STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

RENAISSANCE TERRACE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
257 PATTON LANE
HARRIMAN, TN 37748

NAME OF PROVIDER OR SUPPLIER

IDENTIFICATION NUMBER:
445223

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREVIOUS TAG

F 280
SS-D

483.20(d)(3), 483.10(k)(2) RIGHT TO
PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged
incompetent or otherwise found to be
incapacitated under the laws of the State, to
participate in planning care and treatment or
changes in care and treatment.

A comprehensive care plan must be developed
within 7 days after the completion of the
comprehensive assessment; prepared by an
interdisciplinary team, that includes the attending
physician, a registered nurse with responsibility
for the resident, and other appropriate staff in
disciplines as determined by the resident's needs,
and, to the extent practicable, the participation of
the resident, the resident's family or the resident's
legal representative; and periodically reviewed
and revised by a team of qualified persons after
each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of
facility investigation documentation, observation,
and interview, the facility failed to revise a care
plan to meet current needs for one resident (#2)
of six sampled residents.

The findings included:

Resident #2 was admitted to the facility on
December 19, 2011, with diagnoses including
Epileptic Grand Mal Status, Narcolepsy, and
Psychosis.

This Plan of Correction is prepared and submitted as
required by law. By submitting this Plan of Correction,
RENAISSANCE TERRACE CARE &
REHABILITATION CENTER does not
admit that the deficiency listed
on this form exist, nor does the
Center admit to any statements,
findings, facts, or conclusions
that form the basis for the alleged
deficiency. The Center reserves
the right to challenge in legal
and/or regulatory or
administrative proceedings the
deficiency, statements, facts, and
conclusions that form the basis
for the deficiency.

F280

1. On May 30, 2012, the Director of
Nursing and Assistant Director of
Nursing updated Resident # 2's Care
Plan and Care Card to reflect
incidents and interventions.

2. On June 14, 2012, Nursing
Management completed a review of
care plans for other residents with
incidents to ensure Care Plans and
Care Cards were updated with
incidents and interventions.

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

(1) DATE

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 discloseable 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 discloseable 14
days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued
program participation.
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Medical record review of a Minimum Data Set dated March 20, 2012, revealed the resident was severely impaired with decision-making skills, required extensive assistance with transfers and limited assistance with ambulation. Continued review revealed the resident was unable to balance during transfers and ambulation without human assistance and had no history of falls.

Medical record review of a nurse's note dated March 23, 2012, at 5:30 p.m., revealed the resident fell without injury.

Review of facility investigation documentation dated March 23, 2012, revealed, "...Recommendations to prevent further falls...Assure proper placement of pelvic positioners. Check on resident more frequently..."

Medical record review of nurse's note dated April 11, 2012, at 1:25 a.m., revealed, "...fall in the floor...resident bit (resident's) tongue. Will monitor closely."

Review of facility investigation documentation dated April 11, 2012, revealed, "...unassisted ambulation...resident non-compliant with requesting assistance...Recommendations to prevent further falls...Bed mat alarm with call light activation..."

Medical record review of a nurse's note dated April 17, 2012, at 1:55 a.m., revealed, "...fell in floor...no bruises or injuries noted..."


4. Audits of incidents, cause of incidents, interventions, care plans and care cards update will be completed by nursing management for new incidents twice weekly for 3 weeks, then weekly for 2 months. The Director of Nursing Services or designee will report findings of audits and observations to the Performance Improvement committee monthly, for one quarter for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social
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<tbody>
<tr>
<td>F 280</td>
<td>Services Director, Activities</td>
<td>Director, Admissions/Marketing</td>
<td>Director, Environmental Services</td>
<td>6/22/12</td>
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<tr>
<td>F 280</td>
<td>Director, Staff Development Coordinator, Nutritional Services</td>
<td>Director, Health Information Manager, Therapy Program</td>
<td>Manager, Clinical Case Manager, and MDS Coordinator</td>
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"...Recommendations to prevent further falls...Check resident more frequently throughout night."

Medical record review of a nurse's note dated May 1, 2012, at 7:45 p.m., revealed, "...observed in floor in broda chair on side...no s/s (signs/symptoms) of distress noted."

Review of facility investigation documentation dated May 1, 2012, "...Recommendations to prevent further falls...Ensure resident is in hallway while in broda chair."

Medical record review of a nurse's note dated May 5, 2012, at 12:00 a.m., revealed, "...on floor in room. Head to toe assessment completed swelling and bruising noted to chin...order to send out."

Medical record review of an Emergency Room (ER) Provider Record dated May 5, 2012, revealed, "...chief complaint: Fall injury to chin, ecchymosis (bruise) (around right eye) swelling/erythema (redness) (chin)...Clinical Impression Contusion chin..."

Medical record review of an ER physician's order dated May 5, 2012, revealed, "...return to NH (nursing home) Continue previous orders."

Review of facility investigation documentation dated May 5, 2012, revealed, "...Evaluation of event-cause...impulsive actions...Recommendations to prevent further falls...Padded floor mat on right side of bed. Bed against wall."
Medical record review of the care plan effective through May 29, 2012, revealed, "May be up in Broda chair with pelvic positioners...Mats on floor...Side rails up x 1 while in bed..." Continued review revealed no documentation regarding proper placement of pelvic positioners, more frequent checks, bed mat alarm, ensuring the resident was in the hallway when up in the Broda chair, or placement of the bed against the wall.

Observation on May 24, 2012, at 5:30 p.m., revealed the resident seated in the dining room located across the hall from the nurse's station in a Broda chair with pelvic positioners. Continued observation revealed the resident pulled at the left arm of the Broda chair and staff out of line of sight of the resident.

Observation on May 25, 2012, at 3:15 p.m., revealed the resident was seated between the right side of the nurse's station and a wall in a Broda chair with pelvic positioners. Continued observation revealed the right arm of the Broda chair was in contact with the wall. Continued observation revealed a CNA approximately five feet from the dining room at the end of the hall on the left side of the nurse's station and out of line of sight of the resident. Continued observation revealed no other staff in view.

Interview with Registered Nurse #2 (care plan nurse) on May 24, 2012, at 3:43 p.m., in a conference room, revealed the care plan effective through May 29, 2012, was the resident's current care plan. Continued interview confirmed the facility failed to revise the care plan to meet the current needs of Resident #2.
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility investigation documentation, review of manufacturer's literature, observation, and interview, the facility failed to provide adequate supervision to prevent recurrent falls for one resident (#2) of six sampled residents.

The findings included:
Resident #2 was admitted to the facility on December 19, 2011, with diagnoses including Epileptic Grand Mal Status, Narcolepsy, and Psychosis.

Medical record review of a Resident Fall Evaluation dated December 19, 2011, revealed, "...fell in last 30 days yes at hospital...at risk..."

Medical record review of a physician's order dated December 20, 2011, revealed, "...up in Broda chair with pelvic positioners..."

Medical record review of a Minimum Data Set dated March 20, 2012, revealed the resident was severely impaired with decision-making skills.

On May 29, 2012, Physical Therapy screened Resident #2 for appropriate seating, positioning and safety device. Due to resident's decreased cognitive status, Physical Therapy states the resident is in the appropriate seating system at this time for safety. On May 30, 2012, the Director of Nursing Services and the Assistant Director of Nursing Services immediately verbally re-educated the staff in the Secure Unit regarding the supervision of Resident #2 while up in a Broda Chair with pelvic positioners in place. Also included in the education were the manufacturer's recommendations for residents sitting in Broda Chairs to be in a supervised area, and away from objects. If the wheels are locked on the chair, the caregiver does not leave the resident unattended, especially those residents who have the capability or tendency to move the chair and/or those who may be agitated.

On June 22, 2012, facility staff began direct supervision of Resident #2 while up in a Broda Chair. Direct supervision will continue until assessed by the Resident's physician that the resident is deemed safe to be in a Broda chair without direct supervision.
| F 323 | Continued From page 5 required extensive assistance with transfers and limited assistance with ambulation. Continued review revealed the resident was unable to balance during transfers and ambulation without human assistance and had no history of falls. Medical record review of the care plan effective through May 29, 2012, revealed, "May be up in Broda chair with pelvic positioners...Mats on floor...Side rails up x 1 while in bed..." Medical record review of a nurse's note dated March 23, 2012, at 5:30 p.m., revealed, "... (resident) had pulled (resident's) legs out of the pelvic positioners...got up...fell on...bottom. No injuries..." Review of facility investigation documentation dated March 23, 2012, revealed, "...Recommendations to prevent further falls...Assure proper placement of pelvic positioners. Check on resident more frequently..." Medical record review of nurse's note dated April 11, 2012, at 1:25 a.m., revealed, "...up walking in hall - CNA (Certified Nursing Assistant) observed (resident) fall in the floor...resident bit (resident's) tongue. Will monitor closely." Review of facility investigation documentation dated April 11, 2012, revealed, "...unassisted ambulation...resident non-compliant with requesting assistance...Recommendations to prevent further falls...Bed mat alarm with call light activation..." Medical record review of a nurse's note dated April 17, 2012, at 1:55 a.m., revealed, "CNA..."
| F 323 | On May 30, 2012, the Nursing Management implemented observations and review of other residents regarding supervision when up in Broda chair with pelvic positioners applied, as applicable by the individualized care plan of the resident.

3. Nursing Management completed re-education for Licensed Staff and Certified Nursing Assistants on June 13, 2012, in regards to supervision of residents while up in a Broda chair with applied pelvic positioners, as applicable by the individualized care plan of the resident.

4. According to the resident's care plan, the Director of Nursing Services or designee will conduct audits of residents up in broda chair with pelvic positioners, to assure supervision is in place for safety. Audits will be completed twice weekly for 3 weeks then weekly for 2 months. The Director of Nursing or designee will report findings to the Performance Improvement for one quarter for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the
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observed resident up in room and resident fell in floor...no bruises or injuries noted. Will continue to monitor.

Review of facility investigation documentation dated April 17, 2012, revealed,
"...Recommendations to prevent further falls...Check resident more frequently throughout night."

Medical record review of a nurse's note dated May 1, 2012, at 7:45 p.m., revealed, "Res (resident) in room yelling...observed in floor in broda chair on side...no s/s (signs/symptoms) of distress noted."

Review of facility investigation documentation dated May 1, 2012, "...Recommendations to prevent further falls...Ensure resident is in hallway while in broda chair."

Medical record review of a nurse's note dated May 5, 2012, at 12:00 a.m., revealed, "Resident observed on floor in room. Head to toe assessment completed swelling and bruising noted to chin...order to send out."

Medical record review of an Emergency Room (ER) Provider Record dated May 5, 2012, revealed, "...chief complaint: Fall injury to chin...ecchymosis (bruise) (around right eye) swelling/erythema (redness) (chin)...Clinical Impression Contusion chin..."

Medical record review of an ER physician's order dated May 5, 2012, revealed, "return to NH (nursing home) Continue previous orders."
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Review of facility investigation documentation dated May 5, 2012, revealed: "...Evaluation of event-cause...impulsive actions...Recommendations to prevent further falls...Padded floor mat on right side of bed. Bed against wall."

Review of manufacturer's literature revealed, "...Improper use...Leaving the resident unattended in the chair near other objects...Leaving a resident unattended..."

Observation on May 24, 2012, at 5:30 p.m., revealed the resident seated in the dining room located across the hall from the nurse's station in a Broda chair with pelvic positioners. Continued observation revealed the resident pulled at the left arm of the Broda chair and staff out of line of sight of the resident.

Observation on May 25, 2012, at 3:15 p.m., revealed the resident was seated between the right side of the nurse's station and a wall in a Broda chair with pelvic positioners. Continued observation revealed the right arm of the Broda chair was in contact with the wall. Continued observation revealed a CNA approximately five feet from the dining room at the end of the hall on the left side of the nurse's station and out of line of sight of the resident. Continued observation revealed no other staff in view.

Interview with Registered Nurse (RN) #1 (RN supervisor) on May 25, 2012, at 3:33 p.m., in a conference room, revealed the resident overestimated the resident's ability to walk and was unable to walk. Continued interview confirmed the facility failed to provide adequate...
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<td>Continued From page 6 supervision to prevent recurrent falls and RN #1 stated, &quot;You have to have (resident) in sight.&quot;</td>
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