<table>
<thead>
<tr>
<th>ID TAG</th>
<th>PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>POSITION OF COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Renaissance Terrace Care &amp; 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.”</td>
<td></td>
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<tr>
<td>F 225</td>
<td>483.13(c)(1)(ii)-(iii). (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
<td>F 225</td>
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<td>SS=D</td>
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The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the

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.
F 225 Continued From page 1

continued investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility provided documentation, interview and facility policy review, the facility failed to report an allegation of verbal abuse and initiate an investigation timely for one (#15) of two residents reviewed for allegations of abuse.

The findings included:

Resident #15 was admitted to the facility on March 12, 2009, with diagnoses including Parkinson's Disease, Childhood Polio, and Mental Retardation.

Medical record review of the Minimum Data Set dated May 15, 2011, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living.

Review of facility provided undated documentation written by Licensed Practical Nurse (LPN) #2 revealed "...Observed (Certified Nurse Assistant) (CNA) #1 yelling @ (at) a
**F 225** Continued From page 2

resident (identified as resident #15) because (resident) wanted to go to the bathroom, (CNA #1) stated that (resident) had just gone 20 mins (minutes) ago et (and) it was ridiculous they had to stop what they were doing again to take (resident) it was ridiculous, (CNA #1) did take (resident) et walked away another CNA got (resident) out of the bathroom...

Interview with the DNS in the dietary manager's office and LPN #2 per telephone on August 2, 2011, at 3:15 p.m., revealed the incident happened during a shift. LPN #2 and Registered Nurse (RN) #1 worked just before June 17, 2011, but was unsure which day. Continued interview with LPN #2 confirmed LPN #2 did not report the alleged verbal abuse to the Administrator the day it happened. Continued interview revealed LPN #2 did "...say something about it to RN #1 before leaving from the shift..."

Interview on August 3, 2011, at 3:34 p.m., per telephone with RN #1 revealed the RN did not remember LPN #1 "...say anything about verbal abuse..."

Interview on August 2, 2011, at 3:20 p.m., in the dietary manager's office with the DNS confirmed LPN #2 failed to report the incident timely. Continued interview revealed the DNS did not timely report the allegation of verbal abuse to the administrator or initiate an investigation when the written statement with the allegations was provided to the DNS.

Review of the June 2011, nurse's schedule revealed LPN #2 and RN #1 worked together on June 13, 2011.

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A documented audit by either the Social Worker or the NHA will be conducted for ten random employees for their knowledge for reporting alleged abuse weekly for four weeks and monthly for 2 months. Ten Residents will be interviewed by the Social Worker regarding alleged abuse weekly for four weeks and monthly for 2 months.

4. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with reporting of alleged abuse. The Performance Improvement Committee includes the Administrator, Medical Director, Director of Nursing Services, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.

8/30/11
<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 225</td>
<td>Continued From page 3</td>
<td>Review of the facility's Abuse &amp; Neglect Prohibition Program Policy/Procedure revealed &quot;...Complaints/allegations, observation, or suspicion of neglect, abuse, or misappropriation of personal property must be thoroughly investigated and reported in a consistent and uniform manner, in accordance with state and federal law...The center must ensure that all alleged violations involving mistreatment, neglect, or abuse...are REPORTED IMMEDIATELY TO THE ADMINISTRATOR OF THE CENTER...&quot;</td>
<td>F 225</td>
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<td>F 281</td>
<td>SS-D</td>
<td>C/O #TN00028331</td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
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<td>The services provided or arranged by the facility must meet professional standards of quality.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain a special (low air loss for pressure reduction) mattress for one resident (#6) and failed to follow a physician's discharge order for an alarming seatbelt for one resident (#11) of twenty-five residents reviewed.</td>
<td>1.1</td>
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<td>On August 2, 2011, a low air loss mattress was placed on resident's #6's bed by the unit nurse.</td>
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<td>The findings included:</td>
<td>1.2</td>
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<td>On August 2, 2011, the Velcro safety seatbelt was removed from resident #2's wheelchair by the unit manager.</td>
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<td>Resident #6 was re-admitted to the facility on October 14, 2008, with diagnoses including Physical Therapy, Muscle Weakness and Wasting, and Alzheimer's Disease.</td>
<td>2.1</td>
<td></td>
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<td>Assessments of other residents identified by the Interdisciplinary Team (The DNS, Unit Managers, Social Services, Dietitian, Therapy staff, Activities Director, MDS Coordinator) with high risk for pressure ulcers were completed by Nursing Management on August 12, 2011 and orders obtained as needed.</td>
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<td>2.2 The care plans, care cards and physician orders were reviewed by nursing management on August 7, 2011, for residents having devices in use. No other residents were found to have devices in use that were discontinued.</td>
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F 281 Continued From page 4

Medical record review revealed a Pressure Ulcer had been discovered on the right heel on May 11, 2011.

Medical record review of the Interdisciplinary Progress Notes dated June 22, 2011, revealed "low" Albumin, Protein, and Hematocrit levels.

Medical record review of the Interdisciplinary Progress Notes dated June 29, 2011, revealed the pressure ulcer was healing "slowly" and "Will request LAL (low air-loss) mattress".

Review of the Medical Nutrition Therapy Assessment documentation dated June 30, 2011, revealed, "recommendation of nursing =LAL mattress."

Medical record review of the Pressure Ulcer Scale dated July 27, 2011, revealed the resident was High Risk" for the development of a pressure ulcer.

Medical record review of the Pressure Ulcer Documentation Form revealed a stage II pressure ulcer on the Coccyx had developed and was discovered on August 1, 2011.

Observation of the resident on August 1, 2011, at 9:00 a.m., revealed the resident lying on a regular mattress.

Observation and interview with Registered Nurse (RN #2, performing wound care) in the resident's room on August 2, 2011, at 8:15 a.m., verified the resident was on a regular mattress, and "really needs to be on a low air loss mattress."

3.1 On August 3, 2011, the NHA re-educated the Interdisciplinary Team (The DNS, Unit Managers, Social Services, Dietitian, Therapy Director, Activities Director, MDS Coordinator, and Admissions Coordinator) on skin assessment and interventions to include air mattresses.

3.2 Staff re-education regarding device use was completed on August 19, 2011, by the Staff Development Coordinator and nursing management.

4.1 The DNS will conduct an audit of Interdisciplinary Team (IDT) recommendations and follow-up on ten (10) residents for four weeks then monthly for 2 months. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with quality of care and professional services. The Performance Improvement Committee includes the Administrator, Medical Director, Director of Nursing Services, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.
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<tr>
<td>F 281</td>
<td>Continued from page 5</td>
<td>Observation of the resident on August 2, 2011, at 10:30 a.m., revealed the resident lying on a regular mattress. Observation of the resident on August 3, 2011, at 9:00 a.m., revealed the resident lying on a Low air-loss mattress. Interview with the Interim Director of Nursing in the Director's office on August 3, 2011, at 11:05 a.m., confirmed the facility failed to obtain the special (low air loss) mattress for the resident for over a month after the recommendation was made. Medical record review revealed Resident #11 was admitted to the facility on December 7, 2009, with diagnoses which included Behavioral Symptoms, Depression, Cognitive Impairment, and Mental Impairment. Review of an Interdisciplinary Progress Note dated July 21, 2011, stated, &quot;Velcro seat belt D/C'd (discontinued) on 8/30/11...&quot;. Medical record review revealed a physician's order dated July 30, 2011, to discontinue the &quot;Velcro safety seatbelt...&quot; Observations of the resident on August 2, 2011, at 8:20 a.m., 9:30 a.m. and 10:30 a.m., revealed the resident seated in a wheelchair in the hallway on East Wing, with a velcro safety seatbelt fastened around the residents waist. Interview with Certified Nursing Assistant #2, in</td>
<td>4.2 Nursing Management will conduct an audit of device use; physician orders, care plans, and care cards will be completed for ten (10) residents for four weeks then monthly for 2 months. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with quality of care and professional services. The Performance Improvement Committee includes the Administrator, Medical Director, Director of Nursing Services, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.</td>
<td>8/30/11</td>
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Continued From page 6

the hallway of East Wing, on August 2, 2011, at 10:30 a.m. confirmed the velcro safety seatbelt was fastened around the resident and stated the resident wore the belt whenever up in the wheelchair.

Interview with the East Wing Licensed Practical Nurse (LPN) on August 2, 2011, at 10:30 a.m. confirmed the physician’s order had not been followed for the use of a velcro safety seatbelt.

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to provide nail care and hand hygiene for one resident (#13) of twenty five residents reviewed.

The findings included:

Resident #13 was admitted to the facility on May 10, 2010, with diagnoses including Closed Head Injury, Herniparesis, and Contracted Right Hand.

Medical record review of the Minimum Data Set (MDS) dated May 11, 2011, revealed the resident had impaired communication skills and required assistance with all activities of daily living.

1. On August 2, 2011, Resident #13’s finger nails were trimmed and cleaned and the right hand was cleaned by the LPN.

2. Other residents were assessed by the Unit Managers, for long, nails and those were cleaned and trimmed on August 2, 2011 by the nursing staff.

3. Re-education of nursing staff was completed on August 19, 2011, by the SDC regarding ADL care and the dependent resident.
F 312 Continued From page 7
Observation of the resident in the resident's room on August 1, 2011, at 12:35 p.m., revealed seven of ten fingernails had brown debris under the fingernail tips; the fingernails were 3/8 to 3/4 inch long and jagged, and the right hand was contracted and had a foul odor.

Observation and interview in the resident's room on August 2, 2011, at 1:10 p.m., with MDS Coordinator #1 confirmed seven of ten fingernails had brown debris under the fingernail tips; the fingernails were 3/8 to 3/4 inch long and jagged, and the resident's right hand was contracted and had a foul odor. Interview confirmed the resident's fingernails needed to be cleaned and trimmed, and the resident's right hand had a foul odor and needed to be washed.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program

4. The Unit Managers will conduct an audit of nail care and cleanliness completed for three (3) residents with contracts for four weeks then monthly for 2 months. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with ADL Care for Dependent Residents.

The Performance Improvement Committee includes the Administrator, Medical Director, Director of Nursing Services, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.

F 441 8/30/11

1. Resident #20 was re-assessed by an RN on 8-18-11 and no complications resulted from the pericare. CNA #3 was re-educated by SDC on 8-2-11 regarding pericare. Linen contaminated during incontinence care was changed by the Certified Nursing Assistant on August 2, 2011 at 4:20 pm.
Continued From page 8

determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, review of facility policy and interview, the facility failed to ensure proper hand hygiene/infection control was provided during perineal care for one (#20) of twenty-five residents reviewed.

The findings included:
Medical record review revealed resident #20 was admitted to the facility on April 7, 2011, with diagnoses including Rehabilitation and Convulsions.

Observation on August 2, 2011, at 3:15 p.m., revealed the following sequence with staff performance of incontinence care for the resident:

2. Other residents on that assignment were re-assessed by an RN on 8-18-11 and no complications were identified.

3. On August 2, 2011, 5:00pm, the Staff Development Coordinator re-educated the Certified Nursing Assistant on Infection Control, the use of gloves, hand washing, carrying supplies in pockets, and handling of soiled/clean linen. The RN completed on August 19, 2011, re-education to other nursing staff on Infection Control and, the use of gloves, hand washing, carrying supplies in pockets, and handling of soiled/clean linen.

4. The SDC and nursing management will complete a visual audit of 10 occurrences of incontinent management per week for three (3) weeks and monthly times 2 months. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with Infection Control practices. The Performance Improvement Committee includes the Administrator, Medical Director,
**RENAISSANCE TERRACE CARE AND REHABILITATION CENTER**

**F 441** Continued From page 9

Certified Nursing Assistant (CNA #3) applied gloves, removed an adult brief which contained urine and bowel movement; disposed of the brief in a plastic bag; without washing the hands or changing the soiled gloves, performed urinary incontinence care using disposable cleaning pads; CNA #3 used a different disposable cleaning pad and performed incontinence care to remove the bowel movement; without removing the gloves, CNA #3 reached into the side-leg pocket of their uniform removing a barrier cream; squeezed cream into the soiled gloved hand then applied the cream to the resident's buttocks and applied a clean brief; without removing the soiled gloves, CNA #3 placed the cream back in their uniform pocket and pulled the covers up, then removed the gloves and washed their hands.

Review of the facility policy (un-numbered) titled, Handwashing, revealed hand washing is to be performed "After handling garbage, diapers, etc ..."

Interview with CNA #3 in the hall outside the resident's room on August 2, 2011, at 3:27 p.m., verified the gloves were not changed and the hands were not washed after handling contaminated material.

Interview with the Staff Development Coordinator at the nurses' station on August 2, 2011, at 3:40 p.m., confirmed the facility failed to ensure proper hand hygiene/infection control prevention during incontinence care.

**F 504**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 441</td>
<td></td>
<td>Director of Nursing Services, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.</td>
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<td><strong>F 504</strong></td>
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<tr>
<td>483.75(2)(1) LAB SVCS ONLY WHEN</td>
<td></td>
<td>1. An order for Resident #3 for a BMP was obtained and completed on August 3, 2011. Physician informed of results with no new orders given.</td>
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<tr>
<td>SS-D</td>
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<td>The facility must provide or obtain laboratory</td>
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**DATE SURVEY COMPLETED**
08/03/2011
F 504

Continued from page 10 services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to obtain an ordered laboratory study for one (#3) of twenty-five residents reviewed.

The findings included:

Resident #3 was admitted to the facility on August 28, 2009, with diagnoses including Rehabilitation, Dementia and Alzheimer's Disease.

Medical record review of the physician's orders revealed Basic Metabolic Panel (BMP, electrolyte levels) "every 6 months".

Medical record review revealed the most recent BMP results were December 7, 2010.

Interview and medical record review with the Staff Development Coordinator in the conference room on August 2, 2011, at 8:10 a.m., verified a BMP had not been obtained since December 2010 (6 months ago) and confirmed the facility failed to obtain the ordered laboratory study every six months.

F 514

483.75(I)(1) RES

The facility must maintain clinical records on each
Patient #1 was discharged from the facility on April 18, 2011. On August 2, 2011, the LPN added an attestation statement of late entry to the Medical Record affirming that the Medical Record entries she had written dated 4/17 and 4/18 were written in 2011.

A review of current resident care was conducted by nursing management on August 5, 2011 regarding the documentation in the record. The facility recognized all residents benefit from complete and accurate medical records.

The licensed staff was re-educated by the SDC on completion of the medical record entry to include the month, day, year, and time of each entry. This re-education was completed on August 19, 2011.

Medical Record audits for 10 residents will be conducted by the Unit Managers will be completed weekly for three (3) weeks then monthly for two (2) months. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with completion of the medical record.
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| F 514 |        |     | Continued From page 12 included, "...Family notified..."
|     |        |     | Medical record review of a POST (physician order for scope of treatment) form dated October 1, 2010, revealed, "...DNR..."
|     |        |     | Interview with a Corporate Regional Registered Nurse on August 2, 2011, at 3:20 p.m., in the conference room, confirmed the facility failed to maintain a complete medical record for Resident #1. Resident #6 was re-admitted to the facility on October 14, 2008, with diagnoses including Physical Therapy, Muscle Weakness and Wasting, and Alzheimer's Disease. Review of the Pressure Ulcer Documentation Form (A) revealed the ulcer on the right heel was discovered/assessed May 11, 2011; measured 1.9 cm (centimeters) length X (by) 1.3 cm width X < (less than) 0.1 depth, unstageable and contained 80% (percent) eschar. Further review of the Documentation form (A) revealed the ulcer was assessed on May 18, 2011, one week later and the ulcer remained unstageable, and measured 1.5cm X 2cm X < 0.1 and contained 80% eschar. Review revealed the form ("A") was signed by Licensed Practical Nurse (LPN #3) for entries on May 11 and 18, 2011. Observation of resident #6 on August 2, 2011, at 8:15 a.m., revealed a pressure ulcer on the right heel and a pressure ulcer on the coccyx area. Medical record review and interview with the Registered Nurse Supervisor (RN #3, assigned to entries. The Performance Improvement Committee includes the Administrator, Medical Director, Director of Nursing Services, Assistant Directors of Nursing, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.

1.2 Resident #6 was re-assessed by the RN on August 4, 2011 with findings of staging differential from a Stage II to a Stage III.

2.2 Other resident’s skin assessments were completed on August 4, 2011 by the staff RN. No other discrepancies were found.

3.2 Re-education was completed for the licensed staff on August 19, 2011, by the SDC and unit managers, regarding complete medical record documentation.
Continued From page 13

measure the ulcers weekly) on August 3, 2011, in the
 dictate room, revealed RN #3 had
completed an additional Pressure Ulcer
Documentation Form ("B") with documented entry
dates of May 11, 18 and 25, 2011. RN #3 stated
"determined the ulcers were a stage II."
Continued interview revealed RN #3 "had talked
to LPN #3 and discovered the wound (ulcer) did
not have eschar...must have gotten mixed up..."
Review of the Form (A) and (B) revealed the
dates and measurements were the same; the
form (B) documented by RN #3 revealed the ulcer
did not have eschar and was a stage II instead of
unstageable, and RN #3 confirmed the
documented entries were signed as completed
by RN #3 on May 11, 18, and 25, 2011.

Interview with the Interim Director of Nursing in
the Director's office on August 3, 2011, at 2:10 p.m., revealed RN #3 was hired on June 29, 2011
(seven weeks after RN #3 documented
assessment and measurement of the pressure
ulcer). Continued interview confirmed the facility
failed to provide accurate documentation in the
medical record.

Medical record review of the Pain Management
Medication Administration Record (MAR) dated
May 2011, for resident #5 revealed the resident received "...Duragesic 50 (Fentanyl) Transdermal
(through the skin) Dose: 50 mcg/hr (micrograms
per hour) Daily Every 3 days 2 Nurses to verify
disposal of old patch..." The MAR revealed no
documentation of patch site placement on May
11, 17, 20, 23, 26, 29, 2011, and no verification of
disposal of the old patches was documented on
May 11, 17, 20, 23, 26, 29, 2011.

4.2 Audits will be completed as needed
for information being transcribed into
a different format by the DNS, unit
managers or the NHA to concur
accuracy of the information and noted
to be a copy. Audits will be reviewed
in the monthly Performance
Improvement (PI) Meeting to ensure
compliance with transcribing medical
records. The Performance
Improvement Committee includes the
Administrator, Medical Director,
Director of Nursing Services,
Assistant Directors of Nursing, Social
Services Director, Activities Director,
Housekeeping Supervisor, Nutritional
Service Director, Clinical Case
Manager, MDS Coordinator,
Infection Control Nurse, Maintenance
Director, and Pharmacy Consultant.

8/30/11

1.3 Resident # 5 was re-assessed by the
DNS on August 18, 2011 and had no
complications identified from the
incomplete medical record. Resident
#16 was re-assessed by the DNS on
August 18, 2011 and had no
complications from the incomplete
medical record. Resident #18 was
reviewed and has no physician order
for Fentanyl patches.
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Medical record review of the June 2011 Pain Management MAR revealed no documentation of patch site placement on June 4, 25, 28, 2011, and no verification of disposal of the old patches was documented on June 1, 4, 7, 10, 13, 16, 19, 22, 25, 28, 2011.

Medical record review of the July 2011 Pain Management MAR revealed no documentation of patch site placement on July 1, 4, 7, 13, 16, 19, 22, 25, 28, 31, 2011 and no verification of disposal of the old patches was documented on July 1, 4, 7, 2011.

Medical record review of the May 2011 Pain Management MAR for resident #16 revealed resident (#16) received "...Fentanyl Transdermal Dose: 12 mcg/hr...Daily Every 3 Days Pain Patch 72 Hour."

Continued review revealed no verification of disposal of the old patches was documented on May 4, 7, 13, 28, 31, 2011.

Medical record review of the June 2011 Pain Management MAR revealed no documentation of patch site placement June 24, 27, 2011 and no verification of disposal of the old patches was documented on June 3, 6, 9, 12, 15, 18, 21, 24, 27, 30.

Medical record review of the July 2011 Pain Management MAR revealed no documentation of patch site placement on July 6, 15, 27, 30, 2011 and no verification of disposal of old patches was documented on July 3, 6, 9, 12, 15, 18, 21, 24, 27, 30, 2011.

2.3 Other residents receiving pain medications via patch were assessed for pain management by nursing management on August 12, 2011, and found to have no complications from the incomplete medical record.

3.3 The licensed staff were re-educated by the SDC and the Unit Managers regarding the process for removal and disposal of Fentanyl Transdermal patches. This re-education was completed on August 19, 2011.

4.3 Medication Administration Records (MARS) will be audited by the DNS and Unit Managers for policy accuracy for three times per week for three weeks, then weekly for 3 weeks and then monthly for 2 months. Audits will be reviewed in the monthly Performance Improvement (PI) Meeting to ensure compliance with documentation of removal and disposal of transdermal patches. The Performance Improvement Committee includes the Administrator, Medical Director, Director of Nursing Services, Social Services Director, Activities Director, Housekeeping Supervisor, Nutritional Service Director, Clinical Case
Medical record review of the Pain Management MAR dated May 2011 for Resident #18 revealed the resident received "...Duragesic Patch (Fentanyl) Transdermal Dose: 12.6 mcg...Daily Every 3 Days Two Nurses to verify wasting of old patch." Further revealed no documentation of site patch placement on May 13, 2011 and no verification of wasting old patches was documented on May 13, 16, 19, 22, 25, 28, 31, 2011.

Medical record of the June 2011 Pain Management MAR revealed no documentation of patch site placement was recorded on June 18, 24, 27, 30, 2011 and no verification of wasting old patches was documented on June 12, 30, 2011.

Medical record review of the July 2011 Pain Management MAR revealed no documentation of administration of the patches on July 3, 6, 15, 2011 and no verification of wasting old patches was documented on July 9, 12, 16, 18, 24, 30, 2011.

Interview with the Director of Nursing Services (DNS) in the DNS's office on August 3, 2011 at 10:45 a.m. confirmed the documentation of Fentanyl administration, placement site, and disposal of old patches for residents (#5, #16, and #18) Pain Management MARS was not incomplete.

Manager, MDS Coordinator, Infection Control Nurse, Maintenance Director, and Pharmacy Consultant.

8/30/11

1.4 Resident #18 was assessed and the review found this resident does not have an order for Fentanyl patches for pain and they have never been applied.