MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34NH | A. BUILDING: _____ B. WING _____ | 05/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELWOOD COMM LIVING CENTER | 1036 WEST DRIVE LAUREL, MS 39440 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a recertification survey from 05/28/19 to 05/30/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M735.<br><br>The census at the time of entrance was 48, and the facility was certified for 60 beds. | M 000 | | |
| M 735 | 45.25.1 Medical Records Management<br><br>Medical Records Management.<br><br>1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.<br><br>2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed.<br><br>3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use.<br><br>4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, | M 735 | | 7/19/19 |

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| M 735 | Continued From page 1<br>including the final diagnosis.<br><br>5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards.<br><br>6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.<br><br>7. Medical records of discharged residents shall be completed within sixty (60) days following discharge.<br><br>8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years.<br><br>9. A resident index, including the resident's full name and birth date, shall be maintained.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on staff interview, record review and facility policy review, the facility failed to accurately document Resident #45's skin condition on the weekly skin audits for one (1) of two (2) residents reviewed for Pressure Ulcer concerns, for a total of 15 records reviewed.<br><br>Findings include: | M 735 | 1. Resident #45 was affected by the deficient practice. The Minimum Data Set (MDS) Registered Nurse (RN) Coordinator corrected Resident #45's skin audit on 5/28/2019.<br>2. The MDS RN Coordinator did a 100% audit on all residents with wound/skin issues who had body audits in the past 30 days from 5/15/2019 through 6/15/2019. All residents body audits were correct.<br>3. The MDS RN Coordinator, MDS Licensed Practical Nurse(LPN) | |

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| M 735 | Continued From page 2<br><br>On 05/30/19 at 1:56 PM, an observation of Resident #45's Pressure Ulcer care to the Left Lateral Foot and Right Buttock, provided by Registered Nurse (RN) #1 and assisted by LPN #3, revealed the Stage 2 wound was almost healed. No concerns with care was identified, and no infection control concerns were identified.<br><br>Review of Resident #45's Weekly Pressure Injury Records, from 04/09/19 to 05/16/19, revealed the presence of the Stage 2 Pressure Ulcer to the left gluteal. The Weekly Pressure Injury Records from 04/09/19 thru 05/22/19 revealed the presence of the Unstagable Wound to the right heel. The Weekly Pressure Injury Record from 04/09/19 thru 05/22/19 revealed the presence of the Stage 3 Pressure Ulcer to the right gluteal. The Weekly Non-Pressure Wound Report from 04/09/19 to 05/23/19 revealed the presence of the left lateral foot wound due to trauma from the resident's shoe.<br><br>Review of Resident #45's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/16/19, revealed one Stage 2 and one Stage 3 pressure ulcers which were present on admission, and one Unstagable wound.<br><br>Review of Resident #45's Care Plan revealed the Focus for a Stage 3 Pressure Ulcer (PU) to the right gluteal, an Unstagable Pressure Ulcer to the right heel, and a Non-Pressure/Hypergranulation wound to the left lateral foot related to trauma from shoe. All concerns were initiated on 04/11/19.<br><br>On 05/29/19 at 4:00 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she stated when she does body audits weekly, "If | M 735 | Coordinator, LPNs and RNs were educated on 6/15/2019 by Unit Manager RN on the correct way to document the identification of skin concerns when a body audit is performed.<br>4. The Director of Nursing (DON) will coordinate the daily Interdisciplinary Clinical Meeting to review previous day body audits on residents with wound/skin issues to ensure the RN/LPN documented the correct way to identify any skin concerns on the body audit that was performed. The DON will monitor five (5) times a week for one (1) week starting on 6/17/2019 through 6/23/2019 and then audit weekly x three (3)weeks starting 6/24/2019 through 7/19/2019 to ensure that residents discharged from the facility MDS assessment is coded correctly. All negative findings will be correctly weekly by the MDS Coordinator and the DON will report monthly to the Quality Assurance Committee for review, revision or resolution of plan. | |

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| M 735 | Continued From page 3<br>nothing is new or different I just put skin intact". LPN #1 stated even if they are known to have skin concerns, she would document on the audits no concerns. LPN #1 stated, "If I need to do it different just let me know".<br><br>Review of Resident #45's Weekly Body Audits dated 05/07/19, 05/22/19, and 05/28/19, revealed LPN #1 had documented #1 "Skin Intact". Review of the Weekly Body Audits, dated 04/16/19, 04/23/19, 04/30/19, and 05/14/19, documented by RN #1 or LPN #4 revealed #2 "No new skin alterations" was checked.<br><br>Record review of Resident #45's Admission Record revealed she was admitted by the facility with a Stage 2 PU to the left buttock, a Stage 3 PU to the right buttock, and a Non-Pressure Chronic Ulcer of the Right Heel and Midfoot with unspecified severity, on 04/09/19.<br><br>On 05/29/19 at 4:00 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she stated when she does body audits weekly, "If nothing is new or different I just put skin intact". LPN #1 stated even if they are known to have skin concerns, she would document on the audits no concerns. LPN #1 stated, "If I need to do it different just let me know".<br><br>On 05/29/19 at 3:20 PM, during an interview the Interim Director of Nurses (DON) stated the Charge Nurse was responsible for measuring the wounds, and update the skin assessments. The Interim DON stated it was not correct to put "skin intact" on a body audit if the resident has skin concerns, and confirmed the medical record was inaccurate. | M 735 | | |