for staff to observe R117 for signs and symptoms of cardiac dysfunction such as shortness of breath, cough, abnormal lung sounds, change in mental status, activity intolerance, decreased urine output, edema, dizziness, and weakness. Continued review revealed staff was to document abnormal findings and notify the physician. Additional review of the care plan revealed no resident specific interventions developed in R117's care plan to address his needs related to potential complications from continuously infusing intravenous (IV) fluids. Review of the Physician's Orders for R117, dated [DATE], revealed an order for weekly weights.Review of R117's weights on the facility's document Weight Summary revealed the Director of Nursing (DON) entered the resident's weight of 259 pounds on [DATE], a gain of 6.2 pounds in four days, from the admission weight obtained on [DATE]. Further review revealed LPN1 entered the resident's weight of 267 pounds on [DATE], for a gain of 14.2 pounds in 9 days, from admission. There was no documented evidence, however, to support the facility implemented the resident's care plan and notified the physician of the significant weight changes between [DATE] to [DATE]. Review of R117's weights on the facility's document Weight Summary revealed on [DATE], LPN4 documented the resident's weight of 270 pounds, 13 days from admission, for a gain of 17.2 pounds since admission. Review of the hospital documentation All (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Progress Notes revealed hospital nurses documented R117 arrived on the inpatient unit on [DATE] at 9:44 PM. Further review revealed nurses noted R117's duress alarm activated in R117's room, and they entered to find R117 unresponsive, in pulseless electrical activity (PEA) with agonal breathing. Continued review revealed the nurses activated the Code Blue at 11:59 PM on [DATE]. Further review revealed the physician determined R117 expired at 12:25 AM on [DATE].In an interview on [DATE] at 10:00 AM, R117's family member (FM) 1 stated he visited the resident every day and noticed the resident's legs, feet, and scrotum swelling increasing throughout R117's stay at the facility. FM1 stated he told the staff he wanted to take R117 home early in his stay because he felt staff ignored his worries about the R117's edema (swelling caused by too much fluid trapped in the body's tissues. It can be life-threatening if not treated quickly). In further interview, he stated the facility convinced him to give them a chance to show him they could care for R117. FM1 stated he told the staff on [DATE] that he wanted R117 sent to the hospital due to his concerns with the resident's edema. According to FM1, it was not until he made the request that the facility staff finally arranged to send R117 to the hospital. In an interview on [DATE] at 1:42 PM, Licensed Practical Nurse (LPN) 1 stated she did not remember R117's care plan specifically, but standard interventions for monitoring weight changes included notifying the physician about changes in the resident's weight. LPN1 stated she did not recall notifying R117's physician about the weight gain, nor was she able to find evidence of the physician notification after reviewing R117's chart. Further, she stated she did not remember assessing R117 specifically, but she would listen to resident lung sounds as part of her assessment. She stated she did not always directly assess the resident for edema. However, review of the resident's care plan revealed staff would observe the resident for signs and symptoms of cardiac dysfunction, which included assessing the resident for edema. This was a failure to follow the resident's care plan. In an interview on [DATE] at 11:06 AM, LPN3 stated she did not remember R117's care plan specifically, but she would expect a cardiac care plan to include weighing the resident as ordered and notifying the physician of any changes. She further stated following the care plan was important to take care of each resident in ways that met their needs.In an interview on [DATE] at 6:17 PM, LPN7 stated care plans were the means for communicating to everyone what kind of care each resident needed. LPN7 stated the orders for R117's 24-hour IV antibiotic infusion were something nurses at the facility had never seen before, but they received no guidance on any kind of special precautions or monitoring for the IV. In an interview on [DATE] at 12:34 PM, the Minimum Data Set Coordinator (MDSC) stated she did not recall R117 specifically and had not participated in any interdisciplinary team meetings or root cause analyses related to his care. She further stated general interventions for a resident with cardiac problems would be for staff to follow medication orders, obtain weights and vital signs as ordered, and monitor for signs of fluid overload. She further stated she would also expect an intervention about notifying the physician with any change in condition, including weights.In an interview on [DATE] at 10:11 AM, the Unit Manager (UM) stated it was important for staff to implement care planned interventions to ensure residents received the care they needed. She further stated she conducted spot checks on resident care plans to ensure care planned interventions were implemented. The UM stated she did not know what caused staff to fail to implement the interventions in R117's care plan.In an interview on [DATE] at 1:18 PM, the Advanced Practice Registered Nurse (APRN) stated that any time a resident experienced a rapid weight gain, it was important for staff to notify the APRN or physician. He stated a lot of things could cause weight gain, so if a resident gained weight, his practice was to order a re-weight and focused assessment on the resident to check for fluid overload. Per interview, the APRN stated staff did not notify him of changes in assessment findings, including the weight gain, until [DATE]. In an interview on [DATE] at 5:49 PM, the Director of Nursing (DON) stated she expected staff to follow care plans, including R117's interventions to notify the physician of significant weight changes and edema.In an interview with the Administrator on [DATE] at 1:30 PM, he stated he expected staff to follow the residents' care plans to ensure the residents' care needs and identified interventions were (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	implemented.The facility provided an acceptable IJ Removal Plan on [DATE] alleging removal of the IJ on [DATE] which the State Survey Agency survey team validated prior to exit on [DATE]. The IJ Removal Plan is as follows verbatim: Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.1. Resident number 117 was discharged on [DATE].Address how the facility will identify other residents having the potential to be affected by the same deficient practice.2. All current residents have the potential to be affected. All residents were reassessed and reweighed on 3.7.26. All were reassessed by Director of Nursing Services, Assistant Director of Nursing Services, Unit Manager with any changes of condition reported to the Nurse Practitioner and orders given on 3.7.26.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.3. All care plans were reviewed for residents with congestive heart failure, use of diuretics, and orders for daily or weekly weights by Regional Resident Assessment Specialist on 3/7 /26 to ensure accuracy.Beginning on 3.7.26 all nurses were re-educated by Infection Preventionist/Staff Development, Director of Nursing Services or Assistant Director of Nursing Services regarding care plan policy specifically, implementation and notification to physician with changes of condition. with no nurse working before receiving the education, 13 of 23 currently completed. Post test given to all nurses regarding the education with expected 100% pass rate. If 100% pass rate not achieved, re-education was given. DNS, ADNS, IPSO or unit manager will provide education until all 23 of 23 nurses completed.Education will be added to all new hire orientation for nurses. No outside nursing agencies utilized at this time. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.4. On 3/7 /26 an ADHOC Quality Assurance Performance Improvement (QAPI) meeting was held with the Executive Director, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant, and the Medical Director. This meeting reviewed the alleged deficiency, audit tools, plan and education for all care team members regarding notification of changes.The QAPI (Quality Assurance Performance Improvement) Committee consists of the Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Infection Preventionist/Staff Development, Human Resources Director, Business Office Manager, Therapy Manager, Social Services Director, Activities Director, and MDS Nurse.Beginning 3.8.26 Director of Nursing Services, Assistant Director of Nursing or Unit Manager will audit to ensure that all weight changes resulted in physician or nurse practitioner notification per the care plan. Results of audit will be forwarded to the QAPI Committee for review, presented by the director of nursing.An Ad Hoc QAPI was completed on [DATE] with the Executive Director, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant and Medical Director. This meeting reviewed the audit tools, plan and education audits regarding implementation of care plans related to notification of changes.5. Completion Date [DATE]

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to recognize a change in a resident's condition, to ensure the resident received quality of care based on the facility's identified care and treatment needs for the resident and failed to ensure professional standards of practice for the resident's care were provided that would meet the resident's physical, mental, and psychosocial needs for 1 of 35 sampled residents reviewed for quality of care concerns, Resident (R) 117.R117 gained 17 pounds in 13 days, a significant weight gain with exhibited signs of edema, while a resident at the facility from [DATE] through [DATE]. The facility's failure to recognize the weight gain as a sign of a change in condition beginning on [DATE] resulted in a delay in intervention and treatment for the resident. The resident was sent to the hospital on [DATE] and admitted with diagnoses of fluid overload and myocardial infarction (heart attack). The resident expired at the hospital on [DATE], approximately eight hours and forty-five minutes after his arrival at the hospital. Immediate Jeopardy (IJ) was identified on [DATE] and determined to exist on [DATE] in the area of 42 CFR 483.25, Quality of Care, F684 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F684. The facility's Administrator was notified of the IJ on [DATE]. The facility provided an acceptable IJ Removal Plan on [DATE] alleging removal of the IJ on [DATE]. The State Survey Agency survey team validated the facility's corrective action to remove the IJ prior to exit with remaining non-compliance at a S/S of a D.The findings include:Review of the facility's policy titled, Change in Condition, dated [DATE], revealed the facility's staff was to notify the nurse practitioner and/or physician for changes in condition including abnormal weights, the need to alter medications or treatment, and significant changes in the resident's mental status.Review of the facility's policy titled, Weight Monitoring, dated [DATE], revealed the facility's staff was to weigh residents as ordered. Further review revealed the facility's staff was to re-weigh the resident for a weight change of three pounds or greater in one day or five pounds in one week. Continued review revealed the facility's staff was to notify the physician, the resident, and the resident's representative of the weight change.Review of the hospital record documents, Physician Discharge Summary, and Discharge Papers, dated [DATE], revealed R117 was discharged from the hospital to the facility for short term rehabilitation following a serious illness with sepsis and a spinal abscess, weighing 257 pounds. Further review revealed the hospital diagnosed the resident with atrial fibrillation, coronary artery disease, and pneumonia. Per the Physician Discharge Summary, R117 had stable shortness of breath and coarse breath sounds at discharge from the hospital.Review of R117's admission Record revealed the facility admitted R117 on [DATE] with diagnoses including pneumonia, nontraumatic subdural hemorrhage, and primary hypertension.Review of R117's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed the resident had diagnoses of atrial fibrillation and hypertension. Further review revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight of 15, indicating the resident was moderately cognitively impaired. Continued review revealed the facility documented the resident had an intravenous (IV) access and did not receive diuretics in the lookback period. Additional review revealed R117 planned to return home after discharge. Per the admission MDS, the facility assessed R117 as having shortness of breath when lying flat.Review of R117's Care Plan, dated [DATE], revealed interventions for nurses to weigh the resident as ordered and notify the physician of significant weight changes. Further review of the Care Plan revealed the facility updated the care plan on [DATE] to include identifying the resident as at risk for cardiac dysfunction with interventions of staff to observe R117 for signs and symptoms of cardiac dysfunction such as shortness of breath, cough, abnormal lung sounds, change in mental status, activity intolerance, decreased urine output, edema, dizziness, and weakness. Continued review revealed staff was to document abnormal findings and notify the physician.Review of the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Physician's Orders for R117, dated [DATE], revealed orders for intravenous (IV) nafcillin 0.5 grams per hour (an antibiotic) to infuse at 47 milliliters per hour continuously. Further review revealed orders for weekly weights, oxygen via nasal cannula at 2 liters per minute (L/min), and BiPAP (a device which maintained positive airway pressure) to be worn at night at 30 percent oxygen. Review of the admission Progress Note, dated [DATE], revealed the note stated R117's admission weight was 252.8 pounds.Review of the facility's document Health Status Note, dated [DATE] and written by Licensed Practical Nurse (LPN) 5, stated Family Member (FM) 1 notified her that R117's right hand was swollen. Further review revealed LPN5 documented R117 had swelling, increased confusion from the resident's baseline, and complained of shortness of breath. Per the documentation, LPN5 notified the Advanced Practice Registered Nurse (APRN), who gave orders to continue to monitor the resident. Review of R117's weights on the facility's document Weight Summary revealed the Director of Nursing (DON) entered the resident's weight of 259 pounds on [DATE], a gain of 6.2 pounds in four days, from admission. Further review revealed LPN1 entered the resident's weight of 267 pounds on [DATE], for a gain of 14.2 pounds in 9 days, from admission. Review of the facility's document Skilled Care Nursing Documentation, the assessment dated [DATE], revealed the nurse documented R117 as having shortness of breath and/or labored breathing with exercise and while lying flat. Per the nursing assessment, R117 required supplemental oxygen and maintaining the head of the bed in an elevated position. Further review revealed the nurse documented R117 had edema in both his lower extremities. Review of the Skilled Care Nursing Documentation, the assessment dated [DATE], revealed LPN1 documented R117 as having shortness of breath and/or labored breathing with exercise and while lying flat. Per the nursing assessment, R117 required supplemental oxygen and maintaining the head of the bed in an elevated position.Review of R117's Progress Notes-View All, from [DATE] through [DATE], revealed none of the notes documented the resident had edema or shortness of breath. Further review revealed there was no evidence the facility's staff recognized the resident's weight gain as a significant change in status. Continued record review revealed no evidence the facility staff re-weighed the resident and notified the physician of the significant weight gain after any of the weights taken on [DATE] or [DATE], per the facility policy and resident's care plan. Review of R117's weights on the facility's document Weight Summary revealed on [DATE], LPN4 documented the resident's weight of 270 pounds, 13 days from admission, for a gain of 17.2 pounds since admission.Review of R117's Health Status Note, dated [DATE] and written by LPN4, revealed the resident had +3 to +4 pitting edema in all four extremities, as well as shortness of breath. In an interview on [DATE] at 10:00 AM, R117's family member (FM) 1 stated he visited the resident every day and noticed the resident's legs, feet, and scrotum were increasingly swollen throughout R117's stay at the facility. He further stated he expressed his concerns to staff every day, but they told him the edema was not a problem. FM1 stated he told the staff he wanted to take R117 home early in his stay because he felt staff ignored his worries about R117's edema, but the facility convinced him to give them a chance to show they could care for R117. Per interview, when FM1 expressed his concerns about R117's edema to LPN4 on the morning of [DATE], FM1 stated the LPN4 informed him the APRN wanted to treat the resident in the facility with diuretics (water pills that assisted with removing excess fluid from the body). FM1 stated the APRN initially did not agree to send R117 to the hospital. However, he stated, in the afternoon of [DATE], FM1 repeated his insistence that the facility send R117 to the hospital for evaluation and treatment. FM1 stated after his second request for a hospital transfer, the APRN finally agreed to send R117 to the hospital.In an interview on [DATE] at 1:42 PM, LPN1, who charted R117's weight on [DATE], stated if she noticed a change in a resident's weight, she would re-weigh the resident to check for accuracy, assess the resident for swelling or respiratory distress, and notify the physician for a change of so many pounds [not specific], depending on what was going on with the resident, including diagnoses and overall presentation. LPN1 stated she could not recall if R117 had a weight gain, but if she had noticed one, her practice was to always document when she notified a provider. Per interview, when asked what (continued on next page)

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	185261	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wurtland Nursing and Rehabilitation	100 Wurtland Avenue Wurtland, KY 41144

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	she did in response to the weight gain on [DATE], LPN1 stated she did not recall, but if she notified the physician, she would have charted it. She further stated she did not recall re-weighing R117. In an interview on [DATE] at 9:24 AM, LPN5 stated she recalled FM1 telling her he was concerned about R117's swelling. She further stated she did recall seeing some swelling, but the resident seemed okay to her overall. Per interview, LPN5 knew it was important to watch R117 for signs of fluid overload, such as shortness of breath, because he was on continuous intravenous medication. LPN5 stated she notified the APRN about the swelling, on [DATE], in R117's arm, but the APRN's only order was to continue to monitor the resident without details on what findings would be significant to a potential change in condition. In an interview on [DATE] at 4:52 PM, Licensed Practical Nurse (LPN) 4 stated she assessed R117 in the mid-morning of [DATE] after FM1 expressed concerns to her about R117's swelling. She stated FM1 was frustrated because his concerns had not been addressed. She stated R117 had +3 to +4 pitting edema in all extremities, and his scrotum was also extremely swollen. LPN4 stated she had last seen the resident while assisting with drawing labs on [DATE], and he did not have the level of swelling she saw on [DATE]. Review of the Emergency Medical Services (EMS) Run Sheet, dated [DATE] starting at 3:14 PM, revealed the EMS team assessed the resident as being in acute respiratory distress with increased respiratory effort, crackles/wheezing/diminished for breath sounds, wet cough, and pitting edema in all four extremities. Further review revealed vital signs were unremarkable, and the resident was confused, but he did have some confusion at baseline. Further review revealed EMS continued supplemental oxygen, elevated the head of the bed, and then transferred care to the hospital at 3:40 PM.Review of R117's hospital document, Visit Information, dated [DATE] revealed R117 arrived at the Emergency Department (ED) at 3:36 PM, with a primary diagnosis of fluid overload, followed by acute systolic heart failure, atrial fibrillation, and myocardial infarction. Continued review revealed the hospital weighed R117 at 270 pounds with blood pressures mildly elevated (as high as 156/92) and oxygen saturations that fell as low as 89 percent but were mostly in the mid-90s on supplemental oxygen. Per review of the document, R117's respirations trended higher through his stay in the ED, up to 26 breaths per minute. Additional review revealed the hospital admitted R117 to a medical surgical floor under Advanced Illness Management at 9:39 PM with a full code status. Review of the ED Provider Note, dated [DATE], revealed the ED physician assessed R117 as having edema in his bilateral lower extremities and crackles heard with breath sounds, and R117 complained of shortness of breath. Review of R117's lab values while at the hospital on [DATE] revealed the following levels: baseline troponin (measured heart muscle damage) 381 (very high), 1-hour troponin 364, and 3-hour troponin 405. Further review revealed the following values: ProBNP (measured the severity of heart failure) at 10,234 (very high), blood gas pH 7.4, pCO 252, and HCO3 29.6. These lab values were consistent with respiratory distress, cardiac distress, and myocardial infarction.Review of the hospital's Order Report, dated [DATE] at 4:33 PM, revealed the hospital performed a chest X-ray on [DATE]. Further review revealed the X-ray showed cardiomegaly (enlarged heart) with pulmonary vascular congestion (fluid overload in the lungs), bilateral pleural effusions (pockets of fluid in the lungs), and atelectasis (collapsed lung tissue) of the bilateral lower lobes.Review of the Hospital Medicine Admission note on [DATE], revealed Hospital Physician 1 noted R117 reported becoming more short of breath over the last few days, noticed increased swelling in feet and legs. Physician 3 noted R117 to have marked [fluid] overload with CHF [congestive heart failure] exacerbation. Further review revealed the hospital administered Lasix (to remove fluid, a diuretic) 40 milligrams (mg) IV push, followed by a Lasix drip of 10 mg/hour. Continued review revealed R117's mental status remained alert with some confusion, as had been noted to be his baseline.Review of the hospital documentation All Progress Notes revealed hospital nurses documented R117 arrived on the inpatient unit on [DATE] at 9:44 PM. Further review revealed nurses noted R117's duress alarm activated in R117's room, and they entered to find R117 unresponsive, in pulseless electrical activity (PEA) with agonal breathing. Continued review revealed the nurses activated the Code Blue at 11:59 PM on [DATE].Review of the document Clinical Note, by Hospital (continued on next page)

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He stated a lot of things could cause weight gain, so if a resident gained weight, his practice was to order a re-weigh and focused assessment on the resident to check for fluid overload. In further interview, the APRN stated he would also physically assess a resident with a possible change in condition. Per interview, the APRN stated staff did not notify him of changes in assessment findings, including the weight gain, until [DATE]. In an interview on [DATE] at 5:27 PM, the Medical Director, who was also R117's primary physician, stated he relied heavily on nurses to follow the policies and act appropriately on assessment findings. The Medical Director stated the facility treated residents with acute illnesses and changes in condition wherever possible but would send them to the hospital if they were in distress. In an interview on [DATE] at 5:49 PM, the Director of Nursing (DON) stated her expectations were for staff to ensure accurate weights, re-weigh if there was a discrepancy, and notify the physician. She further stated she could find no evidence staff identified R117's weight gain as a sign of a potential change in condition, nor could she find evidence staff had notified the APRN after [DATE]. The DON stated she recalled staff mentioning to her that R117's hands were swollen, but she did not believe any intervention had been implemented to address the swelling. In an additional interview on [DATE] at 12:42 PM, the DON stated she did not recall identifying R117's weight gain as a significant increase from his admission weight after she entered it in the electronic health record. She further stated she failed to assess R117 after entering his weight on [DATE], even though that was a six-pound weight gain in less than a week, which would be clinically significant per the facility's policy. The DON stated she did not recall notifying the APRN of R117's weight gain.In an interview on [DATE] at 9:30 AM, the Administrator stated he was not clinical, but he expected staff to follow policies and work with the APRN on necessary interventions to treat residents' symptoms such as weight gain and confusion. The Administrator further stated, If we missed a weight, that's on us. The facility provided an acceptable IJ Removal Plan on [DATE] alleging removal of the IJ on [DATE] which the State Survey Agency survey team validated prior to exit on [DATE]. The IJ Removal Plan is as follows verbatim: Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.1. Resident number 117 was discharged on [DATE].Address how the facility will identify other residents having the potential to be affected by the same deficient practice.2. All current residents were re-weighed and reassessed for change of condition on 3.7.26 by Director of Nursing Services, Assistant Director of Nursing Services and Unit Manager with weights being reviewed for the last 6 months. All significant changes in weight resulted in nursing assessment per Director of Nursing Services, Assistant Director of Nursing services, or Unit manager with notification of physician or nurse practitioner for orders as needed. All residents were reassessed and reweighed on 3.7.26. All residents were reassessed by Director of Nursing Services, Assistant Di.[NAME] of Nursing Services, Unit Manager with any changes of condition reported to the Nurse Practitioner and orders given on 3.7.26.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.3. Beginning on 3.7.26 all nurses re-educated by Infection Preventionist/Staff Development, Director of Nursing Services or Assistant Director of Nursing Services regarding the policy of notifying the physician or nurse practitioner of all significant weight changes, and the policy of changes in condition with no nurse working before receiving the education, 13 of 23 completed. Post test given to all nurses regarding the education with expected 100% pass (continued on next page)

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