**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>SS=B</td>
<td>463.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
<td>F 514</td>
<td></td>
<td></td>
<td></td>
<td>In the future surveyors will have access to closed records on the facility's computer system without disclosing the resident's identity prior to review. This will be communicated to the Director of Nursing, Staff Development Coordinator, and Assistant Director of Nursing, so that can be communicated to any surveyor needing to access the medical records. This practice will be reviewed annually by the Quality Assurance Committee to insure future compliance. This measure was put in place on June 8, 2011.</td>
<td></td>
</tr>
</tbody>
</table>

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any predmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to ensure 4 of 4 closed records were readily accessible for review on the facility's computer system.

On 4/26/11 at 11:30 AM, 4 closed records located on the facility's computer system was unable to be accessed by the reviewer, with the access code provided by the facility.

Interview on 4/26/11 at 11:40 AM, with the Staff Development Coordinator (SDC) she indicated the reviewer should have been able to gain access to the closed records on the facility's computer system independently; with the access code provided by the facility. The SDC elaborated who inform the administrator the access code provided to the reviewer by the facility, was unsuccessful, when attempted to access the closed records.

On 4/26/11 at 11:45 AM, the Administrator stated...
Continued from page 1 to the reviewer to reveal the facility specifically, what information needed to be printed from the closed records, for the remainder of the investigation. He elaborated; the facility would access the close records and print the information for the reviewer, upon request of specific documents (prior to the reviewer's review of the closed record documents on the computer system). Interview on 4/28/11 at 12:10 PM, with the Administrator revealed the facility's computer access system was implemented on March 3, 2010 and was finalized on July 29, 2010. Computer access to closed record documents included but was not limited to; documentation by nurses, physician, nurse-aides, physical therapy/rehab, minimum data set and medication administration records. The administrator informed the finalization of the computer system required an access code to gain access to the residents' closed records. He indicated he informed the information technology staff and his corporate supervisor; that the reviewer (state investigator) did not have access to review the closed records independently. The administrator concluded he hoped this issue to be resolved with future visits/review of closed records by state investigators.