Complaint investigation #31612, #31654, #31799, #31993, #32007, #32260, #32466, #32833, #32893, #33321 and #33334, were conducted on February 3, 2014 through March 13, 2014. No deficiencies were cited for complaint investigation #31612, #31799, #31993, #32007, #32260, #32466, #32833, #32893 and #33321. Deficiencies were cited related to complaint investigation #31654 and #33334, under 42 CFR Part 483, Requirements for Long Term Care Facilities.

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each.

“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Renaissance Center does not admit that the deficiencies 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.”

**Step 1:**
The MDS for RR #5 was modified by the Clinical Case Manager on 2/23/2014. The MDS for RR #23 was modified by the Clinical Case Manager on 2/23/2014. The MDS for RR #24 was modified by the Clinical Case Manager on 2/24/2014. The MDS for RR #27 was modified by the Clinical Case Manager on 2/24/2014.
**Step 2:**
Audits were completed by the Clinical Case Manager on residents with wounds since development of the wound or the last years MDS by 3/25/2014. MDS' which were coded incorrectly were modified by the Clinical Case Manager by 3/25/2014.

**Step 3:**
Education was provided to the Clinical Case Manager and MDS Coordinator by the Clinical Reimbursement Manager on 3/15/2014 regarding accurate coding of the MDS for section “M”.

**Step 4:**
Section “M” of the MDS will be audited by the Clinical Case Manager weekly X 4 weeks and monthly X 2 months. Results of the audits will be reported to the Performance Improvement Committee monthly by the Clinical Case Manager and subsequent plans of correction will be implemented based on the results of the audits as necessary.

**Medical record review of the weekly Skin Integrity Report dated October 30, 2013, through February 18, 2014, revealed the resident had a Stage 3 Pressure Ulcer to the sacrum. Continued review revealed on February 5, 2014, the Pressure Ulcer measured 2.7 cm (centimeter) length x (by) 2.5 cm width x 1.0 cm depth with moderate serosanguineous drainage.**

**Medical record review of the quarterly Minimum Data Set (MDS) dated February 6, 2014, revealed the Pressure Ulcer was not recorded on the MDS.**

**Observation and interview on February 18, 2014, at 3:10 p.m. in the resident's room with**
F 278  Continued From page 2

Registered Nurse (RN) #1/Treatment Nurse and Licensed Practical Nurse (LPN) #1 revealed the resident had a Pressure Ulcer to the sacrum.
Continued observation and interview with RN #1 confirmed the Pressure Ulcer was a Stage 3; measured 3.0 cm length x 3.3 cm width x 1.5 cm depth; and had "heavy purulent drainage."

Medical record review of the MDS and interview on February 19, 2014, at 8:20 a.m., in the East Dining Room with RN #1 (responsible for completion of the section of the MDS which identified pressure ulcers), confirmed the MDS was not accurate and failed to include the stage 3 Pressure Ulcer in the assessment.

Resident #23 was readmitted to the facility from the hospital on December 27, 2013, with diagnoses including Septic Shock (resolved), Right Ureteral Stone with Stent Placement, Urinary Tract Infection, history of CVA (Cerebrovascular Accident), Acute Renal Failure (resolved) and Chronic Renal Failure, Gastrostomy Tube and Sacral Pressure Ulcer.

Medical record review of the weekly Skin Integrity Report dated January 2, 2014, and January 7, 2014, revealed a stage 2 Pressure Ulcer to the sacral right buttock which measured 2.3 cm x 0.8 cm with minimal serous drainage.

Medical record review of the quarterly MDS dated January 9, 2014, revealed the Pressure Ulcer was not recorded on the MDS.

Observation and interview on February 18, 2014, at 9:45 a.m., in the resident's room with RN #1 (and LPN #2 present) revealed the resident had an unstagable Pressure Ulcer to the sacrum.
F 278 Continued From page 3

Medical record review of the MDS dated January 9, 2014, and interview on February 18, 2014, at 4:00 p.m., in the Director of Nursing (DON) office with RN #1 confirmed the MDS was not accurate and failed to include the stage 2 Pressure Ulcer in the assessment.

Resident #24 was readmitted to the facility on December 27, 2013, with diagnoses including CVA, Diabetes, Peripheral Vascular Disease, Stage 3 Chronic Renal Disease, Dehydration and Chronic Ischemic Heart Disease.

Medical record review of the weekly Skin Integrity Report dated January 2, 2014, revealed a Stage 3 Pressure Ulcer to the right lateral ankle which measured 3.0 cm length x 1.5 cm width x 0.0 cm depth.

Medical record review of the admission MDS dated January 3, 2014, revealed the Pressure Ulcer was not recorded on the MDS.

Observation and interview on February 18, 2014, at 10:00 a.m., in the resident's room with RN #1 (also present was LPN #3) confirmed the resident had a Stage 3 Pressure Ulcer to the lateral right ankle which measured 1.5 cm x 1.0 cm.

Medical record review of the MDS dated January 3, 2014, and interview on February 19, 2014, at 8:15 a.m., in the East Dining Room with RN #1 confirmed the resident had a Stage 3 Pressure Ulcer and confirmed the MDS was not accurate and failed to include the stage 3 Pressure Ulcer.

Resident #27 was readmitted to the facility from the hospital on January 3, 2013, with diagnoses
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Including Chronic Ischemic Heart Disease, Chronic Airway Obstruction, Osteomyelitis, Hypertension, Dementia, Iron Deficiency Anemia and Severe Protein-Calorie Malnutrition.

Review of the weekly Skin Integrity Report dated January 15, 2014, revealed the resident had four (4) Osteomyelitis wounds to the left lower extremity. Continued review revealed the resident had wounds to the left lateral thigh, the left medial thigh, the left lateral knee and the left medial knee.

Medical record review of the annual MDS dated January 17, 2014, revealed the wounds were not included in the MDS.

Observation and interview on February 20, 2014, at 12:00 p.m., in the resident's room with RN #1 (also present was LPN #4) confirmed the four wounds to the left leg were the result of Osteomyelitis and were present upon admission to the facility. Continued observation and interview revealed RN #1 measured the wounds as follows: Left lateral thigh-0.5 cm x 0.6 cm; left lateral knee-1.5 cm x 1.5 cm; left medial thigh-0.8 cm x 1.0 cm; and the left medial knee-1.4 cm x 1.4 cm. Continued interview revealed moderate to heavy purulent drainage from the wounds.

Medical record review of the MDS dated January 17, 2014, and the weekly skin integrity report dated January 15, 2014, and interview on February 20, 2014, at 12:50 p.m., in the East Dining Room with the MDS staff (LPN #5) confirmed the resident had four wounds resulting from Osteomyelitis and confirmed the MDS was not accurate and failed to include the wounds in the assessment.
F 278  Continued From page 5

C/O #33334

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on facility policy review, medical record review, review of hospital records, and interview, the facility failed to ensure the facility's policy for taking medication and treatment orders was followed for four (#21, #23, #32, #35) of six residents reviewed.

The findings included:

Review of facility policy, Taking Medication and Treatment Orders, revealed, "...Medication and treatment orders will be accepted from authorized, credentialed physicians or from other authorized, credentialed physicians in accordance with state regulations regarding prescriptive privileges. Telephone orders are received by phone from a practitioner who may or may not be in the Center and are an accepted standard of practice. An order received by phone from a practitioner who is in another part of the Center is considered a telephone order...Purpose...To ensure all medication and treatment orders are received from a credentialed practitioner before implementing...Admission, Interim, Re-admission, and Renewal Orders:...All orders must be signed by an authorized, credentialed physician or other authorized practitioner in accordance with state
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

X(1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:  
445223

X(2) MULTIPLE CONSTRUCTION  
A. BUILDING  
B. WING

X(3) DATE SURVEY COMPLETED  
C 03/13/2014

**NAME OF PROVIDER OR SUPPLIER**

RENAISSANCE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

257 PATTON LANE  
HARRIMAN, TN 37748

| 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) | COMPLETION DATE |
|----|--------|-----|-----------------------------------|----|--------|-----|---------------------------------|-----------------|
| F 281 | Continued From page 6  
regulations regarding prescriptive privileges...Person taking the order must be licensed per regulations and can only take the order from a credentialed physician or other authorized practitioner all allowed by state regulations...Person obtaining orders must document T.O. (telephone order) plus the prescriber’s name and title, name and title of the person receiving the order, date, month, year, and time...Prescriber’s signature must be obtained per state regulations...”  
Resident #21 was admitted to the facility on December 9, 2011, with diagnoses including Bipolar Disorder, Epilepsy, and history of CVA (Cerebrovascular Accident), Depression, Attention Deficit Disorder, Anxiety and Attention-Seeking Behavior.  
Medical record review of a nurse’s note dated January 8, 2014, revealed the resident was transferred from the facility to a day surgery center for a colonoscopy.  
Medical record review of a hospital history and physical dated January 8, 2014, revealed the resident was scheduled for an outpatient colonoscopy on January 8, 2014, and when the resident arrived in the colonoscopy suite ”...patient noted...having chest pains...referred from a colonoscopy suite to the ER (Emergency Room) for further evaluation...will admit...on observation status and rule...out from the cardiac standpoint...for the rest of (resident's) chronic medical problems...home medications were resumed...” Continued review revealed all hospital work-ups were within normal limits. The resident was discharged back to the facility on January 10, 2014.  

| Step 3:  
The Nurse Practice Educator educated licensed staff regarding “Taking Medication and Treatment Orders” policy and procedure by 3/26/2014.  

| Step 4:  
Admission and Re-admission orders will be audited by the Director of Nursing/Designee weekly X 4 weeks and monthly X 2 months. Results of the audits will be reported to the Performance Improvement Committee monthly by the Director of Nursing/Designee and subsequent plans of correction will be implemented based on the results of the audits as necessary.  

<p>| 3/31/2014 |</p>
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Medical record review of the hospital's discharge medication orders revealed a handwritten notation "...Dr. (facility physician) wants (resident) to continue with current FSBS (finger stick blood sugars)..." and "...stay on same insulin..." Continued review revealed the handwritten order did not include the date the order was taken, the name and title of the person taking the order, and had not been countersigned by the physician who gave the order.

Resident #23 was readmitted to the facility from the hospital on December 27, 2013, with diagnoses including Septic Shock (resolved), Right Ureteral Stone with Stent Placement, Urinary Tract Infection, CVA, Acute Renal Failure, Hypertension, history of Asthma, Hypothyroidism, Peptic Ulcer Disease, Chronic Aphasia and Right Hemiparesis, Dysphagia (difficulty swallowing) and Gastrostomy Tube.

Medical record review of the hospital's discharge medication orders dated December 27, 2014, revealed a handwritten notation "D/C" (discontinue) Novolog insulin. Continued review revealed the handwritten order did not include the date, the name and title of the person giving the order and taking the order, and the order had not been countersigned by the physician.

Resident #32 was readmitted to the facility from the hospital on December 23, 2013, with diagnoses including history of Nissen Fundoplication (surgical procedure to treat Gastrointestinal Reflux Disease), Mental Retardation, Gastritis, Gastroparesis, and Esophagitis with Chronic Inflammation.
F 281  Continued From page 8

Medical record review of the hospital's discharge medication orders dated December 23, 2013, revealed a handwritten notation "D/C per (named physician) 12-23-13." Continued review revealed the handwritten order did not include the name and title of the person taking the order, and the order had not been countersigned by the physician.

Resident #35 was readmitted to the facility from the hospital on December 28, 2013, with diagnoses including Intracranial Hemorrhage and Scalp Hematoma (caused by a fall in the facility on December 26, 2013), Dementia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, Chronic Renal Disease, Diabetes and Urinary Tract Infection.

Medical record review of a hospital physician's order dated December 28, 2013, revealed, "...Head CT (computed tomography-cat scan)...showed a tiny area of bleed inside skull near right ear region...aspirin was put on hold because of it. Talk to (facility's physician) about when and whether to resume the aspirin..."

Medical record review of the hospital's discharge medication orders dated December 28, 2013, revealed no order for Aspirin.

Medical record review of the facility's printed orders dated December 30, 2013, revealed, "...Aspirin 81 mg (milligram)...daily every day..."

Interview on March 7, 2014, at 10:30 a.m., in the East Dining Room with the Registered Nurse (RN) #1 who initiated the hospital discharge orders confirmed the hospital discharge medication orders did not include Aspirin.
F 281 Continued From page 9
Continued interview revealed the facility physician reordered the Aspirin on December 28, 2013, and stated "...did not want (resident) to have a clot..."
Continued interview confirmed the physician's order to continue Aspirin had not been recorded or countersigned by the physician on December 28, 2013.

Telephone interview and review on March 7, 2014, at 3:40 p.m., of the facility's policy for taking medication and treatment orders with the Director of Nursing confirmed the facility's policy for physician's orders had not been followed for resident's #21, #23, #32 and #35.

C/O #33334

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, observation and interview, the facility failed to ensure Oxygen (O2) therapy was provided for one resident (#25) of four residents reviewed who were receiving O2.

The findings included:
F 309  Continued From page 10

Resident #25 was readmitted to the facility from the hospital on July 11, 2011, with diagnoses including Hypoxemia (decreased O2 concentration in the blood), Cerebrovascular Accident (Stroke), Anxiety, Psychosis, and Convulsions.

Medical record review of the quarterly Minimum Data Set (MDS) dated November 15, 2013, revealed the resident scored 6/15 on the Brief Interview for Mental Status (BIMS) with severe cognitive impairment; required assistance with all activities of daily living (ADL); was bed confined; had shortness of breath; and received O2 therapy.

Medical record review of the care plan updated December 3, 2013, revealed, "...at risk for respiratory distress related to COPD (Chronic Obstructive Pulmonary Disease). Noted to remove oxygen nasal cannula frequently...Goals...Maximize comfort and quality of end-of-life, minimize complications of imminent demise...Encourage resident to comply with oxygen therapy...O2 as ordered. Check O2 sat's as ordered/PRN (as needed)...Observe for signs of resp. (respiratory) distress such as: increased SOB (shortness of breath), dyspnea, decreased O2 sat's (saturation)..."." 

Medical record review of nurses' notes dated November 27, 2013, December 9th and 15th, 2013, January 2nd, 9th, and 20th 2014, February 2nd, 9th and 18th, 2014, revealed O2 therapy at 2 liters per minute per nasal cannula.

Medical record review of the physician's orders dated February 1-28, 2014, revealed, "Oxygen @(at) 2 LPM (liters per minute) as needed..."
F 309 Continued From page 11

Review of facility policy, Oxygen therapy, dated October 1, 2012, revealed, "...High pressure cylinders are set up by a licensed nurse, respiratory therapist, or rehabilitation therapist with a physician's order. With proper training, a certified nursing assistant (CNA) or rehabilitation technician may attach a regulator to a high pressure cylinder, but may not adjust liter flow..."

Random observation and interview on February 18, 2014, at 12:25 p.m., in the resident's room with Licensed Practical Nurse (LPN) #2 revealed the resident was sitting in a chair at the bedside with a nasal O2 cannula in the nose and the tubing attached to a portable O2 tank. Observation revealed the resident was struggling to breathe; was gasping with the mouth open and the head back; had abdominal breathing; and had rapid respirations. Brief interview with the resident at the time of the observation confirmed the resident was having difficulty breathing. Continued observation and interview with LPN #2 confirmed the portable O2 tank was not turned on and the resident was not receiving O2 via the nasal cannula. Continued interview confirmed the resident used O2 "continuously" and often had difficulty breathing as noted during the observation. Observation revealed LPN #2 connected the O2 tubing to the O2 concentrator at the resident's bedside and initiated Oxygen therapy.

Observation and interview on February 18, 2014, at 12:28 p.m., in the resident's room with Registered Nurse (RN) #1 (LPN #2 present) confirmed the resident's O2 sat (Oxygen level) was low at 84%.

F 309 appropriate oxygen use. Results of the audits will be reported to the Performance Improvement Committee monthly and subsequent plans of correction will be implemented based on the results of the audits if necessary. 3/31/2014
F 309  Continued From page 12
Observation and interview on February 18, 2014, at 12:31 p.m., in the resident’s room with RN #1 revealed the O2 sat had increased to 94% since the O2 had been turned on.

Interview on February 18, 2014, at 12:33 p.m., on the 100 hallway with CNA #1 confirmed CNA #1 placed the resident in the chair at the bedside; connected the resident to the portable O2 tank; and turned the O2 to 2 liters per minute.

Interview on February 18, 2014, at 12:35 p.m., in the resident’s room with LPN #2 revealed the resident was "hardly ever" out of bed and used the O2 concentrator continuously while in bed.

Interview on February 18, 2014, at 1:50 p.m., at the nurses’ station with CNA #1 confirmed, "...anytime (resident) is in the wheelchair...placed on O2 because we know...gets short of breath and has trouble breathing..."

C/O #31654, #33334

F 327  483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, the facility failed to provide sufficient fluid with the meal for one (#4) of six residents reviewed for nutrition and hydration.
Continued From page 13

The findings included:

Resident #4 was readmitted to the facility on February 4, 2009, with diagnoses including Cerebrovascular Accident (Stroke), Diabetes, Obesity, Diarrhea and Recurrent Urinary Tract Infection (UTI).

Medical record review of the quarterly Minimum Data Set (MDS) dated October 26, 2013, revealed the resident scored 15/15 on the Brief Interview for Mental Status (BIMS) with no impairment of decision-making skills or cognition; required assistance with all activities of daily living (ADL); and was frequently incontinent of urine.

Medical record review of the care plan updated February 7, 2014, revealed, "...Potential for fluid volume deficit...recurrent UTI...Observe for signs of dehydration...water pitcher at bedside within reach...will provide at least 2 beverages with meal..."

Observation and interview on February 18, 2014, at 11:40 a.m., in the dining room revealed the resident was preparing to eat the noon meal. Observation of the resident's meal ticket revealed, "Water x (times) 2." Observation revealed only one cup of water with the meal.

Observation and interview on February 18, 2014, at 11:55 a.m., at the resident's table in the dining room with the Dietary Manager confirmed the resident was to receive two glasses of water with meals and confirmed only one ten-ounce container of water was served.

C/O # 31654, #33334

F-327

Step 1:
RR #4 was provided an extra glass of water on 2/18/2014 by the Dietary Manager.

Step 2:
Director of Nursing/Designee audited trays to ensure tray cards were followed and each resident had hydration on 2/21/2014. Dietary Manager completed a tray line audit on 2/21/2014. No other issues with hydration were identified.

Step 3:
The Dietary Manager educated the dietary staff by 3/17/2014 regarding...
Division of Health Care Facilities

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NAME OF PROVIDER OR SUPPLIER: RENAISSANCE CENTER  
STREET ADDRESS, CITY, STATE, ZIP CODE: 257 PATTON LANE  
HARRIMAN, TN 37748

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Complaint investigation #31612, #31654, #31799, #31993, #32007, #32260, #32466, #32833, #32893, #33321 and #33334, were conducted February 3, 2014 through March 13, 2014. No deficiencies were cited for complaint investigation #31612, #31654, #31799, #31993, #32007, #32260, #32466, #32833, #32893, #33321 and #33334 under Chapter 1200-8-6 Standards for Nursing Homes.

| N 000 | following the tray card for accuracy. The Nurse Practice Educator educated nursing staff by 3/26/2014 regarding checking the tray card during set up to ensure accuracy of hydration ordered. |

**Step 4:**  
Audits will be conducted by the Dietary Manager weekly X 4 weeks and monthly X 2 months for the accuracy hydration on the tray card. The Dietary Manager will report the results of the audits to the Performance Improvement Committee monthly and subsequent plans of correction will be implemented based on the results of the audits if necessary.  

3/31/2014