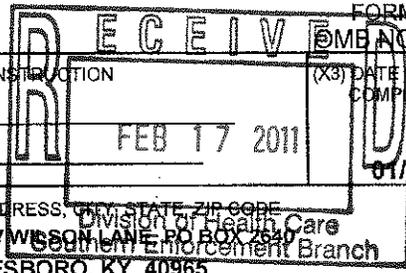


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WISCONSIN LANE, Box 284 MIDDLESBORO, KY 40965
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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 A standard health survey was conducted on January 24-27, 2011. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	Disclaimer Middlesboro Nursing and Rehabilitation Facility does not believe and does not admit that any deficiencies existed before, during or after survey. Middlesboro Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. And, Middlesboro Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Middlesboro Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim action or proceeding.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (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 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 It is and was on the day of the survey the policy and practice of MN&RF to immediately inform the resident's physician when a change in the resident's condition occurs and/or there is a need to alter treatment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dee Maddipati</i>	TITLE <i>Adm. Director</i>	(X6) DATE <i>2/16/11</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.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to immediately inform the resident's physician when a change in the resident's condition occurred for two of twenty-four sampled residents. Resident #9 experienced a significant weight increase (26.5 pounds) in six months; however, there was no evidence the facility had notified the attending physician regarding the significant weight increase. In addition, there was no evidence resident #7 had a bowel movement for twenty-one consecutive shifts. The facility failed to notify the resident's physician for possible treatment/interventions to promote bowel elimination for resident #7.</p> <p>The findings include:</p> <p>1. Resident #1 was observed on January 25, 2011, at 8:40 a.m., to be sitting in a wheelchair in the resident's room. Further observations revealed resident #1 was served the lunch meal in the dining room on January 25, 2011, at 11:50 a.m. The resident received turkey, dressing, carrots, dessert, and a roll for the lunch meal and consumed 100 percent of the meal.</p> <p>A review of the medical record revealed resident #1 was admitted to the facility on October 8, 2009, with diagnoses of Hypertension, Atrial Fibrillation, Osteoarthritis, and Fractured Femur. A review of the annual comprehensive assessment conducted on September 21, 2010, revealed resident #1 was assessed to have short/long-term memory deficit and to require extensive assistance of staff for bed mobility,</p>	F 157	<p>1. The physician for Resident #1 has been notified Re: resident's change in condition. No new orders or changes are noted at present to the physician orders r/t weight gain. The responsible party was informed of the resident's change in condition.</p> <p>The physician for Resident #7 was notified regarding the resident's change in condition and the need to alter treatment. Appropriate orders were obtained related to resident's condition. Resident #7 is currently receiving Dulcolax daily and prn, Docusate twice daily, and Lactulose daily prn resulting in regular bowel patterns.</p>		

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F 157	<p>Continued From page 2</p> <p>transfers, toileting, and bathing. Resident #1's weight was assessed to be 180 pounds and no changes in the resident's weight were noted. A review of the quarterly assessment conducted on November 22, 2010, revealed resident #1 continued to require extensive assistance of staff and the resident's weight was noted to be 194 pounds with no increase in the resident's weight.</p> <p>A review of the weight record revealed resident #1's weight was recorded as 176.5 pounds on July 6, 2010, 175 pounds on August 2, 2010, 180 pounds on September 7, 2010, 187 pounds on October 5, 2010, 194 pounds on November 2, 2010, 197 pounds on December 7, 2010, and 203 pounds on January 4, 2011.</p> <p>A review of the dietary progress notes dated September 21, 2010, revealed the Registered Dietitian (RD) noted the resident's weight was 180 pounds and no significant weight changes were noted. Further review of the progress notes revealed the RD assessed resident #1 on November 17, 2010, and noted the resident's weight was 194 pounds with a seven-pound increase in one month. However, there was no evidence the RD had identified the significant weight increase of 26.5 pounds in the past six months for resident #1.</p> <p>A review of the facility's policy/procedure related to changes in a resident's condition (dated January 9, 2003) revealed the facility nursing staff was responsible for immediately notifying the resident's physician when a significant change in the resident's physical, mental, emotional, or psychosocial status occurred.</p> <p>An interview conducted with the Dietary Manager</p>	F 157	<p>2. A review of residents experiencing a change in condition – physical, mental, or psychosocial – along with life threatening conditions or clinical complication where an altered treatment or new treatment may be needed, were reviewed for immediate physician notification. Residents experiencing changes/treatment/orders needed are listed daily on the Acute Care Log along with physician notification. All residents have been reviewed, and appropriate MD notifications completed, including residents experiencing significant weight gain and altered bowel patterns to assure timely MD notification regarding changes in these specific conditions.</p>		

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F 157	<p>Continued From page 3</p> <p>(DM) on January 26, 2011, at 10:00 a.m., revealed the DM was responsible to complete the nutrition section of the comprehensive assessment. The DM stated the resident's weight was reviewed weekly and any significant weight changes were referred to the Nutritional At Risk (NAR) committee and the RD for further review.</p> <p>An interview conducted with the RD on January 26, 2011, at 2:10 p.m., revealed the RD could not recall if resident #1's weight increase had been reviewed during the weekly NAR meetings. The RD stated he/she did not review resident #1's weight record for the past three or six months when the dietary assessment was conducted on November 17, 2010.</p> <p>An interview conducted with LPN #3 on January 26, 2011, at 3:00 p.m., revealed the nurses were responsible to notify the physician when a significant weight change occurred. LPN #3 stated the facility "focused" on weight loss more than weight gain and the physician had not been informed of the significant weight increase for resident #1.</p> <p>An interview conducted with the Director of Nurses (DON) on January 26, 2011, at 2:50 p.m., revealed the residents' weights were reviewed weekly by the NAR committee and the staff nurses were directed to notify the resident's physician when a significant weight change occurred. The DON stated the facility "focused" more on weight loss rather than weight gain and the resident's physician had not been notified of the weight gain for resident #1.</p> <p>2. A review of the medical record revealed resident #7 was admitted to the facility on</p>	F 157	<p>3. Nursing staff have been educated regarding timely MD notification of significant change in condition including but not limited to: Altered bowel patterns and weight gains. Assessment forms alert nurses to notify the MD when a significant change or occurrence warrants. In addition, the bowel tracking log alerts the nurse to notify the physician regarding the need for an altered treatment. The new weight gain protocol requires timely notification of the MD of any significant weight gain. Inservice education occurred on 2-04-11. (See attachments)</p> <p>4. The Acute Care Log tracks MD notification of any changes in condition. The QA indicator checklist for significant weight</p>		

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F 157	<p>Continued From page 4</p> <p>December 23, 2010, with diagnoses to include Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, Coronary Artery Disease (CAD), Transient Left Ventricular Dysfunction, and Degenerative Arthritis.</p> <p>A review of the admission physician's orders dated December 23, 2010, revealed the attending physician had not prescribed any laxatives, stool softeners, or enemas to be administered either routinely or as needed when resident #7 was admitted to the facility.</p> <p>Resident #7 was observed on January 25, 2011, at 8:45 a.m., to be sitting up in a wheelchair with oxygen being administered per nasal cannula. The resident was further observed on January 26, 2011, at 9:10 a.m., 10:15 a.m., and 1:30 p.m., to be lying in bed.</p> <p>A review of the Bowel Information Tracking Log (BITL) dated December 24, 2010 through January 6, 2011, revealed a bowel movement was recorded at least one to four times daily for resident #7. Further review of the BITL revealed there was no documentation the resident had a bowel movement for 21 consecutive shifts from January 6-14, 2010. However, there was no evidence the resident's attending physician was notified of the change in resident #7's condition until January 12, 2011.</p> <p>A review of the nurse's notes dated January 12, 2011, at 8:00 p.m., revealed resident #7's physician was notified because no routine orders for laxatives were available for the resident and the resident had not had a bowel movement. New orders were obtained for a Fleets enema to be administered on January 12, 2011, and</p>	F 157	<p>gain audits timely MD notification process. Likewise, a QA indicator checklist audits residents general change in condition. (See Attachment)</p> <p>5. Compliance Date: 2-04-11</p>

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F 157	<p>Continued From page 5</p> <p>Lactulose 30 cc to be administered daily. Further review of the nurse's notes dated January 13, 2011 (no time noted), revealed resident #7 had not had a bowel movement in 19 shifts, and Lactulose 30 cc was administered. On January 13, 2011, at 3:35 p.m., the physician was again called when no bowel movement had been observed for 20 shifts and orders were obtained to administer Dulcolax 5 mg to resident #7 daily and as needed. Further review of the BITL revealed two large formed stools and one medium formed stool were documented during the day shift on January 14, 2011.</p> <p>A review of the facility's policy/procedure related to Bowel Care Protocol (no date) revealed if a resident had not had a bowel movement for three days, Step 1 of the bowel protocol would be implemented. The policy noted the following steps: Step 1: MOM 30 cc, if no results in 24 hours, Step 2: Dulcolax Suppository 10 mg, if no results in 12 hours, Step 3: Fleets enema, and if no results, Step 4: 1,000 cc soap suds enema to be administered two times, and if no results, then the physician would be contacted for further directions.</p> <p>A review of the facility's policy/procedure related to changes in a resident's condition (dated January 9, 2003) revealed the facility nursing staff was responsible for immediately notifying the resident's physician when a significant change in the resident's physical, mental, emotional, or psychosocial status occurred.</p> <p>An interview conducted with LPN #4 on January 27, 2011, at 5:50 p.m., revealed the LPN was aware resident #7 had not had a bowel movement for several days, but believed the</p>	F 157			

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F 157	Continued From page 6 resident's family was taking resident #7 to the bathroom. The LPN stated on January 12, 2011, the resident's physician was called after no bowel movement had been documented for 18 shifts. LPN #4 stated resident #7 refused to allow the enema to be administered and Lactulose was administered. The LPN also stated he/she did not assess resident #7's bowel sounds or check the resident for a fecal impaction. LPN #4 stated a staff member spoke to resident #7's family the following day (January 13) and the family denied taking the resident to the bathroom. An interview conducted with resident #7's attending physician (MD #1) on January 27, 2011, at 2:10 p.m., revealed the physician was informed that resident #7 had not had a bowel movement for several days on January 12, 2011. MD #1 stated he/she would have considered the administration of a stool softener after the resident had not had a bowel movement in three days. An interview conducted with the DON on January 27, 2011, at 5:00 p.m., revealed the nurse was responsible to review the physician's orders for routine/as-needed laxatives and call the physician if indicated to obtain medications for the resident.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225	F 225 It is and was on the day of the survey the policy and practice of MN&RF to conduct investigations on all alleged violations involving mistreatment, neglect or abuse including bruising.		

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F 225	<p>Continued From page 7</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct an investigation related to a bruise on resident #9's left forearm/wrist. Observation on January 24, 2011, revealed resident #9 had a bruise to the left forearm; however, the facility had no evidence an investigation had been conducted to determine the cause of the bruise.</p>	F 225	<ol style="list-style-type: none"> 1. On January 25, 2011 an investigation regarding a bruise on the (L) forearm for Resident #9 was completed. The cause was determined to be related to transfer technique. Staff demonstrated proper transfer technique for Resident #9. Resident #9 has declined to use protective sleeve covering. Consulting pharmacist reviewed resident's current medication as part of the investigation. Contributing medication factors noted. 2. All residents receive a weekly skin assessment. Bruising is specifically noted and immediate investigation to the cause of the bruise is begun by the nurse. Bruises/skin changes are noted by the bath team and reported to the nurse for immediate investigation. Bruising observed/assessed by 	

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F 225	<p>Continued From page 8</p> <p>The findings include:</p> <p>During the initial tour conducted on January 24, 2011, at 6:30 p.m., resident #9 was observed with a bruise to the resident's left forearm/wrist.</p> <p>In an interview conducted on January 24, 2011, at 7:20 p.m., resident #9 stated the staff "grabbed my arm while helping me up," it was not "intentional." The surveyor asked resident #9 if he/she had reported the bruise. Resident #9 stated, "They know." Resident #9 was unable to recall when the incident occurred.</p> <p>Review of resident #9's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease, Cerebella, Vascular Disease, History of Hyperglycemia, Hypertension, Cerebellar Degeneration, Atrial Fibrillation, Coronary Artery Disease, Hypothyroidism, and Depression. Review of the Annual Minimum Data Set (MDS) Assessment dated October 29, 2010, revealed the facility had assessed resident #9 as having no cognitive impairment or behavior problems.</p> <p>Review of resident #9's Comprehensive Care Plan dated October 28, 2010, revealed the resident was assessed to require the assistance of two persons for any transfer due to weakness and impaired physical mobility. Review of Transfer Instructions, dated September 21, 2010, by the physical therapist revealed resident #9 was assessed to "require supervision/stand by assist; walk with a walker with assist of one person and always use a gait belt, do not body lift or arm-in-arm the resident."</p>	F 225	<p>CNAs/nurses are immediately reported and investigated. All resident skin assessments were reviewed and visual physical assessment performed to assess for bruising with investigations completed to determine cause and to change the intervention if indicated. Clarification of bruising was distributed to all nurses via nurse inservice education. Likewise, CNAs, CMTs, housekeeping staff were also educated regarding reporting resident bruises to the appropriate charge nurse and/or nurse supervisor.</p> <p>3. To assure all bruises are investigated, multiple tools and systems are in place to alert staff to note, report, and investigate the cause of resident's bruise including a Bruise Investigation Form, Bath</p>		

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F 225	<p>Continued From page 9</p> <p>Review of weekly skin assessments dated January 5, 2011, and January 12, 2011, revealed resident #9 had "ecchymotic areas to bilateral lower and upper extremities." An additional review of the Weekly Skin Assessment dated January 19, 2011, revealed "bruise noted to left upper forearm."</p> <p>During an interview conducted on January 25, 2011, at 4:30 p.m., with Licensed Practical Nurse (LPN) #2, LPN #2 stated he/she was assigned to care for resident #9 on January 25, 2011, but was unaware of a bruise on resident #9's forearm/wrist. LPN #2 further stated resident #9 had an "ecchymotic area to the left forearm but no bruise." LPN #2 stated, "A bruise is an area of injury" and an "ecchymotic area is not the same as a bruise." LPN #2 defined an "ecchymotic area as unrelated to an injury; it occurred due to the resident's medications such as Plavix or Aspirin which thins the blood." The LPN revealed the facility did not attempt to determine the cause because the area was "ecchymotic" and not a "bruise."</p> <p>According to Mosby's Medical Nursing and Allied Health Dictionary (2002), a bruise is defined as "see ecchymosis," and ecchymosis is defined as "capillary leaking into tissue, may be from trauma, injury or blood thinner."</p> <p>Additional interview conducted on January 25, 2011, at 5:10 p.m., with LPN #2 revealed he/she had spoken with resident #9 and would begin an investigation into the cause of the bruise.</p> <p>An interview conducted on January 26, 2011, at 9:45 a.m., with the Director of Nursing (DON) revealed the staff reported to the DON all</p>	F 225	<p>Team Skin Assessments requiring nurse signature, weekly skin assessments by licensed nurse, and shift management reports. Re-education of staff occurred on February 4, 2011 and on February 7, 2011. See Attachments</p> <p>4. The weekly audit of skin assessments is completed by the ADON. Bruising noted will be audited to assure investigation is timely initiated and a cause determined. The findings are reported to the Administrator/DON appropriately.</p> <p>5. Compliance Date: February 7, 2011</p>	

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F 225	Continued From page 10 "abnormal skin impairments." The DON revealed ecchymosis areas on residents had been defined as hemorrhage under the resident's skin and caused by the use of blood thinner medications. A bruise was defined as an injury and was investigated for the cause of injury. The DON stated he/she was unaware of the bruise on resident #9's forearm/wrist until January 25, 2011, and an investigation had begun on January 25, 2011, to determine the cause.	F 225		
F 279 SS=D	Review of the facility's abuse policy (no date) revealed staff was to document and report an injury regardless of how small, unusual, or of unknown origin on the incident and accident report form. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 It is and was on the day of the survey the policy and practice of MN&RF to develop a comprehensive care plan for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. 1. Resident #4 has an indwelling foley catheter with an updated care plan reflecting the care regarding the foley catheter. Resident #1 has an updated care plan	

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F 279	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop a comprehensive care plan with measurable objectives and timetables for two of the twenty-four sampled residents (residents #1 and #4). The facility failed to develop a comprehensive care plan to direct the care related to an indwelling catheter for resident #4. Additionally, resident #1 experienced a significant weight increase; however, the facility failed to develop a plan of care to address the weight increase.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Resident #4 was readmitted to the facility on January 22, 2011, after a hospital stay with medical diagnoses to include Acute Bronchitis, Pneumonia/COPD, HTN, Arthritis Dysphagia, GERD, Generalized Anxiety, and Depression. <p>Observation conducted on January 25, 2011, at 9:30 a.m. and 11:55 a.m., and on January 26, 2011, at 9:15 a.m., revealed resident #4 had an indwelling Foley catheter in place.</p> <p>Review of a Bladder Assessment Form updated January 18, 2011, revealed resident #4 returned from the hospital on January 18, 2011, with a Foley catheter (F/C) in place and was assessed to need the F/C for "exact measurement of urine output at hospital."</p> <p>Review of the Comprehensive Assessment</p>	F 279	<p>addressing the significant weight gain.</p> <ol style="list-style-type: none"> All residents of MN&RF have comprehensive care plans that include measurable objectives and time tables to meet their medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. All residents with indwelling foley catheters and significant weight gains have been assessed and the plan of care revised if indicated. The RN reviews residents who are admitted/readmitted with a foley catheter and/or receive a new order for a foley catheter. The physician's orders are reviewed daily for care plan updates by the RN responsible for the development of care plans. Temporary care plans are available at the nurse's 	

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F 279	<p>Continued From page 12</p> <p>updated on January 24, 2011, after the resident's return to the facility revealed the facility failed to develop a care plan to direct staff of the care related to the indwelling Foley catheter.</p> <p>An interview conducted on January 26, 2011, at 2:25 p.m., with Registered Nurse (RN) #1 revealed he/she was responsible for the resident care plans. RN #1 revealed resident #4 was readmitted to the facility on January 22, 2011, with an indwelling Foley catheter. RN #1 stated a care plan for resident #4's indwelling Foley catheter should have been developed.</p> <p>2. Resident #1 was observed on January 25, 2011, at 8:40 a.m., to be sitting in a wheelchair in the resident's room. Further observations revealed resident #1 was served the lunch meal in the dining room on January 25, 2011, at 11:50 a.m. The resident received turkey, dressing, carrots, dessert, and a roll for the lunch meal and the resident was observed to consume 100 percent of the meal.</p> <p>A review of the weight record revealed resident #1's weight was recorded as 176.5 pounds on July 6, 2010, 175 pounds on August 2, 2010, 180 pounds on September 7, 2010, 187 pounds on October 5, 2010, 194 pounds on November 2, 2010, 197 pounds on December 7, 2010, and 203 pounds on January 4, 2011.</p> <p>A review of the annual comprehensive assessment conducted on September 21, 2010, revealed resident #1 was assessed to have short/long-term memory deficit and to require extensive assistance of staff for bed mobility, transfers, toileting, and bathing. Resident #1's weight was assessed to be 180 pounds and no</p>	F 279	<p>station for immediate care of the foley catheter pending the development of the comprehensive care plan and/or care plan revision. Likewise, weight is reviewed weekly to identify any significant weight change and the care plan is revised as indicated.</p> <p>4. There is a QA indicator check list for foley catheter use review and a checklist to review significant weight gain. Both checklists audit the care plan for revision for these occurrences.</p> <p>5. Compliance Date: 2-04-11</p>	

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F 279	<p>Continued From page 13</p> <p>changes in the resident's weight were noted. A review of the quarterly assessment conducted on November 22, 2010, revealed resident #1 continued to require extensive assistance of staff and the resident's weight was noted to be 194 pounds with no gain/loss in the resident's weight.</p> <p>A review of the comprehensive care plan reviewed by the interdisciplinary team (IDT) on September 21, 2010 and on November 17, 2010, revealed the facility addressed the potential for altered nutrition for resident #1. The nutritional goal was identified to maintain adequate nutritional status as evidenced by a stable weight. Interventions included to provide a regular diet, to monitor meal percentages and offer substitutes as needed, and to increase/decrease portions at mealtimes as appropriate. However, there was no evidence the facility had identified the significant weight increase for resident #1 and no evidence a plan of care had been developed to address the significant weight increase.</p> <p>An interview conducted with RN #1 on January 26, 2011, at 9:50 a.m., revealed the RN was responsible for the development of the care plans for residents at the facility. RN #1 stated he/she did not usually develop a care plan to address weight gain and had not developed a plan of care to address the significant weight increase for resident #1.</p> <p>An interview conducted with the Director of Nurses (DON) on January 26, 2011, at 2:50 p.m., revealed a care plan was not usually developed to address a weight gain unless the resident was on a reducing diet or the resident's weight fluctuated as a result of edema. The DON stated the facility "focused" more on weight loss rather than weight</p>	F 279			

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F 279	Continued From page 14 gain.	F 279		
F 309 SS=D	<p>A review of the facility's policy/procedure related to Care Plans (dated January 9, 2003) revealed the facility was required to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of twenty-four sampled residents. A review of the bowel elimination record revealed a bowel movement was not recorded for resident #7 for twenty-one consecutive shifts. However, there was no evidence the facility followed established protocols to promote regular bowel elimination for resident #7.</p> <p>The findings include:</p> <p>A review of the medical record revealed resident</p>	F 309	<p>F 309</p> <p>It is and was on the day of the survey the policy and practice of MN&RF to 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.</p> <ol style="list-style-type: none"> 1. Resident #7 is currently receiving Dulcolax daily and prn, Docusate twice daily and Lactulose daily prn resulting in regular bowel patterns. 2. All residents have been reviewed for available medications for administration when indicated/needed per the bowel protocol. In 	

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F 309	<p>Continued From page 15</p> <p>#7 was admitted to the facility on December 23, 2010, with diagnoses to include Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, Coronary Artery Disease (CAD), Transient Left Ventricular Dysfunction, and Degenerative Arthritis.</p> <p>Resident #7 was observed on January 25, 2011, at 8:45 a.m., to be sitting up in a wheelchair with oxygen being administered per nasal cannula. The resident was further observed on January 26, 2011, at 9:10 a.m., 10:15 a.m., and 1:30 p.m., to be lying in bed. The resident continued to require oxygen therapy. Thickened liquids were observed to be sitting on the resident's overbed table.</p> <p>A review of the admission comprehensive assessment conducted on January 14, 2011, revealed resident #7 required extensive assistance of staff for bed mobility, transfers, bathing, and toileting needs, and to have impaired thought process with episodes of disorganized thinking. Resident #7 was also assessed to be continent of bowel elimination with no constipation present.</p> <p>A review of the comprehensive care plan for resident #7 revealed the facility identified a problem related to toileting deficit and routine care needs. Interventions included to provide privacy for elimination, to document the number of bowel movements, to keep the call light within reach, and to assist the resident to toilet upon request.</p> <p>A review of the Bowel Information Tracking Log (BITL) dated December 24, 2010 through January 6, 2011, revealed a bowel movement was</p>	F 309	<p>addition, newly admitted or readmitted residents' bowel medications were reviewed for availability and ordered if needed. Likewise, all residents have been assessed per bowel information tracking log, and nursing interventions have been implemented as indicated.</p> <p>3. The bowel protocol policy was revised to assure individualized medications can be obtained per the physician order based upon the patient's assessment. Newly admitted and readmitted residents will be reviewed for bowel management medications and the MD contacted if medication are not ordered/available. Extensive nursing education was conducted on 2-04-11 to assure understanding of bowel protocol and monitoring</p>	

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F 309	<p>Continued From page 16</p> <p>recorded at least one to four times daily for resident #7. However, further review of the BITL revealed there was no documentation the resident had a bowel movement for 21 consecutive shifts from January 6-14, 2011.</p> <p>A review of the nurse's notes dated January 12, 2011, at 8:00 p.m., revealed resident #7's physician was notified because no routine orders for laxatives were available for the resident and the resident had not had a bowel movement. New orders were obtained for a Fleets enema to be administered on January 12, 2011, and Lactulose 30 cc to be administered daily. Further review of the nurse's notes dated January 13, 2011 (no time noted), revealed resident #7 had not had a bowel movement in 19 shifts, and Lactulose 30 cc was administered. On January 13, 2011, at 3:35 p.m., the physician was again called when no bowel movement had been observed for 20 shifts and orders were obtained to administer Dulcolax 5 mg to be administered to resident #7 daily and as needed. Further review of the BITL revealed two large formed stools and one medium formed stool were documented during the day shift on January 14, 2011.</p> <p>A review of the facility's policy/procedure related to Bowel Care Protocol (no date) revealed the nurse aides were responsible to document the residents' bowel movements each shift. The policy directed that the bowel record would be checked daily by the evening or night shift nursing staff. The policy noted if a resident had not had a bowel movement for three days, the resident's name was placed on a bowel list and Step 1 of the bowel protocol would be implemented. The policy noted the following steps: Step 1: MOM 30 cc, if no results in 24 hours, Step 2: Dulcolax</p>	F 309	<p>form. Nurse education also included physical assessment and documentation of bowel sounds. CNAs were educated regarding bowel protocol and changes were made to the tracking form and the necessary reporting process.</p> <p>4. There is a QA indicator checklist to audit bowel elimination patterns and appropriate nursing intervention that is utilized to track compliance. In addition, the bowel log is audited daily by an RN to assure appropriate intervention and follow up by licensed staff.</p> <p>5. Compliance Date: 2-07-11</p>		

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F 309	<p>Continued From page 17</p> <p>Suppository 10 mg, if no results in 12 hours, Step 3: Fleets enema, and if no results, Step 4: 1,000 cc soap suds enema to be administered two times, and if no results, then the physician would be contacted for further directions.</p> <p>Interviews conducted with Certified Nurse Aides #1 and #2 on January 27, 2011, at 2:55 p.m., and 3:30 p.m., revealed the CNAs were required to document the residents' bowel movements on the BITL. The CNAs stated if the resident did not have a bowel movement in six shifts, the information was reported to the charge nurse, and the resident's name was placed on the bowel list. CNAs #1 and #2 stated resident #7's name had been placed on the bowel list. A review of the bowel list confirmed that resident #7 was listed on the bowel list on January 8, 10, 11, and 12, 2011.</p> <p>An interview conducted with LPN #4 on January 27, 2011, at 5:50 p.m., revealed the LPN was aware resident #7 had not had a bowel movement for several days, but believed the resident's family was taking resident #7 to the bathroom. The LPN stated on January 12, 2011, the resident's physician was called after no bowel movement had been documented for 18 shifts. LPN #4 stated resident #7 refused to allow the enema to be administered and Lactulose was administered. The LPN also stated he/she did not assess resident #7's bowel sounds or check the resident for a fecal impaction. LPN #4 stated a staff member spoke to resident #7's family the following day (January 13) and the family denied taking the resident to the bathroom.</p> <p>An interview conducted with the DON on January 27, 2011, at 5:00 p.m., revealed the CNAs were</p>	F 309			

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F 309	Continued From page 18 responsible for documenting the resident's bowel movements on the BITL and to report to the charge nurse if the resident had not had a bowel movement for six shifts. The DON stated the nurse was responsible to review the physician's orders for routine/as-needed laxatives and call the physician if indicated to obtain medications for the resident. The DON also stated if a resident had not had a bowel movement in six shifts, the nurse was responsible to assess the resident for abdominal distention and bowel sounds, and to document the assessment in the nurse's notes.	F 309			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide appropriate treatment and services to restore as much normal bladder function as possible for three of twenty-four sampled residents (residents #4, #7, and #15). Residents #4 and #15 were readmitted to the facility with an indwelling Foley catheter. There was no evidence the facility had determined the medical reason or considered bladder retraining for these residents.	F 315	F 315 It is and was on the day of the survey the policy and practice of MN&RF to assure that residents with an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that		

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F 315	<p>Continued From page 19</p> <p>Resident #7 was admitted to the facility with a Foley catheter in place; however, there was no evidence of a medical reason for the Foley catheter.</p> <p>The findings include:</p> <p>1. Resident #4 was readmitted to the facility on January 22, 2011, after a hospital stay with medical diagnoses which included Acute Bronchitis, Pneumonia/COPD, HTN, Arthritis Dysphagia, GERD, Generalized Anxiety, and Depression.</p> <p>An observation conducted on January 25, 2011, at 9:30 a.m. and 11:55 a.m., and on January 26, 2011, at 9:15 a.m., revealed resident #4 had an indwelling Foley catheter.</p> <p>A review of resident #4's Resident Assessment Protocol Summary dated July 15, 2010, revealed the resident was assessed as frequently incontinent of bladder and on a scheduled toileting program.</p> <p>A review of a Bladder Assessment Form updated January 18, 2011, revealed resident #4 returned from a hospital stay on January 18, 2011, with a Foley catheter (F/C) in place and was assessed to need the F/C for "exact measurement of urine output at hospital." However, there was no evidence the facility had determined a medical reason to continue the use of the Foley catheter. In addition, there was no evidence the facility had re-evaluated resident #4 for retraining of bladder function.</p> <p>A review of the facility's Bladder policy/procedure (no date) revealed the facility was required to</p>	F 315	<p>catheterization is necessary, and that residents incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible including medical assessment for justification for foley catheter use:</p> <p>1. Resident #4 and Resident #15 continue to require a foley catheter for exact measurement of urine output per physician order. Lasix has been increased for Resident #4 The total output for Resident #4 and Resident #15 is being recorded daily for accurate assessment of resident's fluid status by</p>		

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F 315	<p>Continued From page 20</p> <p>evaluate each resident's continence status, to determine an appropriate treatment or management program, to assist residents in regaining continence to their highest practicable level of function, to reduce the potential for urinary tract infections, and to promote the resident's independence and self-esteem. The policy/procedure further directed if a resident had an indwelling urinary catheter, an assessment was required to determine whether the resident had a medical condition to warrant the use of the indwelling catheter.</p> <p>An interview conducted on January 27, 2011, at 2:30 p.m., with RN #2 revealed resident #4 was admitted to the facility on January 22, 2011, after a hospital stay. The RN further revealed resident #4 had a Foley catheter ordered to monitor intake and output and a diagnosis of Urinary Tract Infection.</p> <p>2. Resident # 5 was admitted to the facility on July 22, 2009, with diagnoses of History of CVAs, Chronic Renal Failure, Depression, Pernicious, Anemia, Dementia, and Alzheimer's Disease.</p> <p>An observation conducted on January 27, 2011, at 10:25 a.m. and 2:00 p.m., revealed resident #15 had an indwelling Foley catheter.</p> <p>Record review of a Bladder Assessment dated January 5, 2011, revealed resident #15 was noted to have a Foley catheter upon readmission from the hospital on December 29, 2010, without a medical diagnosis for the Foley catheter. However, there was no evidence the facility had determined a medical reason to continue the use of the Foley catheter. In addition, there was no evidence the facility had re-evaluated resident</p>	F 315	<p>the nurse. Resident #15 continues to receive Lasix daily and require a foley catheter for exact measurement of output per physician's order. Resident #7 continues to require a foley catheter due to urinary retention. An attempt has been made on 1-29-11 to remove catheter but had to be reinserted related to no output. Another attempt was made on 2-11-11 with no success.</p> <p>2. The remaining residents noted to have a foley catheter have had the foley discontinued or have a supporting medical diagnosis to justify foley catheter use.</p> <p>3. The nurses were educated on 2-04-11</p>		

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F 315	<p>Continued From page 21 #15 for possible bladder retraining.</p> <p>An interview conducted with RN #2 revealed resident #15 no medical diagnosis for the Foley catheter. Interview also revealed resident #15 had been straight-cathetered in the past and a Foley catheter anchored; due to the past problems with resident #15's inability to void the Foley catheter was left in.</p> <p>3. A review of the medical record revealed resident #7 was admitted to the facility on December 23, 2010, with diagnoses to include Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, Coronary Artery Disease (CAD), Transient Left Ventricular Dysfunction, and Degenerative Arthritis.</p> <p>Resident #7 was observed on January 25, 2011, at 8:45 a.m., to be sitting up in a wheelchair with a Foley catheter drainage bag attached to the side rail. The resident was further observed on January 26, 2011, at 9:10 a.m., 10:15 a.m., and 1:30 p.m., to be lying in bed. A Foley catheter was observed to be in place with dark amber urine noted in the drainage tube.</p> <p>A review of the bladder assessment completed on January 4, 2011, revealed the contributing diagnosis for the Foley catheter use was identified as Arthritis. The assessment further noted the Foley catheter was in place after the hospital stay and was needed for the exact measurement of urinary output.</p> <p>A review of the intake/output record for resident #7 revealed the output was documented for each shift; however, there was no evidence the output had been totaled to monitor/evaluate the amount</p>	F 315	<p>regarding supporting medical diagnosis to justify foley catheter use. The nurses have also been educated to contact the MD upon admission/re-admission and after placement of a foley catheter to obtain an order to discontinue the catheter if there is no supporting diagnosis for use during the bladder assessment/chart review.</p> <p>4. The admission/re-admission QA audit has been revised to include presence of foley catheter to initiate a review of the necessity of the foley catheter use. MD will be contacted by the nurse performing the QA audit for an order to attempt removal of the foley if not medically justified.</p> <p>5. Compliance Date: 2-04-11</p>	

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F 315	Continued From page 22 of urinary output for resident #7. A review of the facility's Bladder policy/procedure (no date) revealed the facility was required to evaluate each resident's continence status, to determine an appropriate treatment or management program, to assist residents in regaining continence to their highest practicable level of function, to reduce the potential for urinary tract infections, and to promote the resident's independence and self-esteem. The policy/procedure further directed if a resident had an indwelling urinary catheter, an assessment was required to determine whether the resident had a medical condition to warrant the use of the indwelling catheter. An interview conducted with LPN #2 on January 26, 2011, at 4:15 p.m., revealed the licensed nurse was responsible to contact the attending physician when a resident was admitted to the facility with a Foley catheter in place to determine if bladder training should be attempted and discontinue the Foley catheter. LPN #2 stated the physician had not been contacted related to the continued use of the Foley catheter for resident #7. An interview was conducted with RN #2 on January 26, 2011, at 4:20 p.m. RN #2 stated he/she was responsible for completing the bladder assessments for residents upon admission to the facility and believed the nurse had talked with the physician regarding a diagnosis for continued use of the Foley catheter.	F 315	F 333 It is and was on the day of the survey the policy and practice of MN&RF to ensure that residents receive the appropriate dosage of medication. 1. The attending physician for resident #9 was notified on 1-25-11 of the medication error and a blood level specimen was obtained to determine the resident #9's digoxin level. The level was found to be subtherapeutic and the MD did not change the medication dosage or schedule. Alternating doses of digoxin for resident #9 have been separated on different medication record pages and the doses have been separated in the medication cart drawers. The doses have also been marked on the MAR and the box with corresponding colored dots to increase nurse awareness of alternating doses of the same medication. 2. The LPN has also completed a Drug Card on digoxin and has received education regarding following the rights of medication administration as it pertains to this resident and to other residents with similar dosing schedules. All residents receiving alternating doses of the		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333			

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F 333	<p>Continued From page 23 any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure that one of twenty-four sampled residents (resident #9) was free of a significant medication error: Resident #9 was administered Digoxin 0.125 milligram (mg) instead of the physician-ordered 0.0625 milligram dose.</p> <p>The findings include:</p> <p>A medication observation conducted on January 25, 2011 (Tuesday), at 8:35 a.m., with LPN #2 revealed resident #9 was administered Digoxin 0.125 mg.</p> <p>Review of resident #9's Digoxin individual medication package revealed a dose of 0.125 mg. Record review of resident #9's physician order dated December 31, 2010, revealed an order that directed staff to administer Digoxin 0.125 mg on Monday, Wednesday, and Friday and administer Digoxin 0.0625 mg on Tuesday, Thursday, Saturday, and Sunday.</p> <p>An interview conducted on January 25, 2011, at 9:20 a.m., with LPN #2 revealed the Digoxin medication package from the medication resident #9 received stated "0.125 mg." LPN #2 further revealed resident #9 should have received Digoxin 0.0625 mg this day.</p> <p>An interview conducted on January 25, 2011, at 9:30 a.m., with the facility's Consultant Pharmacist revealed the individual doses of</p>	F 333	<p>same medication have had the doses separated on the medication administration record and in the medication cart drawers. These alternating doses have also been marked with the colored dots to increase nurse/CMT awareness during medication administration.</p> <p>3. A new system has been implemented using color dots to mark the MAR and the medication box of alternating doses of medications to increase nurse/CMT awareness during medication administration. The night shift nurse will separate the refill boxes from pharmacy and apply colored dots on the boxes accordingly. Nurses receiving new orders for alternating medications from the physician, will separate medication doses and put colored dots on the corresponding MAR. The changeover nurse will apply dots to the new month's MAR to assure the system is carried over. The nurses and CMTs have been educated to implement this system with any new orders for alternating doses of the same medications.</p> <p>4. The pharmacy will provide a monthly list of residents receiving alternating doses of a medication to the DON. The</p>	

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F 333	Continued From page 24 medication are labeled with the medication contained in the package. Additional interview conducted on January 25, 2011, at 2:50 p.m., with the facility's LPN Pharmacy Consultant, revealed resident #9's Digoxin medication was reviewed to compare amount dispensed with amount administered. The Pharmacy Consultant stated Digoxin 0.125 mg was one dose short which would account for the incorrect dose resident #9 received on January 25, 2011.	F 333	MARs and medication drawers will be audited to ensure the alternating doses are marked correctly with corresponding colored dots to increase nurse/CMT awareness and to prevent medication administration errors. 5. Compliance Date: 2-04-11	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure menus were prepared in advance to meet the nutritional needs for four of twenty-four sampled residents. During the tray line/preparation observation conducted on January 25, 2011, at 5:00 p.m., the menu consisted of pancakes, sausage, yogurt parfait, and beverage. Residents #21, #22, #23, and #24 had a physician's order for a therapeutic diet; however, a review of the menu spreadsheet revealed these diets had not been planned to ensure the dietary requirements were met for these residents. The findings include:	F 363	F 363 It is and was on the day of the survey the policy and practice of MN&RF to ensure that menus meet the nutritional needs of the residents. 1. Residents #21, #22, #23, and #24 are receiving diets that are planned and available to assure the residents' nutritional needs are met. 2. All resident diets were reviewed to assure that each resident in the facility is receiving a diet that is available at the facility and also meets their nutritional requirements. Each resident is receiving the appropriate therapeutic available diet. All MN&RF residents' charts were reviewed for	

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F 363	<p>Continued From page 25</p> <p>1. A review of the medical record revealed a physician's order was obtained on September 14, 2010, for a Mechanical Soft 1500-Calorie, Low Cholesterol Diet for resident #21. However, a review of the Diet Spreadsheet for the Fall/Winter Menus revealed there was no evidence a 1500-Calorie, Low Cholesterol Diet had been planned. Observation of the evening meal tray service on January 25, 2011, at 5:00 p.m., revealed the dietary cook served one pancake, a sausage patty, and a parfait to resident #21.</p> <p>2. A review of the tray card for resident #22 revealed the resident was to receive a Cardiac Diet; however, the Diet Spreadsheet did not include a meal plan for a Cardiac Diet. The Dietary Cook was observed to serve the resident a cubed beef patty, mashed potatoes, and steamed broccoli during the evening meal on January 25, 2011, at 5:00 p.m.</p> <p>3. Resident #23 had a physician's order dated October 22, 2010, to receive a 2-gram (gm) Sodium diet. However, the Diet Spreadsheet did not include a meal plan specific to a 2-gm Sodium diet. The resident received two pancakes, sausage, and yogurt parfait during the evening meal on January 25, 2011, at 5:00 p.m.</p> <p>4. Resident #24 had a physician's order dated January 21, 2011, to receive a 2000-Calorie, Cardiac diet. However, the Diet Spreadsheet did not include a meal plan for the 2000-Calorie, Cardiac diet. The resident was served two pancakes, one sausage patty, and a yogurt parfait for the evening meal on January 25, 2011, at 5:00 p.m.</p> <p>A review of the Diet Spreadsheet for the</p>	F 363	<p>correct physician's diet order. The order was compared to the diet order on file in the kitchen and to the spreadsheet. All residents are receiving the appropriate/therapeutic diet available served at the facility.</p> <p>3. All resident diets on the physician orders are printed monthly by pharmacy and compared to the diets listed on the tray card by the dietary manager. New admission/re-admission orders are reviewed for available diets offered at the facility. Nurses will obtain MD diet orders matching diets offered at the facility prior to submitting a diet order status to the dietary department. The dietary manager reviews orders before they are entered in the tray card system. Dietary staff and nursing staff have been educated regarding available diets and the protocol for obtaining clarified diet orders. Diets are posted at the nurses station. Dietary staff was also educated regarding consistent spread sheet</p>		

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F 363	<p>Continued From page 26</p> <p>Fall/Winter Menus identified specific food items and portions for the following diets: Regular, No Added Salt (NAS), Mechanical Soft, Pureed, 1800-Calorie, Finger Foods, Potassium Restricted, Small Portions, Reduced Concentrated Sweets, and Low Protein.</p> <p>An interview conducted with the Dietary Cook (DC) on January 25, 2011, at 5:45 p.m., revealed the DC had estimated the food selections for the above diet orders from the planned menus on the Diet Spreadsheet.</p> <p>An interview conducted with the Dietary Manager (DM) on January 25, 2011, at 6:30 p.m., revealed the DM was responsible to inform the Registered Dietitian (RD) verbally or thru a communication sheet when a new diet order was prescribed by the physician. The DM stated he/she had provided a list of all current diet orders to the RD when the Fall/Winter Menus were planned.</p> <p>An interview conducted with the RD on January 26, 2011, at 2:10 p.m., revealed the RD had developed the Diet Spreadsheets when the Fall/Winter Menus were planned. The RD stated he/she did not review all the residents' diets prior to preparing the menus/spreadsheets. The RD stated a 1500-Calorie diet should only receive one to two breads, a 2-gm Sodium was not the same as a NAS diet, and the Cardiac diet should include turkey sausage instead of regular sausage.</p> <p>A review of the facility's policy/procedure regarding Tray Accuracy Protocol (no date) revealed the tray cards were generated for each meal and utilized by the dietary staff to ensure the proper diet was served. The policy also directed</p>	F 363	<p>implementation. Nursing staff was inserviced on 2-04-11. Dietary staff was inserviced on 2-04-11. (Attachment)</p> <p>4. The dietary manager will audit monthly the physician orders printed monthly by pharmacy with the tray cards to determine accuracy. Likewise, as a checks and balance system, the registered dietitian is required to review the resident's orders upon admission/readmission to assure diet order compliance with available diets at the facility.</p> <p>5. Compliance Date: 2-04-11</p>		

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F 363	Continued From page 27	F 363			
F 364 SS=D	<p>that tray audits were to be conducted monthly to compare the residents' current physician orders to the tray cards to ensure tray accuracy. In addition, the policy stated the consulting dietitian was responsible to review the physicians' diet orders to ensure tray accuracy.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide foods that were palatable and at the proper temperature during the evening meal on January 25, 2011.</p> <p>The findings include:</p> <p>Observation of the evening meal service on January 25, 2011, at 5:00 p.m., revealed the Dietary Cook (DC) placed food items from the steam table onto plates that were removed from the plate warmer. However, during the preparation of the Restorative Dining Room trays and the Southeast Hall tray carts, the DC was observed to place foods onto plates removed from the counter. Further observations during the evening meal on January 25, 2011, revealed a food cart was delivered to the Southeast Hall at 5:55 p.m. The last tray was removed from the cart at 6:15 p.m., and a test tray was removed from the food cart at that time in order to check</p>	F 364	<p>F 364</p> <p>It is and was on the day of the survey the policy and practice of MN&RF to provide food that is palatable, attractive and at the proper temperature.</p> <ol style="list-style-type: none"> 1. Southeast residents receive meals served in their rooms at appropriate temperatures. The delivery carts were divided to assure the trays are delivered timely by the SRNAs and less waiting by residents for delivery of the 2nd group of meal trays. Resident #21's breakfast meal temperature was audited for temperature compliance. Resident #21 has been re-interviewed and voices no concerns r/t food temperatures at this time. Resident hall trays were divided for efficient delivery on Monday, February 14, 2011 on the unit where resident #21 receives breakfast. 2. Meal service delivery for residents receiving meals in 		

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F 364	<p>Continued From page 28</p> <p>the food temperatures, and to conduct a palatability test of the food. The food temperatures revealed the pancakes were 110 degrees Fahrenheit, sausage patty was 100 degrees Fahrenheit, Yogurt parfait was 56 degrees Fahrenheit, and the milk was 42 degrees Fahrenheit. A palatability test was conducted and revealed the pancakes were cool, the sausage patty was tepid, and the parfait and milk were cool to taste.</p> <p>An interview was conducted with resident #21 at 11:55 a.m. on January 25, 2011. The resident stated food items were frequently cold, especially breakfast food items.</p> <p>A review of the temperatures from the kitchen's steam table revealed the food temperatures ranged from 171 degrees Fahrenheit to 182 degrees Fahrenheit (within normal holding temperatures) when the food was served from the kitchen.</p> <p>An interview conducted with the DM on January 25, 2011, at 6:30 p.m., revealed food temperatures were monitored during test tray audits conducted at least weekly. The DM stated residents had been complaining about cold foods at breakfast and the facility had been working on reorganizing the tray service by dividing the hallways. The DM stated the plate warmer would not hold all the plates utilized during the meal service. The DM stated the facility had not identified any concerns of cold food during the evening meals.</p> <p>A review of the facility's policy/procedure related to Point of Service Food Temperatures (no date) revealed the foods should be delivered to</p>	F 364	<p>room on all halls has been audited after separating carts for quicker delivery and the temperatures at the point of service are in compliance. These meal service delivery audits have been performed for breakfast, lunch and dinner. Nursing staff was educated on 2-07-11 regarding timely delivery of trays to ensure appropriate temperature of foods delivered. The plate warmer spring was replaced to allow for all plates to be heated for meal service for all residents.</p> <ol style="list-style-type: none"> Trays were divided into smaller carts to allow for "batch" delivery from the kitchen and less time waiting to be distributed by staff. This practice now occurs on Southeast for supper delivery and occurs for breakfast on the unit where Resident #21 resides. Cold items such as parfaits are batched by small portions from the cooler. Meal service audit QA includes temperature audit of foods at the point of delivery and the time of service. The audit also reviews time management 	

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

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY 40965	
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F 364	Continued From page 29	F 364	concerns/challenges of tray delivery to resident rooms. QA is conducted randomly for all meals on all shifts each month.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure proper storage and labeling of food items as evidenced by multiple food items stored in the dry food storage area that exceeded the recommended use by dates. The findings include: Observations conducted during the initial tour of the kitchen on January 24, 2011, at 6:50 a.m., revealed the following items were stored and available for use in the dry food storage with labels/dates which exceeded the recommended use by dates: --One opened bottle of Extra Virgin Olive Oil, labeled best used by November 22, 2009. --One opened bottle of Lemon Extract, dated	F 371	5. Compliance Date: 2-14-11 F 371 It is and was on the day of the survey the policy and practice of MN&RF to ensure proper storage and labeling of food items. 1. The dry storage room foods are current and not out of date. All items were checked for the correct expiration dates. 2. Elimination of non-resident food items stored in the dry storage area will eliminate the potential for out of date items. 3. Weekly stock rotation will be completed when	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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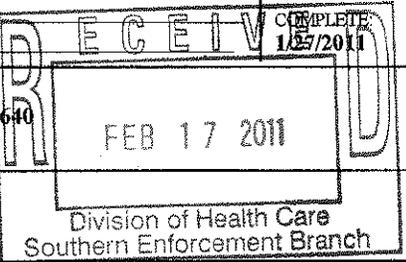
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F 371	<p>Continued From page 30 October 11, 2007. --One opened bottle of Almond Extract, dated February 13, 2009. --Two cans of Easy Cheese/Pasteurized Cheese Snack, expiration date of November 2, 2010 stamped on the cans. --One opened container of Caramel Syrup, labeled "use by" May 17, 2010. --Two opened bottles of Red Wine Vinegar; one dated "best by" February 8, 2010 and one dated "best by" December 11, 2007. --One unopened bottle of Caesar Salad Dressing, "best by" date was November 13, 2009. --Two unopened bottles of Red Wine Vinegar; one dated "best by" July 17, 2010 and one dated "best by" November 10, 2010. --One opened bottle of Red Food Coloring, dated June 27, 2009. --One opened bottle of Mrs. Butterworth's Syrup, dated January 22, 2010.</p> <p>A review of the facility's policy/procedure on Food Shelf Life Recommendations (dated January 14, 1999) revealed recommended Shelf Life is defined as months Unopened (refers to total months product can be stored) and Opened (refers to the total months/days/weeks) the product can be stored after it has been opened. The policy directed the recommended shelf life (RSL) for Bottled (unopened) Salad dressings would be 10-12 months, the RSL for (opened) Olive Oil would be indicated by the expiration date marked on the bottle, the RSL for Syrups (unopened) would be 12 months, the RSL for Vinegars would be 24 months (unopened) and 12 months (opened), and the RSL for Extracts would be 24 months (unopened) and 12 months (opened).</p>	F 371	<p>weekly deliveries arrive and to eliminate the potential for out of date food items to be stored. A form will be completed when stock is delivered by the person putting up stock that rotation is complete.</p> <p>4. The Dietary Manager will complete a QA form monthly to audit dry storage area to assure that stock rotation is being done and out of date items are being discarded per facility protocol.</p> <p>5. Compliance Date: 2-04-11</p>		

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F 371	Continued From page 31 An interview conducted with the Dietary Manager (DM) on January 24, 2011, at 7:00 p.m., revealed the identified food items should have been discarded. The DM stated the dietary staff was responsible for checking expiration dates on food products weekly. The DM stated he/she was not aware these items were still available for use.	F 371			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185240	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE 1/27/2011
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 156	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible</p>		

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNEs AND NFs	PROVIDER # 185240	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/27/2011
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F 156	<p>Continued From Page 1 for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the appropriate liability and appeal notices timely when a change in payor source occurred. Resident #20 received an Advance Beneficiary Notice related to termination of Medicare services/payment; however, the notice was not provided timely.</p> <p>The findings include:</p> <p>A review of the Advance Beneficiary Notice (ABN) for resident #20 revealed the resident's Skilled Services/Medicare benefits ended on December 14, 2010. Review of the certified mail receipts revealed the notice was mailed on December 13, 2010, and received by the responsible party (R/P) on December 21, 2010.</p> <p>An interview conducted with the Bookkeeper on January 26, 2011, at 4:00 p.m., revealed the Bookkeeper was responsible for sending the required notices to the resident or R/P when a change in payor source occurred. The Bookkeeper stated a Therapy Discharge Notice is completed by the therapists when it is determined a resident no longer requires a skilled service. The Bookkeeper stated he/she would attempt to notify the R/P by phone to explain the ABN form and inform the R/P that the form would be mailed. The Bookkeeper could not find documentation in the phone log that resident #20's R/P was notified by phone. The Bookkeeper was unable to provide an explanation of the ABN not being mailed timely.</p>		
F 164	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p>		

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F 164	<p>Continued From Page 2</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the privacy of medical records was maintained during medication administration. Observation on January 25, 2011, of the Southeast hallway revealed the Medication Administration Record (MAR) for resident #13 was left open on the medication cart in the hallway, exposing the resident's medical information to the public and other residents.</p> <p>The findings include:</p> <p>Observation of the Southeast hallway of the facility on January 25, 2011, at 9:40 a.m., revealed the Certified Medication Aide (CMA) entered the room of resident #13 to administer medications to the resident. Further observation revealed the MAR on top of the medication cart in the hallway had been left open which exposed resident #13's personal, confidential information.</p> <p>An interview with the CMA responsible for administering medications on the Southeast Unit was conducted on January 25, 2011, at 9:50 a.m. The CMA revealed he/she was aware the MAR had been left open on the cart. The CMA further revealed he/she was required to protect the residents' medical information and should have covered the MAR when he/she had entered the resident's room.</p> <p>A review of the facility's policy titled Confidentiality of Resident Information dated April 2003 revealed it is the policy of the facility to maintain the confidentiality of the resident's personal and clinical records. The policy further revealed all hard copy printed information must be positioned in such a manner that it cannot be viewed or read by the public or unauthorized staff.</p>		

Licensed Staff meeting

Agenda

2/4/2011

I. Overall Survey Results

II. Bruising- 483.13 F226

The facility must develop and operationalize policies and procedures to identify and report abuse. The facility must identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.

A. Methods of Identification

1. Visual Assessment during skin assessments
2. Visual Assessment during walking rounds
3. SRNA reports
4. Bath team reports
5. Return Home visit/ ER trip skin assessment
6. Therapy reports
7. Has the bruise been previously reported?
 - a) How do you know?

B. Action Following Identification

1. Incident report- bruise investigation
2. Charting/ documentation- Flip chart
3. RP/MD Notification
4. Investigation to identify and remove causative factors
5. Examples of documentation
6. Use of Acute Care Log
 - a) Tracking, quick reference

III. Quality of Care- 483.25 F309

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 any instance in which there has been a lack of improvement or decline- determine if it was available or unavoidable.

This Requires: 1.) Accurate assessment

- 2.) Care plan implemented
- 3.) Evaluation of the results of the interventions and revising the interventions as necessary.

* Review if the interventions were continually and aggressively implemented and updated by facility staff.

A. Bowel tracking/ Bowel log

1. SRNA's reporting any resident with no BM in 6 shifts
2. Nurse role- initiating administration of PRN medication and evaluating effectiveness; reviewing routine medications and contacting MD for routine stool softness or laxatives as needed; Evaluating contributing factors i.e. poor fluid intake, poor food intake, decreased mobility, history of laxative use at home, etc.
3. Importance of all SRNA's, bath team and therapy reporting BM's for accurate tracking
4. Asking nurse when receiving report from hospital of last BM and asking family members when residents return from home visits if any BM while OOF
5. Review medications on admission for PRN orders for constipation and request order from MD if more present, suppositories, etc.
6. Completion of 12, 24 and 36 hour follow up by nurse on the bowel log and new intervention if no results

B. Negative Outcomes from Constipation

- Decreased fluid intake- Dehydration
- Decreased food intake- Weight Loss
- Increased nausea/ vomiting- Dehydration
- Decreased mobility- Multiple complications
- Increased pain and discomfort
- If intervention is delayed- fecal impaction- Sentinel event- Meaning it should never happen- Actual harm citation with severe penalties.

IV. Hydration Protocol

A. Intake and Output

- Importance of accurate documentation per shift
- Totaled each night by 11-7 shift

- 7-3 nurse responsibility to contact MD and document
- Make sure request for IV fluids is documented

B. Hydration Assessment

- Each nurse is responsible for performing a bedside clinical assessment regarding resident's hydration status and document finding in the nurse's notes- i.e. status of mucous membranes, alertness, any increase in confusion, skin turgor, appearance/ small/ concentration of urine.
- Document nursing interventions to increase fluid intake- i.e. popsicles, ice chips, decaffeinated sodas, request to MD for IV fluids, etc.
- If a resident has an IV- fluid must be totaled per shift and documented on IV flow sheet.
- If resident has a catheter- Intake vs. Output must be totaled and assessed regarding hydration status.

C. Medical Justification for Catheter Use:

1. Stage III/IV pressure ulcer to sacrum
2. Urinary retention with 3 documented failed attempts for removal
3. Intractable pain
4. Need for exact measurement of output- this only works short term and you must be totaling and assessing output as a nurse measure- not just on the ADL record.
5. If none of the above are present on admission- Contact MD for an order to discontinue catheter.

Nurse Education
(Attached to meeting agenda)
Date: 2/04/11

Topics:

A) MD Notification of Significant Change in Resident Condition

MD must be notified and notification documented regarding significant changes in resident condition. These include but are not limited to:

- 1) Fall
- 2) Bruise
- 3) Fever
- 4) S/SX of infection
- 5) Critical lab values
- 6) Weight loss/ Weight gain (significant)
- 7) New onset of pain
- 8) Injury
- 9) Decline in cognitive status
- 10) Decline in functional status
- 11) Refusal of critical medications
- 12) New onset of behavioral symptoms
- 13) Development of pressure ulcer
- 14) S/SX dehydration
- 15) Absence of bowel movements
- 16) Seizure activity
- 17) Vomiting/ Diarrhea
- 18) No urine output

B) BM Protocol

When a resident has not had a bowel movement in six shifts, the resident is added to the bowel log with intervention and follow-up documented. If after three days, there is no BM the nurse is required to assess the resident including resident bowel sounds and the presence or absence of abdominal distention. This assessment is documented in the nurse's notes. Any resident not having a bowel movement in three (3) days will be added to the acute care log.

SRNA Agenda
2/7/2011

I. Meal Service

- a. Delivering of Trays
 - 1. Temperature of food delivered
 - 2. Accuracy of diet order vs. available diets
 - 3. Substitute available

II. Bruising/ Ecchymosis

- a. Reporting any bruising/ ecchymosis noted to nurse immediately
- b. Reporting any bruising/ ecchymosis noted on CNA worksheet-
forward to DON and Administrator

III. Reporting of Bowel Movements

- a. Policy Review- reporting any resident not having a BM in 6 shifts to
nurse.
 - 1. Revision of bowel and bladder tracking form to ensure
accuracy when counting shifts without BM
 - 2. Reporting via CNA worksheet

IV. Hydration

- a. Accuracy of PO fluid intake
- b. Importance of encouraging fluids
Ice chips, jello, popsicles, etc.
- c. Not leaving blanks in ADL records- unable to total
- d. Reporting via CNA worksheet

HIPPA COMPLIANCE EDUCATION

February 4, 2011

- 1) Demonstration of MAR/TAR
- 2) Report-Communication of Information during report.
- 3) Conversation at Nurse's Station
 - a. Family Member
 - b. Co-Worker
 - c. Physician's Office
- 4) Management of Reports
 - a. Faxes
 - b. Results
 - c. Clipboards

Weight Gain Protocol

- Weights will be reviewed weekly for any significant weight gains (5 % in 30 days, decrease 7.5 % in 90 days, 10 % in 180 days)
- MD will be contacted with significant weight gains that are above ideal body weight.
- Nutritional Assessment Review will be completed for significant weight gains above ideal body weight monthly.
- Interventions/ diet changes will be individualized depending on resident and MD goals regarding weight and resident preferences regarding diet.
- The resident's care plan will be updated with resident's preferences and interventions regarding weight gain.

Nutritional Assessment/ Review

Resident Name: _____

Room: _____

Date: _____ Current Weight: _____ Ideal Body Weight: _____ Weight Gain: _____ Last Dietician Review: _____ Edema Present: YES NO If yes, location: _____ Diuretic Therapy: _____	Diet: _____ Average PO Intake: _____ Weight Gain Decreases Mobility: YES NO If yes, explain: _____ C/P Updated: _____ MD Notified/ Date: _____
Comments: _____ _____ _____	
Person Completing Form: _____	

Date: _____ Current Weight: _____ Ideal Body Weight: _____ Weight Gain: _____ Last Dietician Review: _____ Edema Present: YES NO If yes, location: _____ Diuretic Therapy: _____ MD Notified/ Date: _____	Diet: _____ Average PO Intake: _____ Weight Gain Decreases Mobility: YES NO If yes, explain: _____ C/P Updated: _____ MD Notified/ Date: _____
Comments: _____ _____ _____	
Person Completing Form: _____	

Quality Assurance Monitoring
For Significant Change in Status

Resident: _____

Date: _____

Decline Noted

Cognitive Status _____

Mood Pattern _____

Behavioral Symptoms _____

ADL Status _____

Incontinence (Bladder) _____

Incontinence (Bowel) _____

Unplanned Wt Loss (30 days & 180 days) _____

Unplanned Wt Gain (30 days & 180 days) _____

Stage II Pressure ulcer development _____

(Site) _____

Restraint Use _____

Overall Deterioration _____

(Specify) _____

Other _____

(Specify) _____

Improvement Noted

Decision Making _____

ADL Status _____

Behavioral Symptoms _____

Mood Pattern _____

Continence _____

Overall Improvement _____

(Specify) _____

Proceed with Significant Change Assessment? _____ Yes _____ No

Rationale: _____

MD Notified (Date) _____

RP Notified (Date) _____

Nurse Signature: _____

Date: _____

MDS Coordinator Signature: _____

Date: _____

MANAGEMENT REPORT

Staff: _____

Date: _____

Charge Nurse: _____

MANAGEMENT

Staffing Problems

-Breaks/Lunches:

-Absences:

NUTRITION/HYDRATION

Meal service

Nutrition concerns

-Snack Pass
-Hydration

Hydration protocol

IV Flow sheets

Bath schedule

Oral care

- Concerns:
-Checked:

Therapy

Concerns:

Splint management

-Refusals:

Supplies needed

CLINICAL/ACUTE

Lab Values

Fall Risk Activity

-Fall Alarms:
-Hipsters:
-Toileting Schedule:
-Climbing Out Of Bed:

Falls

Safety

-Elopement:
-Near Med Errors:
-Almost/Accident Events:
-Security

Pain Management

-Documentation

-Concerns

Residents to ER

-List Photographs Taken

MD's Not Returning Calls

PAIN MANAGEMENT

-PRN Admin- Effective/Ineffective

-New Onset, MD/RP Notified, Added to
Acute Care Log

ACUTE CARE LOG

-Added:

-Documented Nurses Notes:

-Interventions Documented:

-MD Notifications:

*BM Protocol Doc. Nurses Notes

-Interventions Documented:

11-7 Glucometer checks/Refrig. Temps

SOCIAL

Visitors

FAMILY

Concerns:
Compliments:

Activity Participation

Residents Who Need Activity:

SKIN MANAGEMENT

-In House Development:

-Skin Tears:

New Admissions

Readmissions

Behavior Management

EDUCATION

SRNA In-Service

Pre-shift Exercises

Outside Service Concerns

-Pharmacy:

-Lab:

-Hospital:

DECLINE IN CONDITION SIGNIFICANT CHANGE

NEW BRUISING:

Residents with Symptoms of Infection

-RP Notified:

-MD Notified:

Residents with S/SX "Flu" (Cough,
Fever, and Vomiting/Diarrhea, Extreme
Fatigue, Aching, Dizziness)

72 HOUR - ACUTE EPISODE/EVENT DOCUMENTATION

Date	Time	Resident Name	Acute Episode (Highlight When Resolved or Admitted Hospital)	Charting Initiated	MD Notified	MD Respond ed	MD Orders	Family Notified	LABS Collected	Lab Report Re'd	Change/ New Nsg. Interven	Incident Report Initiated	Admit. to Hosp	Init
				Y N									Y N	
				Y N									Y N	
				Y N									Y N	
				Y N									Y N	
				Y N									Y N	
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				Y N									Y N	

Examples of Acute Episodes

- *Antibiotic Use
- *Bedrest
- *BM Protocol
Med Administered
Monitor for results
- *Bruise
- *Critical Labs
PT/INR
Peak/Trough ABT

- *Critical Labs (Cont)
Incr. BUN/Creatinine
Drug Levels
Abnormal UA/C&S
Electrolyte Levels
- *DVT
- *Fall
New Interven.
- *Fever
- *New Admission

- *Fluctuation of Blood Sugars
- *Hydration Follow-up
- *Increase in pain
- *IV
- *Medication Administration
Refusal Significant Med
Withheld Non-significant Med

- *New FX – Hip Precautions
Wt. Bearing Restrictions
- *New G-tube/NG Tube
- *New Occurrence Abnormal
Ecchymosis
- *New Onset Confusion
- *New Onset of Edema

- *New Onset of HTN/
Hypotension
- *New Onset of Violent
Behavior
- *Post ER Visit
- *Pressure Ulcers
- *Readmission

- *S/Sx Infection
UTI – (possible
Wound Infx
URI/Pneumonia
G-tube Infx
- *Seizure
- *Skin Tear
- *Vomiting/Diarrhea
- *Zero Output via F/C

***Pain Management**

- New onset of acute pain
- New Fracture
- Pain r/t UTI
- New Condition
- Worsening of chronic pain
- Surgical Procedure
- Fall/Trauma

Weekly Nurse's Notes

Name: _____

Room#: _____

Mental Status: _____

Lungs: _____ Clear _____ Rales _____ Rhonchi _____ Other _____
 _____ SOB w/ exertion _____ SOB w/ sitting at rest _____ SOB w/ lying flat

Heart Rate: _____ Regular _____ Irregular

Abdomen: _____ Soft _____ Distended

Bowel Sounds: _____ Present _____ Absent

Edema: _____ Location: _____

Current Weight: _____ Date Obtained: _____ Usual Wt. _____

Recent changes in weight: yes/no :if yes, describe: _____

Hydration:

Is resident on I&O _____ Yes / No

Fluids recommended per day: _____

Average Fluid intake per day: _____

Special Conditions: _____

Pain:

New onset of pain? _____ Yes / No

Breakthrough pain? _____ Yes / No

Is pain management effective? _____ Yes / No

If ineffective, change initiated? _____ Yes / No

List non-medication interventions, if applicable?

Any abnormalities noted – please document interventions

Skin Assessment: _____

Bruising /Ecchymosis noted: YES NO

If yes, complete the following:

Location: _____

Investigation Initiated: _____

Added to acute care log: _____

Nurses Signature: _____

Date: _____

BRUISE INVESTIGATION

-3-

Describe Injury (size, color, pain, edema, etc)

Immediate Action Take: (check all that apply):		
<input type="checkbox"/> Physical Assessment complete	<input type="checkbox"/> Reviewed/updated care plan	<input type="checkbox"/> First Aid
<input type="checkbox"/> Medical Treatment per physician ord.		<input type="checkbox"/> 24 hour report
<input type="checkbox"/> Neuro checks		
Resident Condition Before: (check all that apply):		
<input type="checkbox"/> Alert	<input type="checkbox"/> Anxious	<input type="checkbox"/> Moves with assistance
<input type="checkbox"/> Oriented	<input type="checkbox"/> Agitated	<input type="checkbox"/> Total Reliance on staff
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Combative	<input type="checkbox"/> Gait problems
<input type="checkbox"/> Lethargic	<input type="checkbox"/> Not Known	<input type="checkbox"/> W/C self propels
<input type="checkbox"/> Calm	<input type="checkbox"/> Moves independently	<input type="checkbox"/> W/C Staff Assist
Resident Condition After: (check all that apply):		
<input type="checkbox"/> Alert	<input type="checkbox"/> Anxious	<input type="checkbox"/> Moves with assistance
<input type="checkbox"/> Oriented	<input type="checkbox"/> Agitated	<input type="checkbox"/> Total Reliance on staff
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Combative	<input type="checkbox"/> Gait problems
<input type="checkbox"/> Lethargic	<input type="checkbox"/> Not Known	<input type="checkbox"/> W/C self propels
<input type="checkbox"/> Calm	<input type="checkbox"/> Moves independently	<input type="checkbox"/> W/C Staff Assist

Risk Factors for Bruising: <ul style="list-style-type: none"> <input type="checkbox"/> Recent IVs or labs drawn <input type="checkbox"/> Fragile Skin <input type="checkbox"/> Recent hospital/ER visit <input type="checkbox"/> Recent Fall <input type="checkbox"/> Dx of Thrombocytopenia <input type="checkbox"/> Dx of Anemia <input type="checkbox"/> Assisted transfer <input type="checkbox"/> Side rail use <input type="checkbox"/> Mobile in wheelchair <input type="checkbox"/> Combative /Resistive to care 	Medications increasing risks for bruising: <ul style="list-style-type: none"> <input type="checkbox"/> Coumadin <input type="checkbox"/> Heparin <input type="checkbox"/> Lovenox, Fragmin <input type="checkbox"/> Plavix <input type="checkbox"/> Aspirin, Aggrenox <input type="checkbox"/> Pradaxa (risk of bleeding) <input type="checkbox"/> NSAIDS (Ibuprofen, Celebrex, Aleve, Indocin, Motrin) <input type="checkbox"/> Herbal Supplements (Vit. E, Fish oil, garlic, etc) <input type="checkbox"/> Cortisone medications (prednisone) <input type="checkbox"/> Valproic Acid
---	---

Interventions/Action: <ul style="list-style-type: none"> <input type="checkbox"/> Pad wheelchair <input type="checkbox"/> Pad side rail <input type="checkbox"/> Observe/evaluate transfers <input type="checkbox"/> Skin sleeves (arm or leg) <input type="checkbox"/> Pharmacist referral <input type="checkbox"/> Resident education <input type="checkbox"/> Staff education <input type="checkbox"/> Padded footrest 	Causative Factor: <ul style="list-style-type: none"> <input type="checkbox"/> IV access/injection <input type="checkbox"/> Labwork <input type="checkbox"/> Contact with hard surface <input type="checkbox"/> Transfer related <input type="checkbox"/> Assistive Device (w/c, gait belt, etc.) <input type="checkbox"/> Resident self-directing care <input type="checkbox"/> Resident action <input type="checkbox"/> Return from home visit <input type="checkbox"/> _____ <input type="checkbox"/> _____
--	--

Summary/Evaluation: _____

Bath Team Schedule

Date: _____

Shower

Whirlpools

7:00	_____	_____
7:30	_____	_____
8:00	_____	_____
8:30	_____	_____
9:00	_____	_____
9:30	_____	_____
10:00	_____	_____
10:30	_____	_____
11:00	_____	_____
11:30	_____	_____
12:15	_____	_____
12:30	_____	_____
1:00	_____	_____
1:30	_____	_____
2:00	_____	_____
2:30	_____	_____
3:00	_____	_____
3:30	_____	_____
4:00	_____	_____

1. Unfinished Baths

Nurse Signature / Unit

2. Problems / BM's

3. Refusals

4. Skin Observations (Fresh Bruising, Red areas, pressure ulcers, tears, etc.)

Nurse Signature / Unit

5. Documentation Complete:

Signature: _____

I certify that the above were completed and proper sanitation procedures followed:

Admission/Re-admission Initial Audit

Resident Name: _____

Admission Date: _____

Time Patient Arrived: _____

Time Admitting Information Arrived on Unit: _____

Admitting Nurse: _____

- MAR reviewed to assure orders have been transcribed _____
- Pharmacy notified of medications needed _____ Time _____
- TAR – Orders transcribed to TAR correctly _____
- TAR – Supplies on hand for treatment orders _____
 - If not, person notified _____ Time _____
- Diet orders verified for availability _____
- Diet order stat sent to kitchen _____
- Lab orders verified _____
- ADL sheet initiated _____
- Code Status verified _____
- Toileting Schedule _____
- Turning Program _____
- Foley Catheter YES NO
- Bladder Training YES NO
- Bowel Medications Ordered YES NO

Initials _____

Initials _____

--	--

Signature

Signature

QUALITY INDICATOR: Catheter Use Review

THRESHOLD: 100%

Directions: Review at least 5% of residents/medical records.

Consider you latest facility QI Report / 802 & 672 Roster for sample selection

Y = yes

N = no

N/A = Not applicable

Criteria/Questions	Resident							
	1	2	3	4	5	6	7	8
1. Contributing Factor(s): Urinary retention								
Skin Conditions								
Imminent Death								
2. Care plan includes catheter care								
3. There is evidence that this plan of care changed if the need for catheter use changed.								
4. Outcome of catheter use: Underlying problems corrected and catheter removed.								
Catheter in place without complications.								
Catheter in place with complications (e.g. infection)								
5. Evidence of valid justification of catheter use								
6. Foley catheter removed when clinically indicated.								

Note: Questions 1 & 4 are not calculated into formula/threshold

Signature of Assessor: _____

Date: _____

Focus on Quality: Continuous Quality Improvement

Quality Indicator: Significant Weight Gain

Threshold:

Frequency:

Instructions: Pick 6 new residents with significant weight gain in the past month. Review medical record for MD/RP notification and care planning. Mark X – yes, O – no, or NA in columns as indicated.

	1	2	3	4	5	6
1.) Was MD notified of significant weight gain?						
2.) Was RP notified of significant weight gain?						
3.) Was careplan updated as indicated						
4.) Dietitian referral noted?						

Explain any areas of noncompliance noted: _____

IHN Suite
Master File - Problem Complex

Page: 1
 Date: 1/27/11
 Time: 12:12

97 - Middlesboro Nursing & Rehab

PROBLEM NUMBER: 5155
 PROBLEM DESCRIPTION: NUTRITION ALTERED R/T SIGNIFICANT WEIGHT GAIN

Related To	Goal	Approach	Discipline
	5350 WILL MAINTAIN ADEQUATE NUTRITIONAL STATUS AS EVIDENCED BY WEIGHT REMAINING STABLE	5153 SIG: IO MONITOR MEAL CONSUMPTION & COMPLIANCE WITH DIET	LN / NA / DT
	5155 WEIGHT INCREASE WILL NOT NEGATIVELY EFFECT RESIDENTS QUALITY OF LIFE	7205 SIG: IO MONITOR INTAKE & RECORD	NA
		WEIGH PER SCHEDULE AND RECORD	NA
		5159 SIG: D ENCOURAGE DAILY EXERCISE AND ACTIVITY TO INCLUDE: (SPECIFY) _____ _____ _____	LN / NA / SS / ACT
		NOTIFY MD OF SIGNIFICANT WEIGHT GAIN	LN
		NOTIFY RP OF SIGNIFICANT WEIGHT GAIN	
		DISCUSS PRESCRIBED DIET	DT
		INSTRUCT FAMILY & VISITORS IN DIETARY RESTRICTIONS	LN / DT

Bowel Log

Resident Name	Step 1 Bowel Protocol	12 hour Followup	Step 2 Bowel Protocol	24 hour Followup	Step 3 Bowel Protocol	36 hour Followup	Comments
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	
	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	Init _____ Date _____ Time _____ Med _____	Time _____ Results _____ Init _____	

Encourage Fluids and observe for results of Bowel Protocol Steps. Stop Protocol once adequate Bowel Elimination occurs.
 Communicate to next shift each time, if no results after 36-48 hours call MD.

Medication Reconciliation

Resident Name: _____

Date of Admission: _____

Physician Name: _____

On admission the nurse has reviewed admission medications with patient / family _____
 Were you taking any OTHER medications (prescription or over the counter) at home including:

- | | | | | | |
|-----------|--|----------------|--|-------------|--|
| Inhalers | Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Thinners | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sugar Pills | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Laxatives | Yes <input type="checkbox"/> No <input type="checkbox"/> | Water Pills | Yes <input type="checkbox"/> No <input type="checkbox"/> | Herbals | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Vitamins | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Pill | Yes <input type="checkbox"/> No <input type="checkbox"/> | Eye Drops | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | | Other | Yes <input type="checkbox"/> No <input type="checkbox"/> |

* If patient has answered yes to any of the above list the medications, dose, route, and frequency below:

Medication	Dose	Route	Frequency	MD Ordered	
				Yes	No

- Unable to obtain home medication history from patient.
 Family member contacted to obtain home medication history,
 Name of family member contacted: _____

Admission nurse has attempted to reconcile patient's entire medication list, and has notified MD/NP of any medications listed above. MD/Practitioner notified: _____

Influenza (Flu) Vaccine

- I give my consent to receive an annual flu immunization. Offered 10/01 – 3/31
- I have never had a serious allergic reaction to eggs or to a previous dose of influenza vaccine.
 - I have never had a history of Guillain-Barre Syndrome (GBS).
- I have already received a flu immunization this season. Date: _____
- I refuse to receive the flu vaccine.
- Not applicable at this time.

Pneumococcal Polysaccharide 23 Valent (PPV23) Vaccine

- Pneumococcal (PPV23) vaccine is recommended:
1. Every 5 years for 65 years of age and younger
 2. One time only for older than 65
- I give my consent to receive a Pneumococcal (PPV 23) immunization.
- I have already received a Pneumococcal (PPV23) immunization.
 Date of immunization: _____
- I refuse to receive the Pneumococcal (PPV23) vaccine.

I hereby give the facility permission to administer the vaccines as indicated above.
 I have been given the fact sheet on the influenza and the Pneumococcal (PPV23) vaccine that contains information regarding the benefits and risks of the vaccines.

Signature – Patient / Responsible Party: _____

Date: _____

Admission Nurse' Signature: _____

Date: _____

MD/NP has attempted to reconcile medications across the continuum.

MD/NP Signature: _____

Date: _____

COMPLIANCE ROUNDS

Focus on Quality: Continuous Quality Improvement

Date: _____ Unit: _____ Conducted by: _____

Problem to be monitored: Documentation / Follow-up on BM's

Instructions: Check all resident ADL records, treatment records, MAR's and nurses notes as indicated.

Criteria:

1. There is at least one BM recorded in the past 3 days.
2. There is a recorded impaction check and assessment of bowel sounds if there was no BM in 3 days.
3. There is recorded an oral laxative and / or enema's were given when there is no recorded BM in 3 days.
4. There is documentation of MD notification after intervention initiated and no BM noted in 3 days.

Non-compliance location: _____

Summary of Findings: _____

Corrective Action Taken: _____

*Middlesboro Nursing & Rehabilitation
Facility*

Available Diet Orders

Regular

Mechanical Soft

Pureed

No Added Salt (NAS)

1800 calorie

Finger Food

K+ Restriction

Small Portion

Reduced Concentrated Sweets (RCS)

Low Protein

- *If physician orders a diet other than listed above, please contact MD for a diet order change.*

Dietary In-Service

February 4, 2011

AGENDA

- **Spices/Extracts and All food items are to be rotated using First In First Out (FIFO) basis.**
- **Dates are to be checked and food items are to be discarded if out of date.**
- **All food trays used for storing small dry ingredients are to be checked every Tuesday with food delivery.**
- **Diet orders are to match the spreadsheet – Nurses should be notified if a diet order is written that the facility does not offer and/or diet is not on spreadsheet. Dietary Cook should notify nurse if a new admit or post hospital readmit resident comes in with a diet order that the facility does not provide. The nurse should then contact the physician to clarify the diet order. No dietary employee should “guess” or try to calculate what a resident is to receive. All dietary staff should follow spreadsheets.**
- **Temperatures are to be checked prior to tray line service and every 30 minutes during tray line process.**
- **Food is to be batched out in small portions on tray line to keep appropriate food temperatures**
- **New springs have been placed in the plate warmer to allow all plates to be stored in plate warmer.**

NAME OF PERSONNEL ATTENDING	JOB TITLE
Lynda Sturgill	Aide
Shelley Greene	Cook
Marilyn Darnwell	DA
Kanda Allen	DA
Gloria Holton	DA
Edith Parsons	DA
Cora D. Karsson	DA
Fut Lee Barnett	D.A.
Nancy Mills	COOK
Kellen Stager	DA
Judy Collett	Cook
Donna Martin	Aide
Sharon Cox	Aide
Debrae McCall	Dietary

Meal Service Audit

Tray line

Instructions: Observe all dietary staff during meal service and check that all trays are setup appropriately.

<i>QUESTION</i>	<i>YES</i>	<i>NO</i>	<i>COMMENTS</i>
Tray line began at least 10 minutes before scheduled time?			
Items needed are at hand to begin tray line?			
Tray line organized?			
Tray cards in order per table number and or room number?			
Condiments available on trays according to diet?			
Likes/Dislikes honored?			
Mechanically altered and therapeutic diets followed?			
Enough food provided to complete tray line?			
Meal service on time?			
Interruptions Minimal?			
Good Communication between dietary aide and cook during tray line?			
Dietary staff aware/properly placed new admits in location?			
Substitutes available? Same nutritional value? Provided within 15 minutes of request?			
Food temps immediately out of kitchen hot 140-145 cold 40 or below?			
Food prepared in accordance to menu?			
Recipes followed? Food looks like followed menu?			
Food placed on steam table within 30 minutes of service?			
Assistive devices provided?			
Request addressed quickly and courteously by staff?			

Comments: _____

Signature of Assessor: _____ Date: _____

Meal Service Audit

Instructions: Observe all nursing staff during meal service and trays delivered appropriately.

QUESTION	YES	NO	COMMENTS
Trays picked up no longer than 10 minutes of leaving kitchen?			
Trays passed within 15 minutes?			
Are all residents properly dressed for dining areas? Hands, face washed? Hair combed? Glasses, dentures if required?			
Employee sanitizing /washing hands after contact with residents and in between residents?			
Medication passed during meal times in dining areas?			
All residents positioned in a 90 degree angle during meal service?			
Residents sitting at assigned tables?			
Assistive devices being used?			
Televisions turned off? (except for Enrichment dining)			
No social conversations between staff?			
Trays passed according to room numbers and or table numbers?			
One table is served/eating at the same time? No resident is waiting while others are eating?			
P.O.S. Temperatures accurate? (Hot food 115-125, Cold food 40 or below?)			
Role of Courtesy Aide being followed during meal service?			
Adequate Staffing during meal service?			
Call Bell Management – Calls bells answered timely during meal service and residents needs taken care of?			
Residents toileted prior to meal service?			
Licensed staff present during meal service?			
Hydration offered and given prior to meal service?			
Feeding techniques followed – hand over hand-employee/resident positioning eye to eye contact? Communication with resident?			
Necessary behavior interventions in placed and handled appropriately?			
Handy Wipes available in dayrooms?			
Handy Wipes being used on hall trays?			

Comments: _____

Signature of Assessor: _____ Date: _____

Please Remember
to check & record
Your PPM !!

HOLDING TEMPERATURES OF FOODS
CHECK FOOD TEMPS EVERY 30 MINUTES WHILE HOLDING

Date: _____ (Wk: _____ Day _____)

Date: _____ (Wk: _____ Day _____)

PPM	List Times →	7:10 _{am}	7:40 _{am}	8:10 _{am}							
		PPM									
BREAKFAST	Meat										
	Ckd Cereal										
	Eggs										
	Puree Meats										
	Puree Ckd Cereal										
	Pureed Eggs										
	Milk										
	Coffee										
	List Times →	11:25 _{am}	11:55 _{am}	12:25 _{pm}							
LUNCH	Entrée										
	Starch										
	Vegetable										
	Puree Entrée										
	Puree Starch										
	Puree Vegetable										
	Salad										
	Dessert										
	Milk										
	Coffee										
	Alternate Entrée										
	Alternate Vegetable										
	List Times →	4:50 _{pm}	5:20 _{pm}	5:45 _{pm}							
DINNER	Entrée										
	Starch										
	Vegetable										
	Puree Entrée										
	Puree Starch										
	Puree Vegetable										
	Salad										
	Dessert										
	Milk										
	Coffee										
Alternate Entrée											

Hot Foods should not be on the steamtable > 30 minutes prior to service; temps must be taken q 30 minutes while holding. Hot foods must be held at 140 degrees or >; cold foods at 40 degrees or <.

*The 1ST time listed on B, L, & D is the beginning of the line.

Weekly Dry Storage Audit

*** Audit is to be completed every Tuesday with food delivery.**

Question	YES	NO	Comments
1. All food labeled and Dated?			
2. Stock rotated on "first in first out" (FIFO) basis?			
3. Containers with tight fitting covers used for storage of broken lots of bulk food such as rice, pasta, sugar and flour?			
4. Any Scoops stored in containers? (if so please remove)			
5. Any dented cans? (if so please remove)			
6. Dates of spices checked? Any out dated? (if so please list and remove)			
7. Dates of ALL food checked? Any out dated? (if so please list and remove)			

Comments: _____

Signature of Assessor _____ **Date:** _____

Dry Storage & Prep Area Dietary Department

Quality Indicator: Sanitation Dry Storage & Prep Area Compliance Dietary

Directions: Check all criteria listed for compliance and record findings. Take corrective actions as indicated.

Question	Yes	No	Comments
Floor free of spills/debris?			
Ceilings/Vents free from dust/debris?			
Walls free from dirt/dust etc?			
Shelves clean and in orderly fashion?			
All food items dated?			
Opened products i.e. gravy, jello, cake mixes sealed properly? (Sealed in a ziplock bag with open date)			
Any dented cans present? (if yes please remove)			
All temperatures recorded/documentated on daily temp log?			
Any scoops left in container? (if yes please remove)			
Food stored off floor, 6"?			
Food storage bins clean? (i.e. flour bins, condiments)			
Tray station clean and in orderly fashion?			
Thickened Liquid table clean?			
Dates checked? Expired items discarded?			

Signature of Assessor: _____ Date: _____

Focus on Quality Improvement

Quality Indicator: ABN Notice

Threshold: 100%

Frequency: Quarterly

Directions: The designated person will review at least 10 residents requiring Advance Beneficiary Notice for the following:

	YES	NO
Resident Name:		
1. Notice of pending discharge sent by therapy at least five days prior to discharge?		
2. Discharge notice logged on log sheet?		
3. Call made to resident's RP within 24 hrs to notify of pending change in payor source?		
4. Log sheet marked as contact made or message recorded?		
5. ABN mailed via certified mail?		
6. Return receipt requested and received?		
Comments:		

	YES	NO
Resident Name:		
1. Notice of pending discharge sent by therapy at least five days prior to discharge?		
2. Discharge notice logged on log sheet?		
3. Call made to resident's RP within 24 hrs to notify of pending change in payor source?		
4. Log sheet marked as contact made or message recorded?		
5. ABN mailed via certified mail?		
6. Return receipt requested and received?		
Comments:		

	YES	NO
Resident Name:		
1. Notice of pending discharge sent by therapy at least five days prior to discharge?		
2. Discharge notice logged on log sheet?		
3. Call made to resident's RP within 24 hrs to notify of pending change in payor source?		
4. Log sheet marked as contact made or message recorded?		
5. ABN mailed via certified mail?		
6. Return receipt requested and received?		
Comments:		

IN-SERVICE TRAINING REPORT

(COMPLETE IN - SERVICE TRAINING REPORT WITH PERSONNEL ATTENDING)

Facility: Middlesboro Noland Rehab Department: Nursing

Date: 02/04/11 Time: 1:30 pm To: 3:15 pm

Meeting area: Conference Room

Employee group (s) present: Licensed Staff RN/LPN's

Total number employees in group (s): 16

Number present: 13 Number not present: 3 - make-up scheduled

Subject (s) covered: See attached agenda for protocol for alternating doses of medications

Problems, comments, suggestions: No problems voiced

Conducted by: Jimmie Carol Proter

Title: DON

Jimmie Carol Proter Title: DON

IN-SERVICE TRAINING REPORT

(COMPLETE IN - SERVICE TRAINING REPORT WITH PERSONNEL ATTENDING)

Facility: Middleboro Nursing and Rehab Department: Nursing

Date: 02 / 04 / 11 Time: 3¹⁵ pm To: 3⁴⁵ pm

Meeting area: Conference Room

Employee group (s) present: CMT's

Total number employees in group (s): 8

Number present: 8 Number not present: 0

Subject (s) covered: See attached agenda for protocol for alternating doses of medications

Problems, comments, suggestions: None voiced

Conducted by: Jeremie Leavel (RN)

Title: DON

Jeremie Leavel (RN) Title: DON

Received Time: Feb. 28. 2011 12:50PM No. 6594

NAME OF PERSONNEL ATTENDING	JOB TITLE
2/04/11	
D. James James	CMT
Amy Desha	CMT
X. Shirley V. Short Shirley V. Short	CMT
Jan. P. Phelps	CMT
B. Simpson	CMT
Victoria Hershey	C.M.T.
Ashley Claiborne	CMT
Elizabeth Jennesson	CMT

Policy/Protocol for Alternating Dosage of Medication

- Alternating doses of medication are identified on the Medication Administration Record (MAR) by colored dots. The pink dot is used for the higher dose. The blue dot is used for the lower dose. The box of the corresponding medication dosage is marked with the correct colored dot in the medication drawer. The colored dots are available in each medication room.
- The medication boxes are separated in the drawer of the medication carts and the alternating doses are listed on separate sheets of the MAR to decrease the risk of error.
- The nurse receiving an order for alternating doses of a medication is responsible for transcribing the order to separate pages and marking the MAR with the colored dots. The nurse completing changeover at the beginning of the month will mark each new MAR for ongoing orders.
- The nurse/CMT receiving medications from pharmacy each night will mark all "refill" and "new order" boxes with the correct corresponding colored dot.
- The DON/ADON reviews new physician's orders daily for auditing compliance with any new order changes.
- Pharmacy forwards a list of alternating doses each month to the DON and compliance audits are performed monthly by clinical service staff. (See attached form.)

Focus on Quality: Continuous Quality Improvement
 Quality Indicator: Alternating Dose Compliance
 Threshold: 100%
 Frequency: Monthly

Instructions: Pick 6 residents with daily alternating doses of the same drug (Coumadin 2mg M, W, F alternate with 3mg Tue, Thur, Sat, Sun). Review MAR to ensure doses are on separate pages. Review med cart to ensure boxes are separated. Ensure colored dots on boxes correspond with colored dots on correct dosage on MAR. Place X – yes, O – no, or N/A in columns as indicated.

	1	2	3	4	5	6
1.) Are orders for alternating doses on separate pages of the MAR?						
2.) Are boxes of alternating doses of medications separated in drawer?						
3.) Are boxes and MARS labeled with corresponding colored dots? (i.e. higher dosage – neon pink, lower dosage – neon blue)						

Correct any noncompliance noted and explain below: _____

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

PRINTED: 08/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2011
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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY 40965
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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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K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on January 25, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		
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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.