

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345192	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/30/2015
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NAME OF PROVIDER OR SUPPLIER LONGLEAF NEURO-MEDICAL TREATMENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 4761 WARD BOULEVARD WILSON, NC
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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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 observation, staff interview, and record review the facility failed to correctly code range of motion information for 1 of 15 residents (Resident #80) whose minimum data set (MDS) assessments were reviewed. Findings included:</p> <p>Resident #80 was admitted to the facility on 04/24/07 and was readmitted on 06/03/13. The resident's documented diagnoses included hand contracture and dementia.</p> <p>A 12/16/14 Quarterly MDS assessment documented the resident had short and long term memory impairment, was severely impaired with decision making, and had no impairment in his upper extremity range of motion.</p> <p>The January 2015 recapitulation of physician orders documented Resident #80 was to wear his left functional hand splint 4 hours on and 2 hours off from 8:00 AM until 6:00 PM and to have it re-applied at bedtime and continue to wear it until 6:00 AM.</p> <p>At 9:47 AM on 01/27/14 Resident #80 was sitting in a wheelchair in the commons area with a splint applied to his left hand.</p> <p>At 11:32 AM on 01/28/14 Resident #80 was lying across the bed in his room with a splint applied to his left hand.</p>
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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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F 278	<p>Continued From Page 1</p> <p>At 4:02 PM on 01/30/15 occupational therapist (OT) #1 stated she thought Resident #80 had a splint for his left hand since 2013. She reported the resident did have a minimal flexion contracture of the metacarpal with the metacarpal joint being very tight.</p> <p>At 4:32 PM on 01/30/15 Nurse #1, a MDS nurse, stated she recalled that Resident #80 had a left functional hand splint. She reported she gathered information concerning range of motion from resident observation, talking with the nursing staff, and review of physician orders. Since Resident #80 had a splint applied to his left hand for contracture management, she commented the resident should have been coded on MDS assessments as having limited upper extremity range of motion on one side.</p> <p>At 4:50 PM on 01/30/15 the director of nursing (DON) stated the MDS nurse made documentation about Resident #80's left hand splint in her pre-assessment paperwork. He reported she made a data entry error on coding the resident's upper extremity range of motion on the resident's most recent MDS assessment.</p>
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