

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

PRINTED: 05/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>085020 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>05/06/2014 |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINNACLE REHABILITATION & HEALTH CENTER |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3034 SOUTH DUPONT HIGHWAY<br>SMYRNA, DE 19977  |                      |   |
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| F 000   | INITIAL COMMENTS<br><br>An unannounced complaint survey was conducted at this facility from April 30, 2014 through May 6, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 146. The sample size included three (3) active records and three (3) closed records.   | F 000  |   |                      |   |
| F 280<br>SS=D   | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and | F 280  | The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements | 6/24/14              |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administration

(X8) DATE

6/24/14

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 280   | Continued From page 1<br>resident interview it was determined that for three (3) residents reviewed (R3, R1, and R6) the facility failed to review and revise the care plan to address individualized care needs that the facility staff had assessed. For R3 there was no care plan to ensure a coordinated approach to providing psychosocial support to R3. For R1 and R6, there was no individualized care plan to address showering needs for these two residents who repeatedly refused to be showered. Findings include:<br><br>1. R3 had multiple chronic medical problems including a recent serious medical diagnosis. During the initial tour of the facility on 4/30/14 at 9:35 AM, R3 spoke to the surveyor about her health and related concerns. Progress notes in the clinical record identified the following psychosocial issues known to staff:<br><br>-adjustment disorder with depression (a condition involving sad mood that is related to life circumstances such as health problems; social services note 11/7/13 2:45 PM);<br><br>-discouragement (social services note 11/15/13 1:03 PM);<br><br>-struggling to maintain a positive attitude (psychologist note 11/22/13 11:11 AM); and<br><br>-disappointment and sadness (social services note 12/13/13 12:04 PM).<br><br>When reviewed on 4/30/14, R3's care plan failed to identify and define a plan for staff to follow to meet R3's need for psychosocial and mood support. A care plan addressing indicators of depression / sadness was developed on 5/5/14 | F 280  | F 280<br><br>Example 1<br><br>A. R3 care plan was revised to ensure a coordinated approach to psychosocial support.<br>B. All residents have the potential to be affected by this practice. Social Services will review resident MDS that trigger a CAA for psychosocial well being and review care plans to ensure a coordinated approach to care is in place.<br>C. Unit Managers to monitor daily resident change in condition to identify any resident requiring psychosocial and mood support. Educate Social Services on Psychosocial Care Planning ATTACHEMENT A<br>D. Weekly audit of residents on psychologist case load to ensure a care plan is in place that reflects a coordinated approach to providing psychosocial support. The IDCPT will monitor the audits once a week until 100% success is achieved over 3 consecutive evaluations. Results of these audits will be submitted to the QA committee. ATTACHMENT B. | 6/24/14   |

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| F 280   | Continued From page 2<br>after the surveyor questioned the lack of such a care plan.<br><br>Interview with E5 (Social Worker) on 5/6/14 at 1:15 PM revealed that a different social worker (E6) had initially been assigned to R3 who came to the facility expecting a short stay. E5 then became R3's assigned social worker when R3 became a long term resident of the facility. E5 stated that she would become more familiar with R3's psychosocial support needs and work with R3 to develop a plan to address them.<br><br>Findings were confirmed with E1 (Administrator), E2 (Registered Nurse / Director of Nursing), E3 (RN / Assistant Director of Nursing), and E9 (RN / Staff Development) at the exit conference on 5/5/14 at 4:05 PM.<br><br>2. Cross-refer F312, examples 1. Clinical record documentation (treatment record) indicated that R1 repeatedly refused showering but an individualized care plan to address possible reasons for this was not developed.<br><br>Findings were confirmed with E1, E2, E3, and E9 at the exit conference on 5/5/14 at 4:05 PM.<br><br>3. Cross-refer F312, example 2. Clinical record documentation (treatment record) indicated that R6 repeatedly refused showering but an individualized care plan to address possible reasons for this was not developed.<br><br>Findings were confirmed with E1, E2, E3, and E9 at the exit conference on 5/5/14 at 4:05 PM. | F 280  | F280<br><br>Example 2 (Cross-refer F312, example 1 and 2)<br><br>A. R1 and R6 no longer resides at the facility<br>B. All residents have the potential to be affected by this practice.<br>C. Educate LPN and RN Nursing Staff on Resident Refusals. Unit Mangers to review and investigate daily any resident shower refusals. Care Plans will be updated to address possible reasons for refusals.<br>ATTACHEMNT C<br>D. Weekly audits of refusals to be conducted to ensure investigations are completed and ensure individualized care plans are in place. The IDCPT will monitor the audits once a week until 100% success is achieved over 3 consecutive evaluations. The results of these audits will be submitted to the QA committee. ATTACHMENT D | 6/24/14   |
| F 309<br>SS=D   | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING   | F 309  |   |   |

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| F 309  | Continued From page 3<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews it was determined that for two (2) residents reviewed (R1 and R6) the facility failed to provide the necessary care and services to attain the residents' highest practicable physical well-being in accordance with their comprehensive assessment and plan of care. R1 experienced declining health status in October, 2013 including increased pain and breathing issues. The facility staff failed to increase nursing assessment and monitoring of R1 as her health declined (increased pain and respiratory (breathing) problems). R6 had wounds and gangrene (dead tissue) of the right foot which were worsening with no corresponding increase in nursing assessment. Also, a physician's order for a dressing was not implemented in a timely manner. Findings include:<br><br>1. R1 had multiple medical issues involving her lungs and heart. Record review revealed a lack of nursing assessment documentation on 10/11/13, 10/12/13, 10/13/14, and 10/14/13. Following nursing note documentation dated 10/15/13 describing R1's difficulty breathing, there was no nursing assessment documented on 10/16/13 through 10/20/13. A nursing note | F 309   | F309<br><br>A. 1. R1 no longer resides at the facility<br>B. All residents have the potential to be affected by this practice.<br>C. Educate LPN and RN Nursing Staff on assessment and documentation for any change in condition. ATTACHMENT E<br>D. Audits to be performed at daily clinical meeting to ensure that nursing assessments are done for any change in condition. The IDCPT will monitor the audits daily until 100% success is achieved over 3 consecutive evaluations Results of the audits will be submitted to the QA committee. ATTACHMENT F | 6/24/14              |   |

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| F 309 | <p>Continued From page 4</p> <p>dated 10/21/13 timed 9:40 AM indicated that R1 was admitted to the hospital with difficulty breathing.</p> <p>The following indicators of the need for increased nursing assessment and monitoring were found in R1's clinical record:</p> <ul style="list-style-type: none"> <li>-Motrin (a medication used to decrease pain and inflammation) was ordered by the physician on 10/9/13 to be given to R1 four times a day for all over pain;</li> <li>-A physical therapy evaluation was ordered by the physician on 10/10/13 for R1's increasing weakness;</li> <li>-A nursing note dated 10/15/13 timed 3 AM indicated that R1 had difficulty breathing, needed more oxygen than usual, and a physician's order for an inhaled medication to improve breathing was obtained; and</li> <li>-Pain Management Flow Sheet documentation dated 10/16/13 and timed 2:45 PM indicated that R1 had a new onset of rib pain that she (R1) rated as 7 out of 10 on a pain scale with a 2 being an acceptable level of pain to R2.</li> </ul> <p>Interview with E4 (daughter of R1) on 5/5/14 at 12:25 PM revealed that during several visits with R1 in October, 2013 she (E4) noticed that R1's skin color was different than normal and that R1 didn't look good or feel good. E4 explained that she told the staff about her concerns. Despite R1 having increased pain, weakness, shortness of breath, and R1's daughter's reported concerns, the facility failed to implement a corresponding increase in nursing assessment to ensure that R1</p> | F 309 |  | 6/24/14 |
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| F 309  | <p>Continued From page 5<br/>attained her highest level of well-being.</p> <p>Findings were confirmed with E1 (Administrator), E2 (Registered Nurse / Director of Nursing), E3 (RN / Assistant Director of Nursing), and E9 (RN / Staff Development) at the exit conference on 5/5/14 at 4:05 PM.</p> <p>2. R6 was admitted to the facility with multiple wounds and areas of gangrene (dead tissue) of the right foot with severely impaired circulation (blood flow) to the foot.</p> <p>-Two consecutive weekly nursing assessments dated 11/19/13 and 11/27/13 revealed worsening of the wounds and gangrene (dead tissue) but there was no increase in the frequency of wound assessment documentation.</p> <p>-A physician's consultation report dated 11/22/13 completed by E7 (podiatrist consulted for wound care) instructed staff to apply a loosely wrapped dry clean dressing daily to R6's right foot wounds. This instruction, however, was not transcribed as an order until 11/29/13, a week later. Skin prep (a liquid that is applied to the skin to form a protective film) ordered by E8 (attending physician) on 11/19/13 continued to be used through the morning of 11/29/13 despite a different instruction (dry clean dressing only) being received on 11/22/13.</p> <p>-E7's 11/22/13 instruction to apply a dry, clean dressing daily to R6's left foot, incorrectly used "left" instead of "right". R6 had previously had a below the knee amputation of the left leg and had no left foot. The instruction incorrectly referencing the left foot was printed onto the</p> | F 309   | <p>F309</p> <p>A. 2. R6 no longer resides at the facility</p> <p>B. All residents have the potential to be affected by this practice.</p> <p>C. Educate LPN and RN Nursing Staff on assessments, transcribing orders from a consult report and TAR documentation.<br/>ATTACHMENT E</p> <p>D. Weekly Audits of TAR documentation to be completed by Unit Managers. The IDCPT will monitor the audits once a week until 100% success is achieved over 3 consecutive evaluations Results of the weekly audits will be submitted to the QA committee.<br/>ATTACHMENT G</p> | 6/24/14              |   |

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| F 309              | Continued From page 6<br>Treatment Administration Record (TAR) for R6 even though R6 had no left foot. A staff member then crossed out the word foot and wrote stump. This was incorrect, however, since the dry, clean dressing was intended for R6's right foot, not the left leg stump.<br><br>-A nursing note dated 11/24/13 timed 7:45 PM revealed that R6 had returned from a visit home with blood on the dressing on his right big toe after hitting his foot getting in the car. There was no nursing assessment documented regarding the status and appearance of the wound after this incident and prior to R6 being hospitalized on 11/29/13.  | F 309         |   |                      |
| F 312<br>SS=E      | Findings reviewed with E1, E2, E3, and E9 at the exit conference on 5/5/14 at 4:05 PM.<br>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview it was determined that the facility failed to provide the necessary services to two (2) residents reviewed (R1 and R6) to maintain their personal hygiene. Both residents had a pattern of refusing showers documented in the clinical record, however, no individualized plan for maintaining personal hygiene was developed and implemented. | F 312         |   | 6/24/14              |

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| F 312  | <p>Continued From page 7</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS, a standardized assessment form used in nursing homes) for R1 dated 8/17/13 and 10/21/13 indicated that R1 was totally dependent on staff assistance for bathing. Clinical record documentation indicated that R1 refused showers on the following dates in 2013:</p> <p>-July 4, 8, 11, 15,18, 22, and 29;</p> <p>-August 1 and 3 (other shower dates left blank); and</p> <p>-September 12 and 26 (other shower dates left blank).</p> <p>A total of two (2) showers were documented in the facility's care tracker system (a charting system where staff electronically document care provided) during these 3 months (July 28, 2013 and September 8, 2013). All other bathing was documented as a partial bath or a bed bath. The clinical record lacked evidence that the facility identified possible reasons for R1's refusal of showers. The facility then failed to develop an individualized plan for ensuring that R1's hygiene was maintained.</p> <p>2. R6 was totally dependent on staff assistance for bathing according to MDS assessments dated 11/21/13 and 11/29/13. Clinical record documentation indicated that R6 refused showers on November 9, 13, 20, and 27. The clinical record lacked evidence that the facility identified possible reasons for R6's refusal of showers. The facility then failed to develop an individualized plan for ensuring that R1's hygiene was maintained.</p> | F 312   | <p>F312 (Cross-refer F280, example 1 and 2)</p> <p>A. R1 and R6 no longer resides at the facility</p> <p>B. All residents have the potential to be affected by this practice.</p> <p>C. Educate LPN and RN Nursing Staff on Resident Refusals. Unit Mangers to review and investigate daily any resident shower refusals. Care Plans will be updated to address possible reasons for refusals. ATTACHEMNT C</p> <p>D. Weekly audits of refusals to be conducted to ensure investigations are completed and ensure individualized care plans are in place. The IDCPT will monitor the audits once a week until 100% success is achieved over 3 consecutive evaluations. The results of these audits will be submitted to the QA committee. ATTACHMENT D</p> | <i>6/24/14</i>       |   |

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|--------------------|--|---------------|---|----------------------|
| F 312              | Continued From page 8  | F 312         |   |                      |
| F 514<br>SS=D      | <p>Findings reviewed with E1, E2, E3, and E9 at the exit conference on 5/5/14 at 4:05 PM.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review, it was determined that for two (2) residents reviewed (R1 and R6) the facility failed to ensure complete and accurate clinical record documentation. Findings include:</p> <p>1. A physician's order for R1 lacked a clear and accurate date. An order for Motrin (a medication to reduce pain and inflammation) 600 milligrams by mouth every day for 4 days with food contained three different dates- 10/10/13 appeared next to the order; 10/9/13 appeared next to the physician's signature; and 10/8/13 appeared next to a nurse's signature below the physician's signature.</p> | F 514         | <p>F514</p> <p>A. 1. R1 and R6 no longer resides at the facility</p> <p>B. All residents have the potential to be affected by this practice.</p> <p>C. Educate LPN and RN Nursing Staff on transcribing telephone verbal orders ATTACHMENT H</p> <p>D. Weekly Audits of telephone verbal orders documentation to be completed by Unit Managers. The IDCPT will monitor the audits once a week until 100% success is achieved over 3 consecutive evaluations. Results of the weekly audits will be submitted to the QA committee. ATTACHMENT I</p> | 6/24/14              |

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

PRINTED: 05/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |                            |  |
|--|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>PLAN OF CORRECTION  |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>085020</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>05/06/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PINNACLE REHABILITATION &amp; HEALTH CENTER</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3034 SOUTH DUPONT HIGHWAY<br/>SMYRNA, DE 19977</b>   |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |  |
| F 514  | Continued From page 9<br>Findings were confirmed with E1 (Administrator), E2 (Registered Nurse / Director of Nursing), E3 (RN / Assistant Director of Nursing), and E9 (RN / Staff Development) at the exit conference on 5/5/14 at 4:05 PM.<br><br>2. Cross-refer F309, example 2. A consultation form for R6 dated 11/22/13 failed to have a legible (readable) name of the physician completing the form (was only signed with an illegible signature). There was an instruction to apply a dry, clean dressing daily to R6's left foot, however, R6 had previously had a below the knee amputation of the left leg and had no left foot. The consulted physician erroneously used left instead of right. The instruction incorrectly referencing the left foot was printed onto the Treatment Administration Record (TAR) for R6 even though R6 had no left foot. A staff member then crossed out the word foot and wrote stump. This was incorrect, however, since the dry, clean dressing was intended for R6's right foot, not the left leg stump.<br><br>Findings confirmed with E1, E2, E3 and E9 at the exit conference on 5/5/14 at 4:05 PM. | F 514  | F514<br>Example 2 (Cross Refer F309, example 2)<br><br>A. 2. R6 no longer resides at the facility<br>B. All residents have the potential to be affected by this practice.<br>C. Educate LPN and RN Nursing Staff on assessments, transcribing orders from a consult report and TAR documentation.<br>ATTACHMENT E<br>D. Weekly Audits of TAR documentation to be completed by Unit Managers. The IDCPT will monitor the audits once a week until 100% success is achieved over 3 consecutive evaluations Results of the weekly audits will be submitted to the QA committee.<br>ATTACHMENT G | 6/24/14                    |  |



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Pinnacle Healthcare

DATE SURVEY COMPLETED: May 6, 2014

| SECTION                                     | STATEMENT OF DEFICIENCIES<br>Specific Deficiencies   | ADMINISTRATOR'S PLAN FOR CORRECTION<br>OF DEFICIENCIES WITH ANTICIPATED<br>DATES TO BE CORRECTED  |
|---|--|---|
| <p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> | <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from April 30, 2014 through May 6, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 146. The sample size included three (3) active records and three (3) closed records.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p>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.</p> <p>This requirement is not met as evidenced by:</p> | <p>Cross Reference POC for CMS 2567L survey completed May 6, 2014<br/>F-Tags: F280, F309, F312, and F514</p> <p>Completion Date June 24, 2014</p> |

Provider's Signature *John M. Hagg* Title Administrator Date June 6, 2014



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

NAME OF FACILITY: Pinnacle Healthcare

DATE SURVEY COMPLETED: May 6, 2014

| SECTION | STATEMENT OF DEFICIENCIES<br>Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION<br>OF DEFICIENCIES WITH ANTICIPATED<br>DATES TO BE CORRECTED |
|---------|--|--|
|---------|--|--|

|  |   |  |
|--|---|--|
|  | Cross refer to the CMS 2567-L survey ending May 6, 2014, F280, F309, F312 and F514. |  |
|--|---|--|

Provider's Signature *John M. Hogg* Title Administrator Date June 6, 2014

Teaching Plan 2014  
Pinnacle Rehabilitation and Health Center  
3034 South DuPont Blvd.  
Smyrna, D.E. 19977  
302-653-5085

Teaching Plan:

Psychosocial Care Planning: Care planning for residents receiving psychosocial services.

Purpose:

To reinforce to social services the importance of implementing a psychosocial care plan for residents receiving psychosocial services.

Supportive Data:

Social Services will implement appropriate care plan for individuals receiving psychosocial services.

Associated Standards:

Heaton Manual:

- Care Plans- Comprehensive

Desired Resident Outcome:

A psychosocial care plan will be implemented for residents receiving psychosocial services in a timely manner.

Assessment:

1. Review all residents on psychosocial services to ensure coordinated approach to providing support.
2. Random audit weekly of residents seen the prior week for psychosocial services.

Intervention:

1. Implement Associated Standards (see above)
2. Educate Social Services staff.

## Care Plans – Comprehensive

| Highlights                              | Policy Statement  |
|---|---|
| Developing the Comprehensive Care Plan  | An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.  |
| Basis of Comprehensive Care Plan        | <p style="text-align: center;"><b>Policy Interpretation and Implementation</b></p>  |
| Purpose of Care Plan                    | <ol style="list-style-type: none"> <li>1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.</li> <li>2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</li> <li>3. Each resident's comprehensive care plan is designed to:               <ol style="list-style-type: none"> <li>a. Incorporate identified problem areas;</li> <li>b. Incorporate risk factors associated with identified problems;</li> <li>c. Build on the resident's strengths;</li> <li>d. Reflect the resident's expressed wishes regarding care and treatment goals;</li> <li>e. Reflect treatment goals, timetables and objectives in measurable outcomes;</li> <li>f. Identify the professional services that are responsible for each element of care;</li> <li>g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;</li> <li>h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and</li> <li>i. Reflect currently recognized standards of practice for problem areas and conditions.</li> </ol> </li> </ol> |
| Time Frame for Completing the Care Plan | 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).  |
| Revisions                               | 5. Care plans are reviewed by the Care Planning Team at least quarterly.  |

*continues on next page*

F 280 ATTACHMENT A

Assessments and Care Planning

Resident's Right of Refusal

- 6. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.

| References                        |   |             |           |             |           |             |           |             |           |
|-----------------------------------|---|-------------|-----------|-------------|-----------|-------------|-----------|-------------|-----------|
| OBRA Regulatory Reference Numbers | 483.10(b)(4); 483.10(d)(2)&(3); 483.15(b)(1); 483.15(b)(3); 483.20(k)(1)&(2); 483.25  |             |           |             |           |             |           |             |           |
| Survey Tag Numbers                | F154; F155; F242; F279; F280; F309  |             |           |             |           |             |           |             |           |
| Related Documents                 | Care Planning – Interdisciplinary Team<br>Resident/Family Participation – Assessment/Care Plans   |             |           |             |           |             |           |             |           |
| Policy Revised                    | <table border="0"> <tr> <td>Date: _____</td> <td>By: _____</td> </tr> </table> | Date: _____ | By: _____ |
| Date: _____                       | By: _____   |             |           |             |           |             |           |             |           |
| Date: _____                       | By: _____   |             |           |             |           |             |           |             |           |
| Date: _____                       | By: _____   |             |           |             |           |             |           |             |           |
| Date: _____                       | By: _____   |             |           |             |           |             |           |             |           |

**Psychosocial Support Audit: F-280**

**F 280 ATTACHMENT B**

| Date | Room # | Resident Name | Reason for Consult | Intervention and Care Plan in Place<br>Yes/No | Corrective Action |
|------|--------|---------------|--------------------|---|-------------------|
|      |        |               |                    |   |                   |
|      |        |               |                    |   |                   |
|      |        |               |                    |   |                   |
|      |        |               |                    |   |                   |
|      |        |               |                    |   |                   |
|      |        |               |                    |   |                   |
|      |        |               |                    |   |                   |

Date: \_\_\_\_\_ Auditors Signature: \_\_\_\_\_

Teaching Plan 2014  
Pinnacle Rehabilitation and Health Center  
3034 South DuPont Blvd.  
Smyrna, D.E. 19977  
302-653-5085

Teaching Plan: Resident Refusals: Refusal of care/treatment, evaluation of resident preference.

Purpose: To reinforce to the nursing staff the importance of documentation with residents refusing care and evaluation of possible causative factors.

Supportive Data: The nursing staff will evaluate reason for refusal of care/treatment, document education/outcome, adjust care plan (if needed) to support resident preference.

Associated Standards: Heaton Manual:

- Care Plans- Comprehensive
- Charting and Documentation

Desired Resident Outcome: With refusal of care/treatment, evaluation of reason for refusal will occur to identify resident preferences and outcome documented in progress note. Care plan will be adjusted (if needed) to reflect residents' preferences.

Assessment: 1. Assess staff ability to understand the foundation of importance of need to evaluate a refusal of care/treatment and provide supportive documentation regarding possible causative factors.

Intervention: 1. Implement Associated Standards (see above)  
2. Educate licensed staff (RN and LPN)  
3. Unit managers to review refusals with IDT, investigate possible causative factors and ensure

2 of 5

**F 280 ATTACHMENT C**

that the resident care plan specifies preferences, if needed.

3 of 5

# Charting and Documentation

## Highlights

## Policy Statement

All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.

### Policy Interpretation and Implementation

Documentation Requirements

Recording Entries

Recording Accidents/ Incidents

Confidentiality and Release of Resident Information

Use of Abbreviations and Symbols

Documentation Criteria

1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.
2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy.
3. All incidents, accidents, or changes in the resident's condition must be recorded.
4. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office.
5. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records.
6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum:
  - a. The date and time the procedure/treatment was provided;
  - b. The name and title of the individual(s) who provided the care;
  - c. The assessment data and/or any unusual findings obtained during the procedure/treatment;
  - d. How the resident tolerated the procedure/treatment;
  - e. Whether the resident refused the procedure/treatment;
  - f. Notification of family, physician or other staff, if indicated;
  - g. The signature and title of the individual documenting.

## References

|                                   |  |
|-----------------------------------|--|
| OBRA Regulatory Reference Numbers | 483.10(e); 483.60; 483.60(a); 483.75(l)(1)(i)-(iv); 483.75(l)(4)(i)-(iv)                         |
| Survey Tag Numbers                | F164; F425; F514   |
| Related Documents                 | Abbreviations and Symbols (Appendix A)<br>Guidelines for Charting and Documentation (Appendix A) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____ |

4 of 5

# Care Plans – Comprehensive

| Highlights                              | Policy Statement  |
|---|---|
| Developing the Comprehensive Care Plan  | An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.  |
| Basis of Comprehensive Care Plan        | <b>Policy Interpretation and Implementation</b>   |
| Purpose of Care Plan                    | <ol style="list-style-type: none"> <li>1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.</li> <li>2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</li> <li>3. Each resident's comprehensive care plan is designed to:               <ol style="list-style-type: none"> <li>a. Incorporate identified problem areas;</li> <li>b. Incorporate risk factors associated with identified problems;</li> <li>c. Build on the resident's strengths;</li> <li>d. Reflect the resident's expressed wishes regarding care and treatment goals;</li> <li>e. Reflect treatment goals, timetables and objectives in measurable outcomes;</li> <li>f. Identify the professional services that are responsible for each element of care;</li> <li>g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;</li> <li>h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and</li> <li>i. Reflect currently recognized standards of practice for problem areas and conditions.</li> </ol> </li> </ol> |
| Time Frame for Completing the Care Plan | 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).  |
| Revisions                               | 5. Care plans are reviewed by the Care Planning Team at least quarterly.  |

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*Assessments and Care Planning*

Resident's Right of Refusal

6. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.

| References                               |   |             |           |             |           |             |           |             |           |
|--|---|-------------|-----------|-------------|-----------|-------------|-----------|-------------|-----------|
| <b>OBRA Regulatory Reference Numbers</b> | 483.10(b)(4); 483.10(d)(2)&(3); 483.15(b)(1); 483.15(b)(3); 483.20(k)(1)&(2); 483.25  |             |           |             |           |             |           |             |           |
| <b>Survey Tag Numbers</b>                | F154; F155; F242; F279; F280; F309  |             |           |             |           |             |           |             |           |
| <b>Related Documents</b>                 | Care Planning – Interdisciplinary Team<br>Resident/Family Participation – Assessment/Care Plans   |             |           |             |           |             |           |             |           |
| <b>Policy Revised</b>                    | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Date: _____</td> <td style="width: 50%;">By: _____</td> </tr> <tr> <td>Date: _____</td> <td>By: _____</td> </tr> <tr> <td>Date: _____</td> <td>By: _____</td> </tr> <tr> <td>Date: _____</td> <td>By: _____</td> </tr> </table> | Date: _____ | By: _____ |
| Date: _____                              | By: _____   |             |           |             |           |             |           |             |           |
| Date: _____                              | By: _____   |             |           |             |           |             |           |             |           |
| Date: _____                              | By: _____   |             |           |             |           |             |           |             |           |
| Date: _____                              | By: _____   |             |           |             |           |             |           |             |           |

# Shower Refusals Audit

| Date | Room # | Resident Name | Reason for Refusal | Nurses Progress Note present Yes/No | Intervention and Care Plan in Place Yes/No | Corrective Action |
|------|--------|---------------|--------------------|-------------------------------------|--|-------------------|
|      |        |               |                    |                                     |  |                   |
|      |        |               |                    |                                     |  |                   |
|      |        |               |                    |                                     |  |                   |
|      |        |               |                    |                                     |  |                   |
|      |        |               |                    |                                     |  |                   |
|      |        |               |                    |                                     |  |                   |
|      |        |               |                    |                                     |  |                   |

Auditors Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Teaching Plan 2014  
Pinnacle Rehabilitation and Health Center  
3034 South DuPont Blvd.  
Smyrna, D.E. 19977  
302-653-5085

Teaching Plan: Change of Condition in Resident's condition:  
Wound decline documentation.

Purpose: To reinforce to the nursing staff the importance of  
documentation of a wound with declining wound  
status.

Supportive Data: The nursing staff will document wound  
appearance with dressing change on any wound  
that has declined.

Associated Standards: Heaton Manual:  

- Charting and Documentation
- Change in Resident's condition or Status

Desired Resident Outcome: With wound decline, wound documentation will  
increase with dressing change until wound has  
stabilized.

Assessment: 

1. Review previous wound documentation to  
evaluate previous wound status.
2. Assess staff ability to understand the foundation  
of importance of need to evaluate a declining  
wound status and appropriate documentation  
regarding documentation of declining wound status.

Intervention: 

1. Implement Associated Standards (see above)
2. Educate licensed staff (RN and LPN)
3. Random audit of Physician Consult sheets.

4. Weekly audit of TAR to ensure appropriate treatment in place.

# Charting and Documentation

| Highlights  | Policy Statement   |
|---|--|
| Documentation Requirements                          | All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.   |
| Recording Entries                                   | <p style="text-align: center;"><b>Policy Interpretation and Implementation</b></p> <p>1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.</p>  |
| Recording Accidents/ Incidents                      | <p>2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy.</p>   |
| Confidentiality and Release of Resident Information | <p>3. All incidents, accidents, or changes in the resident's condition must be recorded.</p> <p>4. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office.</p>  |
| Use of Abbreviations and Symbols                    | <p>5. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records.</p>   |
| Documentation Criteria                              | <p>6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum:</p> <ol style="list-style-type: none"> <li>a. The date and time the procedure/treatment was provided;</li> <li>b. The name and title of the individual(s) who provided the care;</li> <li>c. The assessment data and/or any unusual findings obtained during the procedure/treatment;</li> <li>d. How the resident tolerated the procedure/treatment;</li> <li>e. Whether the resident refused the procedure/treatment;</li> <li>f. Notification of family, physician or other staff, if indicated;</li> <li>g. The signature and title of the individual documenting.</li> </ol> |

| References                        |  |
|-----------------------------------|--|
| OBRA Regulatory Reference Numbers | 483.10(e); 483.60; 483.60(a); 483.75(1)(1)(i)-(iv); 483.75(1)(4)(i)-(iv)                         |
| Survey Tag Numbers                | F164; F425; F514   |
| Related Documents                 | Abbreviations and Symbols (Appendix A)<br>Guidelines for Charting and Documentation (Appendix A) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____ |

# Change in a Resident's Condition or Status

## Highlights

Protocol for Notifying Attending Physician of Changes in Resident's Medical/Mental Condition

Significant Change of Condition

Protocol for Notifying Resident's Family or Sponsor When There is a Change in the Resident's Medical/Mental Condition

Time Frame for Notifying Family of Changes

Informing Resident of Changes in Care or Treatments

Documentation of Changes in Medical Record

## Policy Statement

Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).

## Policy Interpretation and Implementation

1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:
  - a. An accident or incident involving the resident;
  - b. A discovery of injuries of an unknown source;
  - c. A reaction to medication;
  - d. A significant change in the resident's physical/emotional/mental condition;
  - e. A need to alter the resident's medical treatment significantly;
  - f. Refusal of treatment or medications (i.e., two (2) or more consecutive times);
  - g. A need to transfer the resident to a hospital/treatment center;
  - h. A discharge without proper medical authority; and/or
  - i. Instructions to notify the physician of changes in the resident's condition.
  
2. A "significant change" of condition is a decline or improvement in the resident's status that:
  - a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self-limiting");
  - b. Impacts more than one area of the resident's health status; and
  - c. Requires interdisciplinary review and/or revision to the care plan.
  - d. The final decision regarding what constitutes a significant change in status is based on the judgment of the clinical staff and the guidelines outlined in the *Resident Assessment Instrument* and 42 CFR 483.20(b)(ii).
  
3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:
  - a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
  - b. There is a significant change in the resident's physical, mental, or psychosocial status;
  - c. There is a need to change the resident's room assignment;
  - d. A decision has been made to discharge the resident from the facility; and/or
  - e. It is necessary to transfer the resident to a hospital/treatment center.
  
4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.
  
5. Regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments.
  
6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

continues on next page

F 309 ATTACHMENT E

Assessments and Care Planning

Significant Change Assessments

Updating of Resident Family and Sponsor Information

Protocol for Informing Resident/Sponsor of Change in Status

7. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS 2.0 RAI Instruction Manual.
8. A representative of business office will verify the address and telephone number of the resident's family or representative (sponsor) on a quarterly basis. Any noted changes will be reported to the Director of Nursing Services to ensure that such information is changed in the resident's medical record.
9. A representative of the business office will notify the resident, his/her family, or representative (sponsor), when:
  - a. There is a change in the resident's billing;
  - b. There is a change in the resident's level of care status;
  - c. There is a change in resident rights under federal or state law or regulations; and/or
  - d. There is a change in the rules of the facility that affects the rights or responsibilities of the resident.

| References                        |   |
|-----------------------------------|---|
| OBRA Regulatory Reference Numbers | 483.10(b)(1); 483.10(b)(11); 483.20(b)(2)(ii); 483.40; 483.40(a)(1)(2)  |
| Survey Tag Numbers                | F156; F157; F274; F385  |
| Related Documents                 | Acute Condition Changes - Clinical Protocol Charting and Documentation ( <i>Documentation</i> )<br>Resident Assessment Instrument (MDS 2.0) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____  |

Teaching Plan 2014  
Pinnacle Rehabilitation and Health Center  
3034 South DuPont Blvd.  
Smyrna, D.E. 19977  
302-653-5085

Teaching Plan:

Assessment of pain with new onset, worsening pain, and addition/change of pain medication.

Purpose:

To reinforce to the nursing staff the importance of pain assessment of new or worsening pain as well as increased monitoring and documentation to ensure resident pain level is satisfactory.

Supportive Data:

The nursing staff will assess the possible reason of new or worsening pain and increase monitoring until the resident pain level is satisfactory as well as document the outcome in progress notes.

Associated Standards:

Heaton Manual:

- Charting and Documentation
- Change in Residents Condition or Status

Desired Resident Outcome:

With any new/worsening pain or new pain medication, increased monitoring of pain status will occur until the resident pain level is acceptable.

Assessment:

1. Assess staff ability to understand the foundation of importance of need to assess any for new/worsening pain until pain level is satisfactory to the resident and provide supportive documentation in progress notes.

Intervention:

1. Implement Associated Standards (see above)
2. Educate licensed staff (RN and LPN)

# Charting and Documentation

## Highlights

Documentation Requirements

Recording Entries

Recording Accidents/ Incidents

Confidentiality and Release of Resident Information

Use of Abbreviations and Symbols

Documentation Criteria

## Policy Statement

All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.

## Policy Interpretation and Implementation

1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.
2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy.
3. All incidents, accidents, or changes in the resident's condition must be recorded.
4. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office.
5. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records.
6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum:
  - a. The date and time the procedure/treatment was provided;
  - b. The name and title of the individual(s) who provided the care;
  - c. The assessment data and/or any unusual findings obtained during the procedure/treatment;
  - d. How the resident tolerated the procedure/treatment;
  - e. Whether the resident refused the procedure/treatment;
  - f. Notification of family, physician or other staff, if indicated;
  - g. The signature and title of the individual documenting.

## References

|                                   |  |
|-----------------------------------|--|
| OBRA Regulatory Reference Numbers | 483.10(e); 483.60; 483.60(a); 483.75(l)(1)(i)-(iv); 483.75(l)(4)(i)-(iv)                         |
| Survey Tag Numbers                | F164; F425; F514   |
| Related Documents                 | Abbreviations and Symbols (Appendix A)<br>Guidelines for Charting and Documentation (Appendix A) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____ |

## Change in a Resident's Condition or Status

### Highlights

Protocol for Notifying  
Attending Physician of  
Changes in Resident's  
Medical/Mental Condition

Significant Change of  
Condition

Protocol for Notifying  
Resident's Family or  
Sponsor When There is a  
Change in the Resident's  
Medical/Mental Condition

Time Frame for Notifying  
Family of Changes

Informing Resident of  
Changes in Care or  
Treatments

Documentation of Changes  
in Medical Record

### Policy Statement

Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).

### Policy Interpretation and Implementation

1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:
  - a. An accident or incident involving the resident;
  - b. A discovery of injuries of an unknown source;
  - c. A reaction to medication;
  - d. A significant change in the resident's physical/emotional/mental condition;
  - e. A need to alter the resident's medical treatment significantly;
  - f. Refusal of treatment or medications (i.e., two (2) or more consecutive times);
  - g. A need to transfer the resident to a hospital/treatment center;
  - h. A discharge without proper medical authority; and/or
  - i. Instructions to notify the physician of changes in the resident's condition.
2. A "significant change" of condition is a decline or improvement in the resident's status that:
  - a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self-limiting");
  - b. Impacts more than one area of the resident's health status; and
  - c. Requires interdisciplinary review and/or revision to the care plan.
  - d. The final decision regarding what constitutes a significant change in status is based on the judgment of the clinical staff and the guidelines outlined in the *Resident Assessment Instrument* and 42 CFR 483.20(b)(ii).
3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:
  - a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
  - b. There is a significant change in the resident's physical, mental, or psychosocial status;
  - c. There is a need to change the resident's room assignment;
  - d. A decision has been made to discharge the resident from the facility; and/or
  - e. It is necessary to transfer the resident to a hospital/treatment center.
4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.
5. Regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments.
6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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Significant Change Assessments

Updating of Resident Family and Sponsor Information

Protocol for Informing Resident/Sponsor of Change in Status

7. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS 2.0 RAI Instruction Manual.
8. A representative of business office will verify the address and telephone number of the resident's family or representative (sponsor) on a quarterly basis. Any noted changes will be reported to the Director of Nursing Services to ensure that such information is changed in the resident's medical record.
9. A representative of the business office will notify the resident, his/her family, or representative (sponsor), when:
  - a. There is a change in the resident's billing;
  - b. There is a change in the resident's level of care status;
  - c. There is a change in resident rights under federal or state law or regulations; and/or
  - d. There is a change in the rules of the facility that affects the rights or responsibilities of the resident.

| References                        |  |
|-----------------------------------|--|
| OBRA Regulatory Reference Numbers | 483.10(b)(1); 483.10(b)(11); 483.20(b)(2)(ii); 483.40; 483.40(a)(1)(2)   |
| Survey Tag Numbers                | F156; F157; F274; F385   |
| Related Documents                 | Acute Condition Changes –Clinical Protocol Charting and Documentation ( <i>Documentation</i> )<br>Resident Assessment Instrument (MDS 2.0) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____   |





F 514 ATTACHMENT H

Teaching Plan 2014  
Pinnacle Rehabilitation and Health Center  
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302-653-5085

Teaching Plan: Medication and Treatment orders: verbal orders

Purpose: To reinforce to the nursing staff the importance of timely transcription of telephone verbal orders as well as immediate entry of order into the resident MAR/TAR. To reinforce the need to writing T.O.V.O. with physicians name and date on each telephone verbal order or verbal order.

Supportive Data: The nursing staff will evaluate all consultation forms. Telephone verbal orders to be transcribed correctly and entered into the resident MAR/TAR in a timely manner.

Associated Standards: Heaton Manual:  
• Telephone Orders  
• Verbal orders

Desired Resident Outcome: All orders via consultation form or telephone verbal order will be clarified (if needed), transcribed correctly and placed into the resident MAR/TAR in a timely manner

Assessment: 1. Assess staff ability to understand the foundation of importance of need to clarify and transcribe orders properly in a timely manner.

Intervention: 1. Implement Associated Standards (see above)  
2. Educate licensed staff (RN and LPN)  
3. Random weekly audit of telephone verbal orders.  
4. Random weekly audit of consultation sheets.

# Telephone Orders

| Highlights                   |
|------------------------------|
| Verbal Telephone Orders      |
| Medical Record Entry         |
| Countersigning Verbal Orders |
| Schedule II Drugs            |

| Policy Statement   |
|--|
| Verbal telephone orders may be accepted from each resident's Attending Physician.  |
| <b>Policy Interpretation and Implementation</b>  |
| <ol style="list-style-type: none"> <li>1. Verbal telephone orders may only be received by licensed personnel (e.g., RN, LPN/LVN, pharmacist, physician, etc.). Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record.</li> <li>2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information.</li> <li>3. Telephone orders must be countersigned by the physician during his or her next visit.</li> <li>4. Unless otherwise prohibited by law, verbal telephone orders for Schedule II drugs will be permitted in accordance with facility policy.</li> </ol> |

| References                        |  |
|-----------------------------------|--|
| OBRA Regulatory Reference Numbers | 483.40(b)(3); 483.60(a)  |
| Survey Tag Numbers                | F386; F425   |
| Related Documents                 | The Joint Commission – Accreditation Program: Medicare/Medicaid Long Term Care National Patient Safety Goals (2009) (Appendix A – Resident Safety) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____   |

Orders, Receiving and Transcribing

# Verbal Orders

| Highlights   | Policy Statement   |
|--|--|
| Entering Verbal/Telephone Order onto Clinical Record | Verbal orders shall only be given in an emergency or when the Attending Physician is not immediately available to write or sign the order.   |
| Verification of Verbal Orders                        | Verbal orders must always be based on actual conversations with the prescribing practitioner or on approved written protocols.   |
| Countersigning Verbal Orders                         | <b>Policy Interpretation and Implementation</b>  |
| Verbal Orders Based on Protocol                      | <ol style="list-style-type: none"> <li>1. The nurse receiving the verbal order must write it on the physician's order sheet as "v.o." (verbal order) or "t.o." (telephone order).</li> <li>2. The nurse transcribing the verbal order must read the order back to the physician to ensure that the information is clearly understood and correctly transcribed.</li> <li>3. The physician shall review and countersign verbal orders during his or her next visit.</li> <li>4. If a treatment, test, or another intervention is included in a protocol that has been reviewed and approved by the Medical Director, then a nurse may write a verbal order for a situation that is covered by the protocol. Otherwise, no one should write verbal orders or sign a physician's name to an order that is not based on a conversation with the physician or a faxed order.</li> </ol> |
| Unauthorized Verbal Orders                           | 5. Anyone writing an unauthorized verbal order may be subject to disciplinary action.  |

| References                        |  |
|-----------------------------------|--|
| OBRA Regulatory Reference Numbers | 483.25(l)-(m); 483.40(b); 483.60(a)  |
| Survey Tag Numbers                | F329; F332; F333; F386; F425   |
| Related Documents                 | The Joint Commission – Accreditation Program: Medicare/Medicaid Long Term Care National Patient Safety Goals (2009) (Appendix A – Resident Safety) |
| Policy Revised                    | Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____<br>Date: _____ By: _____   |

