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 _____	02/25/2016

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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to obtain a urinalysis ordered by the primary physician for 1 of 1 sampled residents (Resident #29) whose laboratory results were reviewed. Findings included: Record review revealed Resident #29 was admitted to the facility on 09/13/00 and readmitted on 02/02/15. The resident's documented diagnoses included recurrent urinary tract infections (UTIs), benign prostate hypertrophy (BPH), and dementia. A 02/10/16 8:30 AM order written by Resident #29's primary physician documented, "Initiate Bair Hugger (warming blanket) if temp(erature) decreases below 96 degrees in regard to recurrent hypothermia and can remove when temp(erature) is greater than 97 degrees. U/A (urinalysis) this AM ok (okay) for I & O cath (in and out catheter)." This order was "noted" by the Nurse Supervisor. Review of laboratory results in Resident #29's medical record revealed there were no U/A results from a urine sample which was collected from the resident on 02/10/16. At 11:30 AM on 02/25/16 the Nurse Manager stated urine was not collected from Resident #29	F 281	Response for Tag 281 The facility maintains that services provided or arranged by the facility meet professional standards of quality. How corrective action will be accomplished for those residents affected by the deficient practice: The urinalysis for Resident #29 was collected on 2/26/16. Results of the urinalysis were reviewed by the physician on 2/29/16 and filed in the Resident #29's medical record on 2/29/16. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice Because all residents with orders for urinalysis are potentially affected by the cited deficiency, an audit of urinalysis orders on all resident medical records was conducted and reviewed by the Director of Nursing (DON) and MD. Any discrepancies were immediately addressed by the DON and MD on 3/15/16. Measures that will be put into place or systemic changes made to ensure the deficient practice will not recur. A Lab Studies Tracking process was developed for all residents. A Lab Studies Roster, which will be part of the resident's medical record, will be used to track when lab orders (including urinalysis orders) are written, when specimens are collected and when the results are filed in the medical record.	2/26/16 2/29/16 3/15/16 3/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie M. Branch

TITLE: Center Director

(X6) DATE: 3/17/16

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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F 281	Continued From page 1 in response to the 02/10/16 order for a U/A. He stated he thought the resident's primary physician requested the U/A due to the resident's problem with recurrent hypothermia. According to the Nurse Manager, the facility's audit system should have detected that the urinalysis was not collected as ordered. At 11:34 AM on 02/25/16 the Nurse Supervisor stated the nurse who took the order from the physician or a hall nurse designated by the receiving nurse should have collected the urine sample. She reported she was unsure why the urine was not collected, but commented Resident #29 sometimes resisted care. However, she stated if resident refusal was the cause for failure to collect the specimen, staff members should have attempted re-collection. She explained if the re-recollection effort was not successful then the physician writing the order should have been contacted for guidance on how to proceed. Upon reviewing Resident #29's progress notes, the Nurse Supervisor commented she did not see documentation of refusal, re-collection attempts, or notification of the physician. At 12:40 PM on 02/25/16 the director of nursing (DON) stated the nurse who took or noted the physician order to collect urine for a urinalysis was responsible for making sure the collection was carried out. If the sample was unable to be collected, he reported he expected an explanation to be documented in the progress notes along with documentation of probable attempts to re-collect and documentation that the physician was notified. At 1:50 PM on 02/25/16 Resident #29's primary physician stated he was not notified that the staff	F 281	The Nurse Managers, Ward Clerks and Lab Technician will be trained on the Lab Tracking Process by 3/17/16. A memo will be sent to medical staff, nurses, and the Lab Technician regarding the new process on 3/17/16. The Lab Tracking Process will be implemented by the Director of Nursing and Medical Director for all residents on 3/21/16. How the facility plans to monitor its performance to make sure that solutions are sustained A quality assurance process was implemented under the supervision of the Director of Nursing to monitor the lab tracking process. 1. The Lab Studies Roster for each resident will be reviewed nightly by the 11-7 nurse to validate all lab studies ordered by the physician are completed. Any pending lab studies, noted during the nightly chart check, will be forwarded to the DON/designee daily for follow-up. 2. Each week, the Nurse Manager/Nurse Supervisor will review the Lab Studies Roster for each resident to confirm the lab tracking process is being completed. 3. The findings of the monitoring will be compiled by the Director of Standards Management and submitted monthly x 12 months to the QI Committee for further review or corrective action.	3/21/16 and ongoing 3/24/16 and ongoing

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F 281	Continued From page 2 was unable to collect the U/A he ordered for the resident. The physician reported he wanted a urinalysis completed for the resident because a frequent cause for recurrent hypothermia was a "clandestine" (hidden) infection, and he wanted to rule out a UTI.	F 281	Response for F 309 It is the policy of the facility for staff members to follow physician orders and Speech Therapy (ST) recommendations. How corrective action will be accomplished for those residents affected by the deficient practice	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to follow the physician order and speech therapy recommendation for the administration of liquids for 1 of 1 sampled residents (Resident #85) on aspiration precautions. Findings included: Resident #85 was admitted to the facility on 11/04/15. The resident's documented diagnoses included recurrent aspiration and history of pneumonia. In the resident's 11/04/15 admission history and physical (H & P) her primary physician documented, "...Patient has a past medical history of recurrent aspirations...It is noted from transfer records that she displays pica behavior (appetite for substances that are largely	F 309	• The Nurse Manager sent a message in the electronic documentation system (Caretracker) regarding Resident #85 to all HCTs on 2/24/16. The message reiterated the Nursing Department's requirement to read the resident's meal card. HCTs were reminded that Resident #85 was to receive honey thickened liquids with spoon sips (not a cup).	2/24/16
			• A monitoring process for Resident #85 was implemented on 2/26/16. A nurse monitored Resident #85 at each meal to verify the HCT was providing liquids with a spoon. The monitoring was conducted at each meal x 2 weeks and confirmed HCTs were following Resident #85's meal instructions.	3/5/16
			• The DON sent a Caretracker message to all HCTs in the facility on 2/24/16. The message instructed the HCTs to review the resident's meal ticket prior to feeding a resident.	2/24/16
			• The DON sent an email to all Nurse Supervisors on 2/24/16 instructing them to remind staff to look at the resident's meal ticket and follow the feeding instructions.	2/24/16
			• HCT #1 received retraining on 2/24/16, regarding the Nursing Department's requirement to review the resident's meal ticket before feeding the resident.	2/24/16

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F 309	Continued From page 3 non-nutritive) and consistently chews on sterile towel or on her fingers while on the unit and drools profusely...." On 11/17/15 the resident's care plan identified "Alteration in nutrition: resident requires mechanically altered diet. Swallowing/Chewing problems. Risk for malnutrition r/t (due to) cognition, dehydration, unintended weight changes, aspiration/choking, and dietary complications from medical problems and/or medication use" as a problem (the care plan was last reviewed on 01/28/16). A 12/10/15 physician order documented Resident #85's liquids were being downgraded to honey thick consistency with teaspoon sips only and continuation of aspiration and choking precautions. On 12/11/15 honey thick liquids with spoon/pureed diet was added as an approach to the "alteration in nutrition" care plan. On 12/22/15 spoon sips with teaspoon only and observation of aspiration/choking precautions were added as approaches to the "alteration in nutrition" care plan. In her 01/06/16 assessment the registered dietitian (RD) documented Resident #85 was "on a puree diet with honey thick liquids, fed by staff with teaspoon only." The resident's 01/21/16 quarterly minimum data set (MDS) documented she had short and long term memory impairment, was severely impaired in decision making, was dependent on a staff member for eating, was on a mechanically altered	F 309	• A monitoring plan for HCT#1 was implemented on 2/26/16. A nurse monitored that HCT #1 reviewed the meal ticket and followed the feeding instructions. Monitoring of HCT#1 feeding her assigned residents was conducted each meal x 2 weeks with no further deficiencies.	3/5/16
			<u>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice</u> • Because all residents with Speech Therapy recommendations are potentially affected by the cited deficiency, the Director of Nursing implemented monitoring of all residents who are on Aspiration and Choking Precautions for 7 consecutive meals. Monitoring confirmed resident meal instructions were followed. No other residents were affected by the cited deficiency.	3/11/16
			<u>Measures that will be put into place or systemic changes made to ensure the deficient practice will not recur.</u> • The DON implemented an inservice training on Serving Food and Feeding Residents on 3/11/16. A review of a resident meal ticket and the requirement to review and implement all special meal instructions is included in the training. All nurses and HCTs will attend the training by 3/24/16. The DON will verify, via training rosters, that the training requirement is completed.	3/24/16

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F 309	Continued From page 4 diet, and exhibited no signs and symptoms of a swallowing disorder. A 01/28/16 quarterly care plan review documented, "...She receives a pureed diet with honey thick liquids and remains on aspiration precautions. No significant changes are noted with nutritional status....She uses a teaspoon for all liquids..." On 02/24/16 between 12:48 PM - 12:52 PM health care technician (HCT) #1 turned up Resident #85's cup of honey thick water three times, and allowed the liquid to run into the resident's mouth and possibly down the resident's throat. The resident did not cough, but a large amount of water ran out of her mouth. At this time the HCT stated she usually fed the resident her lunch, and this was the usual way she fed and hydrated the resident. However, after reviewing the resident's meal slip which documented "spoon sips with teaspoon only," HCT #1 reported she did not administer the liquids correctly. On 02/24/16 at 5:50 PM HCT #2 was observed feeding Resident #85 spoonfuls of a honey thickened dairy product. The HCT stated she used the spoon because the resident actually consumed more of her thickened liquids if they were spooned into her mouth. She explained that when taking liquids directly from the cup the beverages ran out of the resident's mouth, and she did not actually swallow a lot of them. At 10:18 AM on 02/25/16, during a telephone interview, the facility's speech therapist (ST) stated the change from administering Resident #85's liquids via cup to administering via spoon	F 309	• The location of information on the resident meal tickets was standardized. Aspiration Precautions, Choking Precautions and special feeding instructions were placed in the same location on each resident meal ticket, to reduce the possibility of instructions being overlooked. How the facility plans to monitor its performance to make sure that solutions are sustained. • A quality assurance process was implemented under the direction of the Director of Nursing to monitor that residents are being provided meals in accordance with the MD orders and Speech Therapy recommendation. On each nursing unit, the Nurse Manager/ Nurse Supervisor/ Nurse will conduct six observations per week of residents who are on Aspiration or Choking Precautions. Two observations will occur at each meal (breakfast, lunch, supper) to confirm residents are being fed according to their instructions. Monitoring results will be forwarded weekly to the DON for review. • The findings of the monitoring will be compiled by the Director of Standards Management and submitted monthly x 12 months to the QI Committee for further review or corrective action.	3/9/16 3/18/16 and ongoing

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F 309	Continued From page 5 was brought about by a modified barium swallow study during which the resident aspirated on liquids drunk from a cup or there was penetration of the laryngeal area. The ST reported she verified the swallow study results which documented it was safer for the resident to take liquids via spoon, and communicated them to the primary physician who wrote an order for liquids to be administered by spoon. According to the ST, Resident #85 had a tendency to gulp her liquids so turning up the cup and pouring liquids into the resident's mouth could cause her to get strangled. She explained that liquids via spoon was part of Resident #85's aspiration precautions. At 12:40 PM on 02/25/16 the director of nursing (DON) stated HCTs should follow instruction on the meal/tray slips which accompany their meals. He reported HCT #1's failure to provide Resident #85's liquids via spoon put the resident at risk for choking which could lead to aspiration pneumonia.	F 309		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520	Response for F520 The facility maintains a QAA Committee comprised of the Center Director, Assistant Center Director, Medical Director, Director of Nursing, Director of Standards Management, Director of Professional Services, Business Manager, Director of Staff Development, Director of Information Management, Director of Psychology, QI Coordinator and Administrative Specialist. The QAA Committee meets monthly. The QAA Committee implemented a plan of correction following the 2/27/15 federal monitoring survey for F309. The plan of correction was monitored by the QAA Committee for 12 months. No further deficiencies were cited related to dialysis during the 2016 CMS Annual Recertification Survey.	

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F 520	Continued From page 6 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to providing the highest practical potential physical, mental, psychosocial well-being which resulted in a repeat citation at F309. The re-citing of F309 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F309: Failure to provide the highest practical potential physical, mental, psychosocial well-being: Based on observation, staff interview, and record review the facility failed to follow the physician order and speech therapy recommendation for the administration of liquids for 1 of 1 sampled residents (Resident #85) on aspiration precautions. Review of the facility's survey history revealed F309 was cited during a 02/27/15 federal monitoring survey, and was re-cited during the current 02/25/16 annual recertification survey.	F 520	How corrective action will be accomplished for those residents affected by the deficient practice Refer to response under F 309 How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice Refer to response under F 309 Measures that will be put into place or systemic changes made to ensure the deficient practice will not recur. Recognizing that F309 is a repeat tag, the facility has implemented the following measures to strengthen the QA Program and reduce the potential for reoccurrence of deficient practice: • The Center Director sent an email to the Clinical Department Supervisors on 3/14/16 about the importance of monitoring the completion of assessments, physician orders and care plan interventions. • The Center Director, Medical Director, Director of Nursing, and Director of Standards Management met on 3/14/16 to evaluate the QAA membership per the CMS/ Nursing Home Regulations. • The facility's scheduled monthly quality round process will be strengthened by requiring Nurse Managers and other clinical supervisors to provide evidence of correction of any deficiencies identified during the quality rounds.	3/14/16 3/14/16 3/24/16

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F 520	Continued From page 7 In an interview on 02/26/16 at 2:30 PM the Director of Standards Management stated on 02/27/15 the facility was cited for an issue with dialysis. She indicated the problem had been corrected. However, she stated the F309 citation this year involved failure to follow a physician order and speech therapy recommendation for providing fluids. She indicated that although the facility received a citation in 2015 and 2016 at F309; she felt the deficient practice was not the same as they involved dialysis in 2015 and the administration of fluids in 2016.	F 520	• A quality assurance process was implemented under the supervision of the Director of Nursing for the MDS Nurse assigned to each unit to monitor completion of assessments, physician orders and care plan interventions. The MDS Nurses will monitor on a weekly basis and submit findings to the DON. How the facility plans to monitor its performance to make sure that solutions are sustained • MDS Nurses will complete a weekly monitoring tool and forward the results to the DON/designee weekly. The results will be reviewed by the DON and ADON and reported to the QAA committee monthly x 12 months. • The QAA Committee will review reports from Nurse Managers and clinical supervisors on a monthly basis x 12 months.	3/21/16 3/24/16 and ongoing 3/23/16 and ongoing