Survey Toolkit

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What You Should Tell Your Employees and Your Patients

At the end of a survey, administrators should meet with employees to discuss the results. In the event of a negative survey outcome, an administrator should address employee and patient concerns. Employees must be given clear direction regarding what will happen next, and patients need reassurance during this time.

Employees

Employees need to be told about survey, certification and enforcement. The administrator or the director of nursing (DON) should have group meetings with the employees to inform them of the findings, what the facility's response to the findings will be and what things they need to do to help, e.g., attend all called in-service training; implement procedures taught; and reassure patients and families. The administrator's goal should be to make the employees an integral part of the solution and not a part of the problem.

Negative survey outcomes often generate media attention. Employees need to know how to deal with the media. Establish a clear chain of command regarding who will be the designated spokesperson(s) for the facility, and give employees instructions on how to respond if they are approached by the media. Those speaking on behalf of the facility need to meet and develop press statements and talking points.

Patients

Meet with the patient council. Inform and reassure all patients that the facility is alleging compliance and doing everything the surveyors have asked them to do. Allow patients time to ask questions.

Guidance for Dealing with Families, Legislators and the Media

The families of patients, legislators and the local media, including newspapers, radio stations and television stations, will want to know about the situation as it relates to survey, certification and enforcement.

Families

Two of the best opportunities to inform family members about what is going on are family nights and written communications. Family nights, sometimes called family council meetings, provide an opportunity for exchange among families, patients and staff. They can be educational and can be held as needed, monthly, bimonthly, quarterly or semiannually. Refer to the *THCA Public Relations Manual* for additional information on "Consumer/Family/Patient Relations Strategies." To access the manual online, visit www.thca.org, click on the "Member Facilities Only" page and then the "Communications" link. In the event of a negative survey, administrators might want to call a special family council meeting.

Facilities should use newsletters, bulletin boards or personal letters to communicate with families. When it comes to communicating with families, newsletters are a great value. For a relatively small investment of time and money, newsletters offer the perfect avenue for information dissemination.

While newsletters are an effective method for reaching a large audience with a variety of information, they can never replace the role of personal correspondence. Some circumstances simply call for the type of special acknowledgement that only a signed or handwritten note can provide. Letters open channels of communication and can help avert problems that arise. Administrators should also remember to keep the lines of communication open with family members during their visits. If they have questions, staff should make time to stop and answer them.

Legislators

It is also important to communicate with and invite members of the Tennessee General Assembly into facilities for discussions and tours. Each facility has one state representative and one state senator who are listed in the THCA *Membership Handbook* under the "Legislators" section. THCA recommends that all member facilities have their legislators in the building at least once a year or as needed. The legislative session typically begins in mid-January and continues until mid-May. The time to meet with legislators is before the legislative session begins.

If facilities have survey outcomes that cause media attention or patient and family concerns, administrators should contact their legislators immediately. Administrators should explain the survey results to the legislator, including the circumstances which led to the state's findings. Facilities that have taken the time to build relationships with legislators will find that contact will go more smoothly.

Media

The media can be contacted via press releases or with telephone calls. Keep an updated list of contact names, news organizations, titles and phone numbers and use it often. Administrators needing assistance identifying the media outlets in their area should contact THCA's Communications Department.

Tours can be beneficial for reporters, as well. Should photographers visit, make sure photo releases are signed for any patients appearing in photographs or on film.

The use of a designated spokesperson is key in managing the media. Reporters appreciate being able to speak with someone in charge. Also, limiting the number of people making statements increases the likelihood of a consistent, accurate and unified message. The designated spokesperson should be a person of authority who is knowledgeable of the industry and daily workings of the facility. That person must be a quick thinker, honest, trustworthy and available at a moment's notice.

Talking Points for Families, Legislators and the Media

- Talk about the most recent survey.
- Explain when and why nursing homes are surveyed, what a deficiency is and what scope and severity mean.

- Explain that while an immediate jeopardy (IJ) citation can sometimes be given for very serious issues, it can and often is cited even when there is never a negative outcome for any patient. Because surveyors incorrect apply the standard of “potential for harm”, the judgment for immediate jeopardy deficiencies is often extremely subjective. The correct regulatory definition is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death to a resident."

- Show the extensive number of regulations on which facilities are surveyed.

- Discuss the survey document itself.

- Explain that in many cases, a single event may generate a lot of deficiency citations at multiple F-tags. This can be misleading to people who think every deficiency is a separate event or issue.

- Discuss how the civil monetary penalties (CMP) imposed on a facility will impact operations.

- Discuss how the survey process negatively impacts staff. Explain how this enforcement environment makes it difficult to recruit and retain qualified staff members and give specific examples. For instance, "My DON, who has worked here for 10 years, is leaving to work in the hospital - she is getting out of long -term care because of the survey process."

- Discuss the facility's survey history.

- Explain how the Facility’s quality improvement program continually works to prevent things from happening and tries to improve things.

- Explain the best practices that have been implemented.

- Give specific examples of how staff works on quality improvement every day.

- Explain the lack of due process in the appeals process and how facilities must appeal to those entities that imposed the penalties. For example, explain to people that CMS’s decisions are presumed to be correct, and for the Facility to win an appeal it has to prove not only that CMS was incorrect, but that the Facility has specific proof of being in compliance.

- Talk about the fact that with an IJ citation, facilities can lose their nurse aide training programs for two years.

- Give specific examples. For instance, "We trained 10 CNAs last year who worked for us. Now, we won't be allowed to do that for two years."

Plan of Correction Resources

The surveyors have ten (10) working days to complete and return to the Facility the 2567, which lists in detail the alleged deficient practices found at a facility. However, a facility needs to start corrective actions immediately following the exit conference with the surveyors.

If there are IJ deficiencies (any citation said to be at a J, K or L scope and severity level), the survey guidelines say surveyors will identify the issues on site, before they exit the building. (see SOM § 2724). Facilities should start an Allegation of compliance (AOC), if they wish a full plan of correction (POC) immediately. (See Days 0 through 22, Abatement period under Timeline from Facility Side on page 7.). If an allegation of removal of the IJ is submitted, the Centers for Medicare and Medicaid Services (CMS) and the Tennessee Department of Health (TDH) Health Care Facilities (HCF) will review it to determine if it is acceptable. The AOC must include the date the IJ was removed and sufficient detail to demonstrate that the IJ has been addressed (see paragraph three below). The SOM and TDH direct the Facility to submit an AOC prior to submitting a full POC in immediate jeopardy situations.

When the 2567 arrives, working copies should be made for the Administrator, DON, etc. The original should be filed. The administrator should then objectively read through the 2567.

When going back over the 2567, the administrator should highlight areas that he believes to be incorrect. For example, in one facility the survey document referred to the right leg of one patient, and that patient did not have a right leg. In another incident, the 2567 described a patient's diagnosis of diabetes, and it was not correct. (You can also reference THCA's Tutorial "The ABCs of POCs on the THCA Website)

The facility has ten (10) days to return the POC to the regional health care facilities survey office. For each deficiency, each one of the four questions included in the cover letter must be addressed, and the answers must be very specific.

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place?

Question three often requires mandatory in-services for all staff, or in some cases all staff of a certain type (i.e. all nursing staff). Carefully consider what inservices are required to correct the deficiencies. Some facilities have found that insufficient inservices have kept their corrective plans from being approved.

Question four should include very specific detail about who is going to be responsible for the action item the Facility will undertake. A facility cannot just say staff or the Quality Assurance (QA) Committee. If it is an important function or one that will be done continuously or on off hours, include in the question the identity of the back-up to the responsible staff member.

A lot of facilities choose to use a disclaimer at the beginning of the AOC or POC or on the cover letter they send with the AOC or POC. This statement basically says that the facility is not admitting to any wrong doing just because a POC is being submitted. Administrators should check with their legal representatives prior to submission of the AOC or POC for recommendations about whether their facility needs to use a disclaimer and what it should say. Also, if the Facility is told it cannot use a disclaimer on the AOC or POC, it should contact THCA or its legal counsel because CMS likely cannot prevent a Facility from in some way stating that they do not admit the findings in the 2567.

The facility should now begin to write the AOC or POCs. Identify the deficiency tag in the middle column titled ID Prefix Tag, and then answer the four questions about that deficiency in the column titled Provider's Plan of Correction. The last column is the completion date. This is the date that surveyors are told everything will be done. This is the date the surveyors may return to the facility for re-survey and will confirm that actions are complete. If mandatory in-services were part of the POC, Administrators should make sure that 100 percent of the affected staff has been in-serviced, and it is documented with sign-in sheets, etc.

If someone is out on leave, vacation, etc., the facility must tell what will be done to in-service him before he returns to the facility or document the phone call for a voice in-service. The surveyors will ask for a list of employees and compare that list to sign-in sheets during the resurvey.

Completed POCs must be returned to the health care facilities regional survey office. If the Facility is submitting an AOC, it should also send the AOC to the CMS Regional office in Atlanta. Contact Information for each office is listed below.

West Tennessee
Shirley Jones, Regional Administrator
2975 Highway 45 Bypass, Suite C
Jackson, TN 38305
(731)984-9684
Fax: (731) 984-0064
E-mail: shirley.l.jones@state.tn.us

East Tennessee
Karen Kirby, Regional Administrator
5904 Lyons View Pike
Knoxville, TN 37919-7520
(865) 588-5656
Fax: (865) 594-5739
E-mail: Karen.kirby@state.tn.us

Surveyors will return to the facility. During the resurvey, the surveyors will look to make sure that the facility is in substantial compliance and has done and are doing everything stated in the POC. If they find the facility has corrected the deficient practices, the surveyor will fill out the postcertification revisit report. Each tag will be listed on the report with the correction date. The surveyor will sign and date the report and will ask the administrator to also sign the report. If there are uncorrected deficiencies that are a lesser scope and severity of an IJ, the surveyor

will also report those to the administrator. If IJ deficiencies are not cleared, decertification of the facility may occur.

SAMPLE

483.65(a) INFECTION CONTROL: The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by: Based on observations it was determined the facility failed to ensure that equipment was properly cleaned between residents to prevent cross-contamination as evidenced by the glucometer not being cleaned between two sampled residents receiving a finger stick blood sugar test (FSBS) by four nurses observed using the glucometer.

The findings included:
Observations in the resident's room on 1/1/08 at 8 a.m. revealed that LPN #1 performed a FSBS on Random Resident #4. LPN #1 was not observed to clean the glucometer after using it.

Observations in the resident's rooms on 1/1/08 beginning at 8 a.m. revealed that LPN #3 performed a FSBS on Random Resident #2 and Resident #11. LPN #3 was not observed to clean the glucometer between the residents.

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The facility has established and maintains an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.

What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #2, Resident #4 and Resident #11 were assessed for signs and symptoms of infection by the DON and the nurse practitioner on 1/1/08.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents receiving finger stick blood glucose have the potential to be affected.

What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? All licensed nurses were in-serviced on the policy and procedure to maintaining a glucometer and cleaning between each patient. The DON and/or the assistant DON will complete med pass reviews with two nurses per day each on different shifts five days a week times 30 days and then weekly if no further issues are noted times 60 days. Cleaning of the glucometer between each patient's use will be monitored. Nursing staff found to be deficient in this practice will be disciplined in accordance with facility policy.

How will the corrective action be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

The DON will provide the administrator with documentation weekly regarding reviews. Results of this initiative will be presented by the administrator at the monthly quality assurance (QA) meeting to determine need for revision of continued oversight.

Immediate Jeopardy: Timeline of Key Events

Day 0, Last Day of Survey - The last day of a survey during which the Tennessee Department of Health (TDH) has determined immediate jeopardy exists in a facility begins the timeline for ensuing IJ-related actions/events.

In some instances, the TDH may determine an IJ identified during a survey has been removed prior to completion of the survey. In such cases, the surveyors will cite the IJ, including the date and time the IJ was identified, the date it began and the date it was removed. It is possible, however, that although an IJ has been removed, a facility may not be in substantial compliance with the regulatory requirements, thus subjecting it to continuing civil money penalties (CMP) and/or other remedies.

After the survey team, TDH regional office manager and TDH central office concur that immediate jeopardy exists, the facility administrator will be notified orally of the decision. This notice may occur at the exit interview or at another time during the survey. In any event, it should occur before the survey team leaves the building. The oral notice should provide specific details, including the patients at risk, and the oral notice is followed up with a written notice issued on or before day 2. (The SOM outlines this process in Appendix Q, Section V and VI).

Timeline from Facility Side

Days 0 through 22, Abatement Period - The facility must abate the IJ through submission of an AOC that is acceptable to both TDH and CMS in order to avoid termination of the provider agreement. Normally, unless an exception is made by CMS for additional revisits (see Day 23 below), the Facility is only given two (2) revisits to come back into compliance.

An AOC's purpose is only to explain how the IJ Is being abated by the Facility, and is not intended to address any non-IJ deficiencies. Non-IJ deficiencies are addressed in the broader POC. Depending on the time and resources available to facilities, some facilities may choose to submit an AOC first (in an effort to more quickly abate the IJ deficiencies), following up later with a POC, while other facilities may choose to submit only one document that encompasses both the AOC and POC and addresses both the IJ and non-IJ deficiencies. The following information must be included (and note it is nearly identical to the POC questions above):

- The date the IJ was removed and sufficient detail to demonstrate that the IJ has been addressed;
- What corrective action(s) will be accomplished for those patients affected by the IJ practice;

- How the facility will identify other patients that may have the potential to be affected by this IJ practice and what corrective actions will be taken for those patients;

- What measures will be put into place or what systemic changes you will make to ensure IJ will not recur;

- How the corrective action(s) will be monitored to ensure the IJ will not recur; and

- What quality assurance program will be put into place including who will monitor and how often.

Timeline from TDH or state affiliate (SA)/CMS Side

Day 2, Initial Notice - No later than two calendar days (one of which must be a working day) following the last day of the survey that identified the IJ, TDH notifies the facility in writing that it is recommending to CMS that the provider agreement be terminated. A temporary manager may be imposed in lieu of, or in addition to, termination. Initial notice must contain, as applicable, the following:

1. The nature of the IJ, including regulatory cites or initial assessment of immediate IJ findings;

2. Request for an allegation of removal of IJ, including evidence of steps taken to remove the IJ. The POC will usually be deferred until IJ has been determined to be removed;

3. Consequences of failure to submit an allegation of removal, e.g., provider agreement termination;

4. Remedies recommended with effective dates;

5. Opportunity for informal dispute resolution;

6. Loss of Nurse Aide Training and Competency Evaluation Program and appeal rights if the program loss is based on a finding of substandard quality of care; and

7. When substandard quality of care is determined, the facility must provide the state with a list of the physicians of those residents who were found to be subject to the substandard quality of care. The state must notify each attending physician and refer the administrator to the state's licensing board.

Day 5, Documentation Sent to CMS - No later than five calendar days after the last day of the survey, TDH forwards all documentation – e.g., notice letter, contract reports, deficiencies – to CMS, or the state Medicaid agency (TennCare) for Medicaid-only facilities.

Day 10, Form 2567 Issued - No later than the 10th working day after the last day of the survey, TDH must send a copy of the deficiency report, Form 2567, to the facility and the CMS regional office.

Days 5 – 21, CMS Formal Notice of Remedies - Sometime within the fifth to 21st calendar day following the last day of the survey, CMS issues a formal notice of remedies to the facility. Formal notice includes the following, as applicable:

1. Facts regarding when the survey occurred, which requirements were found out of compliance, and, where applicable, subsequent actions on the part of the state or facility;

2. Basis for the enforcement remedy, including termination (i.e., the facility has failed to achieve substantial compliance);

3. Enforcement remedy (ies) being imposed and the effective date; e.g., except for state monitoring and civil money penalties, no sooner than two days or 15 days from the facility's receipt of notice, depending on whether or not immediate jeopardy exists;

4. Appeal rights and how to request a formal appeal; and

5. The mandatory enforcement remedies not yet imposed that must occur at a later date if the facility continues to be out of compliance (i.e., mandatory denial of payment for new admissions and/or termination of the provider agreement).

Day 23, Termination of Provider Agreement - In all cases of IJ, when the IJ has not been removed, the provider agreement must be terminated by CMS no later than 23 calendar days from the last day of the survey. CMS may override this requirement, however, if its regional office has approved a third revisit or its central office in Baltimore has approved a fourth revisit.

An Overview of the Provider Appeals Process in Immediate Jeopardy Situations

Disclaimer: The following information is offered as a general overview of the appeals process and is for informational purposes only. Information contained herein should not be relied upon as legal advice and should not be used as a substitute for retaining competent legal representation to protect your interests.

Formal Administrative Appeal Process:

- The formal appeals process for nursing facilities under Medicaid (NFs) and skilled nursing facilities under Medicare (SNFs) (hereinafter referred to collectively as "provider") is set forth in the federal regulations at 42 C.F.R. §§ 498.1 through 498.103. A current copy of these regulations can be accessed online at: http://www.gpoaccess.gov/cfr/index.html.

- Providers dissatisfied with the CMS finding of one or more IJ citations may appeal only when (1) A civil money penalty (CMP) was assessed, and (2) A favorable outcome on appeal would reduce the CMP.

- Providers have a right to be represented by an attorney throughout the appeal process. 42 C.F.R. § 498.10.

- An appeal will "toll" (postpone) payment date of CMPs until fifteen days after a final administrative decision of the appeal is issued.

- Providers have a right to appeal CMS' decision to terminate its Medicaid/Medicare provider agreement.

- Appeal of a decision to terminate a provider agreement does not toll the termination date.

It is important to note that while termination of a provider agreement and most IJ citations are CMS actions that may be appealed under the regulations, not all matters have a right to appeal. 42 C.F.R. § 498.3(b) and (d). For example, the following are not subject to appeal:

- Imposition of state monitoring; and

- The choice of alternative sanction or remedy to be imposed on a provider.

- A provider must request an appeal within sixty (60) days of the date on which it receives notice of CMS' decision to impose remedies based upon survey findings, i.e., receipt of the Form 2567. 42 C.F.R. § 498.40(a)(2). If the facility does not request a hearing within 60 days, CMS' determination is binding. 42 C.F.R. § 498.20(b).

- The hearing request must be in writing and must (1) Identify the specific issues, the findings of fact and conclusions of law with which the affected party disagrees; and (2) Specify the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.40(b).

- Initial appeals are heard before a Department of Health and Human Services administrative law judge (ALJ), who is a member of the Departmental Appeals Board (DAB). 42 U.S.C. § 1395cc(h)(1); 42 C.F.R. § 489.5(b).

- For purposes of the hearing, subpoenas are available to compel the attendance of witnesses.

- Testimony is taken under oath or affirmation and witnesses are subject to cross-examination.

- 42 C.F.R. §§ 498.58 and 498.62.

- On appeal, CMS merely has the duty to come forward with proof that the provider was in violation of the regulations. CMS does not have to prove scope and severity for any given deficiency, e.g., that a deficiency rose to the level of IJ. Once CMS establishes this minimal proof, the burden then shifts to the provider to prove CMS' IJ determination was "clearly erroneous." This is a very heavy standard of proof and not easily overcome.

- If a provider is dissatisfied with the ALJ's decision, it may then request review by the Appellate Division of the DAB. Again, providers have 60 days from receipt of the ALJ's decision to file an appeal. 42 C.F.R. §§ 498.80, 498.82, and 498.83(b).

- A provider that remains dissatisfied with a decision of the Appellate Division is entitled to obtain judicial review of that decision by filing an action in federal district court within sixty days of the final administrative action. 42 U.S.C. § 405(g); 42 C.F.R. § 1395cc(h)(1);

42 C.F.R. § 498.5(c); 42 C.F.R. § 498.90. In the case of CMPs, appeal is made directly to the 6th Circuit Court of Appeals. 42 C.F.R. § 498.90.

- In extremely limited and special circumstances, under a legal concept known as the "collateral matter exception," providers may have a right to appeal directly to federal court (prior to any administrative appeals) in order to obtain a temporary injunction preventing termination of its provider agreement until such time as further legal proceedings can occur.

Informal Dispute Resolution (IDR) Appeal Process:

• The Informal Dispute Resolution (IDR) process is set forth in 42 C.F.R. § 488.331, and its state-specific details are contained in the Tennessee Department of Health's (TDH) IDR policy.

IDR will be conducted by the state survey agency through a desk review, or, in the event that a face-to-face IDR is requested, through a panel of two standard minimum qualification test (SMQT) Certified State staff members not involved in the survey, or one contract Independent panel member and one SMQT certified state agency quality improvement staff member that was not involved in the survey. The independent panel member is defined as a physician licensed to engage in the practice of medicine in the State of TN having experience in a long term care setting. TDH policy states that either panel may hear matters involving remedy assessments of $25,000 or less, but only the Independent Panel can hear matters exceeding remedies of greater than $25,000.

• Any decision by the panel is subject to review and approval by CMS.

• Providers must request IDR in writing within the same ten calendar day period it has for submitting a POC.

• Requesting IDR does not toll any enforcement action taken by CMS.

• A request for IDR is independent of any formal appeal request as set forth above. If both IDR and a formal appeal before an ALJ is sought, two separate requests should be timely submitted.

• IDR is addressed thoroughly in a tutorial in the Summer 2007 edition of *Perspective*, which can also be found online at www.thca.org. The limitations and other aspects of that process are set forth in that article.

List of Clinical Consultants Specializing in Long-term Care Regulatory Issues

Administrative Resources, LTC
Stephen Lee
2022 Pointe Barton Drive
Lebanon, TN 37087-9052
(615) 443-3070
Fax: (615) 443-3070
E-mail: lpatlee@aol.com
Consultant Alliance for Long-Term Care

Dan Beck
1403 Sharpe Avenue
Nashville, TN 37206
(615) 512-0161
Fax: (615) 227-0497
E-mail: rmsdanbeck@comcast.net
www.consultantalliance.org

Cornerstone Consulting Services
Kathy Kyle
875 Walnut Street, Suite 150
Cary, NC 27511
(919) 467-6649
Fax: (919) 468-2551
E-mail: kkyle@cornerstonehcs.com
www.cornerstonehcs.com

Interim Health Care Placements, Inc.
Carol Rains Wilburn
2024 Prescott Way
Spring Hill, TN 37174
(615) 302-0411
Fax: (615) 302-0004
E-mail: CarolWilburn@bellsouth.net
www.interimplacements.com

Kay Wilkes Consulting
Kay Wilkes
2203 Wedgewood Drive
Union City, TN 38261-5733
(731) 884-0550
Fax: (731) 884-0455
E-mail: K_Wilkes@onemain.com

LTC Services, LLC
Rosemary Cox, RN
7736 Stout Road
Germantown, TN 38138-5919
(901) 218-8362
Fax: (866) 795-6698
E-mail: rcox8750@yahoo.com
Polaris Group, Inc.

Gail Reddinger
5431 Nellie Davis Lane
Suite 1100
Tampa, FL 33634-5251
(813) 994-9624
Fax: (813) 886-6045
E-mail: gail.reddinger@polaris-group.com
www.polaris-group.com

Rasberry & Associates Consulting and Training
Odean Rasberry
32 Dove Drive
Dyersburg, TN 38025
(731) 695-0493
Fax: (731) 285-5546
E-mail: gfrasberry@cableone.net

SWK Consulting LLC
Kenda S. Beach
P. O. Box 3287
Irmo, SC 29063
(803) 781-6323
Fax: (803) 753-9912
E-mail: kbeach@swkconsulting.com
www.swkconsulting.com

T L Consulting
Teresa E. Lowery
1140 Mill Road
Trezevant, TN 38258-5457
(731) 669-9367
E-mail: tlc01@onemain.com

Verbanic Consultants, LLC
JoAnn Verbanic
412 Cross Creek Court
Franklin, TN 37067-4007
(615) 595-8611
Fax: (615) 595-0248
E-mail: jverbanic@verbanicconsultants.com
www.verbanicconsultants.com

Disclaimer: *This list is offered as a convenience to members. It is not, nor is it intended to be, a complete or exclusive list of professionals offering these types of services.*

List of Attorneys Specializing in Long-term Care Regulatory Issues

Armstrong Allen, PLLC
Jeff Smith
80 Monroe Avenue, Suite 700
Memphis, TN 38103-2467
(901) 523-8211
Fax: (901) 524-4936
E-mail: jsmith@armstrongallen.com
www.armstrongallen.com

Baker, Donelson, Berman, Caldwell & Berkowitz
Christy Crider
211 Commerce Street, Suite 1000
Nashville, TN 37201
(615) 726-5608
Fax: (615) 744-5608
E-mail: ccrider@bakerdonelson.com
www.bakerdonelson.com

Harry Ogden
2200 Riverview Tower
900 South Gay Street
P. O. Box 1792
Knoxville, Tennessee 37902
(865) 549-7000
Fax: (865) 525-8569
E-mail: hogden@bakerdonelson.com

Bradley Arant Boult Cummings LLP
Michael D. Brent
Christopher C. Puri
1600 Division Street, Suite 700
Nashville, TN 37203
(615) 244-2582
Fax: (615) 252-6361
E-mail: mbrent@babc.com, or cpuri@babc.com
www.babc.com

Chambliss, Bahner & Stophel, P.C.
F. Laurens Brock
1000 Tallan Building
2 Union Square
Chattanooga, TN 37402-2500
(423) 756-3000
Fax: (423) 265-9574
E-mail: lbrock@cbslawfirm.com
www.cbslawfirm.com

Hall Booth Smith & Slover, P.C.
R. Blake Menzel
611 Commerce Street, Suite 2925
Nashville, TN 37203
(615) 313-9913
Fax: (615) 313-8008
E-mail: BMenzel@HBSS.net
www.hbss.net

The Law and Mediation Offices of Rebecca Adelman, PLC
Rebecca Adelman
545 South Main Street, Suite 111
Memphis, TN 38103-4825
(901) 529-9313
Fax: (901) 529-8772
E-mail: rebecca@adelmanfirm.com
www.adelmanfirm.com

Leitner, Williams, Dooley & Napolitan, PLLC
John B. Curtis, Jr.
801 Broad Street, Third Floor
Chattanooga, TN 37402-2668
(423) 265-0214
Fax: (423) 266-5490
E-mail: john.curtis@leitnerfirm.com
www.leitnerfirm.com

McNabb, Bragorgos & Burgess, PLLC
John B. Burgess
81 Monroe, Suite 600
Memphis, TN 38103-2416
(901) 624-0640
Fax: (901) 624-0650
E-mail: jburgess@mbb-law.com
www.mbb-law.com

Waller Lansden Dortch & Davis
William E. Shofner
511 Union Street, Suite 2700
Nashville, TN 37219
(615) 244-6380
Fax: (615) 244-6804
E-mail: wes.shofner@wallerlaw.com
www.wallerlaw.com

Wilkins, Stephens & Tipton, P.A.
David M. Eaton
5200 Maryland Way
Suite 110
Brentwood, TN 37027
(615) 661-7820
Fax: (615) 661-7236
E-mail: deaton@wilkins-law.com

Disclaimer: *This list is offered as a convenience to members. It is not, nor is it intended to be, a complete or exclusive list of professionals offeringthese types of services.*

Making *Friends & Families* Members Ambassadors

When a facility receives a negative survey outcome, family members can offer a different perspective of the facility than what the surveyors see. Administrators should encourage *Friends & Families* members to share their positive experiences with the community. Following is a template that can be used when writing a letter to the editor. The family member should either retype or rewrite this letter, adding specific information about his situation where indicated and send it to the local newspaper. Members preferring a copy of this letter in Microsoft Word should contact THCA's Communications Department.

> Dear Editor,
>
> I am writing in response to your recent article regarding (INSERT FACILITY NAME), "(INSERT NEWSPAPER HEADLINE)" from (INSERT DATE ARTICLE APPEARED IN THE PAPER).
>
> My (INSERT HOW YOU ARE RELATED TO THE PATIENT) has been a patient at (INSERT FACILITY NAME) for (INSERT LENGTH OF TIME AT NURSING HOME). During (HIS/HER) stay there, I have been very pleased with the care that (HE/SHE) has received. The staff, from maintenance, dietary, activity and social services to the administrator and director of nursing, works hard to ensure that the patients are safe and receive excellent care. They are kind and professional and treat the patients very well.
>
> Often, the media choose to focus negative attention on nursing homes, but my experience with my (INSERT FAMILY MEMBER HERE)'s care has been very positive. The nursing home offers a variety of social activities, as well as therapy services. The staff is attentive to the needs of patients and keeps family members informed on their conditions. (INSERT A PERSONAL EXAMPLE OF SOMETHING SPECIAL THE STAFF HAS DONE FOR YOUR LOVED ONE HERE.)
>
> I also know that (INSERT FACILITY NAME) is working hard to address the concerns raised by the Tennessee Department of Health. I have no doubt that they will continue to provide high-quality care to each and every patient who needs it.
>
> I hope that in the future your newspaper will choose to report on the positive news at the nursing home, including the great programs they offer for the patients.
>
> (NAME)
> (ADDRESS)
> (CITY, STATE ZIP CODE)
> (DAYTIME PHONE NUMBER)

Throughout the year, some family members may want to help publicize the good work that a facility is doing in the community and for their loved ones. Following is a suggested template. The family member should either retype or rewrite this letter, including specific information about his situation where indicated and send it to the local newspaper. If a copy of this letter is preferred in Microsoft Word, contact THCA's Communications Department.

> Dear Editor,

In light of the recent negative news coverage about nursing homes, I wanted to share with you my family's positive experiences with (INSERT FACILITY NAME).

My (INSERT HOW YOU ARE RELATED TO THE PATIENT) has been a patient at (INSERT FACILITY NAME) for (INSERT LENGTH OF TIME AT NURSING HOME). During (HIS/HER) stay there, I have been very pleased with the care that (HE/SHE) has received. The staff, from maintenance, dietary, activity and social services to the administrator and director of nursing, works hard to ensure that the patients are safe and receive excellent care. They are kind and professional and treat the patients very well.

In addition to high-quality patient care (INSERT FACILITY NAME) offers a variety of social activities, as well as therapy services. The staff is attentive to the needs of patients and keeps family members informed on their conditions. (INSERT A PERSONAL EXAMPLE OF SOMETHING SPECIAL THE STAFF HAS DONE FOR YOUR LOVED ONE HERE.)

I am truly thankful to the staff of (INSERT FACILITY NAME) for the caring and dedication they have for their patients. My (INSERT FAMILY MEMBER) truly feels that this is (HIS/HER) home, and that the staff is part of (HIS/HER) family, and I would recommend this facility to anyone who finds themselves faced with choosing a nursing home.

(NAME)
(ADDRESS)
(CITY, STATE ZIP CODE)
(DAYTIME PHONE NUMBER)

When a Facility Has a Positive Survey

Not all survey outcomes are negative. Many nursing homes across Tennessee receive positive survey outcomes on a regular basis. However, this type of news is not often covered by the media. Following is a press release template that can be used to share the news with local newspapers and television and radio stations. Facilities should retype the release on facility letterhead and include specific information where indicated. Members preferring a copy of this release in Microsoft Word should contact THCA's Communications Department.

FOR IMMEDIATE RELEASE For additional information contact:

(INSERT ADMINISTRATOR'S FULL NAME)
(INSERT FACILITY PHONE NUMBER)

Nursing home achieves positive survey results

(INSERT YOUR CITY'S NAME), Tenn. – During its annual inspection by the Tennessee Department of Health (TDH), (INSERT FACILITY NAME) received a positive state survey. "The results of this survey demonstrate the dedication and hard work of each member of our staff," said (INSERT ADMINISTRATOR'S FULL NAME), administrator at (INSERT FACILITY NAME). "From housekeeping and food service to activities and

physical therapy, every employee is committed to providing the highest quality of care to our disabled and elderly patients."

Each year, TDH sends a team of inspectors to each nursing home in the state to ensure that facilities are clean, free of potential hazards and following state and federal regulations regarding long-term care. These inspections are called "surveys." During the survey, which is unannounced and usually lasts three to five days, surveyors observe the day-to-day operations of the nursing home, interview patients and review medical records and other documents. After the survey, Administrator (INSERT ADMINISTRATOR'S LAST NAME) was notified by TDH that (INSERT INFORMATION ABOUT SURVEY RESULTS). Some of the positive comments from the survey team included (INSERT EXAMPLES OF POSITIVE COMMENTS FROM SURVEYORS).

"It is a great privilege to recognize (INSERT FACILITY NAME) for receiving positive survey results," said Ron Taylor, executive director of the Tennessee Health Care Association (THCA). "This survey shows that our members are committed to providing high-quality, round-the-clock care to Tennessee's most frail and ill citizens and demonstrates their dedication to the long-term care industry."

(INSERT FACILITY NAME) is a (INSERT NUMBER OF BEDS)-bed facility located in (INSERT CITY NAME). In addition to 24-hour, skilled nursing care (INSERT FACILITY NAME) offers a variety of programs and services to its patients including (GIVE EXAMPLES OF SERVICES FACILITY OFFERS). For more information, or to schedule a tour of the facility, please contact (INSERT CONTACT NAME), (INSERT CONTACT TITLE), at (INSERT PHONE NUMBER).

(INSERT FACILITY NAME) is a member of THCA, a non-profit organization whose members include long-term care facilities throughout the state. For more information about nursing homes, visit www.thca.org.

Facilities might also want to enlist the help of *Friends & Families* members in promoting positive survey results. Following is a template that can be used to help publicize the survey results and the good work the facility is doing in its community. The family member should either retype or rewrite this letter, including specific information about his situation where indicated and send it to the local newspaper. If copy of this letter is preferred in Microsoft Word, contact THCA's Communications Department.

Dear Editor,

Recently I learned that (INSERT FACILITY NAME) has received positive results from its recent inspection by the Tennessee Department of Health, and I wanted to inform the community of the great work this nursing home does.

My (INSERT HOW YOU ARE RELATED TO THE PATIENT) has been a patient at (INSERT FACILITY NAME) for (INSERT LENGTH OF TIME AT NURSING HOME). During (HIS/HER) stay there, I have been very pleased with the care that (HE/SHE) has received. The staff, from maintenance, dietary, activity and social services to the administrator and director of nursing, works hard to ensure that the patients are safe

and receive excellent care. They are kind and professional and treat the patients very well.

Often, the media choose to focus negative attention on nursing homes, but I hope you will take the time to recognize this positive news. In addition to high-quality patient care (INSERT FACILITY NAME) offers a variety of social activities, as well as therapy services. The staff is attentive to the needs of patients and keeps family members informed on their conditions. (INSERT A PERSONAL EXAMPLE OF SOMETHING SPECIAL THE STAFF HAS DONE FOR YOUR LOVED ONE HERE.)

I am truly thankful to the staff of (INSERT FACILITY NAME) for the caring and dedication they have for their patients. I know that their positive inspection was a direct result of their hard work, and I am proud of their accomplishment.

(NAME)
(ADDRESS)
(CITY, STATE ZIP)
(DAYTIME PHONE NUMBER)