

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

PRINTED: 04/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2013
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO, KY 40965		
(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
F 000	INITIAL COMMENTS A standard health survey was conducted on 03/24-27/13. 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		

RECEIVED
APR 19 2013
Health Care
Southern Enforcement Branch

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

TITLE

(X6) DATE

Rebecca A. ...

administrator

4/18/13

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	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure facility staff notified the physician of a significant change in the resident's condition that had the potential for physician intervention for one of nineteen sampled residents (Resident #19). A review of the closed medical record revealed on 02/07/13, at 12:45 PM, facility staff assessed Resident #19 and noted they were unable to gain the resident's attention without the use of "painful stimulation." Documentation in the nurse's notes on 02/07/13, at 8:00 PM, revealed facility staff had assessed Resident #19 to be lethargic, unresponsive, and "refused medication." In addition, documentation revealed on 02/08/13, at 7:00 AM, facility staff assessed Resident #19 and noted the resident was congested, and had "little response with painful stimuli." However, based on documentation, staff failed to notify Resident #19's physician of the change in the resident's condition until 02/08/13, at 9:05 AM (a timeframe of sixteen hours and twenty minutes after facility staff had initially documented a change in the resident's status on 02/07/13, at 12:45 PM). The findings include: A review of the facility's policy titled, "Changes In A Resident's Condition Or Status," dated 11/28/12, revealed it was the policy of the facility to notify the resident, his/her attending physician, and his/her representative of changes in the resident's condition and/or status. The policy also stated the facility would immediately consult the	F 157	1. When the physician was unable to be contacted, the resident was sent to Middlesboro Appalachian Regional Hospital. 2. All residents experiencing a change in condition, physical, mental, or psychosocial – along with life threatening conditions or clinical complications where an altered treatment may be needed, were reviewed for immediate physician notification. Residents experiencing any significant change in condition/needed treatment orders are listed daily on the Acute Care Log with physician notification recorded. All residents have been reviewed and appropriate MD notifications completed. 3. All Licensed Nursing staff have been educated regarding timely notification of the MD when a significant change in condition of a resident occurs. Inservice 4/18/2013. (See Attachments) Further education to the nursing staff was conducted regarding notification of the facility Medical Director when the attending physician is unreachable, no response or return call.		

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F 157	<p>Continued From page 2</p> <p>resident's physician if there was a significant change in the resident's physical, mental, or psychosocial status.</p> <p>A review of the medical record for Resident #19 revealed the facility admitted the resident on 05/05/11, with diagnoses including Organic Brain Damage, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Carotid Artery Stenosis.</p> <p>A review of an annual Minimum Data Set (MDS) assessment for Resident #19 dated 01/10/13, revealed facility staff assessed the resident to have severely impaired cognition, inattention, and disorganized thinking.</p> <p>A review of nurse's notes for Resident #19 dated 02/07/13, at 12:45 PM, revealed facility staff had implemented one to two minutes of painful stimulation in an effort to obtain the resident's attention. Also, documentation on 02/07/13, at 1:05 PM, revealed the resident had congested lung sounds. A nurse's note dated 02/07/13, at 8:00 PM, revealed the resident had refused medications, and was assessed to be lethargic and unresponsive. In addition, documentation on 02/08/13, at 7:00 AM, revealed the resident had very little response with painful stimuli, was "congested and gurgling." A nurse's note dated 02/08/13, at 9:05 AM, revealed a nurse attempted to notify the physician of Resident #19's condition, unsuccessfully. A nurse's note dated 02/08/13, at 11:04 AM, revealed the resident was sent to the hospital.</p> <p>A review of the hospital record for Resident #19 revealed the resident was admitted to the hospital</p>	F 157	<p>4. The facility utilizes an Acute Care Log to track MD notifications of any resident experiencing a change in physical, mental, psychosocial condition. A physician notification compliance audit specifically tracks compliance with timely MD notification and treatment. (See Attachment)</p> <p>5. Compliance date 4/19/2013.</p>		

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F 157	<p>Continued From page 3</p> <p>on 02/08/13 with a diagnosis of "Unresponsive" and "Possible Sepsis."</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 03/27/13, at 2:55 PM, revealed he had been responsible for administering medications to Resident #19 on 02/07/13, at 8:00 PM, and stated Resident #19 refused to take his/her 8:00 PM medications. In addition, LPN #2 stated the resident was lethargic at that time and he had notified the resident's Charge Nurse. The LPN also stated he was not responsible to notify the physician of the resident's condition, and stated it was the Charge Nurse's responsibility to notify the physician.</p> <p>An interview conducted with LPN #3 on 03/27/13, at 3:05 PM, revealed she was the Charge Nurse for Resident #19 on 02/07/13, at 8:00 PM, and was responsible for notifying the physician with any change in the resident's condition. The LPN stated on 02/07/13, at 8:00 PM, Resident #19 was lethargic, did not want to eat or drink, and refused medications. The LPN stated the resident was only responsive to painful stimuli (rubbing the fist over the sternum). The LPN stated she should have notified Resident #19s physician of the change in the resident's condition, but could not recall if she had notified the physician.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 03/27/13, at 2:00 PM, revealed she had been responsible for the care of Resident #19 at the facility on the 6:00 AM day shift on 02/07/13 and 02/08/13. The RN stated she had assessed Resident #19 on 02/07/13, at 12:45 PM and at 1:05 PM. RN #1 acknowledged she had</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>not called the resident's physician after "pinching the resident's arm" for one to two minutes in an effort to stimulate a response on 02/07/13, at 12:45 PM and 1:05 PM, or after she had assessed the resident to have congested lung sounds on 02/07/13, at 1:05 PM. The RN stated after "looking back" she should have notified the resident's physician. RN #1 also stated that on 02/08/13, at 7:00 AM, she had not called the physician because she was waiting for the physician's office to open to notify the physician. The RN stated the physician was hard to notify unless he was in the office. According to RN #1, she had access to the physician's "beeper" number if the physician was needed after office hours, but had not attempted to contact the physician using the "beeper" number until she had called the physician's office at 9:05 AM and learned the office was closed. The RN revealed she was required to notify the physician with any changes in a resident's condition and she was to notify the nursing supervisor or the Medical Director if she was unable to reach a physician. RN #1 acknowledged she had not notified the Director of Nursing (DON) (the supervisor on duty) until 02/08/13, at approximately 10:30 AM, and stated she should have notified the physician and DON sooner.</p> <p>An interview conducted with the physician of Resident #19 on 03/27/13, at 3:50 PM, revealed facility staff should have notified him of Resident #19's condition when the resident first experienced a change in condition (less responsive than usual) on 02/07/13, at 12:45 PM. The physician stated the facility had his "beeper" number as well as his home telephone number and he expected to be notified any time the</p>	F 157			

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F 157	Continued From page 5 resident had a change in his/her cognition. The physician stated he expected to be notified when the resident refused the medication on 02/07/13, at 8:00 PM, as well as when the resident had been assessed to be congested and gurgling on 02/08/13, at 7:00 AM. According to the physician, as a result of the resident's change in condition, he would have immediately sent the resident to the acute care hospital. An interview conducted with the Director of Nursing (DON) on 03/27/13, at 4:15 PM, revealed staff was expected to notify the physician with any change in condition. The DON stated she reviewed the daily report sheets which were filled out by the nurses every day to ensure staff promptly notified the physicians, and had not identified any concern with physicians not being notified promptly.	F 157			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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. This REQUIREMENT is not met as evidenced by: Based on facility policy, observation, interview, and record review, it was determined the facility failed to ensure food served to residents was palatable. Observations and interviews revealed food items were not seasoned and, as a result, were not palatable.	F 364	1. For all residents receiving a regular diet, the food is properly seasoned per the recipe and approved diet i.e. salt, butter, pepper, herbs. For all residents on restrictive diets, who wish to improve their meals, the physician will be contacted for a liberalized diet order. 2. All meals served to residents will be properly seasoned with attention to recipe and quality.		

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F 364	<p>Continued From page 6</p> <p>The findings include:</p> <p>A review of the facility's Nutrition policy/procedures (no date) revealed the residents would be served attractive and tasty foods.</p> <p>A group interview meeting was conducted at 10:30 AM on 03/25/13 with six alert residents in attendance. All six residents agreed the food served at the facility did not have enough (if any) seasoning.</p> <p>Observation of the noon meal in the dining room at 11:50 AM on 03/25/13 revealed 16 residents were eating in the dining room. Eleven of the sixteen residents received carrots on their meal trays. All 11 residents in the dining room refused to eat the carrots served.</p> <p>Interview with the 11 residents at 12:10 PM on 03/25/13 revealed the residents refused to eat the carrots because the carrots did not have any seasoning and did not taste good.</p> <p>A test tray was requested for the noon meal on 03/25/13 and was removed from the meal cart at 12:42 PM. A palatability test conducted of the test tray at 12:43 PM on 03/25/13 revealed the red bliss potatoes (regular and pureed) were bland and did not have any seasoning. In addition, the pureed red bliss potatoes tasted starchy. The regular and pureed carrots were bland and did not have any seasoning.</p> <p>The Dietary Manager (DM) participated in the food palatability test conducted on 03/25/13. The DM agreed/confirmed the red bliss potatoes and</p>	F 364	<p>Dietary staff were educated regarding seasonings and the enhancement seasoning gives to food flavors. (See attachments)</p> <p>Furthermore, individual interviews with all residents will occur to pursue individuals who would prefer a liberalized diet and appropriate physician orders will be obtained if applicable.</p> <p>3. To assure recipes are followed and ample seasonings utilized a daily quality dietary report is completed. Two kitchen staff members taste test all prepared foods, including purees and the report returned daily to the Dietary Manager and Administrator. The report also audits food acceptance noted from the food waste returned to the dishroom and then recorded. Menus are adjusted as needed. (See attached)</p> <p>4. The Quality Assurance Team will review the dietary daily reports to make recommendations for dietary menu changes and to report percentage of compliance of food acceptance and satisfaction. (See attachment).</p>		

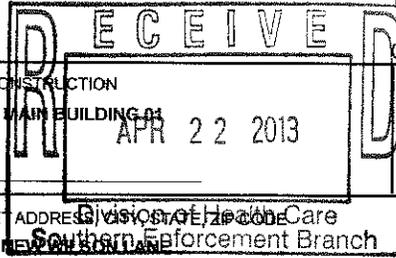
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F 364	<p>Continued From page 7</p> <p>the carrots (regular and pureed) were bland and did not contain any seasoning. A review of the red bliss recipe revealed the potatoes should have been seasoned with margarine and ground rosemary. A review of the buttered carrots recipe revealed the carrots should have been seasoned with margarine and salt.</p> <p>An interview was conducted with the Administrator at 1:00 PM on 03/25/13. The Administrator stated she had gone to the kitchen and tasted the potatoes, and the potatoes should have had salt added. In addition, the Administrator tasted the pureed red bliss potatoes and stated they tasted awful.</p>	F 364	5. Compliance date: 4/19/2013.	

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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEWPORT SQUARE MIDDLESBORO, KY 40965
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Two</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 03/26/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire</p>	K 029		

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

Quinn Madix

TITLE

Administrator 4/19/13

(X6) DATE

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K 029	<p>Continued From page 1</p> <p>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area door was held open in an approved manner. This deficient practice affected one of two smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 95 beds with a census of 91 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 03/26/13 at 11:40 AM, with the Director of Maintenance (DOM), a corridor door to the Laundry room was observed to be held open with a door-closing device. Hazardous area doors cannot be held open in this manner unless connected to the fire alarm system. An interview with the DOM on 03/26/13, at 11:40 AM revealed he was not aware of this requirement.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 029	<ol style="list-style-type: none"> 1. The one hour fire rated construction door is in place and will remain closed. 2. All doors within the facility were reviewed/audited to assure each were in compliance with the regulations; not held open with unapproved device. 3. All Laundry staff, housekeeping staff were educated regarding the proper position of the laundry door. 4. Environmental/Maintenance will audit doors for compliance quarterly. 5. Compliance date April 19, 2013. 	

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K 029	Continued From page 2 Reference: NFPA 101 (2000 Edition). 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 95 beds with a census of 91	K 050	1. Fire Drills are scheduled at varying times on various shifts. 2. The drills will be audited to assure times are rotated. 3. A calendar will be followed, managed only by maintenance director and administrator. 4. The fire drill audit review will assure times are varied. 5. Compliance date April 19, 2013.	

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

PRINTED: 04/10/2013
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 03/26/2013
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO, KY 40965	
(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
K 050	Continued From page 3 on the day of the survey. The findings include: During the Life Safety Code survey on 03/26/13 at 1:30 PM an interview and record review with the Director of Maintenance (DOM) revealed the facility had not been performing fire drills at unexpected times and varying conditions on the second and third shifts as follows: Three fire drills on the second shift from 08/31/12 thru 02/29/13 were conducted between 3:20 PM and 4:03 PM. Three fire drills on the third shift from 06/28/12 thru 12/28/12 were conducted between 11:15 PM and 12:08 AM. The DOM stated he was not aware fire drills should be conducted at unexpected times and under varying conditions. The findings were revealed to the Administrator upon exit.	K 050		