**INITIAL COMMENTS**

There were no deficiencies cited as result of the complaint investigation of 01/31/13. Event ID # NRFH11.

**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 8:56 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...

Placing utensils on sanitized food surfaces:
To immediately correct the placement of utensils on un-sanitized surfaces, the Dietary Manager (DM) discussed with staff on 01/31/13 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.
<table>
<thead>
<tr>
<th>ID PREFERENCE TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFERENCE TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>% COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 1 vegetable product inside the cans. The spatula was then placed flush down on the preparation table.</td>
<td>F 371</td>
<td>The Nutritional Services Department policy, &quot;Sanitation Procedures&quot; 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).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>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).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>A follow-up class on sanitation expectations, related to cited deficient practices, will be held for department staff the week of 2/18/13.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No sanitizing solution was used to wipe down the food preparation table between 8:58 AM and 10:10 AM on 01/30/13.</td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>2/28/13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The DM commented that she preferred the staff not to place utensils directly down on the preparation tables even when they were sanitized.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>At 2:30 PM on 01/31/13 a dietary employee stated she was under the impression it was okay to lay</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
LONGLEAF NEURO-MEDICAL TREATMENT CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
4761 WARD BOULEVARD
WILSON, NC 27893

<table>
<thead>
<tr>
<th>(X9) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| 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 01/31/13 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 |
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**
Longleaf Neuro-Medical Treatment Center

**Street Address, City, State, Zip Code:**
4761 Ward Boulevard, Wilson, NC 27893

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider’s Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 371</td>
<td>Continued from page 3 preferred because it did not cause condensation to develop which could effect the quality of the food items.</td>
<td>F 371</td>
<td>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 to determine need for further education and monitoring.</td>
<td>2/28/13</td>
</tr>
<tr>
<td></td>
<td>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 girts 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</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Event Id:** NRFH11
**Facility Id:** 923375
**If continuation sheet Page:** 4 of 8
### 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
F 371 Continued From page 5

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
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

345192

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED

C

01/31/2013

NAME OF PROVIDER OR SUPPLIER

LONGLEAF NEURO-MEDICAL TREATMENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

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

ID PREFIX TAG

PROVIDER’S PLAN OF CORRECTION (EACH
CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE
DEFICIENCY)

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
plated 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)
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 7 she was unsure about the procedure or schedule for &quot;destaining&quot; 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.</td>
<td>F 371</td>
<td>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.</td>
<td>2/28/13</td>
</tr>
<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The deficiencies determined during the survey are as follows: No Life Safety Deficiencies Noted</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
CENTERs FOR MEDICARE & MEDICAID SERVICES

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1** PROVIDER/SUPPLIER/Clinic IDENTIFICATION NUMBER:
345192

**X2** MULTIPLE CONSTRUCTION
A. BUILDING 02 - BUILDING 02

**X3** DATE SURVEY COMPLETED
02/12/2013

**NAME OF PROVIDER OR SUPPLIER**
LONGLEAF NEURO-MEDICAL TREATMENT CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
4761 WARD BOULEVARD
WILSON, NC 27893

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>DUE COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td></td>
<td>INITIAL COMMENTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K 032</td>
<td>SS=D</td>
<td>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&quot; 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.</td>
<td>3/29/13</td>
<td></td>
</tr>
</tbody>
</table>
| K 066     | SS=D| 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, | |

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

**TITLE**

**DIRECT/ADMIN. 3/24/13**
<table>
<thead>
<tr>
<th>K066</th>
<th>Continued From page 1</th>
<th>K066</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19.7.4</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>K072</th>
<th>A metal container for the cited resident smoking area was ordered February 26, 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3/01/13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K072</th>
<th>(A) An automated Care Tracker documentation system was received February 8, 2013 and will replace the flow sheet documentation that is now maintained in the wall deaks. 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)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/31/13</td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>K072</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>K076</td>
<td>SS=</td>
</tr>
<tr>
<td></td>
<td>D</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX TAG</td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
</tr>
<tr>
<td>K 076</td>
<td>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)</td>
</tr>
</tbody>
</table>
FACILITY REQUEST FOR WAIVER OR VARIANCE

TO BE COMPLETED BY STATE AGENCY

1. Name of Facility: Patient Neurological Center
   Address: 4761 W 81st St

2. Type facility: SNF
   Program: XVII/XIX
3. Vendor No. ____________________
   Provider No. 34512

   General: ____________________

5. Expiration Date of Current Agreement: NA

6. State Agency recommendation: X Approved
   □ Not Approved

7. Reason for Recommendation: XZ 2/2 Take down existing and install new core tracker documentation system
   See attached letter for request.

8. Period for which Waiver/Variance is Recommended: Temporary waiver till 12/31/13

9. ____________________
   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 ____________________

4. Discipline Reviewer Signature ____________________

5. Authorizing Signature
   Acting Director, Survey & Certification ____________________

   Date ____________________
   Date ____________________
   Date ____________________
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 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 inspect 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

http://www.longleafneuromedical.ncdhhs.gov/
Telephone: 252-399-2112 FAX 252-399-2138
4761 Ward Boulevard, Wilson, North Carolina 27893-4359 Courier 01-51-02
An Equal Opportunity Employer and Service Provider