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 08/18/2017

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 The survey team entered the facility on 8/10/17 to conduct a complaint survey and exited on 8/11/17. The survey team returend to the facility on 8/17/17 to obtain additional information and exited on 8/18/17. Immdiate Jeopardy was identified at CFR 483.25 at tage F323 at a scope and severity of J. The immediate jeopardy began on 5/18/17 and was removed on 8/18/17. An extended survey was conducted.	F 000		
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		9/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 09/08/2017

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 08/18/2017

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 323	Continued From page 1 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician and staff interviews the facility failed to prevent 1 of 3 (Resident #1) sampled cognitively impaired residents with exit seeking behaviors from exiting the facility. The resident was found crossing the highway and running down the grassy median between the north and south bound lanes. The Immediate Jeopardy began on 5/18/17 when Resident #1 exited the facility unattended by the facility staff and was observed crossing a divided highway and running down the grassy median between the north and south bound lanes. The Immediate Jeopardy was removed on 8/18/17 when the facility provided evidence of completing policy revision and implementing staff in-service education on the revised elopement policy and procedure based on the approved credible allegation. The facility remained out of compliance with potential for more than minimal harm that is not immediate jeopardy (D) whereby significant corrections were required because the plan of correction was not fully integrated into the facility's quality assurance program. The findings included: Resident #1 was admitted to the facility on 6/13/12 with diagnoses which included bipolar disease, manic depression, Non-Alzheimer's dementia and diabetes mellitus. The Care Area Assessment of the annual Minimum Data Set (MDS) dated 1/23/17 revealed the care areas that triggered and were carried to	F 323	Response for F323 It is the policy of the facility to provide adequate supervision of residents to prevent elopements. The facility conducted an immediate review of the elopement that occurred on May 18 and crafted an action plan to address the deficiencies which led to the incident. The action plan has been integrated into the facility□s Quality Assurance Program. The facility assessed its other residents using the Dewing Wandering Risk Assessment Tool. This assessment identified eleven (11) residents who are at actual risk for wandering/elopement. The corrective actions the facility has implemented will ensure that these residents, and others will be properly supervised. Supervision of Residents Memo A memo was issued by the Center Director to all facility staff members on 8/18/17. The memo instructed staff members who observed a resident wandering or eloping to verbally call/yell for help immediately, follow the resident and maintain eyesight of the resident at all times. The Center Director issued instructions to all Department Managers on 8/18/17 to review the memo with their assigned staff members and obtain signatures from the staff members, acknowledging receipt. All facility staff	

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 08/18/2017

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 323	Continued From page 2 care plan included cognitive loss/dementia, behavioral symptoms and psychotropic drug use. The quarterly MDS dated 4/12/17 revealed Resident #1 was severely cognitively impaired. He had behaviors not directed towards others and rejection of care for 1-3 days. He required supervision for all activities of daily living (ADLs). He had no functional limitations in range of motion and did not use any mobility devices. He was always continent of bowel and bladder. The care plan which was reviewed on 4/26/17 revealed Resident #1 was a wander/elopement risk. "Resident is a wander/paces halls/pilfers through other resident's personal items and tries to open locked unit doors. Risk for injury r/t (related to) elopement." The approaches included; know resident's whereabouts at all times, use diversional techniques as needed. The care plan also addressed psychotropic drug use stating, "Resident requires psychotropic drug use to manage symptoms associated with dementia, schizophrenia." The care plan also stated "Resident with mental illness (Bipolar Disorder and dementia), cognitive impairment, behavioral outbursts such as being combative, resistive, refusing care/assistance/vital signs/refusing meds and meals at times due to thinking they have poison in them, etc. Resident is at risk for decline in psychosocial needs." The behavioral care plan read "Confusion from mental illness -Bipolar and dementia makes it difficult for resident to follow directions or complete task at times; can be resistive or aggressive at times when staff attempts care or assists with tasks; as risk for unmet needs and injury due to behaviors. Resident has h/o (history of) being paranoid and currently will state that his food/medicine have	F 323	members, with the exception of those on approved leave, acknowledged receipt of the memo by 8/31/17. Staff members on leave will receive the memo upon re-entry to work. The memo was incorporated into monthly New Employee Orientation classes beginning September 5, 2017. A monitoring process was implemented under the supervision of the Director of Nursing, starting 9/5/17, that confirms receipt/review of the Supervision of Residents Memo by new facility staff members in New Employee Orientation. The Assistant Director of Nursing (ADON) will generate a monthly Training Compliance Report confirming completion of the memo by the new staff members. The report is submitted to the Director of Standards Management, beginning September 2017, and reported to the QI Committee monthly x 6 months. Supervision of Residents Class A class, entitled Supervision of Residents was developed and implemented on 8/18/17 by the Assistant Director of Nursing. The Center Director deemed the class mandatory for all facility staff. The class consisted of a power point presentation which included instructions for calling for help, paging a Code M-Missing Resident Alert, following the resident and maintaining eyesight of the resident at all times, if there is an elopement. The training included a nine (9) question post-test with a required passing score of 100%. The class was taught by the facility Nurse Preceptors and Staff Development Nurses. With the	

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 08/18/2017

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 323

Continued From page 3

been poisoned, spits, hallucinates he is fighting demons, will barricade himself in a room, won ' t allow staff to enter his room at times, will throw objects occasionally, and will try to open locked unit doorway."

A review of the incident report log revealed a resident elopement was recorded on 5/18/17 at 07:00AM. "Staff report resident pulled several times at dayroom door and it opened. Resident entered out entry door and entered into elevator."

On 8/10/17 at 2:20 PM Health Care Technician (HCT) #2 stated she was assigned as the 5th floor dayroom monitor for the 7:00am to 3:00pm shift. She stated her responsibilities including documenting which residents left the unit. She stated all residents on the 5th floor require an escort to exit the floor. She demonstrated the log where each resident who left the unit was signed out with a staff member and signed back in when they returned to the unit.

Another HCT was interviewed on 8/19/17 at 2:55PM. HCT #3 stated Resident #1 was independent for all activities of daily living (ADLs), walked independently and liked to go to the dayroom or look outside the window at the end of the hall. She stated if Resident #1 went near the exit door the staff were to redirect him. She stated there was a staff member assigned as the day room monitor. HCT #3 stated Resident #1 tried to get out of the locked 5th floor door. She stated she was aware of the one time he did get out but she was unsure of exactly when it happened. HCT #3 stated she had arrived at work the day he got out and other staff called out to her to help find the missing resident from 5th floor. HCT #3 stated she was not aware of how

F 323

exception of those on approved leave, all staff successfully completed the class and post-test by 8/31/17. Staff members on leave will attend the class upon re-entry to work. The class was incorporated into monthly New Employee Orientation classes beginning September 5, 2017. Under the supervision of the Center Director/designee, a monitoring process was implemented on 9/1/17. A Supervision of Residents Audit was implemented which includes eight (8) questions, based on the class content. Nurse Supervisors interview 3 nursing staff members on each shift/on each nursing unit/ daily x 1 month, then weekly x 5 months. Five (5) audits of non-nursing employees are completed daily on weekdays x 1 month, then weekly x 5 months to confirm staff members understand to keep a resident in eyesight at all times if wandering/eloping. Based on the audit plan, a total of 340 audits are completed weekly x 1 month, then 50 audits will be completed weekly x 5 months. Immediate re-education is provided if any staff member answers the audit questions incorrectly. Upon completion, the audits are forwarded to the Center Director/designee for review. The audit process was incorporated into the facility□s QAPI plan, with audit results reviewed monthly by the QI Committee x 6 months, starting in September 2017. (See Attachment A.)

Door Security Video
Prior to the 8/18/17 Complaint Survey, a video which emphasizes the importance

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 08/18/2017

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 323 Continued From page 4

or where he got out. She added in the past she had observed Resident #1 to push, bang, hit and kick the exit doors on the 5th floor.

On 8/10/17 at 5:00PM the 5th floor unit manager stated the dayroom monitor stays in the dayroom for the whole 8 hour shift because some of the residents do not get along so the HCT assigned to the dayroom tries to keep those residents separated, keep the area uncluttered and to monitor the entry door to prevent elopement. She stated there were several residents on the floor who tried to elope and the list included Resident #1. The unit manager said Resident #1 would pack his belongings into a pillow case so that was when the staff knew he wanted to go home. She stated the resident could become agitated when the staff tried to redirect him or asked him too many questions. She added she was aware Resident #1 had exited the 5th floor dayroom unit entry door and got out of the building. She stated he was wearing a wander management alarm bracelet and went out a side exit on the administration side of the building which did not alarm because it deactivated automatically at 6:00am. The unit manager reported when Resident #1 was returned to the 5th floor he was assessed for injury and then he went into his room, slammed the door closed and did not want to be disturbed. She added she visited him but he would not talk to her. She said an investigation was started and it was found that the HCT in the dayroom had been pulled from another floor.

The facility security officer (FSO) #1 was interviewed on 8/11/17 at 7:45AM. He was the FSO on duty on 5/18/17 when the phone in the security office rang and he was told a male resident was coming down the elevator. He

F 323

of maintaining security of resident unit doors and techniques for redirecting residents away from the entrance door, was developed by the Staff Development Department, under the supervision of the Director of Nursing. The Center Director issued instructions on 7/12/17 for all facility staff to complete the video by 8/31/17. All staff members, with the exception of those on approved leave, completed the video training by 8/31/17. Staff members on leave will complete the video upon re-entry to work. The video was incorporated into monthly New Employee Orientation classes for all new employees beginning September 5, 2017. Under the direction of the Director of Nursing, a monitoring process was implemented. The Assistant Director of Nursing (ADON) will confirm each month that new employees have completed the video training in New Employee Orientation. The ADON will forward a monthly Training Compliance Report to the Director of Standards Management for review. Training compliance will be reported monthly to the QI Committee x 6 months, starting in September 2017.

Elopement Policy Revision
The Elopement Policy (AM 11-4) was revised by the Director of Nursing on 8/18/17 to include the requirement for staff members to maintain eyesight of the resident at all times in the event of an elopement. Further revisions were made to the policy on 8/28/17 to clarify steps to take if a resident wanders or elopes. The policy revisions were approved on 8/29/17

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 08/18/2017

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 323

Continued From page 5

stated he and the other 2 facility staff members (HCT #5 & Housekeeper #1) went out of the office into the 1st floor lobby area where he had to swipe his identification badge to enter into the 1st floor hallway. He stated he saw the house supervisor (HS) coming towards him in the hallway but he did not see the resident. He stated the HS asked him if he had seen the resident but he told the HS no. The FSO stated he went to his left down the administration hallway and did not see anyone so then went down the stairwell near the 1st floor entry door with the HS. The stairs led down to the basement. He stated he then went down the fire escape and did not see anyone. He stated he received a phone call the resident was apprehended by 3 other staff members. The FSO stated he picked up the resident and the staff members in the FSO car and returned them to the facility to the main front entrance. He stated he escorted Resident #1 back to his room on the 5th floor then went to view the surveillance video tape with other facility staff.

HCT #4 was interviewed on 8/11/17 at 8:45AM. She stated on 5/18/17 she was pulled from her regular 2nd floor 11:00pm to 7:00am position and placed as the dayroom monitor on 5th floor because they needed more help. She stated Resident #1 came to the dayroom, watched TV and that he walked up and down the hall and he kept standing at the entrance door. She said she didn't know the resident's name but that she saw him wiggling the L-shaped thing then the door opened and she saw him go out the door which automatically locked when it closed. She said she then got up and unlocked the entrance door with her badge and told him to come back because security was going to get him. She

F 323

by the Center Director, Medical Director, Director of Nursing and Director of Standards Management and by the QI Committee on 8/31/17. The revised policy was distributed to all facility staff members via email on 8/31/17 and all staff members, with the exception of those on approved leave, are required to acknowledge receipt by 9/08/17. Staff members on leave will review the policy and acknowledge receipt upon re-entry to work. The memo was incorporated into monthly New Employee Orientation classes beginning September 5, 2017. A monitoring process was implemented under the supervision of the Director of Nursing, starting 9/5/17, that confirms receipt/review of the Elopement Policy by new facility staff members. The ADON will generate a monthly Training Compliance Report confirming review/receipt of the memo by new staff members. The Training Compliance Report is submitted to the Director of Standards Management, beginning September 2017, and reported to the QI Committee monthly x 6 months.

DAYROOM MONITOR / HALL MONITOR POLICY
To further clarify resident supervision requirements, the Director of Nursing developed a policy (NM #5) which outlined the supervision requirements for nursing staff who are assigned to monitor the Dayroom or Hallway. The policy directs the staff to be observant of residents who position themselves at the unit entrance door and to redirect the resident away

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 08/18/2017

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 323

Continued From page 6

stated Resident #1 shook his head no as the elevator door closed then she went back onto the unit and yelled for help. She said she didn't see any other HCTs but 2 nurses came. HCT #4 reported the nurses went down the elevator and she stayed on the floor to monitor the medication cart and watch the dayroom. HCT #4 said she didn't know the nurses names. HCT #4 added she had probably worked on 5th floor 5-10 times since the first of the year and had been the dayroom monitor before. She did not know how frequently but usually when she was pulled to work another floor it was not to monitor the dayroom because only 5th floor had a day room monitor on the 11:00pm to 7:00am shift.

On 8/11/17 at 9:00AM the House Supervisor (HS) said Resident #1 was independent and ambulatory. She reported he frequently paced the hall way with a bag/sack packed and always "ready to go." The HS said on 5/18/17 she was sitting in the supervisor's office when the phone rang and Nurse #1 told her a resident got out the 5th floor unit entry door and was on the elevator. HS said she went outside the office which was located on 1st floor beside the elevators to wait for the resident to exit the elevator. After a few seconds she noted the door did not open so she looked down the hall towards the front reception door and saw the resident there. She said she called his name for him to come back but he started running and went to the right towards administration wing. She said she ran after him but did not see him anymore. She said to her knowledge all the doors down that hall were locked so she went back to the wall phone in the middle of the 1st floor main hall and called the "Code M" for missing resident. She said numerous staff started arriving along with FSO #1

F 323

from the door. The policy was distributed to all nursing staff on 8/28/17 as a read and sign document. All nursing staff, with the exception of those on approved leave, acknowledged receipt/review of the policy by 9/8/17. Under the supervision of the Director of Nursing, a monitoring process was implemented on 9/5/17. A Dayroom Monitor/ Hall Monitor Observation Tool is used to conduct observations of staff who are assigned to the Dayroom or Hallway. The Nurse Supervisor/Nurse in Charge on each nursing unit conducts 1 observation each shift, on each nursing unit, using the Dayroom Monitor / Hall Monitor Observation Tool. The observations are done each shift to confirm the dayrooms and hallways are monitored as required by policy. Monitoring is done each shift on all nursing units daily x 1 month, then weekly x 5 months. Based on the audit plan, a total of 105 audits are completed weekly x 1 month, then 15 audits are completed weekly x 5 months. The observations are recorded on the audit tool and forwarded to the Director of Nursing daily for review. The DON forwards the audits to the Director of Standards Management who compiles the results. The audit process was incorporated into the facility□s QAPI plan, with audit results reviewed monthly by the QI Committee x 6 months, starting in September 2017. (See Attachment B)

OFF UNIT TRANSPORT POLICY
An Off- Unit Resident Transport Policy (AM 10-105) was developed by the Director of Nursing and Director of

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 08/18/2017

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 323

Continued From page 7

who helped her check the doors along the administration hall to make sure they were locked and to look for Resident #1 in the few unlocked rooms. HS said she could not remember which phone (wall phone or facility provided cell phone) she used to call FSO but she said she told FSO that the resident was out of the unit (5th floor) and possibly out of the building. The HS said the portable phone could call other phones but it could not be used for the intercom system to announce the Code M.

During an interview on 8/11/18 at 9:40AM Health Care Technician (HCT) #1 stated she heard the code announced over the intercom system so she came down the middle stairs from the 2nd floor to the 1st floor where someone told her the resident was seen going towards the administration wing. HCT #1 said she passed by the HS and the ADON when she saw a fire door across from one of the offices. She said they had looked in all the unlocked rooms and bathrooms but he was not found. HCT #1 said she then told a nurse "He must have gone out the fire door," so she and the nurse went out the fire door. She and the nurse were running and looking next to the loading docks at the back of the facility and still did not see him so they continued around the back of the building past the fenced in outdoor resident area. She said they saw some people standing outside the school next door so the nurse went in that direction and she went towards the boiler building. HCT #1 then stated she was looking around the outside of the boiler building when she saw something moving. She went through the shrubs and saw Resident #1 going into the edge of the ditch beside the highway so she screamed his name and he took off running across the highway. HCT #1 said she could not

F 323

Standards Management to ensure staff are aware of the proper ways to transport residents within the facility, on the grounds of the facility and off campus to prevent a lapse in supervision. The policy was approved by the Center Director, Medical Director, Director of Nursing and Director of Standards Management on 8/29/17. The policy was approved by the QI Committee on 8/31/17. The policy was distributed to all facility staff members via email on 8/31/17 and all facility staff members, with the exception of those on approved leave, are required to acknowledge receipt by 9/08/17. Staff members on leave will review the policy and acknowledge receipt upon re-entry to work. The policy was incorporated into monthly New Employee Orientation classes beginning September 5, 2017. A monitoring process was implemented under the supervision of the Director of Nursing, starting 9/5/17, that confirms receipt/review of the Off Unit Transport Policy by new facility staff members. The ADON will generate a monthly Training Compliance Report confirming receipt/review of the policy by new staff members. The report is submitted to the Director of Standards Management, beginning September 2017, and reported to the QI Committee monthly x 6 months

OFF UNIT TRANSPORT CLASS
Using the Off- Unit Transport Policy (AM 10-105) as the guide, a class was implemented on 9/1/17 by the Director of Nursing for all facility staff who transport

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 08/18/2017

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 323 Continued From page 8

cross the ditch where she was because it was 5-7 feet deep so she ran along the ditch in the same direction as the resident was running down the median. There was an opening near the corner of the fenced in lot so that was where she crossed the edge of the ditch and the highway after an unknown person stopped his vehicle and stopped traffic. She said she crossed the road and told the resident not to run anymore. She said at this point the resident stopped running and she took him by the arm and told him they needed to cross the road now while the traffic was stopped. She said he tried to pull away and did not want to go back but she talked to him and convinced him to return to the facility side of the road. Once back on the facility side of the road they walked back along the fenced in lot (outside the fence) and that was when the nurse (Nurse #1) came and assisted her. HCT #1 said Resident #1 told her he didn't want to go back and he continued to try to pull away from her until the nurse arrived then he gave up and kneeled down to his knees. She said HCT #5 saw them and came to assist too. HCT #1 said the HCT #5 took her place beside Resident #1. Then the FSO saw them and he brought the car over to them and everyone got into the car.

On 8/11/17 from 10:00am until 10:35AM a walking tour with HCT #1 of the area from the fire exit door to the place where she saw him cross the highway was conducted. The distance measured approximately 1000 feet. Based on the interview with HCT #1 the resident then ran down the median another 1000 feet to the point where HCT #1 crossed the highway to Resident #1. The speed limit on the highway was 45 miles per hour.

F 323

residents. A class schedule was implemented and the class was deemed mandatory for nursing, social work, activities and psychology staff. The classes are taught by the Nurse Preceptors and Staff Development Nurses and staff members are required to complete the class by 9/8/17. A ten (10) question post-test with an expected passing rate of 100% is used to verify staff member�s understanding of the training. All facility staff, with the exception of those on approved leave, will complete the class by 9/8/17. Completion of the class is confirmed by means of a class roster. Under the supervision of the Director of Nursing, a monitoring process was implemented on 9/5/17. An Off- Unit Transport Observation Tool is used to conduct observations of staff members who are transporting residents. Nurse Preceptors and Staff Development Nurses conduct 15 observations weekly x 6 months, using the Off--Unit Transport Observation Tool. The Observation Tool is used to confirm staff members are maintaining eyesight of the residents during the transport process. The audit tools are forwarded to the Director of Nursing daily. The audit process was incorporated into the facility�s QAPI plan, with audit results reviewed monthly by the QI Committee x 6 months, starting in September 2017. (See Attachment C)

DOOR LOCK PREVENTATIVE MAINTENANCE PROGRAM
The magnetic lock on the door was readjusted on 5/18/17 to ensure an

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 08/18/2017

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 323	Continued From page 9 On 8/11/17at 10:50AM during a phone interview Nurse #1 said she had just completed her medication pass, taken her cart into the medication room then when she went out of the medication room to get some cups HCT #4 told her a man just left out of the unit on the elevator. Nurse #1 said she normally worked on a different floor and she was not familiar with the resident so she obtained a description of the resident. Nurse #1 said she called the HS to report the elopement then she also called the FSO. She stated she did not call a Code M because she did not know the resident's name and she knew the HS office was beside the elevator. While on the phone with the FSO she heard the overhead page for the Code M. She said she called the HS first because she knew the supervisor's office was next to the elevator. Nurse #1 said she then went down the elevator but stopped on each of the floors to see if he was there. Once on 1st floor she was told the resident went down the administrative hall so she checked the doors and did not see him. She stated a fire exit door was observed so she opened it and it did not alarm. She said she went outside the building with others but she did not remember who. She said she saw some people standing outside the school next door so she ran over towards them but as she got closer she could see it was not the resident. She then went towards the highway and saw Resident #1 running down the highway median and a facility staff member (HCT#1) was yelling she needed help. Nurse #1 said she could not cross the ditch so she was running down the highway towards the other staff up past the fenced in lot and saw HCT #1 walk the resident back across the highway while holding onto the resident's arm. She said she used her personal cell phone to call the ADON to get the FSO to bring the car to pick	F 323	adequate connection between the magnet and striker plate on the door. A new magnetic door lock was installed on 5/19/17. As a systemic action, locks were ordered for other residential magnetic doors and replaced on 6/6/17. A monitoring program was implemented under the supervision of the Plant Operations Director in June 2017. Inspection of all magnetic locks in the residential units was conducted in June 2017, July 2017, August 2017, and September 2017. Monitoring will continue to be done monthly x 12 months to confirm proper functioning of the residential magnetic unit door locks. The lock is inspected to verify there is proper alignment, and a pull strength test is performed. Results of the monthly audit are forwarded to the Director of Standards Management for review. The audit process was incorporated into the facility□s QAPI plan, with audit results reviewed monthly by the QI Committee x 12 months, starting in September 2017.	

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 08/18/2017

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 323	Continued From page 10	F 323		

them up. She stated Resident #1 had tried to run again while being escorted away from the highway. She said when she took him by the arm to assist HCT #1 the resident went down on his knees like he was giving up. Nurse #1 reported she assessed Resident #1 for any injuries while waiting on the FSO car to arrive. She said he had no obvious injury.

On 8/11/17 at 2:15PM HCT #5 said she was in the FSO office heard the overhead page so she and the other person went through the 1st floor front reception door. That was when the HS told her the resident name and that he was seen going down the administrative hall. She said she went down the hall checking doors but when he was not found she and the nurse from another unit want out the main front door. She said they searched towards the street in front of the building when another staff member arriving to work said "They got him." She then went through a parking lot and continue to walk until she saw HCT #1 and a nurse (Nurse #1) struggling with Resident #1 so she went to assist them because he was being resistant. She saw they were holding him by cuffed arms (the HCT had her left arm overlapped at the elbow and holding on by the wrist to the resident ' s right arm) and he was elbowing them and they were walking in a circle. She said she called the resident ' s name as she was approaching and he just dropped to his knees. She did not hear the resident say anything. She said she rode in the FSO car back to the building to the front door. She assisted Resident #1 inside the building then she obtained a wheelchair and pushed him back to the 5th floor. She said there were others with her while transporting him back to 5th floor.

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 08/18/2017

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 323	Continued From page 11	F 323		

On 8/11/17 at 4:07PM Resident #1's physician stated the resident had 2 strikes against him because he had both schizophrenia and a major neurocognitive disorder. The physician reported he was both the medical and psychiatric doctor for the resident. He was aware the resident had eloped and he saw the resident on 5/23/17 and the resident had refused to allow a blood draw to check a lab level required for his clozapine (antipsychotic medication used to treat schizophrenia). The doctor stated the resident told him the world was coming to an end then quoted scripture. The doctor said Resident #1 was always psychotic to a certain level and never had a day when he was not psychotic, just that some days were better than others. The doctor said he did not think anyone would have a higher suspicion that he would act to get out one day verses any other day. He stated Resident #1 had a preoccupation with leaving and he just went out that day unexpected and then his fight or flight response kicked in. He said the resident had been off the unit and on 1st floor going to activities and to attend church.

On 8/11/17 at 5:00PM Resident #1 was observed sitting on the side of his bed eating his dinner meal. When he answered questions he only answered he did not remember except he did say what town he was from. He said he did not remember going out of the facility.

On 8/17/17 at 8:00PM the surveillance video was observed. There was only video and no sound. There were 5 separate camera recordings. The surveillance video demonstrated Resident #1 was dressed in long pants with a long sleeve shirt and was wearing shoes. The information from the recorded surveillance video follows:

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 08/18/2017

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 323	Continued From page 12	F 323		

The 5th floor dayroom/nursing station camera revealed Resident #1 pulled on the 5th floor magnetic exit door 3 times and on the third pull at 6:23:41AM the door came open. He exited the door went straight to the elevator and continuously pressed the elevator button. The elevator door opened and he went into the elevator.
At 6:23:50AM HCT #4 used a badge to open the 5th floor magnetic door and she was able to see the resident get on the elevator. She did not attempt to touch the resident but appears to be talking to him. When the elevator door closed she used her badge to return to the unit. The facility documentation record of the video surveillance stated HCT #4 "gets to unit door & yells out."
At 6:23:54AM HCT #4 reentered the unit.
The 5th floor elevator video demonstrated Resident #1 exiting the magnetic door at 6:23:41am and holds the elevator button.
At 6:23:55AM HC#4 was in the exterior 5th floor elevator area with the resident and at 6:24:01am the resident entered the elevator and the door closes. After the door closed HCT #4 used her badge to reenter the locked magnetic entry dayroom door. The elevator door reopened and Resident #1 stepped off the elevator then quickly back onto elevator. At 6:24:23am the elevator door closed again.
At 6:24:34AM A nurse is seen leaving the 5th floor magnetic entry dayroom door and goes to elevator. She gets on the elevator to the right of the one the resident was on.
The 1st floor elevator camera surveillance video demonstrated:
At 6:25:11AM Resident #1 exited the elevator and walks toward the front main entrance.
At 6:25:13AM Resident #1 stopped and looked

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 08/18/2017

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 323	Continued From page 13	F 323		

backwards behind himself then starts jogging/running towards the front entrance.
At 6:25:24AM the HS comes into view at the elevator and started walking towards Resident #1. She did jog/run for a short time.
At 625:47AM the HS stopped and went to the phone located on the wall across the hall from the cafeteria. The resident continued to jog/run towards the front main entrance. While on the phone the HS turned to face the phone and had her back to the resident.
At 6:25:58AM Resident #1 turns and walks toward the administrative hall. HS has her back to the resident at this time.
At 6:26:06AM the HS hangs up the phone and looks around. The resident is not in sight.
At 6:30:25AM HCT #1 is observed walking down the 1st floor hallway.
The rear building (nurse entry) camera demonstrated:
At 6:25:01AM until 6:25:12am the door opens, movement was seen then Resident #1 is seen running on sidewalk to the right. The facility document this as the fire exit door of the administration hallway.
At 6:25:17AM the resident was out of camera view.
At 6:26:09AM FSO#1 walks out the fire exit door.
At 6:29:53AM HCT #1 and 4 other staff came out the fire exit door and run out of view.

On 8/18/17 at 9:30AM the Administrator along with the Director of Nursing and the Standards of Care (QI) nurse were informed of the immediate Jeopardy.

An acceptable Credible Allegation was received on 8/9/17 at 7:30PM and follows:

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 08/18/2017

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 323	Continued From page 14 This plan of correction constitutes Longleaf Neuro-medical Treatment Center's credible allegation of compliance. F323: Supervision to Prevent Accidents Response for Tag F323 The resident left the unit, and got on the elevator. An HCT exited the unit behind the resident, attempted verbal re-direction, which was unsuccessful. The elevator door closed and the HCT lost sight of the resident. The HCT went back into the unit to alert unit staff of the elopement. A nurse exited the unit without announcing an overhead page for the elopement. Upon exiting the elevator, the resident proceeded down the hallway and eloped from the facility. The House Supervisor observed the resident after he exited the elevator. The House Supervisor stopped in the hallway to use the telephone to announce a Code M, which is the emergency code for an elopement. As she was using the telephone, she turned her back, and lost sight of the resident. The resident then exited the building through a fire exit located on the 1st floor of the facility. The deficient practice was a failure by the House Supervisor to maintain line of sight vision of the resident. The House Supervisor decided to page the emergency code, to obtain additional assistance, rather than maintaining supervision of the resident and attempting redirection. There was an immediate response when the resident, cited in this Immediate Jeopardy citation, eloped from the facility. When the resident was observed eloping from the locked nursing unit due to a door lock malfunction, staff responded, located the resident and returned him safely to the facility within thirteen (13) minutes.	F 323		

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 08/18/2017

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 323	Continued From page 15 Corrective action will be taken by the Director of Nursing with the HCT (HCT#4) and House Supervisor upon their return to work. The nurse (nurse #1) involved is no longer employed at the facility. The corrective action will be taken before they accept their assignment. The following actions have been implemented prior to 8/18/17 to address the elopement. 5-18-17 - A review of the elopement event and development of an action plan was initiated by the Standards Department. 5-18-17- Immediately following the elopement, the Plant Operations staff assessed the lock on the 5th Floor unit door and determined a door malfunction had occurred. The striker plate was not aligned properly with the magnet on the door hardware. The striker and magnet were not making a secure connection which contributed to the door releasing when the resident jerked on the door handle. The Plant Operations staff readjusted the door alignment on the 5th Floor Door Lock. 5-18-17- The Center Director made a decision to replace the lock on the 5th Floor unit entrance door. The lock was replaced. As a systemic action, a decision was made to replace all the resident unit door locks and requisitions were submitted to order locks to replace the locks currently in use. The Plant Operations staff readjusted the striker and magnet on the lock on 5/18/17, so there was a proper connection. The 5th floor magnetic door lock was replaced on 5/19/17. 5-18-17- Discussion occurred regarding the feasibility of adding a lock to the exit from which the resident escaped. However, the exit is a designated fire exit located in an administrative office suite designated as business occupancy.	F 323		

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 08/18/2017

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 323	Continued From page 16 A decision was made by the Center Director to research this issue further with DHHS Life Safety, as business occupancy areas are required to have free egress in the event of an emergency. An email was received from the Business Manager that the door lock project was sent out for E Quote. Per the email, depending on the cost, it could require additional purchasing/bid process. On 7/12/17, the Purchasing Director received E Quote pricing for installation of 14 additional card access doors. Cost to add card readers was $39, 400. On 7-12-17, the Purchasing Director sent an email to the Center Director stating a request for quote (RFQ) had to be sent due to the cost. On 8-15-17- an on-site visit was conducted by a DHHS Property and Construction Architect to assess possible solutions for lock additions to business occupancy areas. On 8-16-17- Center Director received a report from the DHHS Property and Construction Architect summarizing the North Carolina State Building Code Requirements for institutional and business occupancy areas. Recommendations given regarding how to address fire egress issues associated with fire exits in business occupancy areas. On 8-16-17, the Center Director forwarded a copy of the report to the Assistant Director, Neuromedical Treatment Centers and Deputy Secretary Facility Based Behavioral Health and Developmental Disability Services at the Division of State Operated Healthcare Facilities. 5-24-17- An email was sent from the Assistant Center Director to the Business Manager requesting information about extending the alarm programming for the fire exit (from which the resident eloped) from 6pm-6am to a 24 hour alarm. The Business Manager sent an email response to the Assistant Center Director	F 323		

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 08/18/2017

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 323	Continued From page 17	F 323		

regarding the reprogramming of the door alarms. It had been determined by the Business Manager that the alarm system was an old system, dating back to 1998. The Plant Operations staff did not have the knowledge to reprogram the alarms.
5-24-17- Event Review Committee (subcommittee of QI), reviewed the event and approved an action plan to address the elopement.
5-25-17- A meeting was held with the Business Manager, Plant Operations Director, Plant Operations Assistant Director, Police Chief, and IT Director to discuss reprogramming of alarms on exit doors. On 5-31-17, the Business Manager sent an email response to the Assistant Center Director regarding the reprogramming of the door alarms. It had been determined by the Business Manager that the alarm system was an old system, dating back to 1998. The Plant Operations staff did not have the knowledge to reprogram the alarms.
5-31-17- The Business Manager sent an email response to the Assistant Center Director recommending that access control be added to all doors. Per the Business Manager, the process to obtain approval/funding for the additional card access readers would be a sole source contract as addition of the new card readers would be added to the current card reader system (GALAXY). The Business Manager sent door lock project out for E Quote and pricing was obtained for installation of 14 card access readers for $39,400.
5-31-17- Director of Nursing (DON) conducted a Nurse Supervisor Meeting. DON provided instructions for staff to monitor doors at all times and be sure staff were pulling doors closed when entering and exiting units. (These expectations regarding door security were already in place.

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 08/18/2017

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 323	Continued From page 18 DON reminded the Nurse Supervisors to re-educate their staff members about the importance of securing doors.) The Nurse Supervisors submitted meeting minutes with signature rosters to the Director of Nursing. 6-5-17-Entrance magnetic door locks replaced on 4th Floor, 3rd Floor and 6th Floor (Resident Activity Area). 6-5-17- Center Director consulted with Elevator Contractor regarding feasibility of retrofitting elevators with a locking mechanism to control resident access. Due to age of elevators, and potential maintenance issues associated with the keying mechanisms, the elevator contractor did not recommend this as a viable option. 6-6-17- Door Lock replaced on 2nd Floor, and door locks on Alzheimer 1st Floor, Alzheimer 2nd Floor were checked. 6-7-17- A monitoring plan for resident unit door locks was developed and implemented. A monthly check of all unit door locks to verify proper alignment and functioning was added to the Plant Operations Preventative Maintenance Program. 6-8-17- Staff Development staff began a planning process to develop a video on Door Security/Elopement Prevention. Content was developed and videotaping was completed. 6-14-17- 5th Floor Nurse Manager conducted a staff meeting in which she provided instructions related to hall monitoring, staff monitoring of resident rooms, and dayroom staff monitoring. HCTs, LPNs, and RNs attended the meeting. 6-14-17- 7/20/17- Nurse Managers for the Alzheimer Unit, 2nd Floor, 3rd Floor, and 4th Floor conducted staff meetings to review door monitoring requirements. (The door monitoring requirements were not new. The instructions were a reminder to staff about the importance of	F 323		

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 08/18/2017

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 323	Continued From page 19 securing doors.) HCTs, LPNs and RNs attended the meeting 6-22-17- Director of Nursing communicated a policy change in an email to the Nurse Supervisors requiring that pulled staff who are not familiar with the residents on that unit, not be assigned as the Dayroom Monitor. In addition, staff who are assigned as Dayroom Monitors must position themselves close to the entrance door. The policy change was that staff who are pulled and do not know the residents on that unit are not assigned to be the dayroom monitor role. This policy change was discussed in the meetings the Nurse Managers had with their staff. 6-22-17- 1st version of the Door Security/Elopement Prevention video was submitted to Director of Nursing for review. 6-22-17- A walk-through was conducted by the Center Director, Assistant Center Director, Business Manager and Director of Standards Management to review the results of the facility assessment regarding the various locking arrangements in place at facility exits (e.g. maglocks, key locks, free access) 7-5-17- Email received from the Business Manager that the door lock project was sent out for E Quote. Per the email, depending on the cost, it could require additional purchasing/bid process. 7-12-17- Purchasing Director received E Quote pricing for installation of 14 additional card access doors. Cost to add card readers was $39, 400. 7-12-17- Purchasing Director sent an email to the Center Director stating a request for quote (RFQ) had to be sent due to the cost. 7-12-17- Center Director ' s office sent an email to all facility staff regarding a requirement to review a Door Security/Elopement Prevention Video that was posted to the LMS Training	F 323		

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 08/18/2017

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 323	Continued From page 20 System. All facility staff are to review the training by 8/31/17. The video was assigned through the Learning Management System, which generates an email to the employee when it is assigned. All facility staff have email. The Staff Development Department generates reports from the LMS system so we can track that training was completed. The target completion date for the training is August 31, 2017 and 344 out of 433 staff members have completed as of 8/9/17. 7-25-17- Director of Nursing issued a memo to all nursing staff about resident monitoring requirements. The memo was sent via email from the DON to the Nurse Supervisors. The Nurse Supervisors were to print it off and share with staff. Several units have already shared the information, and others are in process. Remainder of units will be sharing the information at their August 2017 staff meetings. 8-2-17- Center Director provided the Executive Team an update on the cost of the additional card access doors. 8-11-17- Every 30 minute monitoring of the fire exit (from where the resident eloped) was implemented by Longleaf Police/Security. 8-15-17- On site visit conducted by a DHHS Property and Construction Architect to assess possible solutions for lock additions to business occupancy areas. 8-16-17- Center Director received a report from the DHHS Property and Construction Architect summarizing the North Carolina State Building Code Requirements for institutional and business occupancy areas. Recommendations given regarding how to address fire egress issues associated with fire exits in business occupancy areas. 8-16-17- Center Director forwarded a copy of the report from DHHS Property and Construction	F 323		

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 08/18/2017

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 323	Continued From page 21 Architect to the Assistant Director, Neuromedical Treatment Centers and Deputy Secretary Facility Based Behavioral Health and Developmental Disability Services at the Division of State Operated Healthcare Facilities. The following corrective actions are being implemented on 8/18/17 to address the IJ citation: The Center Director sent an email to all facility staff on 8/18/17 addressing resident supervision requirements. Department Managers were instructed on 8/18/17 to review the email with their assigned staff and obtain the staff member ' s signature on a training roster, acknowledging receipt of the information. Starting 8/18/17, the Department Manager/Supervisor will be required to review the email with each of their assigned staff members when the staff member reports for duty. This educational process will continue each shift until all facility staff have confirmed receipt of the email with a target completion date of 8/31/17. Retraining of all facility staff on resident supervision, including resident elopement, was initiated on 8/18/17 and will continue until all staff are trained. The Director of Nursing implemented a plan for the Staff Development Nurses and Nurse Preceptors to provide training sessions on each shift beginning with the 3-11 shift on 8/18/17. As staff members report to work, they will attend the training session and sign the training roster acknowledging understanding of the training. Training content includes the importance of supervision of all resident to ensure safety and prevent accidents, the responsibilities of staff members if an accident is observed, and the requirements if a	F 323		

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 08/18/2017

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 323	Continued From page 22 resident wanders or elopes from the facility. Successful completion of a post- test will be required of all facility staff. Retraining will continue each shift until all facility staff are trained with a target completion date of 8/31/17. The Missing Resident Policy was reviewed/revised by the Director of Nursing to include the requirement that residents must remain in eyesight of the staff member if wandering / elopement is observed. A memo was sent by the Center Director on 8/18/17 describing the changes that are reflected in the policy. The policy will be forwarded to the QI Committee for approval at the next scheduled meeting on 8/23/17. As part of the validation process on 8/18/2017 at 9:00 PM, the credible correction was reviewed and verified including interviews with staff, record review of emails and policy revisions. Facility staff were able to describe the education received on resident elopement and how to respond to Code M. A review of the communication emails and the 30 minute monitoring of the fire exit doors was also completed.	F 323		