

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345516	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/20/2013
--	---------------------------------	--	--

NAME OF PROVIDER OR SUPPLIER CONOVER NURSING AND REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH STREET SOUTH WEST CONOVER, NC
--	---

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------------	-----------------------------------

F 278	<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 pressure ulcers present on admission for 1 of 3 residents reviewed for pressure ulcers. (Resident #110).</p> <p>The findings are:</p> <p>Resident #110 was admitted to the facility on 01/13 with diagnoses of hip fracture and pressure sore to the sacrum.</p> <p>A review of Resident #110's medical record revealed several wound care sheets dated 01/23/13. The information provided indicated a sacral Stage 2 pressure area; surgical wounds, skin tears and a Stage 1 to the right heel. A wound sheet dated 02/19/13 indicated the right heel to have an unstageable pressure ulcer.</p> <p>Review of the treatment records dated 01/13 and 02/13 revealed Resident #110 received skin prep to bilateral heels twice daily.</p> <p>Observation of wound care on 02/19/13 at 2:54 PM noted Resident #110 was lying in bed with heels elevated and observed to have a blacken area to the right heel.</p> <p>Interview with Nurse #1 on 02/20/13 at 9:31 AM revealed Resident # 110 was admitted with a boggy,</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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345516	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/20/2013
--	---------------------------------	--	--

NAME OF PROVIDER OR SUPPLIER CONOVER NURSING AND REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH STREET SOUTH WEST CONOVER, NC
--	---

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------------	-----------------------------------

F 278	<p>Continued From Page 1</p> <p>non-blanchable reddened area to her right heel. The Nurse added she staged the right heel as a Stage 1 because it was red and non-blanchable. Nurse #1 added that on 02/19/13 was the first time she had noted the Resident's heel to be black in color.</p> <p>An admission minimum data set (MDS) assessment dated 01/30/13 indicated Resident #110 with one Stage 2 on admission and no other pressure areas or deep tissue injury.</p> <p>Interview with the MDS nurse on 02/20/13 at 4:33 PM revealed that she coded the admission MDS according to the wound care sheets and must have missed the sheet for the right heel. The MDS nurse further stated there was an error in her coding and she should have coded Resident #110 as having one stage 1 pressure ulcer upon admission.</p> <p>Interview with the Director of Nursing (DON) on 02/20/13 at 4:49 PM revealed she would have expected the Nurse to have staged the wound on admission as a deep tissue injury since the area was boggy, however felt the treatment and interventions were appropriated even though the nurse inaccurately staged the area. The DON added she would have expected the MDS nurse to have coded for what the wound care sheet indicated.</p>
--------------	--