

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>345502</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>8/15/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE PARK NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 FAITH CHURCH RD INDIAN TRAIL, NC</b>	
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<b>F 274</b>	<p><b>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</b></p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change assessment for one (1) of three (3) sampled residents who required a comprehensive assessment following a significant change in condition. (Residents #2)</p> <p>The findings are:</p> <p>Resident #2 was admitted to the facility in 02/12. Diagnoses included hypertension, osteoarthritis, dysphagia and peripheral neuropathy.</p> <p>A quarterly Minimum Data Set (MDS) dated 05/03/12 coded Resident #2 as requiring supervision with eating and as having no pressure areas.</p> <p>The next MDS, a quarterly assessment dated 07/02/12, coded Resident #2 as requiring extensive assistance with eating and as having one unstageable pressure ulcer. There was no significant change assessment in the medical record or any documented reason that a significant change assessment was not completed.</p> <p>A review of Resident #2's wound/ulcer flow records dated 05/16/12 specified an unstageable pressure area to the left hip. A wound/ ulcer flow record dated 07/27/12 revealed Resident #2 acquired two stage II pressure areas and two areas of unstageable suspected deep tissue injury. A wound/ ulcer flow record dated 07/30/12 specified an acquired stage II pressure area.</p> <p>Observation of Resident #2 on 8/15/12 at 11:00AM revealed Resident #2 in bed on an air mattress, lying on her right side with pressure relieving boots on bilateral feet.</p> <p>Observation of Resident #2's skin on 8/15/12 at 2:52PM revealed only three pressure areas with skin intact and blanchable.</p> <p>Interview with MDS nurse #1 on 08/15/12 at 3:54 PM revealed that no significant change assessment was completed either with the 07/02/12 MDS or within 14 days of the onset of the other pressure ulcers. The MDS nurse stated that a significant change assessment should have been completed for Resident #2 with the 07/02/12 MDS.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 274</b>	Continued From Page 1		
<b>F 278</b>	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the minimum data set to reflect the correct number of unstageable pressure ulcers present on admission and weight loss for one (1) of three (3) sampled residents. (Resident #1).</p> <p>The findings are:</p> <p>1a. Resident #1 was admitted to the facility in 05/12 with diagnoses of dementia, pressure ulcer to buttock and hypertension.</p> <p>A review of Resident #1's medical record revealed an Admission Nursing Assessment dated 05/26/12. The information provided specified a harden area to the right and left heel. A wound/ ulcer flow sheet dated 5/26/12 specified suspected deep tissue injury to the right heel noted on admission. No other pressure areas were noted on admission.</p> <p>Continued medical record review revealed a nurse's noted entitled skin/ wound/ treatment dated 5/26/12. The nurse's note specified Resident #1's skin with no redness of the elbows, buttocks or heels; callusing to the right heel and a suspected deep tissue injury (pressure ulcer #1) to the left heel. The note further documented a resolved pressure ulcer to the right buttock with pink normal skin and blanchable erythema observed to the</p>		

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<b>F 278</b>	<p>Continued From Page 2</p> <p>sacral area.</p> <p>An admission minimum data set (MDS) assessment dated 06/01/12 coded Resident #1 with three unstageable pressure ulcers with suspected deep tissue injury, two of which were present upon admission.</p> <p>Further review of the medical record revealed a wound /flow record dated 06/01/12 which specified a right buttock suspected deep tissue injury present on admission.</p> <p>Interview with the treatment nurse on 08/15/12 at 3:20 PM revealed that she examined Resident #1's skin on 05/27/12 and there was no pressure area noted to the right buttock upon admission. She further stated that she made an error in documentation on the 06/01/12 wound/flow record and should have documented the wound as occurring in house.</p> <p>Interview with the MDS nurse on 08/15/12 at 3:40 PM revealed that she coded the admission MDS according to the 06/01/12 wound/ulcer flow sheets which indicated the left heel and right buttock as present on admission. The MDS nurse further stated that there was an error in her coding and she should have coded Resident #1 as having one unstageable pressure ulcer upon admission.</p> <p>1b. Resident #1 was admitted to the facility on 05/12 with diagnoses of dementia, esophageal reflux and hypertension.</p> <p>Review of Resident #1's weight record revealed a 05/27/12 weight of 85 pounds (lbs).</p> <p>Review of the physician history and physical dated 05/29/12 recommended Resident #1 to continue on an appetite stimulant for 30 more days.</p> <p>A dietary initial assessment dated 05/30/12 documented Resident #1's height was 59 inches and weight was 85 lbs. She was eating 75-100% and on weekly weight.</p> <p>An admission minimum data set (MDS) assessment dated 06/01/12 coded Resident #1 with weight loss but on a physician prescribed weight loss regimen.</p> <p>Interview with the Dietary manager on 07/15/12 at 3:55 PM revealed that she completed the admission assessment nutritional status section on the MDS and miscoded Resident #1 as having weight loss and being on a physician prescribed weight loss regimen.</p>		
<b>F 514</b>	<p>483.75(1)(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>		

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<b>F 514</b>	<p>Continued From Page 3</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: Based on record review and staff interview the facility failed to ensure accurate documentation of a wound/flow record resulting in the miscoding of an admission minimum data set assessment (MDS) for one (1) of three (3) sampled residents. (Resident #1)</p> <p>The findings are:</p> <p>Resident #1 was admitted to the facility in 05/12 with diagnoses of dementia, pressure ulcer to buttock and hypertension.</p> <p>A review of Resident #1's medical record revealed an Admission Nursing Assessment dated 05/26/12. The information provided specified a "harden " area to the right and left heel. A wound/ ulcer flow sheet dated 5/26/12 specified suspected deep tissue injury to the right heel noted on admission. No other pressure areas were noted on admission.</p> <p>Continued medical record review revealed a nurse's noted entitled skin/ wound/ treatment dated 5/26/12. The nurse's note specified Resident #1's skin with no redness of the elbows, buttocks or heels; callusing to the right heel and a suspected deep tissue injury (pressure ulcer #1) to the left heel. The note further documented a resolved pressure ulcer to the right buttock with pink normal skin and blanchable erythema observed to the sacral area.</p> <p>An admission minimum data set (MDS) assessment dated 06/01/12 coded Resident #1 with three unstageable pressure ulcers with suspected deep tissue injury, two of which were present upon admission.</p> <p>Further review of the medical record revealed a wound /flow record dated 06/01/12 which specified a right buttock suspected deep tissue injury present on admission and a right heel suspected deep tissue injury occurring in house.</p> <p>Interview with the treatment nurse on 08/15/12 at 3:20 PM revealed that she examined Resident #1's skin on 05/27/12 and there was no pressure area noted to the right buttock upon admission. She further stated that she made an error in documentation on the 06/01/12 wound/flow record and should have documented the wound as occurring in house.</p> <p>Interview with the MDS nurse on 08/15/12 at 3:40 PM revealed that she coded the admission MDS according to the 06/01/12 wound/ulcer flow sheets which indicated the left heel and right buttock as present on admission. The MDS nurse further stated that there was an error in her coding and she should have coded</p>		

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<b>F 514</b>	Continued From Page 4 Resident #1 as having one unstageable pressure ulcer upon admission.
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