STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	08/24/2015

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SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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F 000	INITIAL COMMENTS A recertification Quality Indicator Survey was conducted August 17, 2015 through August 24, 2015. The deficiencies are based on observation, record review, resident and staff interviews for 27 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations 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 DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor	F 000	Please begin typing your responses here: The Sibley Renaissance is filing the following plan of correction for purposes of regulatory compliance, in response to the annual Medicare QIS survey conducted on August 17, 2015 through August 24, 2015. The facility is submitting correction to comply with applicable law and not as an admission or statement of agreement with respect to alleged deficiencies herein.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elise Miller

TITLE: Administrator

(X6) DATE: 9/18/15

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 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 MN midnight Neuro - Neurological NP - Nurse Practitioner 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 s/he she/he SCC Special Care Center Sol- Solution TAR - Treatment Administration Record S/he she/he	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced	F 242		

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F 242	Continued From page 2 by: Based on record review, family interview, and staff interview for one (1) of 27 sampled residents, it was determined that the facility staff failed to honor Resident #263's preference to have a bath or shower every day. The findings include: On August 17, 2015 at approximately 4:10 PM, a face-to-face interview was conducted with Resident #263's family member. When asked if the resident received the same number of baths or showers in a week based on past preferences, the family member stated, " No." He/she added, " My [named relationship of family member] prefers a bath or shower, every day, as [he/she] does at home. [He/she] hasn't had a bath since [he/she's] been here. Yesterday, I had to ask the staff to give [him/her] a bath and they did." On August 24, 2015 at approximately 10:00 AM, a review of the physician's history and physical revealed that the resident was admitted to the facility for rehabilitation, secondary to Debility, and had no bathing restrictions. A review of the Minimum Data Set dated August 6, 2015, under Section G (Functional Status), revealed that Resident #263 required one (1) person to assist with bathing, dressing, and mobility. A further review of the 'activities of daily living' section of the resident's record revealed that the facility staff had performed "peri-care only " on the following days: August 6, 8, 10, 11, 12, 14, 15, 16, 19, 20, and 22, 2015. There was no evidence that the resident received a full bath on	F 242	**Response to F242 483.15(b)-Resident Hygiene Preference wasn't honored:** 1. The hygiene preference was provided and no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. This deficiency was noted and addressed by the Director of Nursing (DON) in staff meetings on August 28th, 31st; September 2nd and 4th 2. Every resident having the potential to be affected by the same deficient practice will be identified on admission by asking their preference for a bed bath or shower and this preference will be documented in an admission note. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: The staff will offer hygiene based on preference daily. 4. Two Quality Compliance Coordinators on the unit will monitor performance through monthly random audits to ensure that hygiene preferences are addressed and honored. 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 9/30/15.	9/30/15

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F 242	Continued From page 3 the aforementioned days. On August 24, 2015 at approximately 10:15 AM, a face-to-face interview was conducted with Employee #6, who was asked why the resident had not received a daily bath or shower. He/she stated, " I ' m not sure. They [the staff] did bathe him/her a few times and [he/she] had a shower a couple of days, but only peri-care was mainly given." There was no evidence that facility staff honored Resident #263's preference to have a bathe. The record was reviewed on August 24, 2015.	F 242		
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 August 21, 2015 at approximately 3:15 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The findings include: 1. Privacy curtains were torn in two (2) of 12 resident's rooms including rooms #304A and	F 253	**Response to F253-1 & 2 (Torn or Unattached Privacy Curtains):** 1. No direct impact identified to residents from this deficient practice. Curtains were reattached, replaced, repaired or added in rooms #304A, #311 A&B, #314B, #329 by 9/2/15. The areas were revisited on 9/12/15. 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. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: Curtains will be visibly inspected during scheduled quarterly Environment of Care (EOC) rounds. 4. The plan of correction will be integrated into the quality assurance system through quarterly scheduled environmental rounds. The nursing staff currently places work orders for defective curtain. 5. The corrective action was completed on 9/2/15.	9/2/15

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F 253	Continued From page 4 # 311A. 2. Privacy curtains were not attached in three (3) of 12 resident's rooms (#311B, #314B, #329). 3. The grab bar located in the bathroom of room #314 was loose in one (1) of 12 resident's rooms observed. These observations were made in the presence of Employee #3 and Employee #10 who acknowledged the findings.	F 253	**Response to F253-3 (Loose Grab Bar):** 1. No direct impact identified to residents from this deficient practice. The loose hand rail was re-secured to the wall in room #314. 2. In order to prevent other residents from being affected by the same deficient practice Plant Operations staff will monitor unit for loose hand rails and fix as needed to stay in compliance. 3. The following systemic change will be put into place to ensure the deficient practice will not recur: Plant Operations staff will perform monthly Environment of Care (EOC) rounds. 4. The plan of correction will be integrated into the quality assurance system through environmental rounds and reporting to the EOC Committee. Environmental rounds are aggregated and monitored for deficient trends and corrective measures are implemented as necessary. Plant Operations monitors the work order system for completion and satisfaction rates. Both measurements are reported quarterly to the Environment of Care Committee. 5. The corrective action was completed on 8/21/15	8/21/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		

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F 280	Continued From page 5 by: Based on record review, resident interview, and staff interview for one (1) of 27 sampled residents, it was determined that the facility staff failed to allow participation in care planning, as evidenced by staff failure to offer Resident #13 the opportunity to provide input in his/her care and treatment. The findings include: On August 19, 2015 at approximately 12:38 PM, during a resident interview, Resident #13 revealed that he/she was not included in his/her care planning meetings, stating, "I have not spoken to a social worker or a case worker, since I've been here." On August 21, 2015 at approximately 1:35 PM, a review of the Admission Minimum Data Set [MDS] dated July 29, 2015 revealed that the resident was admitted to the facility on July 22, 2015 with diagnoses that included Cancer, Diabetes Mellitus, Atrial Fibrillation, Anemia, and Debilitation. Section C- Cognitive Patterns of the MDS revealed that the resident scored "15" on the Brief Interview for Mental Status (BIMS); which indicated that the resident was cognitively intact. A review of the Case Manager notes on July 27, 2015, August 11, 2015, August 12, 2015, August 13, 2015, and August 21, 2015, lacked documented evidence that the resident was offered to participate in his/her plan of care or that the plan of care was discussed with the resident. On August 21, 2015 at approximately 3:00 PM, a	F 280	**Response to F280 483.20 (d)(3)-Resident not involved in Care Planning:** 1. The information needed to participate in care plan meetings was provided and no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. This deficiency was noted and addressed in staff meetings by the Director of Nursing (DON) on August 28th, 31st, September 2nd and 4th. 2. Every resident having the potential to be affected by the same deficient practice will be identified on admission and will be informed of care plan meetings. Residents and family members who would like to participate in the care plan meeting will be identified by the Activities Coordinator or designated nursing staff during their routine rounding. The Case Coordinator will also remind the residents of the opportunity to participate in care planning meetings during the resident's initial assessments. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: signage in rooms will indicate day and time of care plan meetings with information regarding scheduling a care plan meeting. 4. Two Quality Compliance Coordinators on the unit will monitor performance through random audits when rounding to ensure residents/family are aware of the care plan meetings and their ability to participate. 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 9/30/15.	9/30/15

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F 280	Continued From page 6 face-to-face interview was conducted with Employee #12, regarding communication and interaction with the resident and resident involvement in the care planning process. The employee communicated that he/she was involved in the meetings on both days; and that the Case Coordinators were responsible for letting the resident know about discharge planning. When asked what [his/her] interaction was with the resident. He/she stated, "I spoke with the [resident's family member] yesterday. I did not speak with the resident." When queried if he/she asked the resident to provide input in his/her care plan and discharge planning process, he/she stated, " I do not see where I documented that." Facility staff failed to allow Resident #13 to participate in his/her care planning. The record was reviewed on August 21, 2015	F 280		
F 309 SS=D	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 two (2) of 27 sampled residents, it was determined that the facility staff failed to ensure that each resident received the necessary care	F 309		

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F 309	Continued From page 7 and services to attain or maintain the highest practicable physical, mental, and/or psychosocial well-being, as evidenced by: failure to clarify a physician ' s order as it relates to parameters of administration for an antihypertensive medication [Metoprolol] for one (1) resident; failed to follow physician ' s orders for the application of a scrotal support garment and failure to clarify the physician ' s order to identify a wearing schedule for the support garment for one (1) resident. Residents #139 and 195. The findings include: 1. Facility staff failed to clarify a physician ' s order for blood pressure parameters for Resident #139 who was prescribed Metoprolol [Anti-hypertensive medication]. On August 24, 2015 at approximately 10:00 AM, a review of the Admission Minimum Data Set dated August 3, 2015 revealed that the resident was admitted to the facility on that day with diagnoses that included a Left Hip Infection and Hypertension. The physician's orders dated August 15, 2015, directed the following: "Metoprolol Succinate (Toprol-XL) [Anti-hypertensive medication] 50mg [milligrams] oral daily. Hold for SBP [Systolic Blood Pressure] less than [missing numeric value] mmHg or HR [Heart Rate] less than 55 beats per minute. Do not crush or chew. Diagnosis Association: Hypertension." The physician's medication order lacked documented evidence of a numeric value in the space of the order allotted for " Systolic blood pressure " [the space remained blank].	F 309	**Response to F309-1 (Missing Parameters for Metoprolol Orders):** 1. There are no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. This deficiency was noted and addressed in staff meetings by the Director of Nursing (DON) on August 28th, 31st, September 2nd and 4th. 2. Other residents having the potential to be affected by the same deficient practice will be identified and staff re-education on policy number# 01-28-13, "Parameters for administering anti -hypertensive medication" will be completed. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: orders for anti- hypertensive medications must include parameters for administration to be considered complete. 4. The education & training specialist will conduct random medication passes to observe staff administration of anti-hypertensive medication in accordance to parameters for administration. In addition, two Quality Compliance Coordinators will monitor performance through random monthly audits of the medication administration record and physician orders for residents prescribed anti-hypertensive medication to ensure proper administration and order completeness. The findings will be presented at the quarterly meeting of the Renaissance Compliance & Quality Assurance Committee. The Chief Medical officer will notify the ordering physician of this finding in writing by 9/30/15 5. Education will be completed by 9/30/15	9/30/15

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F 309	Continued From page 8 On August 24, 2015 at approximately 10:02 AM, a face-to-face interview was conducted with Employee #8 who was asked what the blood pressure parameters were on the order. He/she reviewed the order and stated, " They are not written here on the order, but I will get this clarified." Facility staff failed to clarify the missing numeric value in the " hold for ... " parameters of administration of the physician ' s Metoprolol order. The record was reviewed on August 24, 2015. 2. A review of the clinical record for Resident#195 lacked evidence that facility staff followed physician ' s orders for the application of a scrotal support garment. Further, it was determined that staff failed to clarify the physician ' s order for use of the device as evidenced by the lack of a wearing schedule for the garment. A. Facility staff failed to apply a scrotal support garment that was ordered by the physician to manage scrotal edema for Resident #195. Resident #195 was admitted August 1, 2015 with diagnoses that included " scrotal edema. " A face-to-face interview was conducted with Resident #195 on August 19, 2015 at approximately 10:00 AM. In response to the query " do you feel there is enough staff to give you assistance when needed ..., " Resident #195 responded " no. " S/he further stated that [he/she] was unable to get assistance to apply a scrotal support garment that the doctor ordered, " or either they just don ' t know how to put it on	F 309	**Response to F309-2 (Lack of Wearing Schedule on Order for Scrotal Support):** 1. No further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged This deficiency was noted and addressed in staff meetings by the Director of Nursing (DON)on August 28th, 31st;September 2nd and 4th. 2. Other residents having the potential to be affected by the same deficient practice will be identified via chart reviews verifying complete orders for medical devices/apparel to include instructions for application, duration, and frequency. 3.The following systemic changes will be put in place to ensure the deficient practice will not recur: specific staff and staff in general will be re-educated (nurse and physician) regarding physician orders for application of medical devices/apparel to include instructions for application, duration and frequency.. 4. Random monthly audits of MD orders for medical devices/apparel (i.e. scrotal support) to include instructions for application, duration and frequency will be conducted by quality nurses. Two Quality Compliance Coordinators will monitor performance through monthly random audits to ensure MD orders for medical devices/apparel (i.e. scrotal support) includes instructions for application, duration and frequency. 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. The Chief Medical officer will notify the ordering physician of this finding in writing by 9/30/15. 5. Corrective action will be completed by 9/30/15.	9/30/15

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F 309	Continued From page 9 ...I don ' t even wear it. " A review of physician ' s orders dated August 1, 2015 revealed " Scrotal Support. " A review of the Medication and Treatment Administration Record [MAR/TAR] for August 2015 lacked evidence of the application of the scrotal support garment. A face-to-face interview was conducted with Employee #13 on August 24, 2015 at 3:00 PM. In response to a query regarding the prescribed scrotal support garment; s/he stated that the resident was very private and didn't want assistance with the application of the garment. Towels were offered to the resident so that s/he was able to elevate [his/her] scrotum when seated. A nurse ' s entry dated August 14, 2015 at 8:01 PM, " ...Scrotum still swollen pt [patient] encouraged to keep same elevated ... " A physician ' s entry dated August 19, 2015 at 3:51 PM, " Scrotum is mildly edematous - less so than previous exam ...continue scrotal elevation/sling when ambulating ... " The clinical record lacked evidence of application of the scrotal garment and/or rejection of its application by the resident. There was no evidence of the order for the scrotal support garment on the MAR/TAR. B. Facility staff failed to clarify the physician ' s order for the application of the scrotal support garment. The physician ' s order dated August 1, 2015	F 309		

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F 309	Continued From page 10 read, " Scrotal Support. " The resident ' s admitting diagnoses included scrotal edema. The order lacked evidence of a wearing schedule for the scrotal support and/there was no evidence that facility staff queried the physician for clarity regarding the application of the scrotal support. The findings were acknowledged during a face-to-face interview with Employee #13 on August 24, 2015 at 3:00 PM.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on August 17, 2015, it was determined that the facility failed to prepare food under sanitary conditions as evidenced by two (2) of eight (8) soiled convection ovens, five (5) of five (5) six-inch deep third pans and 12 of 12 six-inch one-sixth pans and seven (7) of seven (7) that were stored wet, and two (2) of seven (7) half sheet pans that were dented in several areas.	F 371	**Response to F371-1 (Soiled Convection Ovens):** 1. Cited convection ovens were cleaned on 8/17/15. 2. Daily monitoring by management will prevent residents from having potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur. All sanitation staff and production staff will be in-serviced by 10/2/15. Management team will need to sign off that this process is being completed consistently. 4. The Chef, Sous Chef or manager on duty will monitor this daily to maintain compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. These findings will be presented during our monthly managers meeting. 5. Corrective action will be completed by 10/2/15.	10/2/15

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	095030	A. BUILDING _____ B. WING _____	08/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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F 371	Continued From page 11 The findings include: 1. Two (2) of eight (8) convection ovens were soiled at the bottom with burnt food deposits. 2. Five (5) of five (5) six-inch deep third pans and 12 of 12 six-inch one-sixth pans were stored wet. 3. Seven (7) of seven (7) half sheet pans were stored wet and two (2) of the seven (7) were dented in several areas and needed to be discarded. These observations were made in the presence of Employee #9 and Employee #11 who acknowledged the findings.	F 371	**Response to F371-2 (Stored Wet Pans):** 1. Cited pans that were stored wet were washed and sanitized and then placed on drying rack on 8/17/15. 2. Daily monitoring by management will identify other residents from having the potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur. All sanitation staff will be in-serviced by 10/2/15 on requirements for storing wet pots and pans properly. 4. This practice will be monitored daily by management to maintain and sustain compliance at 90% or above. Sanitation leader will do pot and pan audits to help maintain consistency. 5. Corrective action will be completed by 10/2/15.	10/2/15
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents, it was	F 386	**Response to F371-3 (Dented Pans):** 1. Cited dented pans were purged on 8/17/15. 2. Monthly monitoring by management will prevent residents from having potential to be affected by the same practice. 3. The following systemic change will be put in place to ensure the deficient practice will not recur. Sanitation manager will due monthly checks on pots and pans to ensure that dented pans are purged. Staff will be educated to bring any dented pans to management's attention. 4. The Chef, Sous, or manager on duty will monitor this daily to maintain compliance. The quality assurance process will be utilized to maintain and sustain 90% or above compliance. 5. Corrective action will be completed by 10/2/15.	10/2/15

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F 386	Continued From page 12 determined the physician failed to write a complete order as evidenced by the lack of a wearing schedule for a prescribed scrotal support garment. The findings include: Resident #195 was admitted August 1, 2015 with diagnoses that included " scrotal edema. " A review of physician ' s orders dated August 1, 2015 read " Scrotal Support. " A physician ' s progress note dated August 20, 2015 at 6:25 PM read, " Scrotal edema has improved ...patient is feeling more comfortable than before, aggressive dieresis undertaken ... " The order for the scrotal support [garment] lacked evidence of a wearing schedule. The physician failed to include the frequency that staff should apply the garment and/or remove the scrotal support. The findings were acknowledged during a face-to-face interview with Employee #13.	F 386	**Response to F386 (Lack of Wearing Schedule on Order for Scrotal Support):** 1. No further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged This deficiency was noted and addressed in staff meetings by the Director of Nursing (DON)on August 28th, 31st; September 2nd and 4th. 2. Other residents having the potential to be affected by the same deficient practice will be identified via chart reviews verifying complete orders for medical devices/apparel to include instructions for application, duration, and frequency. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: specific staff and staff in general will be re-educated (nurse and physician) regarding physician orders for application of medical devices/apparel to include instructions for application, duration and frequency. 4. Random monthly audits of MD orders for medical devices/apparel (i.e. scrotal support) to include instructions for application, duration and frequency will be conducted by quality nurses. Two Quality Compliance Coordinators will monitor performance through monthly random audits to ensure MD orders for medical devices/apparel (i.e. scrotal support) includes instructions for application, duration and frequency. 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. The Chief Medical officer will notify the ordering physician of this finding in writing by 9/30/15. 5. Corrective action will be completed by 9/30/15.	9/30/15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514		

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F 514	Continued From page 13 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents, it was determined that facility staff failed to document the treatment plan/instruction(s) for the care of Resident # 150 ' s wound post discharge from the facility. The findings include: A review of the Clinical Notes revealed the following: · A review of a Nurses ' Progress Note dated May 11, 2015 revealed, " ...[sacrum] stage 2, lotion applied ... " · A review of a Nurses ' Progress Note dated May 12, 2015 revealed, " Patient seen for pressure ulcer assessment and care. Location: Right medial buttocks, at the edge of the sacrum, Stage II ... Assessment: small 1 x 0.5 s 0.1 cm stage II with clean red wound bed ...Plan of care and goals: Prevent further breakdown with use of a pressure reduction mattress and regular turning of patient. · A review of a Dietitian ' s Progress Note dated May 13, 2015 revealed, " ...Physical: Altered skin: ...Stage 2 on buttocks ... " A review of the " Pressure Ulcer Wound Care " order dated May 12, 2015 directed, " Three times daily and PRN [as needed], apply skin barrier cream to area after cleansing skin with	F 514	**Response to F514 483.75 (l) (1)-Missing Wound Post Discharge Documentation:** 1. No further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged This deficiency was noted and addressed by the Director of Nursing (DON) in staff meetings on August 28th, 31st, September 2nd and 4th. 2. Every resident having the potential to be affected by the same deficient practice will be identified on admission. Staff will be re-educated on documentation of identified pressure ulcers/wounds and documentation of education provided regarding the care of the wound. Case coordinators are to read and acknowledge notes regarding wound care documented by nursing staff, wound care nurses and physicians 3. The following systemic changes will be in place to ensure that the deficient practice does not recur: a. All pressure ulcers and wounds will be identified and documented on admission and documented in the daily nursing assessment b. The nurse who has identified the wound will notify the physician of the wound and that a wound care consult has been initiated c. Wound care education will be documented by nursing staff d. A list of residents with pressure ulcers/wound care will be added to the charge nurse shift report sheet.	

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F 514	Continued From page 14 disposable cleaning wipes. " A review of the " Discharge Instructions " dated May 12, 2015 lacked evidence that the patient and/or responsible party was provided a documented treatment plan/ instruction(s) on how to care for his/her sacral wound post discharge from the facility. A face-to-face interview was conducted on August 24, 2015 at approximately 3:30 PM with Employee #7. He/she acknowledged the findings. The record was reviewed on August 24, 2015.	F 514	Con't **Response to F514 483.75 (l) (1) -Missing Wound Post Discharge Documentation:** e. A list of residents on pressure ulcer/wound care treatment will be provided to case coordinators every Monday and shared during daily leadership meetings at 0815 weekdays. f. All residents undergoing pressure ulcer/wound care treatment will be updated in care plan meetings where the case coordinator is present. 4. Random chart audits of discharge notes of those residents who have required wound care will be completed by the quality nurses to ensure documentation of wound care instructions/education at time of discharge. Two Quality Compliance Coordinators will monitor performance through monthly random audits to ensure discharge notes of those residents who have required wound care are completed. 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. Corrective action will be completed by 9/30/15	9/30/15