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

PRINTED: 01/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085052		08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE HEALTHCARE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

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F 000	INITIAL COMMENTS Facility requested an IDR for tags F314 and F 279 example #2. Revised report as of 1/6/2011. F 279 example #2 removed. On 1/5/2011 facility notified the division that they withdrew the request to dispute F 314. Revised report sent to the facility on 1/7/11 An unannounced annual survey was conducted at this facility from August 4, 2010 through August 12, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was one hundred-twenty (120). The survey sample totaled thirty six (36) residents.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that three (R3, R126 and R167) out of 36 sampled residents were not provided care and services in a manner that promoted dignity. Findings include: 1. R3 was observed on 8/10/10 at 9:20 AM, 10:15	F 241	F 241 Dignity and Respect of Individuality 1. (a) R3 was provided with a protective/absorbent towel upon notification of this issue. The clinical record for R3 was updated to reflect this resident's need for protective/absorbent towel when in wheelchair in order to clean excessive and/or oral secretions. (b) R3's clothing will be changed as needed due to excessive and/or oral secretions. (c) R3's CNA assignment sheet reflects the need for protective/absorbent towel when resident is in wheelchair. (d) Unit Manager and/or designee will ensure daily that R3 has protective/absorbent towel when in wheelchair and document on treatment record that this is in place two times per shift on 7-3 shift and 3-11 shifts. The DON and/or designee will complete a random audit to ensure that the protective/absorbent towel is in place based on observation and review of TAR (October 15, 2010). 2. (a) Residents who dine together at a table and/or residents who share a room will receive their meals at the same time. (b) All residents are given the choice to eat in their room, dining room, and/or appropriate requested place for each meal. Residents who elect to change their location for their meal will have their meal delivered to them at the same time their roommate and/or others at the table they are seated at receive their meal. Residents that are identified as "residents who require assistance with feeding" will have their meal delivered to them at the same time	10/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Yeashefski
TITLE: NHA
(X6) DATE: 1/17/11

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 241	Continued From page 1 AM, 12:30 PM and 1:45 PM to be sitting in a wheelchair in the hallway with a large wet spot on the front of his shirt. The resident had a problem of drooling saliva from his mouth and usually had a towel with him to keep his face dry. During these observations there was no towel in his wheelchair. During the 10:15 AM observation the resident was seen lifting the bottom of his shirt to wipe his face exposing his abdomen and his peg tube. 2. Observations during lunch on 8/4/10 revealed that at 12:05 PM R126's roommate was delivered her lunch and started eating. R126 received her lunch tray at 12:25 PM. R126 had to watch her roommate eat lunch for 20 minutes before she received her own tray. 3. On 8/11/10 dinner observations were made in the Bethany Unit. At 4:50 PM one resident R167 was observed sitting at a table with three other residents. At 4:55 PM R167 was not given her tray however the three other residents sitting at her table received their trays and were eating. Interview with E11 (LPN Unit Manager) at 5:05 PM revealed that R167 was a "feeder" and someone would have to feed her. She would be served next to last. At 5:10 PM R167 was given her tray. At 5:14 PM a staff member began assisting R167 with eating (19 minutes later). The facility failed to ensure R167's dignity by calling her a "feeder" verses a resident that required assistance with eating. The facility failed to provide a dignified dining experience for R167 by having her observe other residents eat for 19 minutes before being assisted with eating.	F 241	their roommate and/or table they seated at has meal delivered to them. The resident that requires assistance with feeding will receive assistance at the same time other residents he/she is seated with are eating. (c) Audits will be completed by the DON and/or designee to ensure that residents who dine together are served meals at the same time and residents who dine in their room receive their meals at the same time (October 15, 2010). 3. Staff Development Coordinator and/or designee will educate all staff members on the appropriate verbiage related to "residents who require assistance with feeding" versus "feeders." Staff Development Coordinator and/or designee will educate staff members on the requirement that all residents are to have a dignified dining experience. This includes but is not limited to the timeliness of food being served to residents seated at the same table, residents receiving their meal at the same time if in their room, and/or assistance required by any resident with others or in their room with a roommate(October 15, 2010). 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010). **F247 Right to Notice Before Room/Roommate Change** 1. Residents will be notified of the admission of a new roommate prior to arrival (August 13, 2010). 2. All residents have the potential to be impacted by a roommate arrival and/or change of roommate. Resident will be notified before room/roommate change (October 15, 2010).	
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	F 247		10/15/10

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F 247	Continued From page 2 A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and procedures and interview it was determined that the facility failed to consistently notify residents of the admission of new roommates. Findings include: Review of the facility's policy and procedure "Admission Policy" revealed "4. Each resident will be notified by a staff member regarding the impeding arrival of a roommate." Interview with R276 on 8/4/10 at 1:52 PM revealed she had four roommates in the last 4 weeks. R276 stated when the bed is empty she knows she will be getting a new roommate. On 8/9/10 at 11:35 AM interview with E8 (unit secretary) revealed the staff do not always know when they are getting a new resident until about an hour before they show up. On 8/9/10 at 11:40 AM interview with E9 (LPN) revealed the staff are suppose to let residents know when they are getting a new roommate. E9 continued to state that sometimes the staff just introduces the residents to each other when the new roommate arrives. On 8/9/10 at 11:45 AM interview with E10 (RN Unit Manger) revealed if there is a room change she notifies the roommate. Sometimes she does	F 247	3. (a) The admissions director and/or designee will notify residents of room and/or roommate changes prior to the occurrence. This will be completed verbally and in writing. (b) A copy of the notice will be filed in the medical record under Social Services. (c) An audit will be completed by the NHA and/or designee to ensure that all residents have been notified of room/roommate changes (October 15, 2010). 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010).	

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F 247	Continued From page 3 not know of an admission until the resident shows up. She confirmed that the staff do not always let the residents know that they are getting a new roommate until the new resident arrives.	F 247		
F 253 SS=B	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 observation and interview it was determined that the facility failed to provide housekeeping services in one room to maintain a clean and odor free environment. Findings include: Observations in room 226a on 8/4 (afternoon) and 8/5/10 (throughout day) revealed a smell of urine. There were three open empty plastic urinals hanging on a-beds side of the room. During one observation the resident was eating his lunch and three flies were around the resident and his bed. There was a smell of urine. On 8/9/10 at 9:25 AM the room smelled of urine and there were two empty urinals hanging in room. An interview on 8/9/10 at 12:24 PM with E12 (housekeeping director) confirmed the smell of urine and revealed that both gentleman in the room had issues that resulted in urine being spilled in room. He further stated that the resident in 226b had expired this weekend and a thorough cleaning would be done. Observation on 8/10/10 at 11:20 AM revealed a	F 253	**F253 Housekeeping and Maintenance Services** 1. When the survey was completed and it was noted that Room 226 had an odor of urine that room was thoroughly cleaned (August 12, 2010). 2. (a) A random audit will be conducted on each Nursing Unit by the Director of Environmental Services/Housekeeping to ensure that all rooms are free of odor. Any room with an odor will be cleaned immediately. Environmental Rounds will be completed by the NHA/Environmental Director/and/or designee weekly to ensure rooms are odor free (October 15, 2010). 3. Room 226 will be deep cleaned at least one time per week to facilitate an odor free environment. Resident in room 226a will be given new urinals daily to facilitate an odor free environment and documented by the nursing assistants on room 226a record (October 15, 2010). 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010).	10/15/10

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F 253	Continued From page 4 smell of urine. An interview with nurse E4 (nurse) on 8/11/10 at 1 PM revealed that R34 wants to use his urinal independently but often spills some of the urine on the floor, the fall mats, the bed and himself then the staff have to go behind him to clean up.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that one (R3) out of 36 sampled residents failed to have a comprehensive care plan for an identified need. Findings include:	F 279	1. (a) R3 was provided with a protective/absorbent towel upon notification of this issue. The clinical record for R3 was updated to reflect this resident's need for protective/absorbent towel when in wheelchair in order to clean excessive and/or oral secretions(August 12, 2010). (b) R3's clothing will be changed as needed due to excessive and/or oral secretions (Ongoing). (c) R3's CNA assignment sheet reflects the need for protective/absorbent towel when resident is in wheelchair (August 13, 2010). (d) Unit Manager and/or designee will ensure daily that R3 has protective/absorbent towel when in wheelchair and document on treatment record that this is in place two times per shift on 7-3 shift and 3-11 shifts (Ongoing). R286 was discharged on 8/6/10 therefore; no corrective action was able to be completed. 2. All residents have the potential to be impacted. A random audit of resident care plans will be completed by the DON and/or designee to ensure that new admissions and long term care residents have comprehensive care plans appropriate for deficit areas (October 15, 2010). 3. (a) All resident's dignity care plans will be reviewed and updated and will continue quarterly. 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010).	10/15/10

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F 279	Continued From page 5 1. R3 had a diagnosis of a brain injury and had a problem with drooling saliva from his mouth. The resident's quarterly MDS dated 5/30/10 indicated he needed extensive assistance with hygiene. However, observation revealed that he was able to wipe the saliva from his face independently. On 8/6 and 8/9/10 R3 was observed with a towel in his wheel chair and wiping his own face as necessary. On 8/10/10 the resident was observed at 9:20 am, 10:15 am, 12:30 PM and 1:45 PM in his wheelchair without a towel. He had a large wet spot on his shirt. He was also observed lifting up the bottom of his shirt to wipe his face exposing his abdomen and g-tube. Review of the aide flow sheets lacked evidence that the staff had instructions to provide a towel to R3 so he could wipe his own face. Review of the current care plan lacked any indication of the resident having a problem with drooling and his ability to wipe his own face with a towel. An interview with E5 (LPN)on 8/11/10 confirmed that R3 had no care plan addressing his drooling and use of a towel to stay dry.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to develop a care plan during the interim admission assessment period for an actual pressure ulcer for one (R266) out of 36 residents sampled. Findings include:	F 281	**F281 Services Provided Meet Professional Standards** 1. (a) R266's care plan was corrected immediately upon notification of deficient practice (August 12, 2010). 2. All residents have the potential to be impacted for failure to develop interim care plan upon admission. Staff Development and/or Assistant Director of Nursing are reviewing all new admissions within 72 hours of admission for immediate care needs that require care planning and communication prior to the completion of the comprehensive care plan (Ongoing). All new admissions are reviewed within one week of admission at High Risk Meeting (Ongoing). A random audit will be completed by the DON and/or designee for completion of interim care plan upon admission (October 15, 2010). 3. Staff Development Coordinator and/or designee to educate all professional staff on the development of an interim care plan (October 15, 2010). 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010).	10/15/10

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F 281	Continued From page 6 Cross refer F314 example 2 R266 was readmitted to the facility on 7/22/10. The Resident Admission Assessment form documented R266 had two stage II pressure ulcers on her sacrum and one unstageable pressure ulcer to her left heel. Review of the care plans on 8/11/10 revealed the facility failed to develop a care plan for R266's actual pressure ulcers with interventions and evaluations. Interview with E6 (Wound Nurse) on 8/12/10 at 10:10 AM confirmed that the facility failed to develop an interim care plan for R266's actual pressure ulcers to her sacrum and left heel. E6 continued to state that a care plan was developed after reviewing this issue with the surveyor.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to provide necessary treatment and service for two (R105	F 314	F 314 Treatment/Svcs to prevent/heal pressure sores 1. (a)R105 was assessed by interdisciplinary team and had air mattress and off load heels implemented on July 15, 2010. R105 is currently being followed by wound care specialist and wound care team weekly (Ongoing until heeled). R105's heel has significantly improved. (b) R266 was assessed by the interdisciplinary team and appropriate interventions implemented. R266 is followed by the wound care specialist and wound care team weekly (Ongoing until heeled). R266's wound has significantly improved. 2. All residents are at risk for pressure ulcers.	10/15/10

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F 314	Continued From page 7 &R266) out of 36 sampled residents who had pressure ulcers (PU). The facility failed to involve the interdisciplinary team to accurately assess R105's risk for development of a new PU when R105 experienced a change in condition following a cerebral vascular accident (CVA). This failure resulted in lack of interventions being implemented and R105 acquired a new, unstageable left heel PU. The facility also failed to provide the necessary services in measuring and documenting in order to accurately assess and monitor R266's stage IV pressure ulcer on her left heel. The facility also failed to notify the interdisciplinary team to accurately assess and monitor R266's stage IV pressure ulcer. Findings include: 1. R105 was readmitted to the facility on 7/6/10 following treatment in a hospital for cerebral vascular accident and generalized muscle weakness. R105's additional diagnoses included diabetes mellitus type I, dementia, and hypertension. Review of R105's significant change Minimum Data Set (MDS) assessment dated 7/13/10 revealed the resident's ability to perform activities of daily living (ADL) had deteriorated from the previous assessment and the resident no longer ambulated, required total assistance of staff for bed mobility, was totally incontinent of bowel and bladder and was severely impaired for daily decision making. In addition, there was no documentation indicating that R105 had any pressure ulcer (PU). R105's Nursing"Resident admission assessment" dated 7/7/10 noted the resident did not have any skin impairment and that the skin was intact.	F 314	3. (3a) The Braden Scale is a predictor for pressure ulcer risk and scores which trigger interdisciplinary consults. The trigger is 16 or less and triggers a nutrition and rehab evaluation request (see attached policy). R105 Braden Score was a 17 which does not trigger an interdisciplinary consult. A review of the Braden Scale for all admissions / readmissions will be brought into the "High Risk Meeting" following admission/readmission. The admission/readmission will be reviewed by the interdisciplinary team for clinical risk factors related to pressure ulcer prevention and implementation of recommended interventions. (3b) The Staff Development Coordinator and/or designee will educate all licensed Nursing Staff on professional standards of assessment and measuring of pressure wounds on admission/readmission. (3c) When therapy notices a change in the status or condition of the resident or residents complains of condition change the therapist will document the change/condition in the 24-hour report and verbally notify nursing staff. (3d) Audits will be completed by DON and/or designee will audit 25% of all new admissions to ensure that admission/readmission was reviewed by interdisciplinary team for pressure ulcer risk, measurements completed, and interventions implemented. DON/Director of Rehabilitation and/or designee will audit therapy evaluation/notes and communication against 24-hour report to ensure pertinent information is cross referenced. (October 15, 2010). 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010).	

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F 314	Continued From page 8 Review of R105's "Braden Scale for Predicting Pressure Sore Risk" dated 7/6/10 revealed that R105 was assessed "17" or not to be considered at risk for developing PU Review of "Occupational Therapy (OT) Evaluation and Plan of Treatment" dated 7/7/10 documented "Skin integrity-reddened areas (bilateral heels boggy with blotchyness. Nsg. (nursing) notified and are providing an air mattress with orders to elevate heels when in bed)." In the summary of this evaluation, it indicated that R105 presented with total dependency for ADL's transfers and mobility due to recent onset of CVA. The evaluation noted for "risk factors-due to the documented physical impairments and associated functional deficits, the patient is at risk for cardiac insufficiency, decrease in level of mobility, increased dependency upon caregivers, increased agitation and decreased skin integrity." Upon completion of the above OT evaluation, the "Rehab. Screening Form" was completed by the above OT(E8). Review of the "Rehab. Screening Form" dated 7/7/10 indicated for "positioning equipment/splinting devices" and for "Skin assessment/Braden Score", to implement an intervention to "elevate bilateral heels." Subsequently, the "Transfer Status and Rehab. Communication Form" was completed by the above OT on 7/7/10. Review of this communication form noted for "precautions: elevate bilateral heels." This form documented the process in which this intervention would be implemented which included "original form would be placed in the medical record under "Restorative Section". In addition, a copy to the RNAC (Registered Nurse Assessment	F 314		

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F 314	Continued From page 9 Coordinator) and charge nurse/unit manager. Nurse to transcribe orders to CNA (Certified Nursing Assistant) flow record. A copy of the Transfer Status form may also be attached to the CNA flow record." An interview with the OT (E8) who completed the above evaluation, "Rehab. Screening Form", and "Transfer Status and Rehab. Communication Form" on 8/11/10 at approximately 11:20 AM revealed that the interventions to elevate the heels and for the use of the air mattress was to relieve pressure from the reddened area of the heels noted during the 7/7/10 evaluation. Although E8 recalls communicating the need for these interventions verbally with a nursing staff member in the unit, E8 did not recall the individual's name.	F 314		
	An interview with E5 (charge nurse) on 8/11/10 at approximately 10 AM confirmed that the intervention to elevate bilateral heels, as noted on the "Transfer Status and Rehab. Communication Form" dated 7/7/10 was not implemented, as evidence of lack of documentation of this intervention on the CNA flowsheet for July 2010. An interview with E3 (Assistant Director of Nursing/ADON) on 8/11/10 at approximately 4:30 PM confirmed that interventions recommended by therapy to elevate heels bilaterally on 7/7/10 were not implemented. In addition, there was no evidence that the facility proceeded to obtain and implement the use of an air mattress on 7/7/10, as documented by the therapy department. An additional interview with E2 (Director of Nursing/(DON) on 8/11/10 at approximately 5 PM confirmed that the facility failed to implement the			

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	085052		08/12/2010

NAME OF PROVIDER OR SUPPLIER
RENAISSANCE HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE
26002 JOHN J WILLIAMS HIGHWAY
MILLSBORO, DE 19966

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F 314	Continued From page 10	F 314		

interventions recommended by therapy on 7/7/10 to elevate R105's bilateral heels and to use an air mattress. However, E2 reiterated that since R105 was assessed as not at risk for development of PU (score of 17) using the Braden scale, no interventions to relieve pressure of the heels were implemented when R105 was readmitted to the facility on 7/7/10. Lastly, E2 related to the surveyor that she was not aware until during this survey that the therapy department documented reddened heels on 7/7/10 when R105 was readmitted.

Review of the weekly nursing Skin Rounds" on 7/13/10 noted skin was intact. Nurse's note dated 7/16/10 timed 2:30 PM indicated that E5 (LPN) was called to the therapy department to assess a necrotic area of R105's left heel measuring 3 cm. in length and 3.5 cm in width without depth.

Review of the "Weekly Wound Assessment" initiated by E5 on 7/16/10 noted R105 had a nosocomial (facility acquired) pressure ulcer of right heel. The wound was reassessed on 7/22/10, 7/28/10, 8/5/10 and 8/11/10. Interviews with both E5 (LPN) and the Staff Educator (E6) who documented the above reassessments on 8/11/10 at approximately 11 AM revealed that they incorrectly noted that the wound site was right but rather, it was the left heel.

Review of the physician's order dated 7/21/10 noted the following interventions to include off load heels while in bed, skin prep. to bilateral heels every shift, and to apply topical dimethicone to sacrum every shift and as necessary.

Although R105 had acquired a PU of the left heel on 7/16/10, the facility failed to implement

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F 314	Continued From page 11 intervention to off load heels until 7/21/10. Review of the "Wound Evaluation Form" completed by E7 (nurse practitioner) dated 7/22/10 and 7/29/10 noted left heel "suspected deep tissue injury" measuring 3 cm. (L), 3 cm. (W) and no depth and 2.5 cm (L), 2.5 (W) and no depth respectively. In the "Additional comments" Pt. (patient) on air loss mattress. Suspend heels with foam booties. There is a possibility of worsening secondary to suspected deep tissue injury." An interview with E7 (nurse practitioner) on 8/12/10 at approximately 9:50 AM revealed that her first assessment of R105's left heel was on 7/22/10, approximately 15 days after readmission on 7/7/10. E7 related that completion of the Braden scale should be interdisciplinary including the therapy department. During the interview, E7 was questioned whether the left heel impairment was deep tissue injury (DTI). E7 reiterated that DTI is suspected and that confirmation of DTI would only be via ultrasound imaging during the initial assessment of the wound. Since E7 currently does not utilize ultrasound imaging in her practice, E7 related that she is unable to confirm that this is or is not a DTI. 2. The facility's policy and procedure for "Pressure Ulcer Prevention and Management" revealed " Purpose : To identify individuals at risk for skin breakdown and develop an ongoing plan of care for prevention, recognition and treatment of pressure ulcers. Assessment: 7. Involve Interdisciplinary Team as appropriate to ensure nutrition, hydration and all other interventions are implemented timely in order to prevent alterations	F 314		

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F 314	Continued From page 12 in skin integrity as well as heal any problems that may occur. Implementation 1. Any resident with a total score of 16 or less on the Braden Scale are considered to be at risk for developing pressure ulcers.... 8. All residents scoring 16 or less on the Braden Scale will be reviewed in weekly high risk meeting to ensure appropriate nutrition and pressure relieving interventions/strategies are implemented. "Wound Identification Procedure: 2. When a skin condition is identified (other than Stage I Pressure Ulcer), Nursing will: d. Complete wound assessment weekly, document wound appearance include location, size, type, odor, and drainage using the Weekly Wound Assessment sheet. " R266 was readmitted to the facility on 7/22/10 with diagnoses that included abnormal gait, diabetes mellitus type II, hypertension, and hip joint replacement. The MDS dated 7/29/10 documented R266 was cognitively intact for daily decision making. R266 required one person to assist with bed mobility, dressing, personal hygiene and bathing. She required two people to assist with transfers and toilet use. R266 was documented as having 2 stage II pressure ulcers and 1 stage 4 pressure ulcer. Review of R266's readmission "Resident Admission Assessment" form dated 7/22/10 documented for skin condition "bilateral scattered bruises arm, ... Left heel red with black forming... Right buttock 2 1/2 cm x 1/2 cm abrasion left buttock 2 cm x 2 cm." Review of the Braden Scale for Predicting	F 314		

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F 314	Continued From page 13 pressure sore risk dated 7/22/10 documented R266 was scored as 17. ("Any resident scoring 16 or less is considered High Risk, A therapy Screen and Diet Alert must be initiated.") The Braden Scale did not rate R266 as a high risk for pressure sore even though the facility documented R266 had 3 pressure ulcers including a stage IV on re-admission to the facility. Review of R266's nurses notes revealed on 7/22/10 "The left heel is red with black areas..." 7/27/10 3;30 PM "...Allevyn heels in place." On 7/28/10 6:20 PM "... heel lift boot to left heel to prevent breakdown..." On 7/23/10 the physician ordered "air mattress, skin prep to heels bid (twice a day)." Review of the Skin Rounds Sheets for R266 revealed there was no documentation describing the condition of the skin and all bony prominences or measurements on the form for two weeks. Review of the wound sheets revealed on 8/5/10 R266 had her first wound documentation and measuring 14 days after it was identified. Review of the "Wound Evaluation Form" dated 8/6/10 from E7 (nurse practitioner) revealed "Stage unable to determine Highest Stage: unable to determine thickness (left blank)... Additional comments: Education provided to patient on off loading, pt. verbalizes understanding. Encourage nutrition and hydration. Pt states she does not like wearing foam booties in bed, but readily agrees to do so to heal blister. Blister appears to be reabsorbing,	F 314		

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F 314	Continued From page 14 anticipate full healing with no complication with continued off loading." On 8/11/10 at 10:15 AM interview with E6 (facility wound nurse/educator) confirmed that she did not measure R266's left heel pressure ulcer until 8/5/10. She was not notified by the staff that R266 had a stage IV pressure ulcer to her left heel. E6 also stated that when the Braden Scale is 16 or below she is notified then she notifies the nurse practitioner/ wound nurse. However because the Braden Scale did not trigger the staff did not notify her of the wound. She continued to state that the RNAC notified her of the wound and she immediately assessed the wound. E6 continued to state that the wounds on R266's sacrum were healed. The facility failed to document weekly measurements and assess R266's left heel wound to ensure appropriate interventions were in place to enhance healing.	F 314		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations in the dietary area on 8-12-10 and 8-12-10 and throughout the facility during the survey, it was determined that the facility was not insect free. Findings include: 1. On 8/04/10, while interviewing resident R133, two (2) flies were observed around and on the resident in his room.	F 469	**F469 Maintains Effective Pest Control Program** 1. When survey was completed and it was noted that pest control was an issue; specifically flies within the facility the Maintenance Director researched the purchasing of air curtains. Air Curtains are to be ordered and installed immediately upon receiving (October 15, 2010). 2. All residents have the potential to be effected by pests.	10/15/10

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F 469	Continued From page 15 2. On 8/10/10 @ 11:20, one (1) fly was observed around the Fenwick Unit nurse's station. As a resident passed by, while doing a physical therapy walk, she voiced annoyance at the pest buzzing around her. 3. On 8/11/10 @ 13:30, two (2) flies were observed around the lowerator / trayline / steam table area of the kitchen. 4. On 8/11/10 @ 14:35, one (1) fly was observed around the Fenwick Unit nurse's station. 5. Cross refer F253 example #1. Flies were seen in Room 226a on 8/4 and 8/5/10. The flies were seen around the lunch tray, the bed and the resident's urinals that were stored open.	F 469	3. (a)The facility will install air curtains in the service hallway, kitchen, and high traffic areas such as the court yard doors but is not limited to only these specific areas. (b) The facility will further install the WS-85 Insect Control System which attracts specifically flies to a light and consume them thus having the potential to eliminate flies which cross the air curtain and/or enter through other doors not appropriate for air curtains. The WS-85 Insect Control System will be installed throughout the facility (October 15, 2010). A random audit will be conducted by the Maintenance Director and/or designee to determine the decrease in pests within the facility. 4. All audits will be reviewed in monthly QA meeting for a minimum of three (3) months or until substantial compliance is achieved (October 15, 2010).	

DELAWARE HEALTH AND SOCIAL SERVICES
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DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Renaissance Healthcare

DATE SURVEY COMPLETED: August 12, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from August 4, 2010 through August 12, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was one hundred twenty (120). The survey sample totaled thirty-six (36) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-241 Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-247 Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-253 Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-279
3201.1.0	**Scope**	Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-281
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey report date completed 8/12/10, F241,	Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-314 Refer to Plan of Correction as stated on CMS-2567 completed on 08/12/2010 for F-469

Provider's Signature Carol Leaskofski Title NHA Date 9/3/2010

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	F247, F253, F279, F281, F314, and F469.	