STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345192	A. BUILDING _____ B. WING _____	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

(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) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as result of the complaint investigation of 01/31/13. Event ID # NRFH11.	F 000		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to place utensils on sanitized food preparation surfaces, failed to cover baked goods while they were cooling, failed to monitor food storage areas according to facility expectations, and failed to remove stains from kitchenware. Findings include: 1. At 8:58 AM on 01/30/13 a box of canned green peas, a box of egg noodles, 3 individual cans of green peas, 2 cans of soup, and 4 other cans of vegetables were sitting on a food preparation table. At 9:20 AM on 01/30/13 a dietary employee began using a can opener on the cans of green peas. She used a spatula to completely lift the lids off the cans. The spatula went down into the	F 371	Longleaf Neuro-Medical Treatment Center will continue to ensure that: 1) Foods are procured from sources approved or considered satisfactory by Federal, State or local authorities; and 2) Store, prepare, distribute, and serve food under sanitary conditions. <u>Placing utensils on sanitized food surfaces</u>: To immediately correct the placement of utensils on un-sanitized surfaces, the Dietary Manager (DM) discussed with staff on 1/31/13 the placing of utensils only on sanitized surfaces. The DM/designee spot checked for compliance during daily rounds. In addition, the can openers are being re-sharpened in an effort to prevent the need of utensils to remove lids. These were added to Plant Operations quarterly preventative maintenance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Center Director

(X6) DATE: 2/13/13

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 correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345192	A. BUILDING _____ B. WING _____	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

(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) COMPLETION DATE
F 371	Continued From page 1 vegetable product inside the cans. The spatula was then placed flush down on the preparation table. Between 9:20 AM and 10:10 AM on 01/30/13, before surveyor intervention, dietary employees moved the spatula to different locations on the preparation table including where the boxes and cans were sitting. At 9:38 AM on 01/30/13 a dietary employee used a spoon to place seasoning down into a kettle used for cooking food. The spoon was then placed flush down on the preparation table. Between 9:38 AM and 10:10 AM on 01/30/13, before surveyor intervention, dietary employees moved the spoon to different locations on the preparation table including where the boxes and cans were sitting. No sanitizing solution was used to wipe down the food preparation table between 8:58 AM and 10:10 AM on 01/30/13. At 2:12 PM on 01/31/13 the dietary manager (DM) stated spray bottles of quaternary sanitizer were supposed to be kept at each food preparation station. She reported staff were trained to use these bottles to sanitize preparation surfaces between all food preparation tasks. The DM commented that she preferred the staff not to place utensils directly down on the preparation tables even when they were sanitized. At 2:30 PM on 01/3/13 a dietary employee stated she was under the impression it was okay to lay	F 371	The Nutritional Services Department policy, "Sanitation Procedures" was revised (effective 2/13/13) to include expectation that utensils are not placed on un-sanitized surfaces, non-food preparation items such as boxes and cans should not be placed on food preparation surfaces, and that food preparation surfaces are to be sanitized before and after each use and when contaminated. (See attachment 1). The expectation has also been added to each food preparation employee's daily checklist (See attachment 2). The policy revision was reviewed by a Registered Dietitian 2/11/13 prior to implementation. Staff will be trained on this policy revision and expectations and personally receive a copy of the policy on 2/12/13 and 2/13/13. (See attachment 3). A follow-up class on sanitation expectations, related to cited deficient practices, will be held for department staff the week of 2/18/13. The facility will explore and identify resources and process to provide ServSafe training for department staff by 2/28/13 and then the training will be provided as soon as possible. The department supervisors' daily rounds monitoring tool has been updated (effective 2/14/13) to include monitoring of this expectation. (See attachment 4). Supervisors will take corrective action when indicated. The DM/designee will be conducting monitoring rounds regarding compliance with this expectation three times/week for 2 weeks, then weekly and will take corrective action when indicated. (See attachment 5). All monitoring results will be analyzed and forwarded to the QI Department monthly x 12 months to determine need for further education and monitoring.	2/28/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345192	A. BUILDING _____ B. WING _____	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

(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) COMPLETION DATE
F 371	Continued From page 2 utensils down on preparation surfaces as long as they were sanitized. She reported spray bottles of quaternary sanitizer were supposed to be used on preparation surfaces between each and every food preparation task. 2. At 9:16 AM on 01/30/13 three fruit pies were removed from the oven, and placed to cool on the food preparation counter. They were not covered. At 9:51 AM on 01/30/13 a dietary employee sliced up the fruit pie, covered the slices, and placed the slices into storage. At 9:53 AM on 01/30/13 a pan of red velvet cake was removed from the oven, and placed to cool on the food preparation counter. It was not covered. At 10:11 on 01/30/13 a dietary employee began icing the cake, covered the slices, and placed them into storage. At 2:12 PM on 01/31/13 the dietary manager (DM) stated food items should be covered at all times to prevent insects, dust, and germs from contaminating them. She reported this was especially important with food items that would not be reheated before serving to kill germs and bacteria. At 2:30 PM on 01/3/13 a dietary employee stated foods which were cooked, but not yet placed on the steam table or in a storage area, should be covered with plastic wrap or parchment paper to prevent contamination. She reported that for cooling baked goods, parchment paper was	F 371	Covering baked goods while cooling: To immediately correct the covering of baked items while cooling, the DM discussed with staff 1/31/13 covering baked goods while cooling. The DM spot checked for compliance during daily rounds. The Nutritional Services Department policy "Temperature and Food Safety Handling Techniques" was revised (effective 2/13/13) to include expectation of covering baked goods while cooling. (See attachment # 6) The expectation was also added to the baker's daily checklist effective 2/14/13. (See attachment # 7). The policy revision was reviewed by a Registered Dietitian 2/11/13 prior to implementation. Staff will be trained by the DM/designee on this policy revisions and expectation and will personally receive a copy of the policy 2/12/13-2/13/13. (See attachment 3). A follow-up inservice by a Registered Dietitian on sanitation expectations , related to the deficient practices will be held for department staff during the week of 2/18/13. The facility will explore and identify resources and process to provide ServSafe training for department staff by 2/28/13 and then the training will be provided as soon as possible. The department supervisors' daily rounds monitoring tool has been updated (effective 2/14/13) to include monitoring of this expectation. Supervisors will take corrective	

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	345192	A. BUILDING _____ B. WING _____	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 3 preferred because it did not cause condensation to develop which could effect the quality of the food items. 3. During initial tour of the kitchen, which began at 9:42 AM on 01/28/13, a five-pound bag of mild cheddar cheese found in the salad walk-in refrigerator was opened but without a label and date on it. A container of cottage cheese with the use-by date of 12/30/13 was still in the walk-in, and two bowls of applesauce were uncovered. In a reach-in refrigerator in the baking section a container of leftover pumpkin mousse was found with a dispose date of 01/25/13, and there were two cups of an unidentified liquid without a label or date. In the fruit/vegetable walk-in refrigerator leftover carrots in a tray pan and leftover mashed potatoes in a tray pan were found, both with a dispose date of 01/26/13. In addition, in this storage area a gallon container of banana peppers was opened, but without a label and date. In the dry storage room a five-pound bag of grits and a bag of macaroni noodles were open but without a label and date. Also in dry storage two dented cans were not removed from the usable stock including a 6-pound, 8-ounce can of crushed tomatoes and a 6-pound, 11-ounce can of crushed pineapple. In a reach-in refrigerator in the nourishment preparation area two bowls of applesauce were uncovered, and there were two cups of an unidentified liquid without a label or date. In the dairy/meat walk-in refrigerator a bag of shredded Swiss cheese, a pack of sliced Swiss cheese, two bags of Parmesan cheese, a pack of sliced American cheese, and a five-pound bag of shredded mild cheddar were opened, but did not have labels or dates on them. In addition, a tub of partially frozen chicken, which was thawing in	F 371	action when indicated. (See attachment 4). The DM/designee will be conducting monitoring rounds regarding compliance with this expectation 3 times/ week for 2 weeks beginning 2/14/13, then weekly and will take corrective action when indicated. (See attachment 5). All monitoring results will be analyzed and forwarded to the QI Department monthly x 12 months to determine need for further education and monitoring. <u>Monitoring storage areas:</u> To immediately correct the items stored that were not meeting expectations, items cited were discarded. The jar of banana peppers was discarded by the DM on 1/28/13, however an unidentified staff member placed another opened/unlabeled jar of bananas peppers in the refrigerator and it was discarded 1/30/13. The DM discussed with staff 1/28/13 and 1/31/13 expectations regarding labeling, wrapping, expiration dates, and dented cans. The DM/designee spot checked for compliance with expectations during daily rounds. The Nutritional Services policies "Portioned Foods", "Food Storage" " Use of Leftovers", and "Temperature and Food Safety Handling Techniques" were revised effective 2/13/13 to include specific expectations regarding wrapping, labeling, dating, expiration dates, and not using dented cans. (See attachments # 8, 9, 10, 11). The policy revisions were reviewed by a Registered Dietitian 2/11/13 prior to implementation. Staff will be trained by the DM/designee on policy revisions and expectations and personally receive a copy of the policies 2/12/13-2/13/13. (see attachment # 3).	2/28/13

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	345192	A. BUILDING _____ B. WING _____	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

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F 371	Continued From page 4 the walk-in, did not have a label and date on it to indicate when it was pulled from the freezer and placed in the refrigerator to thaw. Two turkey breasts and one smoked turkey breast which were thawing in the walk-in did not have labels or dates on them. In the walk-in freezer in the basement of the facility an opened bag of breaded chicken filets did not have a label and date on it. During a follow-up tour of the kitchen, beginning at 8:42 AM on 01/30/13, in the salad walk-in refrigerator three bowls of puree apricot, six bowls of applesauce, one bowl of prune puree, two bowls of pineapple, two bowls of pears, and 21 bowls of puree fruit cocktail were not covered. In addition, an opened 16-ounce bag of coconut did not have a label and date on it. A gallon container of banana peppers in the fruit/vegetable walk-in refrigerator was opened, but without a label and date. At 2:12 PM on 01/31/13 the dietary manager (DM) stated all opened food items placed in storage, all food items removed from original packaging and placed in storage, and all leftovers placed in storage should have a label and dates on them documenting what the items were, when they were placed in storage, and when they were to be removed from storage and discarded. She reported it was facility expectation that foods not be used past their "use-by" or expiration dates, cooked leftovers which were once on the steam table should be used or discarded within three days, and the food in dented cans was not to be used. The DM also commented it was facility expectation that foods prepared and placed in bowls and tray pans and placed in storage for	F 371	A follow-up inservice class by a Registered Dietitian on sanitation expectations related to the cited deficit practices will be held for all department staff the week of 2/18/13. The facility will explore and identify resources and process to provide ServSafe training for department staff by 2/28/13 and then the training will be provided as soon as possible. The DM, Business Manager, and Administrative Specialist met with the Ingredient Control Clerk and US Foods representative 2/5/13 to review expectations regarding not receiving/ shelving dented cans, checking storage daily, removing/discarding or returning to vendor dented cans. The Ingredient Control Clerk is the department staff member responsible for stocking shelves and checking for/removing dented cans. This staff member's daily checklist was updated to reflect expectation (see attachment # 12) The department supervisors' daily rounds monitoring tool has been updated to include monitoring of these expectations. Supervisors will take corrective action when indicated. (see attachment # 4) The DM/designee will be conducting monitoring rounds regarding compliance with these expectations three times per week for 2 weeks beginning 2/14/13 and then weekly and take corrective action when indicated.(see attachment # 5). All monitoring results will be analyzed and forwarded to the QI Department monthly x 12 months to determine need for further education and/or monitoring.	2/28/13

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LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

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F 371	Continued From page 5	F 371		

more than five to ten minutes should be covered, and all items removed from frozen storage and transferred to refrigerated storage should have a label and date indicating when they began the thawing process. According to the DM, foods past their "use-by" or expiration dates or foods in dented cans were not necessarily "bad", but the facility did not want to take any chances that they might endanger the health of the residents. She commented it was important to use up completely thawed meats within a couple of days so placing a date on them when the thawing process began was important to prevent possible bacterial formation. The DM stated her supervisors and the cooks were supposed to monitor all storage areas daily to make sure food items were labeled and dated per facility expectations, to remove outdated leftovers and foods past their "use-by" and expiration dates, and to remove dented cans from regular stock and place them in the damaged section for credit from the vendor.

At 2:30 PM on 01/3/13 a dietary employee stated all foods placed in storage were supposed to have a date on them documenting when they were received in the facility. In addition, she reported another date was placed on them if they were opened or removed from their original packaging. The employee commented all cooked leftovers were supposed to have a label placed on them indicating what they were, when they were placed in storage, and when they were to be removed from storage. In addition, she explained a label was to be placed on meats removed from the freezer and placed in the refrigerator to thaw, indicating when the transfer in storage occurred. She stated that she was trained not to use dented cans or foods past their "use-by" or expiration

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	345192	A. BUILDING _____ B. WING _____	C 01/31/2013

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F 371	Continued From page 6 dates, and trained to cover all prepared food items which were going to be stored in refrigerators or freezers. She reported the dietary employee in charge of checking in dry goods was responsible for separating out dented cans and making sure opened food items in the dry storage room were labeled and dated. In the other storage areas the employee commented the supervisors and any dietary employees who entered the storage units daily were responsible for checking labeling and dating, removal of items past their "use-by" or expiration dates, and making sure prepared items were covered. 4. During inspection of kitchenware, beginning at 10:37 AM on 01/30/13, 8 of 30 plates were covered with a dark brown stain, and 7 of 30 coffee mugs had brown stains and residue inside them. 15 of 60 items or 25% of the kitchenware examined was stained. At 2:12 PM on 01/31/13 the dietary manager (DM) stated she was unsure about the facility's schedule or frequency for "destaining" kitchenware, unsure about the agent used for "destaining", and unsure about the last time kitchenware was "destained". She stated some of the plates found during the kitchenware inspection were so badly stained she would probably order new plates to replace them. At 2:30 PM on 01/3/13 a dietary employee stated coffee mugs were supposed to be "destained" using bleach every Wednesday and Saturday. However, she reported she did not think that the coffee mugs had undergone the "destaining" process in a good while, but was unsure why the bleaching had not occurred. She commented	F 371	Stains on kitchenware: To immediately correct not removing stains from cups and plates, 4 cases of cups (192 total) and 16 cases of plates (192 total) were ordered. All stained cups and plates were removed from service 2/7 /13 and replaced with new kitchenware. (see attachment # 13) A Nutritional Services policy "Kitchenware" was developed to be effective 2/13/13 (see attachment # 14). The policy addresses the expectation that stained plates and cups are removed from service and replaced and cups are plates are soaked on Wednesdays and Saturdays. The policy was reviewed 2/11/13 by a Registered Dietitian. Any plates/cups not successfully de-stained will be replaced. The Business Manager and Purchasing Officer has contacted the plate vendor Aladin seeking guidance in appropriate de-staining products. The product Oxiclean was purchased and tried beginning 2/11/13. Staff will be trained by the DM/designee on the policy and expectations and personally receive a copy of the policy 2/12/13-2/13/13. (see attachment # 3) The expectations were also added to the tray carrier daily check lists (see attachment # 15)	

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F 371	Continued From page 7 she was unsure about the procedure or schedule for "destaining" kitchenware other than coffee mugs. The employee stated the dietary staff was supposed to pull damaged kitchenware with cracks, chips, and discoloration that could not be removed and present it to a supervisor or the DM so they could decide if it should be discarded.	F 371	A follow-up inservice class by a Registered Dietitian on sanitation expectations related to the cited deficient practices will be held the week of 2/18/13 with all department staff. The department supervisors' daily rounds monitoring tool has been updated (effective 2/14/13). Supervisors will take corrective action when indicated. (see attachment # 4) The DM/designee will be conducting monitoring rounds regarding compliance with these expectations three times were week for 2 weeks beginning 2/14/13 and then weekly and will take corrective action when indicated. (see attachment #5). All monitoring results will be analyzed and forwarded to the QI department monthly x 12 months to determine need for further education and/or monitoring.	2/28/13

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345192	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I construction, multi-story, without a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: No Life Safety Deficiencies Noted	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

L William ROSS — Director/Admin. — 3/14/13

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 correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345192	A. BUILDING 02 - BUILDING 02 B. WING _____	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, multi-story, with a partial automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/12/13 at approximately noon the following exit access was observed as non-compliant, specific findings include; the loading dock was greater than 30" above the grade below without a proper guard. Guards shall be not less than 42" high to prevent falls over the open side. 7.2.2.4 and 7.2.2.4.6.	K 032	Materials for the guard were ordered to include double chain guard and center post. The double chain guard and post were installed February 27, 2013 and is 42" high. Center staff that utilize this loading dock (Warehouse/Receiving, Environmental Services, and Plant Operations) are being retrained regarding the safety of this area to include assuring the guard chain is secured after use and alerting Plant Operations regarding needed repairs. Signs were also ordered February 27, 2013 to remind staff to secure the guard after use; these will be posted at the loading dock when they arrive. This area will be routinely inspected by Plant Operations.	3/29/13
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids,	K 066		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

William R By — Director/Admin. — 3/27/13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345192	A. BUILDING 02 - BUILDING 02 B. WING	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

(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) COMPLETION DATE
K 066	Continued From page 1 combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	A metal container for the cited resident smoking area was ordered February 25, 2013 and will be placed in the area on March 1, 2013. In addition, replacement containers were also ordered for the staff smoking areas and were replaced March 1, 2013.	3/01/13
K 072 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/12/13 at approximately noon the following smoking regulation was non-compliant, specific findings include; a metal container with a self-closing cover into which ashtrays can be emptied in the smoking area per paragraph 4 above was not provided. (Outside basement theater and Scott back porch) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.	K 072	(A) An automated Care Tracker documentation system was received February 6, 2013 and will replace the flow sheet documentation that is now maintained in the wall desks. The vendor's projected schedule of installing the system, including 28 kiosks, uploading resident and staff information and staff training in use of the system is July 31, 2013 (See attached waiver request)	7/31/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

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	345192	A. BUILDING 02 - BUILDING 02 B. WING _____	02/12/2013

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K 072	Continued From page 2 7.1.10 This STANDARD Is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/12/13 at approximately noon the following means of egress was non-compliant, specific findings include; A. Wall desks that did not retract near room 509 typical on floors 5, 4 and 3. B. There were lifts plugged into the corridor on both the north and south ends of the 2nd floor corridor.	K 072	Once the system is implemented, the wall desks/flow sheets will be removed. In the interim, staff will be retrained to retract and lock the wall desk after each use by March 15, 2013. Nursing will routinely monitor for compliance.	
		K 072	(B) The lifts plugged into the corridor on 2nd floor have been removed to a designated room for charging. Staff will be retrained to store and charge lifts in the designated room for this purpose and will be instructed to never charge lifts in the corridor by March 15, 2013. Nursing will routinely monitor for compliance.	3/29/13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD Is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/12/13 at approximately noon the oxygen storage was non-compliant, specific findings include; full and empty oxygen cylinders	K 076		

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LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

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K 076	Continued From page 3 were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (oxygen storage on 5th and 3rd floors)	K 076	Empty and full cylinders will not be stored together. The Director of Nursing sent out a memo to Nurse Supervisors reminding them of this staff expectation and for the Supervisors to monitor during daily rounds. Nursing staff will also be retrained regarding correct process to include immediately removing empty cylinders from the unit to the empty cylinder section of the oxygen storage room in the basement by March 15, 2013. Nursing will routinely monitor for compliance.	3/29/13

FACILITY REQUEST FOR WAIVER OR VARIANCE

TO BE COMPLETED BY STATE AGENCY

☒ Life Safety Code (405.1134a)

☐ 7-Day R.N. Requirement

☐ Medical Director (4DS.1911b)

☐ Physical Environment

☐ Patient Room Size (405.1134c)

☐ Beds Per Room (405.113-k)

1. Name of Facility: Longleaf Neuromedical Center

   Address: 4761 Ward Blvd

   Wilson, NC 27893

2. Type facility: SNF

   Program: XVIII/XIX ☒ XIX ☐

3. Vendor No. _____

   Provider No. 345192

4. Date of Survey: Life Safety Code 2/12/13

   General: _____

5. Expiration Date of Current Agreement:

   NA

6. State Agency recommendation: ☒ Approved

   ☐ Not Approved

   ☐ Waiver/Variance Previously Approved

7. Reason for Recommendation: K72 Take down existing and install new care tracker documentation system.

   See attached letter for request.

   (by: DRW)

8. Period for which Waiver/Variance is Recommended: Temporary waiver till 7/31/13.

9. 4/3/2013
   Date

10. _____
    Authorizing Signature of State Agency

TO BE COMPLETED BY REGIONAL OFFICE

1. Waiver/Variance Approved
   (a) _____
   (b) _____
   (c) _____
   (d) _____

2. Waiver/Variance Not Approved
   (a) _____
   (b) _____
   (c) _____
   (d) _____

3 _____
Program Reviewer Signature

_____
Date

4. _____
Discipline Reviewer Signature

_____
Date

5. _____
Authorizing Signature
Acting Director, Survey & Certification

_____
Date

North Carolina Department of Health and Human Services
Longleaf Neuro-Medical Treatment Center

MAR 26 2013

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

William R. Benton, Jr., M.A., N.H.A.
Center Director

March 14, 2013

Ms. Della Woollen, Engineer
Building System Engineer
DHSR Construction Section
2705 Mail Service Center
Raleigh, NC 27699-2705

Dear Ms. Woollen:

In response to the February 12, 2013 Life Safety survey conducted at our facility, the Plan of Correction is attached. However, we would like to request the following waiver:

K072

We are requesting a waiver on tag K072. An automated CareTracker documentation system was received February 6, 2013 and will replace the paper flow sheet documentation that is now maintained in the wall desks. The projected schedule of completion for installing the 28 kiosks, uploading resident and staff information, and staff training in use of system is July 31, 2013. Once the CareTracker system is implemented, the wall desks/flow sheets will be removed. In the interim, staff will be retrained to retract and lock the wall desk after each use by March 15, 2013. Nursing will routinely monitor for compliance.

Therefore we are requesting a time waiver up to July 31, 2013.

It is our desire to meet all life safety codes. Your consideration of these requests is appreciated.

Sincerely,

William R. Benton, Jr.
Center Director