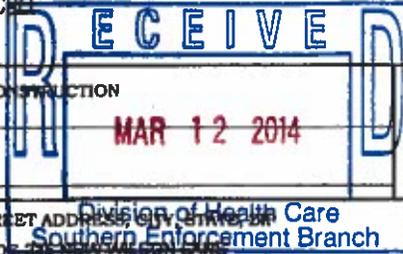


DEPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

2ful SC98

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	WING B WING	(X3) DATE SURVEY COMPLETED 02/13/2014
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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE MIDDLESBORO, KY 40065
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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)	(X8) COMPLETION DATE
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F 000	INITIAL COMMENTS	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 156 SS=D	A standard health survey was conducted on 02/11-13/14. Deficient practice was identified with the highest scope and severity at "D" level. 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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 residents stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. 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. 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,	F 156	It is and was on the day of the survey, the policy of Middlesboro Nursing & Rehabilitation Facility to assure responsible parties receive proper Advance Beneficiary Notices including the appeal rights, process and contact information. 1. The two resident responsible parties, Rt #18 and Rt. # 19 were re-issued a corrected Advanced Beneficiary Notice with the Appeal Rights and Appeal Contact Information. More specifically, the information informed the residents' responsible parties that Medicare would not likely continue to provide coverage in specific circumstances. The new Advance Beneficiary Notices were re-mailed and certified by the bookkeeper to the two affected residents on February 18, 2014 and included the date of non-coverage and the contact information including phone numbers for the appeal process. The notice explained the right to an appeal and how to request the appeal. (See specific letters to responsible party, letter #1). To date the two residents affected by this practice have not returned the notification receipt. The notice was re-mailed certified on March 7, 2014. A phone call by the bookkeeper to the responsible party occurred requesting the receipt on March 6, 2014 and again on March 11, 2014. The bookkeeper spoke with both responsible parties. 2. A three month review of all residents who received Medicare benefits and who could have been affected by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alice M. Adair</i>	TITLE <i>Administrator</i>	(X8) DATE <i>3/11/14</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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	FACILITY CONSTRUCTION A. BLDG _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2014
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 156	<p>Continued From page 1</p> <p>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 inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility</p>	F 156	<p>Omission of the appeal information was conducted by the bookkeeper. The bookkeeper then reissued certified letters which included appeal information to the affected resident responsible party on March 11, 2014. Included in the certified mailing was the appeal information including the appeal contact information. Also, included was a letter explaining the delay in receiving appeal information. (See letter #1). A receipt acknowledging the responsible party/resident received the notice is in progress. A follow-up phone call to the responsible parties will be conducted by the bookkeeper to assure the facility receives the acknowledgement and has record that the correct appeal rights were distributed.</p> <p>3. A notebook with the Advance Beneficiary notices and instructions is maintained in the bookkeeper's office and is available and utilized by the bookkeeper and other staff in the bookkeeper's absence. When the bookkeeper is absent, the office manager/or the social services manager will issue the Advance Beneficiary Notices. On March 6, 2014 the social services coordinator and office manager were trained in proper Advance Beneficiary Notices distribution and appeal rights when Medicare benefits could change for the resident. (See attached education agenda and sign-in sheet.) There is weekly discussion of Medicare skilled service changes and/or discharges in a Quality Assurance Meeting where the bookkeeper and therapist are in attendance. Changes in skilled benefit coverage is consistently addressed at the weekly meeting. Following the meeting the bookkeeper issues notification and appeal rights to the responsible party. (See attached a spreadsheet is maintained for compliance).</p> <p>4. The bookkeeper will prepare a summary of the Advance Beneficiary Notices distributed monthly. The Advance Beneficiary Notice report is submitted to the Quality Assurance Team for review of compliance. The summary will check the date mailed, date returned receipt, date of discharge, type of notice, and appeal rights submitted. (See attached summary sheet).</p> <p>5. Compliance date March 12, 2014.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) COMPLETE CONSTRUCTION BUILDING _____		(X3) DATE SURVEY COMPLETED 02/13/2014
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 156	<p>Continued From page 2</p> <p>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, record review, and a review of the facility's policies, the facility failed to ensure the resident and/or resident's responsible party was provided information regarding appeal rights for two of nineteen sampled residents (Residents # 18 and #19) when a Medicare Non-Coverage letter was issued.</p> <p>The findings include:</p> <p>Review of the facility's Medicare Beneficiary Notice policy dated May 2012 revealed the Advance Beneficiary Notice (ABN) would be given to beneficiaries to convey that Medicare would not likely provide coverage in specific cases. The policy noted the ABN would identify the items or services that might not be covered by Medicare. The policy also indicated that the date of the non-coverage and the appeal information regarding rights to appeal and directions on how to request an appeal would be provided.</p> <p>1. Record review revealed an Advance Beneficiary Notice (ABN) was issued to Resident #18 on 02/01/14 when the resident no longer required medically necessary skilled care on a daily basis and only needed restorative care. The ABN noted the coverage ended on 02/02/14;</p>	F 156		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	<input checked="" type="checkbox"/> COMPLETE A BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED 02/13/2014
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO, KY 40285		
(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 156	Continued From page 3 however, there was no evidence the facility provided the resident or his/her responsible party information regarding the resident's appeal rights or how to file an appeal. 2. Record review revealed Resident #19 was issued an ABN notice on 05/17/13 after daily skilled care was not required. The notice stated the coverage ended on 05/21/13. However, there was no evidence the facility provided the resident or his/her responsible party information regarding appeal rights or how to file an appeal. Interview conducted with the facility's Bookkeeper on 02/13/14, at 1:30 PM revealed she had not been trained to provide the appeal information to residents who still had Medicare Part A days remaining. The bookkeeper stated she provided that information to the residents who were receiving Medicare Part B benefits, but not to Medicare Part A recipients.	F 156			
F 371 SS=D	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, interviews, and a review	F 371			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	COMPLETE CONSTRUCTION A BLDG B WING		(X3) DATE SURVEY COMPLETED 02/13/2014
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE MIDDLESBORO, KY 40665		
(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 371	<p>Continued From page 4</p> <p>of the facility's policies, it was determined the facility failed to ensure food items were prepared under sanitary conditions. Observations of the noon meal on 02/11/14 revealed Dietary Employees #1 and #2 failed to change their gloves or wash their hands when they left an area of meal preparation and before they returned to the area of meal preparation after direct contact had been made with other surfaces in the kitchen area.</p> <p>The findings include</p> <p>A review of the facility's policy for Glove Use (no date) revealed staff must replace disposable (single-use) gloves as soon as practical when the gloves become contaminated, torn, or punctured, exhibit signs of deterioration, or when their ability to function as a barrier is compromised. In addition, the policy revealed staff must perform hand hygiene after gloves are removed.</p> <p>1. An observation of the noon meal preparation was conducted on 02/11/14 at 11:42 AM. During the meal preparation, Dietary Employee #1 left the cook stove area, went to the three-compartment sink area of the kitchen located across the room, and picked up a spatula with her gloved hands. The employee returned to the cook stove, began to prepare a grilled cheese sandwich, then left the cook stove area again, and obtained several small plates while wearing the same gloves. Dietary Employee #1 was then observed to return to the cook stove, continued preparation of the grilled cheese sandwich and, on one occasion during the preparation of the sandwich, touched the grilled cheese sandwich while wearing the same gloves.</p>	F 371	<p>F 371 It is and was on the day of the survey the policy and practice of Middlesboro Nursing and Rehabilitation Facility to assure residents receive food that is procured, stored, prepared and served under sanitary conditions.</p> <p>1. Middlesboro Nursing & Rehabilitation Facility will assure residents receive food served under sanitary conditions. The resident receiving a sandwich or grilled cheese prepared by employee #1, now receives food, sandwiches prepared under sanitary conditions by proper glove use by employee #1 and employee #1 was re-educated by the Dietary Manager. Employee #1 has demonstrated proper glove use when preparing food and proper hand sanitation when leaving and returning to the service area to the dietary manager. All staff have demonstrated proper glove use and sandwich preparation to the Dietary Manager. Food removed and served from the oven with glove mits will be served following proper glove disposal, hand sanitization and re-application of gloves. Employee #2 and all dietary staff have demonstrated proper hand sanitizing steps following oven mit and disposable glove use to the Dietary Manager. (See education agenda and sign-in sheet 3/7/2014).</p> <p>2. All residents receiving sandwiches and food prepared in the dietary department of Middlesboro Nursing & Rehabilitation Facility will receive food that is procured, prepared, stored and served under sanitary conditions. The dietary department will demonstrate to the Dietary Manager the proper glove use and hand sanitation for all foods prepared for all residents under various circumstances, such as preparation of sandwiches, cooked food removed from the oven, staff moving from clean area to dirty area and back to clean area and proper hand sanitation in each of the above circumstances. A return demonstration of glove use and hand sanitation by all Dietary staff is to be conducted on March 7, 2014. See attached education sheet and acknowledgement of information received by the dietary staff.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	<input type="checkbox"/> MULTIPLE CONSTRUCTION <input type="checkbox"/> A BUILDING <input type="checkbox"/> B WING		(X3) DATE SURVEY COMPLETED 02/13/2014
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 371	<p>Continued From page 5</p> <p>An interview was conducted with Dietary Employee #1 on 02/11/14 at 11:52 AM. The employee acknowledged she should have changed her gloves and washed her hands before she returned to the cook stove area after she obtained supplies.</p> <p>2. An observation conducted on 02/11/14 at 11:48 AM of Dietary Employee #2 revealed the employee left the steam table area and went to the confectioner's oven while wearing gloves. The employee was observed to put oven mitts on directly over her gloved hands. Dietary Employee #2 proceeded to remove a pan of cornbread from the oven while wearing the oven mitts, then removed the oven mitts from her gloved hands, and returned to the steam table to serve food. However, Employee #2 failed to remove her gloves and wash her hands after she removed the oven mitts from her hands and was observed to return to the steam table to continue serving food.</p> <p>An interview was conducted with Dietary Employee #2 on 02/11/14 at 11:53 AM. The employee stated gloves should be changed any time she left the steam table.</p> <p>An interview was conducted with the Dietary Manager (DM) on 02/11/14 at 11:55 AM. The DM stated employees should change gloves any time they go from one area to another or come into contact with other objects.</p>	F 371	<p>3. All new dietary hires will receive glove use and proper hand sanitation education. New hires will be checked off on proper hand sanitation procedures by an assigned dietary manager assistant. (See form for new hire education). Each new hire will complete a return demonstration using various scenarios of glove use and hand washing while in the dietary department. An annual education and return demonstration will occur for the current staff. (See form to be used for each staff member). Educational materials are also posted for dietary staff as reference tools regarding glove use and hand sanitation. (See attached educational materials.)</p> <p>4. A monthly audit/observation of dietary staff for proper glove use and proper hand sanitation techniques will be conducted by the Dietary Manager. In addition, the Quality Assurance Nurse will assign periodical meal audits to QA team members at a minimum of quarterly. The meal audit will include observation of glove use by the dietary staff during tray line and food preparation. To assure residents receive food that is procured, stored, prepared and served under sanitary conditions. A monthly audit is completed by the Dietitian, weekly the Dietary Manager Assistant completes additional Quality Assurance Audits for storage, temperature control, dates, food source condition and sanitation conditions and practices. The Quality Assurance Reports will be returned to the Quality Assurance Team for evaluation of staff performance and regulatory compliance. (See audit forms attached). The audit will include use of gloves and hand sanitation methods while on tray line and while general food preparation is being prepared.</p> <p>5. Compliance date March 12, 2014.</p>		

Part B & Part A ABN Procedures

1. Therapy will give you a therapy discharge notice. Verify that they have given you two day notice on the medicare part b's and 3 day notice on the medicare part a's. (Remember weekends do not count in the days.)
2. From the Therapy Discharge notes write the residents name on the calendar under the date they will be discharged.
3. In Point Click Care get the Responsible Parties: Name, address, phone number and the residents medical record number.
4. On you desktop double click on the ABN folder.
5. Part B's you will double click on the Medicare Non-coverage notice icon
6. You will fill in their name and resident number and type of therapy they are being discharged from. If resident has all 3 disciplines and they are for the same date you can put OT PT ST. However, if they are discharging on different dates then you will have to send one out for each discipline for each discharge date.
7. Print 3 copies: 1 is for the RP to sign 1 is a copy for the RP and 1 is for you to keep
8. You will then double click on the Medicare Non-Coverage Cover Letter and fill out and print.
9. You will then double click on the ABN spreadsheet icon and you will fill it in starting with the date of discharge, the residents name, yes for the Medicare notice of non coverage being sent, the certified number, yes to doctors orders, the name of the RP and the date and time you called them to notify them of the discharge.
10. You then will try to contact the RP via phone. If you reach the RP explain to them about the Medicare Notice of Non Coverage (See attached wording). You will then mark that you spoke with them and that you are sending the letter certified. If you do not reach the RP then leave a message to call you and mark on the spreadsheet that you left msg and you are sending certified.

11. You must send the two copies for the RP one you will highlight where they are to sign, one you will stamp copy on the front and copy on the signature line to show that is their copy. You will fill out the certified card and mailing envelope, make sure you put in a self addressed stamped envelope for the RP to return the notice to you signed.
12. Now if a resident is Medicare Part A, you will send out the Medicare Notice of Non-Coverage, but you will have to fill out the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) (see attached copy of this form)
13. You will put the date of the notice and you will put the dates in the blank areas under the reason and you will put what their other insurance will be and that will be private pay or Medicaid only.
14. You will put in the residents name and their medical record number
15. You will make two copies. 1 for the RP to sign, 1 as a copy for the RP and 1 for us to keep.
16. You will highlight the signature line of the one they need to sign and stamp copy on the top and on the signature line.
17. You will send this form along with the Medicare Notice of Non Coverage.
18. You will log everything in the same way on the ABN spreadsheet except you will go to the new abn cert log 2014 and put the information in there.
19. You will also call the RP and notify them of the discharge (see attached for wording)
20. You will also send a self addressed stamp envelope with these.
21. On the ABN's for Medicare Part A you will make a copy of the therapy notification, the SNFABN, medicare notice of non coverage, the green part of the certified that shows the date you sent who you sent it to and the price.)

Middlesboro Nursing and Rehabilitation Facility

235 New Wilson Lane
Middlesboro, KY 40965
606-248-0925

Notice of Medicare Non-Coverage

Patient name:

Patient number

The Effective Date Coverage of Your Current:

Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {Skilled Therapy} services after the effective date indicated above.
 - You may have to pay for any services you receive after the above date.
-

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
 - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
 - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
 - If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
 - Neither Medicare nor your plan will pay for these services after that date.
 - If you stop services no later than the effective date indicated above, you will avoid financial liability.
-

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.

- Call your QIO at: Health Care Excel, 1-800-288-1499 to appeal, or if you have questions.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011)

OMB approval 0938-0953

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information _____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative

Date

Form CMS 10123-NOMNC (Approved 12/31/2011)

OMB approval 0938-0953



2003 J.F.C.I. Quality Award Recipient

"Kentucky's 1996 Facility of the Year"



ALICE W. MADDOX, B.S.N.
Administrator

Dear Responsible Party

You are receiving this letter regarding _____'s Medicare Skilled coverage stay at Middlesboro Nursing & Rehabilitation Facility from _____ to _____. At the time of the Notice of non-coverage, Middlesboro Nursing and Rehabilitation Facility failed to include appeal rights and appeal contact information. Please find enclosed information.

We kindly request you return the enclosed document with signature in order for the facility records to reflect the corrected notice was sent to and received by the affected party. If you have any further questions or concerns please feel free to contact Sheri Craycraft at 606-248-0925.

Sincerely,

Sheri Craycraft, Bookkeeper
Middlesboro Nursing & Rehabilitation Facility

Advanced Beneficiary Notice Procedures

Agenda

March 6, 2014

- I. Therapy will give the Bookkeeper a Therapy Discharge Form that will have the residents name, the date of discharge and if the resident is being discharged from Medicare Part A early or Medicare Part B.**
- II. The regulation says we have to have the ABN's mailed out two days prior to the discharge date, but our policy is to get the ABN's out the same day that we are notified.**
- III. Form CMS 10123 (General Notice Expedited Review) is to be sent out for all residents that are being discharged from Medicare Part B.**
- IV. Form CMS 10055 (SNF-ABN) and Form CMS 10123 (General Notice Expedited Review) is to be sent for all residents who are discharging from Medicare Part A before their 100 days because they do not meet the daily skilled nursing requirements.**
- V. The form CMS 10055 (SNF-ABN) must have written on it the following denial paragraph:**
 - Medicare covers medically necessary skilled care needed on a daily basis. You only needed (non-skilled services) after (date of discharge). Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning (date of discharge) is not covered under Medicare.**
- VI. Look on residents face sheet for the name of the Responsible Party, their address, phone number, and relation to resident. You will need to write down the resident's medical record number, all this is needed for the forms you fill out.**
- VII. Type on the ABN the residents name and Medical record number. (note the CMS 10055 cannot be typed on you will have to print out a copy and hand write the denial paragraph and fill in the information at the bottom.**

- VIII. 3 copies have to be made. The first copy highlight the signature line, the second copy is to be stamped (copy), these are the two copies that have to be sent to the responsible party. The third copy is for our records and proof we sent.**
- IX. ABN cover letter must accompany each ABN that is sent to a responsible party, make sure that all the names reflect the current resident you are working on.**
- X. Put the two copies in an envelope and address to the responsible party and prepare the certified paperwork to put on the letter. (All ABNS MUST BE SENT CERTIFIED, NO EXCEPTIONS)**
- XI. In the ABN log book you will need to put the resident's name, the date of discharge, check the ABN sent and put the date sent, write the certification number in the box.**
- XII. The responsible party needs to be called and you will let them know that you are notifying them that the resident is being discharge from either Medicare Part A or Medicare Part B and you must read the ABN to the responsible party. You must document on the same sheet put the person you spoke with the date and the time, if you get no answer then put either left message or did not answer phone and put that you did read to the responsible party and you also sent the certified letter. (Very important that this is documented)**
- XIII. Attach the bottom part of the green and white certified mail receipt, make sure it is dated and initialed to the copy and the therapy notification sheet and file in the ABN certified letters sent file.**
- XIV. Once you get the return receipt back you will put on the ABN log the date the responsible party signed for the letter. The responsible party will send back the ABN (not all the time) signed and you will stamp it received and write the date in there and then log it on the ABN log and then you will pull the copy out of the ABN certified letter file and staple it to the front and file and put it in the Signed ABN's binder.**

Dietary In-Service

March 7, 2014

Agenda

- **Review of deficiency and plan of correction with all dietary staff.**
 - **The deficiency is as followed:**
 - **F371 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:**
 1. **Based on observation, interviews, and a review of the facility's policies, it was determined the facility failed to ensure food items were prepared under sanitary conditions. Observations of the noon meal on 02/11/2014 revealed Dietary Employees #1 and #2 failed to change their gloves or wash their hands when they left an area of meal preparation and before they returned to the area of meal preparation after direct contact had been made with other surfaces in the kitchen area.**
- **Dietary Staff given a copy of the complete deficiency and Dietary Manager read to all staff.**
- **Plan of correction will be as followed:**
 - **MN&RF will enforce the policy of glove use and hand washing in the dietary department.**
 - **Through the quality assurance committee observations during meal service audits will reflect glove use and hand washing procedures. Meal service audits to be updated to capture proper hand sanitation. The dietary manager or designee will be responsible to complete weekly audits.**
 - **As a visual reminder to dietary signs and pictures will be posted in the dietary department as a reminder to practice proper hand sanitation and glove use.**
 - **Dietary staff provided with a "proper glove use fact sheet" that provides further education on proper steps and use of gloves.**



Proper Glove Use Fact Sheet

When using gloves, you should:

Wash your hands before putting them on and when changing to a fresh pair.

Make sure they fit properly. A glove that is too big will not stay on your hand, and one that is too small will rip or tear easily.

Change them when necessary. You should change them at the following times:

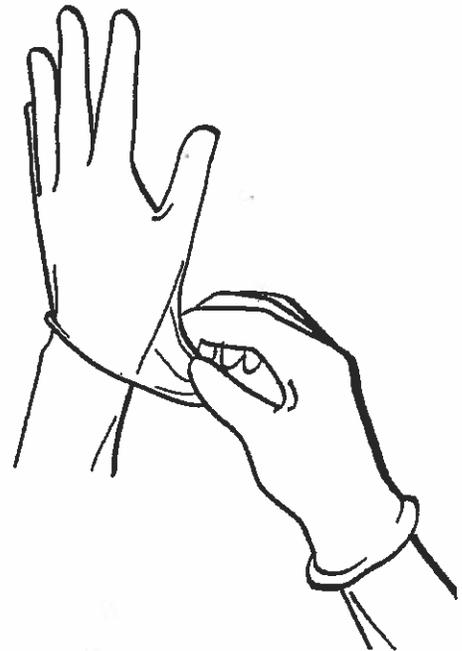
- As soon as they become soiled or torn
- Before beginning a different task
- At least every four hours during continual use
- After handling raw meat, fish, or poultry and before handling cooked or ready-to-eat food

Gloves can help keep food safe by creating a barrier between hands and food. But if they are not properly used, they can contaminate food just as easily as dirty hands.

Remove them properly.

Grasp them at the cuff and peel them off inside out over your fingers. Avoid touching your palm or fingers with the glove.

Never wash and reuse them. Foodhandling gloves should only be used for one foodhandling task.



Change Them!

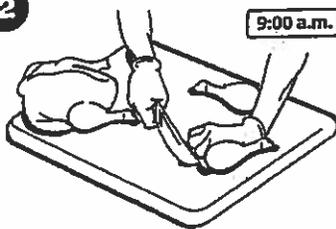
Directions: Circle the activity(s) that would require the employee to wash his or her hands and change gloves.

1

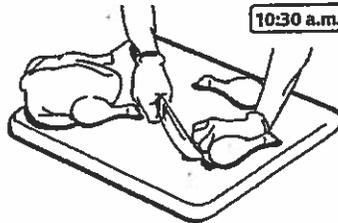


The sandwich maker is assembling a hamburger.

2

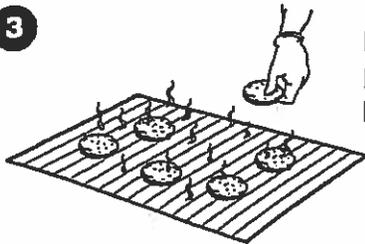


9:00 a.m. The chef preps raw chicken.

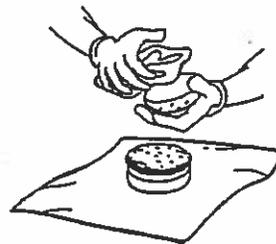


10:30 a.m. The chef is still prepping raw chicken.

3

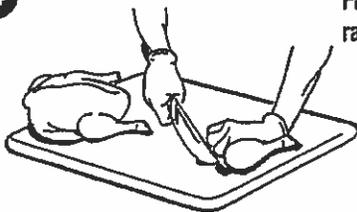


First, the grill operator places a hamburger patty on the grill.

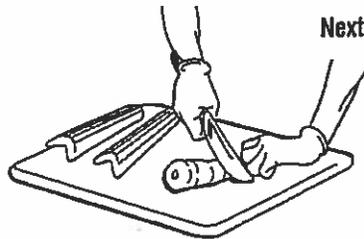


Next, he assembles a hamburger.

4



First, the chef preps raw chicken.



Next, she preps produce.

Take 'Em off Safely

Directions: Circle the picture of the foodhandler properly removing gloves.

1



2



Proper Glove Use Fact Sheet Optional Activity Answers

1. Change Them!

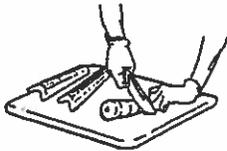
The following activities require the employee to wash his or her hands and change gloves:



1. The sandwich maker assembles a hamburger. The gloves are ripped, which requires them to be changed. They are also too large for his hands.



3. The employee switches from handling raw ground beef to handling a bun. Gloves must be changed after handling raw meat and before handling ready-to-eat food, such as a bun.



4. The employee switches from preparing raw chicken to prepping produce. Gloves must be changed before beginning a different task.

Activity #2 The employee trimming raw chicken does not require a glove change since the employee has been continuously performing the same task for only an hour and a half. If you are performing the same task without interruption—and your gloves have not become torn, or contaminated—a glove change may not be necessary for up to four hours.

2. Take 'Em Off Safely



Foodhandler #2 is properly removing the gloves. He is grasping them at the cuff and peeling them off inside out over his fingers. This will keep the dirty gloves from contaminating his hands.

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?			
During Tray Line was proper hand sanitation used by all staff? I.e. gloves changed when contaminated, after use of oven mitts, no contact with face or other objects to contaminate hands. If so, was proper hand sanitation completed?			

Comments: _____

Signature of Assessor: _____ Date: _____

Quality Indicator: Meal Service Audit

Threshold: 100% Compliance

Frequency: Weekly

Directions: Observe all nursing staff during meal service. Observe timing of meal carts and delivery of trays.

Area of Observation: _____

Criteria	Yes	No	Comments
Timeliness of Service			
Time trays arrived on unit			
Time trays picked up by nursing			
Hall trays arranged according to room number			
Hall trays passed according to room number			
Dayroom trays arranged according to table			
Dayroom trays passed by table			
Condiments are available			
Any substitutes requested?			
If yes, time substitute was requested and received.			
Special requests requested?			
Resident informed of time special request would be honored			
List special requests			

Point of Service Temperatures (List Foods Tested)
Hot Foods (115-125 degrees)
Cold Food (>/= 40 degrees)

Quality of Life/Environmental Management	Yes	No	Comments
Are residents properly dressed for dining areas?			
Hands, face washed, hair combed, glasses/dentures, etc.			
All residents positioned appropriately (upright)?			
Are residents sitting at assigned tables?			
Televisions off?			
Conversation of staff appropriate and resident focused?			
Residents waiting while other residents are eating?			
Medications passed in the dining room?			
Any disruptive behaviors noted?			
Managed appropriately?			

Meal Service Protocol/ Staff Participation	Yes	No	Comments
Are residents at the meal location on time?			
Hydration offered prior to meal service?			
Courtesy aide assisting with nonfeeding tasks?			
Assigned staff on correct assignments?			
Adequate staff during meal service?			
Licensed staff present during meal service?			
Assistive devices in use?			
Are call bells being answered timely?			

Meal Service Infection Control	Yes	No	Comments
Handiwipes available in dayroom?			
Staff assisting residents to use handiwipes prior to meal? In dayroom? On halls?			
Any residents with signs/symptoms of infection in group setting?			
Employees sanitizing/ washing hands after contact with residents and in between residents?			
Any staff members noted to be directly contacting resident food, straw, silverware, etc?			
Kitchen: During tray line was proper hand sanitation used by all staff? i.e gloves changed when contaminated, after use of oven mitts, no contact with face or other objects to contaminate hands. If so, was proper hand sanitation completed?			

Areas of Noncompliance:

Immediate Actions Taken: -

Names of Observer: _____ Date: _____

Updated March 3, 2014

Demonstrations for proper hand hygiene for Dietary Department

Below are 4 Scenarios of what to do when hands become contaminated.

Scenario #1

The dietary staff received a call for a grilled cheese sandwich. The cook answered phone. What steps should be taken next?

- 1. Hands are to be washed using the proper hand washing techniques.**
- 2. Begin to retrieve items needed to prepare grilled cheese. (Pan, spatula, bread, and cheese.)**
- 3. Hands are to be washed using the proper hand washing techniques.**
- 4. At area of preparation put gloves on**
- 5. Begin to assemble cheese sandwich and begin to grill**
- 6. Gloved hands should not touch anything while preparing. If you must change stations you must remove gloves and wash hands.**

Scenario #2

Oven timer has gone off rolls are ready to be removed from oven. What are the proper techniques?

- 1. Remove gloves and wash hands**
- 2. Place oven mitts on and remove item from oven.**
- 3. Wash hands**
- 4. Put new gloves on and continue service.**

Scenario #3

Dietary Aide #3 is on tray line when the door bell rings. It is a resident requesting a cup of ice. What are the proper hand sanitation techniques?

- 1. Wash Hands**
- 2. Get resident a cup of ice**
- 3. Hand to resident**
- 4. Wash hands**
- 5. Return to station on tray line**

Scenario #4

During "clean side" in dish room a dietary employee drops a cup on the floor. The employee proceeds to pick the cup up. What should this employee do now before returning to her position?

- 1. Remove gloves**
- 2. Wash hands / dry**
- 3. Replace gloves and return to putting clean dishes up.**

Dietary Glove Use and Proper Hand Sanitation Checklist

- Observe employee demonstrating hand hygiene practices and glove use. Document any corrective action and or comments below.

Questions	YES	NO	Corrective Action
<i>Hands are properly washed before putting on a new pair of gloves by demonstrating the steps below.</i>			
Hot Water Used			
Soap			
Lather for at least 20 seconds washing hands including under finger nails			
Rinse			
Dry with paper towel			
<i>Preventing Contamination by hands are gloves changed when:</i>			
Switching from Raw to RTE foods			
Working for long periods with potentially hazardous foods			
Returning to kitchen from any activities			
Sneezing, touching your skin or hair, or smoking			
Changing tasks (oven mitts, handling raw food, sanitizer towels, dirty plates etc.)			
Are gloves disposed of after each use			
Is employee minimizing food contact with bare hands by using utensils?			
Employee demonstrates knowledge of hand hygiene and single use gloves?			

Comments: _____

Circle : New Hire Annual

Employee Name: _____

Date of observation: _____

Observers Name: _____

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?			
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Food placed on steam table within 30 minutes of service?			
Assistive devices provided?			
Request addressed quickly and courteously by staff?			
During Tray Line was proper hand sanitation used by all staff? I.e. gloves changed when contaminated, after use of oven mitts, no contact with face or other objects to contaminate hands. If so, was proper hand sanitation completed?			

Comments: _____

Signature of Assessor: _____ Date: _____

**SANITATION/FOOD SAFETY
DIETARY DEPARTMENT**

*1-2 items
D-3*

Instructions: Evaluate at items on the checklist as Acceptable, Needs Improvement, or Unacceptable. A qualifying comment should accompany any item scored as Unacceptable. An item should not be scored Acceptable if it has a qualifying comment that needs attention. Upon completion of the checklist, score the percentage of compliance. Count the number of Acceptable and Needs Improvement ratings and divide by the Total Number of items checked. If a specific item on the checklist is marked N/A (for Not Applicable), do not include it in the Total Number of items checked.

Quality Assurance Document

Acceptable Score: 90% Actual Score _____
Facility Name/ #: **9590**

Unacceptable
Needs Improvement
Acceptable

Date: _____

Unacceptable
Needs Improvement
Acceptable

ITEMS CHECKED: _____ POINTS	0	1/2	1	ITEMS CHECKED: _____ POINTS	0	1/2	1
1. COOK'S WORK AREA				4. REFRIGERATOR/FREEZER STORAGE			
a. Range, oven, grill clean				a. Refrigerator has internal thermometer and temp between 35° and 40°: Temp: _____			
b. Hood, filters clean				b. Freezer has internal thermometer and temp 0° or below: Temp: _____			
c. Tilting braising pan clean				c. Refrigerator/freezer temps recorded daily			
d. Convection oven clean				d. Refrigerator motors			
e. Steamer clean/free of mineral deposits				e. Freezer motors			
f. Food processor clean				f. Refrigerator clean			
g. Mixer/table clean				g. Freezer clean			
h. Slicer/table clean				h. Food covered, dated, labeled			
i. Food portion scale clean				i. Outdated food/leftovers discarded			
j. Cutting boards clean				j. Internal food temps appropriate			
k. Can opener clean				k. Proper storage raw/cooked food			
l. Cutlery/rack clean				l. food defrosted in refrigerator in drip pan			
m. Work table clean				SECTION 4: TOTAL POSSIBLE POINTS _____			
n. Garbage cans clean/covered				5. DISHROOM			
o. Food not in danger zone				a. Dishmachine clean, no lime build-up			
p. Food cooked to proper internal temperature				b. Grease traps/drains			
q. Proper use of gloves				c. Overshelf/undershelf			
SECTION 1: TOTAL POSSIBLE POINTS _____				d. Garbage disposal			
2. COLD FOOD PREP AREA				e. Garbage cans clean, covered			
a. Toaster clean				f. Wash and rinse temps _____			
b. Coffee machine-exterior/interior-tank, glass, spigots clean				g. Test results recorded on low temp machines _____			
c. Blender clean				h. Proper chemicals used			
d. Milk dispenser clean				i. Proper procedure used			
e. Work tables clean				j. Floor mats in place and clean			
f. Vegetable prep sink clean				SECTION 5: TOTAL POSSIBLE POINTS _____			

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: _____

Completed
Weekly (TUE)

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

PRINTED: 02/27/2014
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 02/12/2014
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	<p>Continued From page 1</p> <p>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</p> <p>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 97 beds with a census of 94 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/12/14 at 2:30 PM an interview and record review with the Director of Maintenance (DOM) revealed the facility had not performed fire drills at unexpected times and varying conditions on the second and third shifts. Review of documentation revealed the facility conducted three fire drills on the second shift from 05/31/13 through 11/29/13 between 3:00 PM and 3:55 PM. In addition, three fire drills were conducted on the third shift from 06/23/13 through 12/03/13 between 11:30 PM and 12:13 AM.</p> <p>An interview with the DOM on 02/12/14 at 2:30 PM revealed it was difficult to conduct fire drills at</p>	K 050	<p>2. The drills will evaluate employee performance with variations in staffing level and assess resident response.</p> <p>3. To assure fire drill times will vary throughout the year, a form with the previous drill on the specified shift will be recorded prior to the upcoming drill. The system will assure drill times vary on each shift. (See attached form).</p> <p>4. The quarterly Safety Quality Assurance Committee will audit the report forms to evaluate any variance and assure the drills meet regulatory compliance.</p> <p>5. Compliance date March 7, 2014.</p>	

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

PRINTED: 02/27/2014
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 02/12/2014
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 2 unexpected times and under varying conditions. The facility was cited for the same deficient practice on 03/26/13. The findings were revealed to the Administrator upon exit.	K 050			

FIRE DRILL EVALUATION AND REPORT

Emergency 24 Operator: _____ Responded: YES/NO/EXPLAIN Date: _____

Time Alarm Sounded: _____ Time Announced: _____ Time Cleared: _____

EVALUATION

1. Did staff from each department respond appropriately to the immediate Fire Duties and Response?

	Yes	No		Yes	No
Licensed staff	_____	_____	Business Office	_____	_____
Nursing Assist	_____	_____	Dietary	_____	_____
Activity Staff	_____	_____	Laundry	_____	_____
Maintenance	_____	_____	Housekeeping	_____	_____

Comments: _____

	Yes	No
a. Staff response as follows:		
RACE implemented	_____	_____
<u>Rescue</u> (Remove resident to safe area)	_____	_____
<u>Alarm</u> (Sound the alarm / announce Code red/ location)	_____	_____
<u>Contain</u> / Confine the fire (Close doors/windows)	_____	_____
<u>Extinguish</u> the fire (without risking your safety)	_____	_____
b. Was the alarm silenced?	_____	_____
Resident count performed	_____	_____
Results : _____		
c. Visitors controlled/counted	_____	_____

2. Emergency Organizational Duties & Response:

- Incident Commander Identified
- 2-Way Radio in use
- Census manager and assignment manager (Clipboard)
- Resident count reported accurately.
- Ancillary manager/staff report to census/assignment nurse to await assignment.
- Housekeeping, Dietary, Activity, and Therapy staff assigned duties by nurse.
- Unit opposite area of trouble responded appropriately.
- Incident Commander directed care and managed area of trouble.

3. Evacuation Preparation:

- Resident's evaluated for wheelchair/bed mobilization if time allowed.
- CNA's arrived in area of trouble and assist in resident room, 2-staff per room or more.

4. Evaluation:

Signature of Person Completing Form

Signature of Administrator

Original: Place in binder in the front office

Copy: Send to Safety Committee to be reviewed during meeting.