

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

PRINTED: 10/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2014
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NAME OF PROVIDER OR SUPPLIER  SIBLEY MEM HOSP RENAISSANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification Quality Indicator Survey was conducted on September 8 through September 12, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 21 sampled residents.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p><b>Abbreviations</b>  AMS - Altered Mental Status  ARD - assessment reference date  BID - Twice a-day  B/P - Blood Pressure  cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide  CRF - Community Residential Facility  D.C. - District of Columbia  D/C discontinue  DI - deciliter  DMH - Department of Mental Health  EKG - 12 lead Electrocardiogram  EMS - emergency medical services (911)  g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning  FU/FL Full Upper /Full Lower  ID - Intellectual disability  IDT - interdisciplinary team  INR - International Normalised Ratio  L - Liter  Lbs - pounds (unit of mass)  MAR - Medication Administration Record</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *D. Elise Miller* TITLE *Administrator* (X6) DATE *10/27/14*

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.

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F 000	Continued From page 1 MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician 's order sheet Prn - As needed Pt - Patient Q - Every QIS - Quality Indicator Survey Rp, R/P- responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	F 000	<b>Response to F157 (483.10(b)(11):</b>  1. There are no further corrective actions as the resident has been discharged to the home. The RN/LPNs involved will be identified by 10/27/14 and counseled by the Director of Nursing (DON) by 11/12/14.  2. Other residents having the potential to be affected by the same deficient practice will be identified through 20 random audits per month, for four months, of staff involved.  3. The following systemic changes will be put in place to ensure the deficient practice will not recur: a. Wound Competency for individual RN/LPNs involved by 11/12/14. b. Documentation workshop to include wound consult and wound documentation for all RN/LPN staff by 11/12/14.  4. Two Quality Compliance Coordinators will monitor performance through monthly random audits. Staff will be re-educated if non-compliance is found. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee.  5. The corrective action will be completed on or by 11/12/14.	11/12/14	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the	F 157		11/12/14	

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F 157	<p>Continued From page 2</p> <p>resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for one (1) of 21 sampled residents, it was determined that facility staff failed to notify the physician when Resident #258 was assessed with altered skin integrity that progressively worsened.</p> <p>The findings include:</p> <p>A review of the medical record (electronic health record) for Resident #258 revealed the resident</p>	F 157	<p><b>Response to F 253- 1 and F-253-2 (Soiled or non-functioning bathroom vacuum vents)</b></p> <ol style="list-style-type: none"> <li>1. Soiled or non-functioning bathroom vacuum vents in the South side resident rooms #316, #317, #319, #323, #325, #326, #327, #328, #330 will be cleaned or repaired by 11/12/14.</li> <li>2. In order to prevent other residents from being affected by the same deficient practice of soiled or non-functioning vents work orders should be submitted to Plant Operations and Maintenance (O&amp;M) for any repairs needed.</li> <li>3. The following systemic change will be put in place to ensure the deficient practice will not recur: Plant O&amp;M Staff perform monthly Environment of Care (EOC) Rounds and the EOC Committee members perform semi-annual EOC Rounds and will pay attention to exhaust vents and will submit work orders (WO).</li> <li>4. The plan of correction will be integrated into the quality assurance (QA) system through scheduled environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Plant O&amp;M monitors the WO system for completion and satisfaction rates. Both measures are reported and reviewed by the EOC Committee.</li> <li>5. Corrective actions completed by 11/12/14.</li> </ol>	11/12/14
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F 157	Continued From page 4 [Note: physician telephone order 8/8/14 for urinalysis, culture and sensitivity]  August 9, 2014 2100 (11 PM) "bruising rashes in the groin area. Barrier cream applied at sacral area "  August 9, 2014 1900 (8PM) " stage II pressure ulcer on midline sacrum "  August 14, 2014 7:05 AM " Rash "  August 14, 2014 2311 (11:11PM) " rash sacral area "  August 17, 2014 4:33 PM " developed a stage two Decubitus to sacral with measurements of ½ x ½ cm and ¼ cm deep. Applied Mepilex [Antimicrobial foam dressing for acute and chronic wounds with signs of infection] to area and ordered a wound consult. We need to order a special mattress and aggressively do our turn and repositioning every 2 hours. "  August 17, 2014 1900 (8PM) " excoriation, severe redness to anal area "  August 18, 2014 7:12 AM " sacral decub [Decubitus] is getting better, chart checked " [SIC]  August 19, 2014 7:21 AM "redness at sacral and perineal area "  The wound specialist consultation was conducted on August 21, 2014 and the assessment was recorded as follows:	F 157	<b>Response to F 253-4 (Low Water Temperatures in North side rooms #301, #310 and #313)</b> 1. The water temperature in North side resident rooms #301, #310 and #313 were adjusted on 9/10/14. 2. In order to prevent other residents from being affected by the same deficient practice of Low Water Temperatures Plant O&M Staff will monitor and manually adjust the water temperature as needed to stay in compliance. 3. The following systemic change will be put in place to ensure the deficient practice will not recur: Plant O&M Staff perform monthly Environment of Care (EOC) rounds and EOC Committee members perform semi-annual EOC Rounds and will pay attention to required water temperatures and will submit work orders for adjustment. 4. The plan of correction will be integrated into the quality assurance system through scheduled environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Plant O&M monitors the work order system for completion and satisfaction rates. Both measures are reported and reviewed by the Environment of Care Committee for quality assurances. 5. Corrective action was completed on 9/10/14.	9/10/14

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F 157	Continued From page 5 August 21, 2014 6:21 PM [wound specialist initial consult] " requested to see patient by staff for assessment of redness to buttocks and gluteal cleft ....skin is red on both buttocks with mild skin denudement ...indicative of a yeast infection. In addition, the patient has a small 1.0 x 1.0 cm open area in upper gluteal cleft which is moisture associated skin damage (MASD) due to patient ' s incontinence. This is not a pressure ulcer...apply Nystatin powder to yeast infection on medial buttocks and perineal area ...apply silver powder to small wound due to MASD and cover with Calazime skin barrier cream light coating only ..." [SIC]  Facility staff failed to notify the physician when Resident #258 was assessed with altered skin integrity. A period greater than two (2) weeks lapsed before a wound specialist consultation was requested and a treatment regimen initiated to manage the resident's skin impairment. The record was reviewed September 11, 2014.	F 157			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observations made during an environmental tour of the facility on September 10, 2014 at approximately 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by	F 253			

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F 253	<p>Continued From page 6</p> <p>non-functioning bathroom vents in nine ( 9) of nine ( 9) resident's rooms surveyed on the South side unit, dusty vents in five (5) of nine (9) resident's rooms surveyed on the South side unit, marred door jams in eight (8) of 15 resident's rooms on the South side unit, low water temperatures on three (3) of nine (9) resident's rooms surveyed on the South side unit, loose and/or damaged window screens in two (2) of nine (9) resident's rooms surveyed on the North side unit, loose wallpaper in two (2) of nine (9) resident's rooms surveyed on the South side unit, privacy curtains that were not attached to hooks in five (5) of 18 resident's rooms surveyed from both units, a torn privacy curtain in one (1) of nine (9) resident's rooms surveyed on the North side unit, and a bathroom light that failed to illuminate in one (1) of nine (9) resident's rooms surveyed on the North side unit.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Bathroom vacuum vents were not suctioning in nine (9) of nine (9) resident's rooms surveyed on the South side unit including rooms #316, #317, #319, #323, #325, #326, #327, #328, #330.</li> <li>2. Bathroom vacuum vents were soiled with dust in five (5) of nine (9) resident's rooms located on the South side unit including rooms #319, #323, #327, #328 and #330.</li> <li>3. Door jams were marred in eight (8) of 15 resident's rooms on the South side unit including rooms #305, #308, #309, #311, #318, #320, #321, and #323.</li> <li>4. Water temperatures measured below 95</li> </ol>	F 253	<p><b>Response to F 253-5 (Loose or Torn Window Screens)</b></p> <ol style="list-style-type: none"> <li>1. Loose or Torn Window Screens in the North side resident rooms # 301 and #307 will be repaired by 11/12/14.</li> <li>2. In order to prevent other residents from being affected by the same deficient practice of Loose or Torn Window Screens work orders should be submitted to Plant Operations and Maintenance (O&amp;M) for any repairs needed.</li> <li>3. The following systemic change will be put in place to ensure the deficient practice will not recur: Plant O&amp;M Staff perform monthly Environment of Care (EOC) Rounds and the EOC Committee members perform semi-annual EOC Rounds and will pay attention to Loose or Torn Window Screens and will submit work orders for repairs.</li> <li>4. The plan of correction will be integrated into the quality assurance system through scheduled environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Plant O&amp;M monitors the work order system for completion and satisfaction rates. Both measures are reported and reviewed by the Environment of Care Committee for quality assurances.</li> <li>5. Corrective actions will be completed by 11/12/14</li> </ol>	11/12/14	11/12/14

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F 253	Continued From page 7 degrees Fahrenheit in three (3) of nine (9) resident's rooms located on the North side unit including rooms #301, #310 and #313.  5. The left window screen was torn in one (1) of nine (9) resident's rooms (#301) on the North side unit and the right window screen was loose in one (1) of nine (9) resident's rooms (#307) on the North side unit.  6. The wallpaper was hanging loose from the wall in the bathroom of resident's rooms #323 and #328, two (2) of nine (9) resident's rooms surveyed on the South side unit.  7. Privacy curtains were not completely attached to curtain hooks in five (5) of 18 resident's rooms including rooms #304, #309, #311, #313 and #325.  8. The privacy curtain located in room #301 (B bed) was torn, one (1) of nine (9) resident's rooms surveyed on the North side unit.  9. A bathroom light located in room #313 failed to illuminate with the wall switch was in the on position in one (1) of nine (9) resident's rooms surveyed on the North side unit.  These observations were made in the presence of Employee #10 who acknowledged the findings.	F 253	<b>Response to F 253-6 (Loose Wallpaper)</b> 1. Loose Wall Paper in the bathroom of South side resident rooms #323 and #328 will be repaired by 11/12/14. 2. In order to prevent other residents from being affected by the same deficient practice of Loose Wallpaper, work orders should be submitted to Plant Operations and Maintenance (O&M) for any repairs needed. 3. The following systemic change will be put in place to ensure the deficient practice will not recur: Plant O&M Staff perform monthly Environmental Rounds and the Environment of Care (EOC) Committee members perform semi-annual Environmental Rounds and will pay attention to Loose Wall Paper and will submit work orders for repairs. 4. The plan of correction will be integrated into the quality assurance system through scheduled environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Plant O&M monitors the work order system for completion and satisfaction rates. Both measures are reported and reviewed by the Environment of Care Committee for quality assurances. 5. Corrective actions will be completed by 11/12/14	11/12/14	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.	F 278		11/12/14	

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F 278	<p>Continued From page 8</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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 assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview for one (1) of 21 sampled residents, it was determined that facility staff failed to accurately code the admission Minimum Data Set (MDS) under Section M, Skin Conditions to reflect the alteration in skin integrity for Resident #258.</p> <p>The findings include:</p>	F 278	<p>Response to F253-7 and F253-8:</p> <ol style="list-style-type: none"> <li>1. No direct impact identified to patients from this deficient practice. Curtains were reattached, or repaired in rooms #304, #309, #311, #313, #325 and #301 (B bed) by 9/15/14. The areas were revisited on 10/20/14.</li> <li>2. In order to prevent other residents from being affected by the same deficient practice staff have been reminded to place work orders for defective curtains in a timely manner.</li> <li>3. The following systemic changes will be put in place to ensure the deficient practice will not recur: Curtains will be monitored during scheduled quarterly curtain inspections or Environment of Care (EOC) rounds.</li> <li>4. The plan of correction will be integrated into the quality assurance system through quarterly scheduled environmental rounds. In the interim staff are to place work orders for defective curtains.</li> <li>5. The corrective action was completed on 9/15/14</li> </ol>	9/15/14	9/15/14

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F 278	<p>Continued From page 9</p> <p>A review of the admission Minimum Data Set (MDS) for Resident #258, completed August 15, 2014 [ARD date August 11, 2014] under Section M; Skin Conditions revealed the section was blank (no coding), indicative of no skin impairment.</p> <p>Resident #258 was admitted with skin impairment at the sacrum, a bony prominence located at the base of the spine [common site for pressure ulcers ref. Cuddigan, Pressure Ulcers in America 20001] as evidenced by the following nurse's admission note:</p> <p>August 4, 2014 (admission date) at 1606 (4:06 PM), "sacral redness, barrier cream applied."</p> <p>The nursing documentation lacked evidence of a clinical basis for the resident's skin impairment [e.g. pressure related, moisture associated etc.] and/or wound characteristics (length, width and depth).</p> <p>However, a consultation conducted by the wound care nurse on August 21, 2014 (beyond the ARD date) revealed the following, " skin is red on both buttocks with mild skin denudement ...indicative of a yeast infection. In addition, the patient has a small 1.0 x 1.0 cm open area in upper gluteal cleft which is moisture associated skin damage (MASD) due to patient ' s incontinence. "A subsequent wound care assessment dated September 11, 2014 revealed a stage 2 pressure ulcer at the sacrum.</p> <p>A face-to-face interview was conducted with</p>	F 278	<p><b>Response to F 253-9 (Non-functioning bathroom light)</b></p> <ol style="list-style-type: none"> <li>1. The non-functioning bathroom light in North side resident room #313 will be repaired by 11/12/14.</li> <li>2. in order to prevent other residents from being affected by the same deficient practice of non-functioning bathroom lights work orders should be submitted to Plant Operations and Maintenance (O&amp;M) for any repairs needed.</li> <li>3. The following systemic change will be put in place to ensure the deficient practice will not recur: Plant O&amp;M Staff perform monthly Environmental Rounds and the Environment of Care (EOC) Committee members perform semi-annual Environmental Rounds and will pay attention to non-functioning bathroom lights and will submit work orders for repairs.</li> <li>4. The plan of correction will be integrated into the quality assurance system through scheduled environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Plant O&amp;M monitors the work order system for completion and satisfaction rates. Both measures are reported and reviewed by the Environment of Care Committee for quality assurances.</li> <li>5. Corrective actions will be completed by 11/12/14</li> </ol>	11/12/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>096030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIBLEY MEM HOSP RENAISSANCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5265 LOUGHBORO ROAD NW WASHINGTON, DC 20016</b>		
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F 278	Continued From page 10 Employee #15 on September 12, 2014 at 9:30 AM. In response to a query regarding why the resident's skin alteration was not captured on the admission MDS, he/she stated that the alteration was observed but there was no option available to code under Section M of the MDS.  Facility staff failed to code Section M, Skin Conditions of the admission MDS. The record was reviewed September 11, 2014.	F 278	<b>Response to F278 (483.20(g)(j)):</b>  1. The MDS with an Assessment Reference Date (A2300) of 8/11/14 and completion date (Z0500B) of 8/15/14 has been modified, transmitted, and accepted into the Quality Improvement and Evaluation System Assessment Submission and Processing System (QIES ASAP). There are no further corrective actions as Resident #258 has been discharged to home. The MDS-PPS & Admissions Coordinator will be identified and counseled by Director of Nursing by 11/12/14.		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR  A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.  A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--	F 285	2. Other residents having the potential to be affected by the same deficient practice will be identified through a collaborative peer review process.  3. The following systemic changes will be put in place to ensure the deficient practice will not recur a. Establish a weekly collaborative peer review meeting for accurate entry into the Minimum Data Set (MDS) to be congruent with documentation in the EHR by 10/27/14. b. Establish a monthly MDS auditing process (with audit tool) to include a minimum of 20 MDS assessments 11/12/14.  4. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee.  5. The corrective action will be completed on or by 11/12/14.	11/12/14	
				10/27/14	
				11/12/14	
				11/12/14	



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F 285	<p>Continued From page 12</p> <p>July 7, 2014, revealed that Resident #226 was identified as "negative" for mental illness (MI) and "mental retardation" [Intellectual Disability (ID)].</p> <p>A review of the Admission MDS [Minimum Data Set] with an Assessment Reference Date (ARD) of July 14, 2014 revealed that Section A 1500 [Preadmission Screening and Resident Review] was coded as "No", indicating that Resident #226 did not have a serious mental illness or Intellectual Disability or related condition. Section A1510 (Level II PASRR Conditions) was blank, indicative of no diagnoses (e.g. MI or ID) that required a Level II screen.</p> <p>The psychiatric consultation dated July 24, 2014 revealed, " Reason for Consult- Belligerent Behaviors ...History, exam, findings: Chart reviewed, case discussed with Attending, who requested the exam re [regarding]: the patient's belligerence and escalation of same. Patient with numerous medical issues, under guardianship, developmentally impaired. Reliability as a historian is poor. Apparently history of non compliance further complicating discharge planning. Diagnostic Impression: organic anxiety or affective syndrome secondary to developmental impairments. " [SIC]</p> <p>There is no evidence that Employee # 16 accurately completed the "Pre-Admission Screening/Resident Review to reflect the resident ' s history of Intellectual Disability.</p> <p>A face-to-face interview was conducted with Employee #16 in response to a query regarding the Resident #226 ' s PASRR screen. He/she</p>	F 285	<p><b>Continued Response to F285 (483.20(m), 483.20(e):</b></p> <p>4. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance &amp; Quality Assurance Committee.</p> <p>5. The corrective action will be completed on or by 11/12/14.</p>	11/12/14	

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F 285	Continued From page 13 acknowledged that the assessment was not accurate. Employee #16 acknowledged that he/she was aware that Resident #226 had a positive screen for intellectual Disability and that a level 2 screen was not conducted. A request for a level 2 screen through the Department of Disability Services (DDS) was initiated by an outside social service agency. The Level II assessment was pending.  Facility staff failed to ensure that the "Pre-Admission Screen/Resident Review was accurately completed for Resident #226. The record was review September 10, 2014.	F 285	<b>Response to F309 #1 (483.25):</b>  1. There are no further corrective actions as the resident has been discharged to the home. The RN/LPNs involved will be identified by 10/27/14 and counseled by the Director of Nursing (DON) by 11/12/14.  2. Other residents having the potential to be affected by the same deficient practice will be identified through 20 random audits per month, for four months, of staff involved.  3. The following systemic changes will be put in place to ensure the deficient practice will not recur: a. Wound Competency for individual RN/LPNs involved by 11/12/14. b. Documentation workshop to include wound consult and wound documentation for all RN/LPN staff by 11/12/14.  4. Two Quality Compliance Coordinators will monitor performance through monthly random audits. Staff will be re-educated if non-compliance is found. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee.  5. The corrective action will be completed on or by 11/12/14.	11/12/14
F 309 SS=G	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 record review and staff interview for six (6) of 21 sampled residents, it was determined that facility staff failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable well-being as evidenced by failure to promote wound healing for one (1) resident with altered skin integrity that progressively worsened and	F 309		11/12/14
				11/12/14
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F 309	<p>Continued From page 14</p> <p>developed into a pressure ulcer; failed to clarify physician orders to include the dose for administration of supplements for four (4) residents and failed to administer insulin in accordance with physician orders for one (1) resident. Residents' # 258, 29, 273, 279, 280, and 281.</p> <p>The findings include:</p> <p>1. Facility staff failed to implement necessary care and services when Resident #258 was assessed with impaired skin integrity. Licensed nurses applied skin barrier cream and failed to notify the medical team for approximately two (2) weeks as the resident's altered skin progressively worsened.</p> <p>A review of the clinical record for Resident #258 revealed the resident was admitted on August 4, 2014. According to the physician's History and Physical (H&amp;P) examination dated August 4, 2014, the resident was admitted post acute hospitalization secondary to a chief complaint of "weakness" and new diagnosis of neoplasm of the brain. Admitted to [skilled nursing facility named] on "August 4, 2014 for rehabilitation with PT/OT [physical and occupational therapy] and to start chemotherapy and radiation therapy in 2 weeks ... "Additional diagnoses included Hypertension, Depression, Gastroesophageal Reflux Disease, and Seizure precautions. The section of the H&amp;P labeled 'Skin' read, "no rashes or lesions noted."</p> <p>A review of the admission Minimum Data Set (MDS) completed August 15, 2014 [ARD date August 11, 2014] revealed Resident #258 was coded as "12" under Section C, Cognitive Patterns, indicative that the resident was</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>moderately impaired cognitively. Under Section G, Functional Status, the resident was coded as requiring extensive assistance for bed mobility, transfer, locomotion and bathing. He/she was coded as frequently incontinent of bowel and bladder in Section H and the areas designated to identify skin alterations under Section M, Skin Conditions remained blank, indicative of no skin impairment.</p> <p>The medical record (electronic health record) revealed that Resident #258 was admitted with skin impairment as noted in the following nurse ' s notes:</p> <p>August 4, 2014 (admission date) at 1606 (4:06 PM), " sacral redness, barrier cream applied. "</p> <p>August 4, 2014 1945 (7:45 PM), " blanchable redness on sacrum, cream applied. "</p> <p>August 5, 2014 at 8:30 AM, " redness to sacrum, blanchable barrier cream applied "</p> <p>August 6, 2014 at 10:00 AM, " applied barrier cream to perianal and sacrum for redness "</p> <p>There was no evidence that nursing staff fully and/or consistently assessed the characteristics of Resident #258's skin impairment. There was no documented evidence of an assessment of the size (length, width and depth), type of tissue and presence (or absence) of odor.</p> <p>Nursing staff failed to notify the physician regarding Resident #258 ' s skin impairment. A period of approximately two (2) weeks lapsed [August 4 through August 18, 2014] before a</p>	F 309			

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F 309	Continued From page 16 request for wound consultation was initiated. A " barrier cream " was applied to the affected site for approximately two (2) weeks without evidence of effectiveness and the skin impairment progressively worsened as evidenced by the following nurse ' s notes:  August 6, 2014 1600 (4PM) " redness on sacrum; turned every 2 hours "  August 7, 2014 9:00 AM "redness to sacrum area, blanchable, barrier cream applied "  August 7, 2014 1940 (7:40 PM) "redness on sacrum barrier cream applied"  August 8, 2014 11:53 PM " [Dr named] called tonight due to patient complaint of burning sensation while urinated, new orders given " [Note: physician telephone order 8/8/14 for urinalysis, culture and sensitivity]  August 9, 2014 2100 (11 PM) "bruising rashes in the groin area. Barrier cream applied at sacral area "  August 9, 2014 1900 (7PM) " stage II pressure ulcer on midline sacrum "  August 14, 2014 7:05 AM " Rash "  August 14, 2014 2311 (11:11PM) " rash sacral area "  August 17, 2014 4:33 PM " developed a stage two Decubitus to sacral with measurements of ½ x ½ cm and ¼ cm deep. Applied Mepilex to area and ordered a wound consult. We need to order	F 309			

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F 309	<p>Continued From page 17 a special mattress and aggressively do our turn and repositioning every 2 hours. "</p> <p>August 17, 2014 1900 (7PM) " excoriation, severe redness to anal area "</p> <p>August 18, 2014 7:12 AM " sacral decub is getting better, chart checked "</p> <p>August 19, 2014 7:21 AM " redness at sacral and perineal area "</p> <p>August 21, 2014 7:19 AM " [relative named] verbalized concerned about [him/her] condition ...[he/she] is out of it ...[resident] is sleepy and not eating and drinking. The nurse have noticed patients poor appetite and difficulty of drinking thin liquid. Patient was constantly coughing when water given ...notified doctor ... "</p> <p>August 24, 2014 8:38 AM " ...perineum is red with rash, sacrum stage 2 measuring 1.0 x 0.8 cm, it is red, treatment applied ... "</p> <p>August 30, (12M) " sacral stage 1 perineal excoriation "</p> <p>The wound specialist consultation was conducted on August 21, 2014 and the following was determined:</p> <p>Notes recorded by Wound Care Nurse:</p> <p>August 21, 2014 6:21 PM [wound specialist initial consult] " requested to see patient by staff for assessment of redness to buttocks and gluteal cleft ...skin is red on both buttocks with mild skin denudement ...indicative of a yeast infection. In</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>addition, the patient has a small 1.0 x 1.0 cm open area in upper gluteal cleft which is moisture associated skin damage (MASD) due to patient 's incontinence. This is not a pressure ulcer...apply Nystatin powder to yeast infection on medial buttocks and perineal area ...apply silver powder to small wound due to MASD and cover wth Calazime skin barrier cream light coating only .... " [SIC]</p> <p>August 25, 2014 5:34 PM (4 days post initiation of treatment) [wound specialist] " follow-up wound care to perineal yeast rash ...the rash at the perineum, groins and inner are improving. Skin is less red, some peeling skin. The erosion on the sacrum is smaller ... " [SIC]</p> <p>September 4, 2014 2:36 PM [wound specialist] follow-up perineal yeast rash and erosion on sacrum ...the yeast rash and redness has improved by about 50%. There are some redness and rash at the inner thigh, groins, sacrum and buttocks ... " [SIC]</p> <p>A face-to-face interview was conducted with the Employee #14 (wound care nurse) on September 11, 2014 at approximately 2:00 PM. He/she stated that the initial wound specialty consultation revealed the resident had a yeast infection of the perineum and buttocks and Nystatin [antifungal (yeast) medication] was recommended. Follow up assessments revealed the affected areas were improving. An assessment of the site on September 11, 2014 revealed the site at the gluteal cleft was now a stage 2 Pressure Ulcer and treatment recommendations were made to the physician.</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>According to physician 's orders, Resident #258 's medication regimen included but was not limited to the following:</p> <p>August 16, 2014 Radiation therapy [outpatient] Mondays, Wednesdays and Fridays</p> <p>August 21, 2014, Nystatin 100,000 unit/gram powder; apply 3 times daily for " rash " to buttocks, sacrum and inner thigh, then apply a thin layer of calazime cream [skin barrier cream] to seal in the Nystatin powder</p> <p>The record revealed that Temodar 100mg daily [antineoplastic agent - oral chemotherapy] was included in the resident's medication regimen during the period of August 13, 2014 through September 5, 2014.</p> <p>According to Nutrition notes, Resident #258 sustained significant weight loss and poor appetite as evidenced by the following:</p> <p>Initial nutrition assessment dated August 16, 2014 read, " patient with 4 pound weight loss from 8/4/14 to 8/13/14 ...suboptimal oral intake related to exhaustion ...recommendations, feeding assistance, Ensure complete tid [three times daily] "</p> <p>Successive nutrition notes dated August 20, 27, September 3 and 8th included assessments, interventions and physician notification regarding the resident's nutritional status.</p> <p>The nutrition note proximal to the record review read as follows: Nutrition Follow-up, September 8, 2014, 3:43 PM " patient with 14 pound weight</p>	F 309		
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