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 08/20/2016

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

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F 224 SS=J	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN CFR(s): 483.13(c) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility neglected to initiate emergency medical treatment for 1 of 1 residents, Resident # 1, who was found without a pulse and respirations. Neglect included nursing staff ' s lack of knowledge of the resident ' s code status, staff not immediately initiating cardiopulmonary resuscitation (CPR) and calling 911, and staff not knowing how to call a code when a resident required immediate medical treatment. Resident # 1 was pronounced dead in the facility. The Immediate Jeopardy (IJ) began on 6/19/16 for Resident #1 when the resident was found not breathing and without a pulse by staff in the resident ' s room and staff neglected to immediately initiate CPR and call 911 for the resident. Immediate jeopardy was identified on 8/19/16 at 4:57 PM. The immediate jeopardy was removed on 8/20/16 at 1:50 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not	F 224	Response for tag F224 The facility maintains that written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property were developed and implemented. The resident affected by the deficient practice has expired. Because all residents who are a full code are potentially affected by the deficient practice, an audit of the code status of all residents was conducted on 8/20/16 by the Director of Nursing, Assistant Director of Nursing and RN Supervisors. Code status was based on physician orders. Of the 197 residents who were at the facility, 120 were full codes. The DON implemented a process on 8/20/16 where each staff member is given a worksheet, which lists the code status of each resident, during shift report. The staff member retains the worksheet throughout the shift so there is immediate access to	9/13/16

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

Electronically Signed | 09/09/2016

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F 224	Continued From page 1 immediate jeopardy) to ensure monitoring of remedies put in place are effective. Findings included: A review of the facility's resident care policy, effective 7/1/2011, titled "Medical Emergencies" in part read: " All medical emergencies involving residents shall be responded to in a timely manner according to established procedures. All physicians, registered nurses, licensed practical nurses, and health care technicians are trained and competent in cardiopulmonary resuscitation (CPR), the Heimlich maneuver, and automated external defibrillator (AED) use. " Further review of the resident care policy revealed that in the event of a cardiac/respiratory arrest/life-threatening situation (Code Blue), the first staff member on the scene is to summon initial assistance by shouting " EMERGENCY " or pulling the call bell from the electrical socket for a continuous ring. The staff member deciding that immediate measures are needed will send a staff member to announce " CODE BLUE " and location three (3) times and call Emergency Medical Services (EMS) and tell the emergency situation, facility floor, room number, resident ' s name, age, and diagnosis, if known. Trained staff members are to initiate emergency first-aid measures and basic life support as indicated, including CPR (unless a Do Not Resuscitate (DNR)), AED, Heimlich Maneuver, and/or insert airway, start oxygen 4L/minute, suction, and perform venipuncture. Record review revealed Resident #1 was	F 224	code status. On 9/6/16, code status for all residents was rechecked, based on the physician orders, and the accuracy of the Code Status Worksheets was confirmed. The Unit Nurse Manager, where the Code Blue occurred, communicated expectations regarding timely response to medical emergencies with the unit nursing staff, in a staff meeting on 6/27/16. All other facility nursing staff were informed of the expectation for timely response to medical emergencies in meetings conducted by their Nurse Managers/Nurse Supervisors on 7/15/16, 7/26/16, 7/29/16, 7/30/16 and 8/10/16. Nurse #1, HCT #1, HCT #2, and House Supervisor #1, who were directly involved in the Code Blue event on 6/19/16, were retrained on response to medical emergencies on 7/27/16 by a Nurse Preceptor. Retraining included review of the facility□s Medical Emergency Policy (AM 11-15) which states the first person on the scene will remain with the resident, summon for help and initiate CPR if resident is not a DNR. Based on the surveyor findings on 8/19/16, the facility submitted a 24 hour report for alleged neglect to DHSR, Healthcare Personnel Investigations, and initiated an investigation on 8/19/16. Nurse #1, HCT #1, HCT #2, and House Supervisor #1 were placed on investigatory leave pending the outcome of the alleged neglect investigation. All RNs, LPNs and CNAs who are	

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F 224	Continued From page 2 admitted to the facility on 3/8/16 with a diagnosis history that included Alzheimer ' s disease, essential primary hypertension, and severe chronic obstructive pulmonary disease (COPD), specifically emphysema. Further review of Resident #1 ' s medical record revealed a physician order sheet, titled " Admission/Orders/New Admission " , was completed and signed by the facility ' s physician on 3/8/16 and indicated the resident did not have Advance Directives in place. A social worker admission note dated 3/16/16 at 11:09 AM stated that Resident # 1 had been admitted on 3/8/16 with a family member serving as Guardian of Person (GOP) and was considered a full code. The Resident Care Plan, dated 3/16/16, showed that Resident # 1 was care planned as a full code with no living will or treatment limitation. The most recent Minimum Data Set prior to Resident # 1 ' s death was dated 5/19/16 and showed that the resident was cognitively intact, exhibited behaviors of rejection of care and physical and verbal behavior towards others, was occasionally incontinent of urine, was receiving oxygen (O2) therapy, and required only supervision with activities of daily living (ADLs), except bathing which required extensive assistance. Review of a nursing note written by Nurse # 1, dated 6/19/16 at 2:30 PM, showed that, at approximately 1:10 PM, health care tech (HCT) # 1 informed Nurse # 1 that there was " something wrong " with Resident # 1. Upon assessing Resident # 1, Nurse # 1 found the resident unresponsive and palpated no pulse. The note	F 224	assigned to the unit where the Code Blue occurred, were retrained on emergency response procedures on 7/27/16 and 7/28/16 by the Nurse Preceptors. The training included a review of the Medical Emergency Policy (AM 11-15) and a power point presentation covering steps for initiating a code blue, review of the emergency paging instructions, AED demonstration and code status information. The training covered the requirement for the staff member who finds an unresponsive resident to remain with the resident, call for help and immediately start chest compressions if the resident is not a DNR. Nurse Preceptors and Staff Development Nurses initiated re-training of all facility RNs, LPNs and CNAs on Emergency Medical Response on 8/18/16 and training was completed on 8/26/16. Any staff member, who was on leave or a temporary employee who was not available for training will receive training by the Nurse Preceptors upon re-entry to work. New Employees will receive training on Emergency Medical Response in Healthcare Worker Orientation and will complete training prior to having a resident care assignment. Emergency Response Competency Validations were conducted by the Nurse Preceptors and Staff Development Nurses for all RNs, LPNs and CNAs starting 8/30/16. Nursing staff were required to demonstrate competency with overhead paging, code status, and how to respond to Code Blues. Staff also had to	

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F 224	Continued From page 3 stated that Nurse # 1 called for help and sent for Resident # 1 ' s chart to determine the resident ' s code status. Nurse # 1 then documented that she called the House Supervisor on duty and for staff to get the crash cart. The note also stated that Nurse # 1 auscultated Resident # 1 for heart rhythm and utilized the pulse oximeter and blood pressure with no reading. She reported that the resident ' s skin was cool to touch and CPR was initiated and automated external defibrillator (AED) was applied until emergency medical services (EMS) arrived. Nurse # 1 ' s note also indicated that staff from other units responded to the code and assisted with CPR. In an interview with Nurse # 1 at 2:30 PM on 8/18/16, she stated that Resident # 1 could communicate her needs and was fine on the morning of 6/19/16, but had chosen to stay in her room most of the day, which was not unusual. Nurse # 1 reported that Resident # 1 had been talking that morning and was up and down out of bed to go to the bathroom and was found on 6/19/16 right before lunch by HCT # 1 laying on her back on her bed. HCT # 1 reported to her that Resident # 1 did not " look right " and she went into the room to assess the resident. Nurse # 1 stated she found the resident on the bed with no pulse and no respirations noted. The resident ' s skin was warm in parts, but there were areas that were cooler than others like the feet and hands. Resident # 1 ' s color was the same, mouth was open, and eyes were closed. Nurse # 1 reported that she called for help to the House Supervisor while another staff member went to get the resident ' s chart to find out the code status and get a crash cart. She then stated that she initiated CPR and the AED was placed on the resident, but there was no heart rhythm present. Nurse # 1 stated that she made a mistake by leaving the	F 224	demonstrate proper hand placement for chest compressions and how to use an ambu-bag . Competency Validations were completed on 9/9/16. Any staff member who was on leave or temporary employees who were not available will complete the Emergency Response Competency Validation upon re-entry to work. As an additional measure, random audits were conducted on 8/8/16 and 8/9/16 by four external evaluators to verify staff members could verbalize correct responses for how to overhead page, how to respond if a resident was found unresponsive, how to immediately know a resident□s code status, how to correctly perform chest compressions and how to use an ambu-bag. Results of the audits were reviewed by the Director of Nursing on 9/9/16 and retraining was provided for staff members as needed. The same auditing process is also scheduled for 9/10/16. As on ongoing monitoring process, the DON implemented an audit process on 9/3/16 consisting of 6 daily audits on each shift by the Nursing House Supervisor. Staff member□s knowledge of emergency response is confirmed via staff interviews. Results of the audits are forwarded to the DON daily for review and corrective action as warranted. The auditing process was incorporated into the facility QAPI plan, with audit results reviewed monthly by the QI Committee x 6 months. A class on the Nurse□s role in a Code Blue was developed by the Nurse Preceptors and designated as required	

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F 224	Continued From page 4 room, not knowing the resident ' s code status, and not initiating CPR for Resident # 1. She reported that she should have stayed in the room and just called out for help, but she did not feel that Resident # 1 had any signs of life when she entered the room and that she should have initiated CPR, but she did not feel that would have prevented the resident ' s death. In a follow up interview with Nurse # 1 at 2:16 PM on 8/19/16, she stated she was CPR certified, but did not initiate chest compressions because she was unsure of the resident ' s code status because she did not write it down from the shift change meeting and could not remember. She reported that compressions were begun after the code was called and the crash cart arrived. Nurse # 1 reported there was a backboard and Ambu bag on the crash cart. In an interview with HCT # 1 on 8/19/16 at 1:27 PM, she stated that she cared for Resident # 1 on a regular basis and the resident was fine in the morning of 6/19/16 and before she went lunch. She reported when she got back from her lunch break, she went to the resident ' s room to get the resident ready for lunch and the resident did not respond when name was called and when she tapped the resident. HCT # 1 then stated that she checked her pulse and there was no pulse so she called another HCT (HCT # 2) into the room while she went to get the nurse. She reported that the nurse entered the room and checked for pulse, but the resident was not responding. Nurse # 1 went to get the chart and she and HCT # 2 stayed in the room. Nurse # 1 came back into the room and stated that the resident was a full code, but no one started chest compressions. Nurse # 1 left the room again to call a code, but there was a problem with the overhead paging system, so Nurse # 1 called the House Supervisor who was	F 224	training for all facility RNs and LPNs on 8/30/16. All RNs and LPNs completed the training by 9/7/16, with the exception of those on leave or temporary employees who were unavailable. Staff members on leave and temporary employees will receive the training upon re-entry to work. Competency Validations were conducted by the Nurse Preceptors, starting 9/8/16 to validate each nurse□s understanding of the class content. Competency validations will be completed by 9/12/16. Nurses who are on leave or unavailable for training will complete the training and competency validation process upon re-entry to work. Training and Competency Validation will be incorporated into Healthcare Worker Orientation for new nurses and will be provided by the Nurse Preceptors starting September 2016. The Staff Development Director will track completion of these requirements and provide a monthly report to the Director of Nursing (DON) of compliance. The DON will review the results and take corrective action as warranted. The report of training compliance will be reviewed monthly by the QI Committee beginning September 2016 x 6 months. CPR Competency Validations for all RNs, LPNs, CNAs were conducted by the BLS instructors beginning 8/30/16. Nursing staff were required to demonstrate knowledge of how to correctly perform CPR, including correct hand placement and correct application of an Ambu-bag. All Competency Validations were	

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F 224	Continued From page 5 able to call the code overhead. HCT # 1 stated she knew how to do CPR, but did not initiate CPR because she was waiting for direction from the nurse. There was a crash cart on the way to the room and other nurses responding to the code started to enter the room. HCT # 1 stated she was not in the room when chest compressions were initiated so she could not say how long it took for someone to start CPR on Resident # 1, but the incident started around 1:00 PM when she found the resident unresponsive. At 6:31 PM on 8/19/16, via telephone, HCT # 2 reported that HCT # 1 approached her and asked her to go to Resident # 1 ' s room to see if the resident was breathing. She stated she checked the resident ' s pulse and saw no chest rise and hollered for the nurse to come to the room. She recalled that the House Supervisor called the code and when she got to the unit, she told HCT # 2 to go get the crash cart. HCT # 2 said she went to get the crash cart and took it to the resident ' s room. On 8/19/16 at 3:42 PM, HCT #3 stated that Resident# 1 ' s behavior on 6/19/16 was normal. The resident stayed in bed that day. During lunch, he saw HCT # 1 go into Resident # 1 ' s room and looked out of the room to get HCT # 2 ' s attention. HCT # 3 reported that later he saw several people go into Resident # 1 ' s room and he was looking for Nurse #1, so he looked in the room for her and she told him to get the resident ' s chart and bring it to the room and that the House Supervisor was on the way down to the room. HCT # 3 stated that he was not sure who had called the code, but the resident was never left alone after she was found. He reported that he was CPR certified and that he was aware that residents ' code status was kept on the chart and on a list at the nurses ' station.	F 224	completed by 9/9/16 with the exception of employees on leave and temporary employees. Staff members who were unavailable for training will complete the CPR competency validation upon re-entry to work. A quality assurance process was implemented under the supervision of the Staff Development Director to evaluate that RNs, LPNs and CNAs initiate CPR immediately if the resident is not a DNR. Practice demonstrations will be utilized to assess CPR response. The practice demonstrations will be provided monthly x 3 months, beginning October 2016, then quarterly x one quarter. The results of the monitoring will be reviewed monthly by the DON, with immediate corrective action for any staff member who does not perform satisfactorily. The results of the monitoring will be reviewed monthly by the QI Committee x 6 months. To verify the facility□s CPR training processes, an audit of two CPR classes was conducted by an outside reviewer (BLS instructor) on 9/9/16. Results of the audit will be reviewed by the Director of Standards Management and Staff Development Director on 9/12/16 to determine if any improvements are required prior to the facility□s next scheduled CPR class. A quality assurance process was implemented under the supervision of the Director of Staff Development to include an audit of one CPR class for each BLS instructor quarterly to verify effectiveness of CPR training. Results of the audit will be compiled by the Director of Staff	

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F 224	Continued From page 6 Review of a nursing note by House Supervisor # 1, dated 6/19/16 at 4:00 PM revealed that House Supervisor # 1 arrived to the unit at approximately 1:15 PM and found Resident # 1 non-responsive with no heart rated noted per auscultation, no pulse palpitated, no reading on the pulse oximeter, and no blood pressure reading. House Supervisor # 1 ' s note then indicated that CPR was initiated, the AED was used and the code and EMS were called in addition to the on-call doctor. House Supervisor # 1 also documented that she attempted to start an intravenous (IV) line without success. EMS arrived at approximately 1:25 PM and took over the code by continuing CPR without success. It was noted that EMS contacted the doctor and medical examiner, time of death was pronounced at 1:32 PM. A follow up telephone order was received to pronounce expiration at 1:35 PM. In an interview with House Supervisor # 1 at 4:20 PM on 8/18/16, she stated that she was on another floor when Nurse # 1 called her and stated that something was wrong with Resident # 1 and she wasn ' t sure, but she thought the resident was " gone " . House Supervisor # 1 stated she called the code and left the 4th floor to go to the 1st floor to assess Resident # 1. She reported that when she arrived on the unit, Nurse # 1 was at the nurses ' station and she wondered why she was not in the room with the resident, but she didn ' t have time to ask because she was heading straight to the resident ' s room. House Supervisor # 1 reported that she told someone to get the crash cart while she was walking to the resident ' s room and once she entered the resident ' s room she found the resident lying on the bed on her back and other staff that had responded to the code had entered the room and immediately initiated CPR. She stated that while	F 224	Development and reported to the QI Committee quarterly x 12 months. Per facility policy (NM #1), all direct care nursing employees (e.g. HCTs, LPNs, RNs) are required to complete BLS training as part of New Employee Orientation and annually. The training covers the requirement for HCTs, RNs, and LPNs to initiate CPR if the resident is not a DNR, Call a Code Blue and call 911. A quality assurance process was implemented under the supervision of the Staff Development Director to verify completion of BLS by all required staff members. Completion of training will be verified by the Staff Development Director monthly with results reported to the Director of Nursing for immediate action if warranted. Training compliance will be reported to the QI Committee monthly x 12 months. A Code Blue Response Drill process was initiated under the supervision of the Director of Staff Development on 8/19/16 to evaluate staff response to emergencies. Drills were conducted on 8/19/16, 8/23/16, 8/29/16 and 9/8/16. A schedule for monthly Code Blue Response Drills will be implemented for August, September and October 2016 by the Director of Staff Development, with one drill occurring on each shift monthly. The DON and Staff Development Director will review the results following each drill to determine any additional training needs. Following completion of the October 2016 drills, a formal review of the	

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F 224	Continued From page 7 they were administering CPR, she called EMS. She also reported that she tried to start an IV, but was unsuccessful. EMS arrived and took over the CPR and put the resident on their machine, but the resident registered as a flat line. House Supervisor # 1 stated that Resident # 1 was non-responsive, with no respiration, no pulse, cold skin in some place, and skin coloration had begun to change when she entered the resident ' s room. She reported that she had been involved in several codes before and knew when there were no signs of life present and Resident # 1 did not look like there was life present when she entered the room. The House Supervisor stated that the HCT who found the resident should not have left the room, but should have yelled out for help and that Nurse # 1 should have known the resident ' s code status and initiated CPR. She felt that Nurse # 1 panicked as it was her first code and she did not appear to know what to do. House Supervisor # 1 stated that all nursing staff should know the resident ' s code status because it was given during report at shift change, it was located at the nurses ' station, there was a coded dot on the chart for the DNR residents, and there was a page in the front of each resident ' s chart indicating their advanced directives including their code status. She reported that Nurse # 1 had told her that she tried to call the code herself, but was unable to do so because she did not know how to work the overhead paging system. During a phone interview with House Supervisor # 1 at 4:03 PM on 8/19/16, she stated that she was on the 4th floor when Nurse # 1 called her and said she thought something was wrong with Resident # 1 and she thought the resident might be " gone. " House Supervisor # 1 stated that when she arrived on the 1st floor unit, Nurse # 1 was on the phone at the nursing station and she	F 224	drill process by the Staff Development Director and Director of Nursing will occur to determine if the drill process or drill frequency requires revision. Recommendations for any revisions to the drill process will be submitted and approved by the QI Committee. Results of the Code Blue Response drills will be reviewed by the QI Committee monthly x 12 months. A yellow colored sticker with Code Blue paging instructions was added to all telephones in resident care areas on 7/14/16. The process was expanded on 8/26/16 and stickers were added to all telephones in the facility. All Department Managers were instructed to educate their assigned staff members about overhead paging on 8/26/16. A competency validation process for overhead paging was initiated for all facility staff on 8/30/16 and was completed on 9/9/16. The competency validation consisted of each staff member acknowledging awareness of the purpose of the yellowed colored sticker located on the telephone and demonstrating how to correctly overhead page a code blue. Staff members who are on leave will receive training and a competency validation on overhead paging upon re-entry to work. An ongoing monitoring process was initiated, under the supervision of the Assistant Center Director, on 9/09/16 to confirm staff members can correctly overhead page in case of emergencies. Each Department Manager/designee will audit 2 of their assigned staff members weekly x	

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F 224	Continued From page 8 proceeded to the resident ' s room and found the resident supine in bed. House Supervisor # 1 reported that she asked the resident ' s code status while feeling for a pulse and told staff in the room to get the crash cart. Nurse # 1 entered the room and told the House Supervisor that she had tried to call a code, but was unable. House Supervisor # 1 stated that she then when out of the room and called the code and 911. Staff began responding from other units and asked if the resident was supposed to be given CPR. The House Supervisor informed them that Resident # 1 was supposed to be receiving CPR and the back board was placed under the resident and staff initiated CPR. She reported that she did not call the code prior to arrival on the unit and that no one was doing chest compressions when she arrived on the unit. House Supervisor # 1 informed that it was approximately 8 to 10 minutes from the time she received the call from Nurse # 1 until CPR was initiated. In a follow up phone interview with House Supervisor # 1 on 8/19/16 at 5:45 PM, she recalled that she called code blue and EMS before she left the 2nd floor in route to the resident ' s room on the 100 hall. She estimated that the time between receiving Nurse # 1 ' s call and the start of chest compressions (CPR) was approximately 8 to 10 minutes. In an interview with Nurse # 2 at 2:58 PM on 8/18/16, she stated that she was on the 5th floor on 06/19/16 when the code was called for a resident on the 1st floor. She reported that she and another nurse responded to the code, which took approximately 2 minutes, and there were multiple staff standing in Resident # 1 ' s room when they arrived, but no one was doing CPR on the resident. Nurse # 2 stated that the crash cart was in the resident ' s room when she arrived to	F 224	2 months, then 5 of their staff members monthly x 4 months starting 9/12/16. Department Managers/designee will confirm staff awareness of the yellow colored sticker and confirm the staff member can demonstrate how to overhead page. Immediate retraining will be provided by the Department Managers/designee for any identified deficiencies. Audit results will be submitted to the Assistant Center Director and reported monthly to the QI Committee x 6 months. To ensure RNs, LPNs and CNAs have immediate access to each resident□s code status, the Director of Nursing implemented a worksheet on 8/20/16. Staff members receive a worksheet with each resident□s code status during each shift report. The worksheet is retained by the staff member throughout the shift and shredded at the end of each shift. A quality assurance process was implemented under the direction of the DON, to validate that staff members are using the code status worksheets. 6 audits are conducted daily on each shift by the Nursing House Supervisor beginning 9/3/16 and continuing for six months. Staff members are required to confirm awareness of the code status worksheet process and confirm he/she has a worksheet on their person. Results of the audit are forwarded to the DON daily for review and corrective action as warranted. The auditing process was incorporated into the facility QAPI plan, with audit results reviewed monthly by the	

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F 224	Continued From page 9 the unit, but it was unopened. The nurse who came from the 5th floor with her asked if the resident was a Do Not Resuscitate (DNR) and Nurse # 2 reported that she initiated CPR once she found out the resident was a full code. She stated that they did put the AED on the resident, but there was no heart rhythm. She reported that at some point during CPR, Nurse # 1 did assist with chest compressions, but there had been no one doing CPR prior to her getting to the resident ' s room. She stated that she would have expected to see CPR being done when they entered the room and that nurses should have known the resident ' s code status because it is given at report for all residents on the unit and there are other places where the residents ' code statuses were located including a list at the nurses ' station and an orange dot on the residents ' charts who had a DNR in place. In a follow up interview with Nurse # 2, via telephone, on 8/19/16 at 5:50 PM, she reiterated that when she responded to the code and arrived in Resident# 1 ' s room there were no chest compressions being done. She stated that Nurse # 1 stated the resident was not a DNR, so the back board was placed under the resident and CPR was initiated. The House Supervisor was on the phone calling EMS and Nurse # 1 relieved her with the chest compressions while a nurse, who is no longer employed at the facility, was providing oxygen through the Ambu bag. In an interview with Nurse # 3 on 8/19/16 at 2:53 PM, she stated that she was working on the 2nd floor of the unit when she heard the code. She reported that she put her meds away to prepare to respond to the code when HCT # 2 came to the 2nd floor to retrieve the crash cart. HCT # 2 took the elevator back to the 1st floor while she	F 224	QI Committee x 6 months. An emergency cart was obtained for the unit where the Code Blue occurred on 8/18/16. An AED was purchased on 8/19/16 and added to the emergency cart. A facility wide review was conducted by the Center Director and Director of Nursing on 8/23/16 to assess if any additional areas, accessible by residents, could benefit from emergency equipment. To ensure quick access to emergency equipment, a requisition was completed to purchase three additional emergency carts and AEDs, to be placed in activity and dining areas outside of the resident units. Three AEDs were received on 9/1/16. Receipt of the emergency carts is pending with a projected delivery date, confirmed by the Business Manager, as 9/23/16. Emergency carts and AEDs are in place for all resident units as of 8/19/16 . The emergency cart and AED for the unit where the Code Blue occurred on 6/19/16, was added to an existing quality assurance process, under the direction of the Director of Nursing, which requires that AEDS are checked every shift to verify they are operational. Results of the emergency equipment auditing will be reviewed monthly by the QI Committee starting September 2016 x 6 months. The facility will continue to review all code blues to determine any opportunities for improvement. Effective 8/20/16, the Director of Standards Management will be immediately notified of all Code Blues. The Director of Standards	

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F 224	Continued From page 10 took the stairs and made it to the unit before the HCT did with the cart. Nurse # 3 reported that when she entered resident ' s room there was staff present, but no CPR was being done. Other nurses responding to the code entered the room and initiated CPR immediately upon entry. Nurse # 3 stated that if a resident was DNR they were listed at the nurses ' station, it was on their medication administration record (MAR), and there was a dot on the chart indicating DNR status. On 8/19/16 at 6:09 PM, Nurse # 4 reported that she heard the code called overhead and she and another nurse, who is no longer employed at the facility, responded and confirmed that the resident was a full code. The nurse from the 5th floor, Nurse # 2, did chest compressions and AED pads were put on Resident # 1. The House Supervisor entered and tried to start an IV, but could not get it started. EMS entered, confirmed full code status, and took over with the CPR. At 6:42 PM on 8/19/16, Nurse # 5 reported that she was on the 3rd floor with the House Supervisor when the House Supervisor received the call from Nurse # 1. She reported that House Supervisor # 1 immediately left the unit and she heard a code being called over the overhead system a few minutes later. Nurse # 5 stated that when she arrived on the unit, there was a whole group of staff in the room and Nurse # 2 was doing compressions. She reported that she went to get the IV pole. Nurse # 5 stated that she was never aware of a problem with the overhead system and that there was a dot that would be on the chart of residents who were a DNR and there was also a list of DNR resident on the report sheets and the DNR status of all resident on the unit should be specified during shift change.	F 224	Management/designee will review the Code Blue to confirm CPR was initiated for any resident who was not a DNR. If there is a delay in CPR, this will be referred to the Center Director and Director of Nursing and a 24 hour report for alleged neglect will be initiated. Results of the code blue reviews will be reviewed monthly by the QI Committee x 12 months. All facility employees will continue to attend Resident Rights Training during New Employee Orientation and annually. In the training, employees are informed of the requirement to report all allegations of abuse, neglect, and exploitation. A monitoring process was implemented under the supervision of the Staff Development Director, to confirm completion of Resident Rights Training by all employees and report compliance to the QI committee monthly, starting September 2016 x 12 months.	

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F 224	Continued From page 11 In an interview with the Standards Management Director at 5:15 PM on 8/18/16, she stated that Resident # 1 was found unresponsive in the resident ' s bedroom so it was recorded in the facility ' s incident report as are any incidents involving a code. She reported that the event was reviewed as a part of their patient safety review process and some opportunities for improvement were identified such as the procedure for calling a code, knowing residents ' code status, and having a crash cart readily available on the 1st floor of the unit. The facility initiated emergency response retraining for all staff on that unit, a requisition was completed for an additional crash cart to be placed on the unit for the 1st floor since the only crash cart for the unit was located on the 2nd floor, and they put stickers on each phone, on each unit in the facility, that gave step-by-step directions on how to use the overhead paging system used to call an emergency code. The Standards Management Director also stated that the facility had requested funding for additional training for all nursing staff regarding emergency response and codes as well as implementing a program where the facility would start holding mock code drills. In an interview with the Director of Nursing (DON) on 8/18/16 at 7:57 PM, he stated that all nursing staff was responsible for knowing resident code status and any staff who was trained should initiate CPR. He reported that the facility had implemented sheets of all residents for staff to use to keep on them with their code status and other pertinent information for the duration of their shift and to be shredded at the end of each shift. The DON stated that it was his expectation that staff should not leave the room of an unresponsive resident, they should call out and	F 224		

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F 224	Continued From page 12	F 224		

initiate CPR, if they are trained, and the resident is a full code.

In an interview with the Standards Management Director on 8/19/16 at 2:02 PM, she stated there were orange sticker on the name label on each chart of resident with a DNR status and staff were trained regarding this sticker during orientation. In addition, during every shift report staff was to tell what residents were DNR. The Standards Management Director confirmed Resident #1 ' s medical record was correctly designated the resident as being a full code, but nursing staff did not initiate CPR to Resident #1 on 06/19/16. Facility administration decided all staff should have been re-educated, so they had a meeting on 6/22/16 and again on 8/19/16 to address action items. They started re-education of entire facility staff on night shift on 8/18/16 and asked staff what the orange sticker on the charts meant and asked them to explain how the overhead paging system worked. They also asked staff what they would do if they found a resident unresponsive. . There was also a mock code drill done on 8/19/16 in the AM.

On 8/20/16 at 08:20 AM, the DON reported that he felt the nurse (Nurse # 1) panicked and the HCT (HCT # 1) was unsure if she should give CPR and wanted the nurse to verify the resident ' s status before she did anything. Nurse # 1 ran out of the room to call the House Supervisor and was unsure if the overhead paging system was working. He stated that nurses need to know the code status of their residents and there were measures in place for them to know because it had been addressed months prior. The code status was relayed during shift report, there was a dot on the chart for residents with DNR, and a list

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F 224	Continued From page 13	F 224		

of DNRs was kept at the nursing station. He reported that the overhead paging system had changed at the end of April and it was discussed in a supervisors ' meeting and an email was sent out alerting staff of the change. The DON stated that the code status for Resident # 1 as a full code should have been known by staff and CPR should have been initiated immediately upon finding the resident without a pulse and respirations, but he did not feel the location of the crash cart on the 2nd floor of the unit contributed to the resident expiring.

The Center Director was notified of the immediate jeopardy at 4:57 PM on 8/19/16.
The facility presented a credible allegation on 8/20/16 at 1:39 PM. The credible allegation read:

The main resident cited in this Immediate Jeopardy citation has expired. A review of code status for all residents at the facility was completed on 8/20/16 by the Director of Nursing, Assistant Director of Nursing and RN Supervisors. Code status was based on physician orders. Of the 197 residents who are currently at the facility, 120 are full codes and could be at risk for the same deficient practice The resident who expired had a history of emphysema. The resident was found unresponsive in her bedroom on 6/19/16. There was a delay in calling a Code Blue and a delay in initiating CPR. The resident expired. Four staff members were directly involved in the situation which included two HCTs and two RNs. A Nurse Preceptor completed retraining of the four staff members, on response to medical emergencies, on 7/27/16. Retraining included review of the facility ' s Medical Emergency Policy (AM 11-15) which states the first person on the scene will

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F 224	Continued From page 14	F 224		

summon for help and initiate CPR if resident is not a DNR. The death was reported to the state on 6/20/16.
The following corrective actions were implemented:
A 24 hour report for alleged neglect was submitted to DHSR, Healthcare Personnel Investigations, on 8/19/16. As a plan of protection, the four staff members involved will be placed on investigatory placement with pay, pending an investigation. According to the work schedule, all four staff members are currently scheduled off and will be placed on investigatory placement with pay when they return to duty. One HCT and two RNs will be placed on investigatory leave on 8/22/16 and one HCT will be placed on investigatory leave on 8/23/16. None of the four staff members will have contact with the residents prior to placement on investigatory leave.
A review of the Code Blue was initiated on 6/22/16. The review was conducted by the Director of Standards Management, in conjunction with the Assistant Director of Nursing. The event was discussed in the facility ' s Event Review Committee on 6/22/16. The Event Review Committee is an extension of the facility ' s Quality Improvement Committee. Based on the event analysis, an action plan was developed and forwarded to the Center Director and Director of Nursing. On 8/19/16, the Event Review Committee reviewed the action items and recommended additional items to improve resident care, which included enhanced monitoring processes to validate staff competency.
All staff members on the Alzheimer Unit, where the Code Blue occurred, were retrained on emergency response on 7/27/16 and 7/28/16 by

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F 224	Continued From page 15	F 224		

the Nurse Preceptors. The training included a review of the Medical Emergency Policy (AM 11-15) and a power point presentation covering steps for initiating a code blue, review of the emergency paging instructions, AED demonstration and code status information. The training covered the requirement for the staff member who finds an unresponsive resident to remain with the resident, call for help and immediately start chest compressions if the resident is not a DNR.
Retraining of all facility Nursing Staff by the Nurse Preceptors and Staff Development Nurses, on Emergency Medical Response was initiated on 8/18/16 and continued through 8/19/16. The training included a review of the Medical Emergency Policy (AM 11-15) and a power point presentation covering steps for initiating a code blue, review of the emergency paging instructions, AED demonstration and code status information. The training covered the requirement for the staff member who finds an unresponsive resident to remain with the resident, call for help and immediately start chest compressions if the resident is not a DNR. 210 staff members were trained on 8/18/16, 8/19/16 and 8/20/16. Retraining will continue each shift until all nursing staff are trained, with a target completion date of 8/31/16. .Any staff not trained will be trained before working on the hall again.
New Employees will receive training in New Employee Orientation and will complete training prior to having a resident care assignment.
Per facility policy (NM #1), all direct care nursing employees (e.g. HCTs, LPNs, RNs) are required to complete BLS training as part of New Employee Orientation and annually. As part of the training, HCTs, RNs, and LPNs are required to initiate CPR if the resident is not a DNR and

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F 224	Continued From page 16	F 224		

call 911. The Staff Development Director/designee tracks employee completion of required training and provides each Department Manager with a report of compliance.
Department Managers are responsible for ensuring their assigned employees complete BLS as required by facility policy.
Mock Code Drills were identified as an enhanced training opportunity for staff on 6/22/16. Planning was initiated and a Mock Code Blue drill was conducted on 8/19/16. A schedule for monthly mock Code Blue drills on each shift, was finalized on 8/19/16. Mock Code Blue drills will be conducted monthly, starting August 2016 on each shift to evaluate staff ' s response to emergencies.
An emergency cart was obtained for Alzheimer 1st floor on 8/18/16. An AED was purchased on 8/19/16 and added to the emergency cart on Alzheimer 1st floor. The emergency cart for 1st floor Alzheimer was added to an existing quality assurance process, under the direction of the Director of Nursing, which requires that AEDs are checked every shift to verify they are operational.
A sticker with Code Blue paging instructions were added to all telephones in resident care areas on 7/14/16. Audits were conducted on 8/18/16 and 8/19/16 to validate nursing staff members (e.g. RNs, LPNS, and HCTs) had knowledge of the paging instructions posted on the telephones and how to call a Code Blue. 174 employees were audited and all employees were able to respond affirmatively.
The facility implemented a process in May 2015 in which code status is reviewed at each shift report and DNR status is noted on the resident ' s medical record, via an orange dot. The orange dot is used to identify residents who are DNR. When a physician order is written for DNR, the

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F 224	Continued From page 17 orange dot is placed on the name label of the medical record. Physician orders for full code and DNR are reviewed by the nurse. To enhance staff awareness of each resident ' s code status, the Director of Nursing implemented a worksheet on 8/19/16 to be used by staff members during each shift. During shift report, code status will be verified and written on the worksheet for quick access throughout the shift. The worksheets will be shredded at the end of each shift. Debriefing of the Code Blue event with the Alzheimer Unit nursing staff was conducted by the Director of Nursing on 7/20/16 and 8/9/16 to review the event and review expectations for emergency response for any future Code Blues. The Alzheimer Unit Nurse Manager communicated expectations regarding timely response to medical emergencies with the Alzheimer nursing staff, in a staff meeting on 6/27/16. All other facility nursing staff were informed on the expectation for timely response to medical emergencies in a meetings conducted by their Nurse Managers/Nurse Supervisors on 7/15/16, 7/26/16, 7/29/16, 7/30/16 and 8/10/16. On 8/20/16 at 1:50 PM, the credible allegation was validated. Staff interviews with HCTs and licensed nurses revealed the facility implemented corrective measures, including in-servicing of nursing staff regarding knowing residents ' code statuses and where to find the code statuses, the proper procedure and protocol for calling a Code Blue, and how to respond when a resident is found unresponsive.	F 224		
F 309 SS=J	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must	F 309		9/13/16

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F 309	Continued From page 18 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, record review, and staff interviews, the facility failed to immediately initiate cardiopulmonary resuscitation (CPR) and call Emergency Medical Services (EMS) for 1 of 1 resident, Resident # 1, found without a pulse or respirations. Resident # 1 was pronounced dead in the facility. Findings included: The immediate jeopardy began on 6/19/16 when Resident # 1 was found lying on the bed, without pulse or respirations, and facility staff did not immediately initiate CPR and contact EMS. Immediate jeopardy was identified on 8/19/16 at 4:57 PM. A credible allegation was presented by the facility and was accepted on 8/20/16 at 1:39 PM. The immediate jeopardy was lifted on 8/20/16 at 1:50 PM. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of remedies put in place are effective. Findings included: A review of the facility's resident care policy, effective 7/1/2011, titled "Medical Emergencies" in part read: " All medical emergencies involving residents shall be responded to in a timely manner according to established procedures. All	F 309	Response for Tag F309 The facility maintains that all residents are provided 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. The resident affected by the deficient practice has expired. Because all residents who are a full code are potentially affected by the deficient practice, an audit of the code status of all residents was conducted on 8/20/16 by the Director of Nursing, Assistant Director of Nursing and RN Supervisors. Code status was based on physician orders. Of the 197 residents who were at the facility, 120 were full codes. The DON implemented a process on 8/20/16 where each staff member is given a worksheet, which lists the code status of each resident, during shift report. The staff member retains the worksheet throughout the shift so there is immediate access to code status. On 9/6/16, code status for all residents was rechecked, based on the	

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F 309	Continued From page 19 physicians, registered nurses, licensed practical nurses, and health care technicians are trained and competent in cardiopulmonary resuscitation (CPR), the Heimlich maneuver, and automated external defibrillator (AED) use. " Further review of the resident care policy revealed that the facility provides on-site Basic Life Support (BLS) which includes CPR, the Heimlich maneuver, and AED. The facility does not provide Advanced Cardiac Life Support. Review of the history and physical (H&P), completed by the facility ' s physician and dated 3/8/16, revealed Resident # 1 was admitted with a diagnosis history that included shortness of breath with ambulation, chest pains, and wheezing. A Physician order sheet, titled " Admission/Orders/New Admission " , completed and signed by the facility ' s physician on 3/8/16, indicated that Resident # 1 had no Advance Directives in place. A social worker admission note, dated 3/16/16 at 11:09 AM, stated that Resident # 1 had been admitted on 3/8/16 with a family member serving as Guardian of Person (GOP) and was considered a full code. The Resident Care Plan, dated 3/16/16, showed that Resident # 1 was care planned as a full code with no living will or treatment limitation. The most recent Minimum Data Set prior to Resident # 1 ' s death was dated 5/19/16 and showed that the resident was cognitively intact, exhibited behaviors of rejection of care and physical and verbal behavior towards others, was occasionally incontinent of urine, was receiving oxygen (O2) therapy, and required only supervision with activities of daily living (ADLs), except bathing which required extensive	F 309	physician orders, and the accuracy of the Code Status Worksheets was confirmed. The Unit Nurse Manager, where the Code Blue occurred, communicated expectations regarding timely response to medical emergencies with the unit nursing staff, in a staff meeting on 6/27/16. All other facility nursing staff were informed of the expectation for timely response to medical emergencies in meetings conducted by their Nurse Managers/Nurse Supervisors on 7/15/16, 7/26/16, 7/29/16, 7/30/16 and 8/10/16. Nurse #1, HCT #1, HCT #2, and House Supervisor #1, who were directly involved in the Code Blue event on 6/19/16, were retrained on response to medical emergencies on 7/27/16 by a Nurse Preceptor. Retraining included review of the facility□s Medical Emergency Policy (AM 11-15) which states the first person on the scene will remain with the resident, summon for help and initiate CPR if resident is not a DNR. Based on the surveyor findings on 8/19/16, the facility submitted a 24 hour report for alleged neglect to DHSR, Healthcare Personnel Investigations, and initiated an investigation on 8/19/16. Nurse #1, HCT #1, HCT #2, and House Supervisor #1 were placed on investigatory leave pending the outcome of the alleged neglect investigation. All RNs, LPNs and CNAs who are assigned to the unit where the Code Blue occurred, were retrained on emergency	

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F 309	Continued From page 20 assistance. Review of the facility ' s incident/accident log from June 2016 showed that a code was called for Resident # 1 and the resident expired in the facility on 6/19/16. In a nurse ' s note, dated 6/19/16 at 2:30 PM, Nurse # 1 wrote that at approximately 1:10 PM, health care tech (HCT) # 1 informed Nurse # 1 that there was " something wrong " with Resident # 1. Upon assessing Resident # 1, Nurse # 1 found the resident unresponsive and palpated no pulse. The note stated that Nurse # 1 called for help and sent for Resident # 1 ' s chart to determine the resident ' s code status. Nurse # 1 then documented that she called the House Supervisor on duty and for staff to get the crash cart. The note also stated that Nurse # 1 auscultated Resident # 1 for heart rhythm and utilized the pulse oximeter and blood pressure with no reading. She reported that the resident ' s skin was cool to touch and CPR was initiated and automated external defibrillator (AED) was applied until emergency medical services (EMS) arrived. Nurse # 1 ' s note also indicated that staff from other units responded to the code and assisted with CPR. In an interview with Nurse # 1 at 2:30 PM on 8/18/16, she stated that Resident # 1 could communicate her needs and would often refuse care and treatment. She reported that the resident was fine on the morning of 6/19/16 and had chosen to stay in her room most of the day, which was not unusual. Nurse # 1 reported that Resident # 1 had been talking that morning and was up and down out of bed to go to the bathroom and was found right before lunch by HCT # 1 laying on her back on her bed. HCT # 1 reported to her that Resident # 1 did not " look right " and she went into the room to assess the	F 309	response procedures on 7/27/16 and 7/28/16 by the Nurse Preceptors. The training included a review of the Medical Emergency Policy (AM 11-15) and a power point presentation covering steps for initiating a code blue, review of the emergency paging instructions, AED demonstration and code status information. The training covered the requirement for the staff member who finds an unresponsive resident to remain with the resident, call for help and immediately start chest compressions if the resident is not a DNR. Nurse Preceptors and Staff Development Nurses initiated re-training of all facility RNs, LPNs and CNAs on Emergency Medical Response on 8/18/16 and training was completed on 8/26/16. Any staff member, who was on leave or a temporary employee who was not available for training will receive training by the Nurse Preceptors upon re-entry to work. New Employees will receive training on Emergency Medical Response in Healthcare Worker Orientation and will complete training prior to having a resident care assignment. Emergency Response Competency Validations were conducted by the Nurse Preceptors and Staff Development Nurses for all RNs, LPNs and CNAs starting 8/30/16. Nursing staff were required to demonstrate competency with overhead paging, code status, and how to respond to Code Blues. Staff also had to demonstrate proper hand placement for chest compressions and how to use an	

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F 309	Continued From page 21 resident. Nurse # 1 stated she found the resident on the bed with no pulse and no respirations noted. The resident ' s skin was warm in parts, but there were areas that were cooler than others like the feet and hands. Resident # 1 ' s color was the same, mouth was open, and eyes were closed. Nurse # 1 reported that she called for help to the House Supervisor while another staff member went to get the resident ' s chart to find out the code status and get a crash cart. She then stated that she initiated CPR and the AED was placed on the resident, but there was no heart rhythm present. Nurse # 1 stated that she made a mistake by leaving the room, not knowing the resident ' s code status, and not initiating CPR for Resident # 1. She reported that she should have stayed in the room and just called out for help, but she did not feel that Resident # 1 had any signs of life when she entered the room and that she should have initiated CPR, but she did not feel that would have prevented the resident ' s death. In a follow up interview with Nurse # 1 at 2:16 PM on 8/19/16, she stated she was CPR certified, but did not initiate chest compressions because she was unsure of the resident ' s code status because she did not write it down from the shift change meeting and could not remember. She reported that compressions were begun after the code was called and the crash cart arrived. Nurse # 1 reported there was a backboard and Ambu bag on the crash cart. In an interview with HCT # 1 on 8/19/16 at 1:27 PM, she stated that she cared for Resident # 1 on a regular basis and the resident was fine in the morning of 6/19/16 and before she went lunch. She reported when she got back from her lunch break, she went to the resident ' s room to get the resident ready for lunch and the resident did not	F 309	ambu-bag . Competency Validations were completed on 9/9/16. Any staff member who was on leave or temporary employees who were not available will complete the Emergency Response Competency Validation upon re-entry to work. As an additional measure, random audits were conducted on 8/8/16 and 8/9/16 by four external evaluators to verify staff members could verbalize correct responses for how to overhead page, how to respond if a resident was found unresponsive, how to immediately know a resident□s code status, how to correctly perform chest compressions and how to use an ambu-bag. Results of the audits were reviewed by the Director of Nursing on 9/9/16 and retraining was provided for staff members as needed. The same auditing process is also scheduled for 9/10/16. As on ongoing monitoring process, the DON implemented an audit process on 9/3/16 consisting of 6 daily audits on each shift by the Nursing House Supervisor. Staff member□s knowledge of emergency response is confirmed via staff interviews. Results of the audits are forwarded to the DON daily for review and corrective action as warranted. The auditing process was incorporated into the facility QAPI plan, with audit results reviewed monthly by the QI Committee x 6 months. A class on the Nurse□s role in a Code Blue was developed by the Nurse Preceptors and designated as required training for all facility RNs and LPNs on 8/30/16. All RNs and LPNs completed	

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F 309	Continued From page 22 respond when name was called and when she tapped the resident. HCT # 1 then stated that she checked her pulse and there was no pulse so she called another HCT (HCT # 2) into the room while she went to get the nurse. She reported that the nurse entered the room and checked for pulse, but the resident was not responding. Nurse # 1 went to get the chart and she and HCT # 2 stayed in the room. Nurse # 1 came back into the room and stated that the resident was a full code, but no one started chest compressions. Nurse # 1 left the room again to call a code, but there was a problem with the overhead paging system, so Nurse # 1 called the House Supervisor who was able to call the code overhead. HCT # 1 stated she knew how to do CPR, but did not initiate CPR because she was waiting for direction from the nurse. There was a crash cart on the way to the room and other nurses responding to the code started to enter the room. HCT # 1 stated she was not in the room when chest compression were initiated so she could not say how long it took for someone to start CPR on Resident # 1, but the incident started around 1:00 PM when she found the resident unresponsive. At 6:31 PM on 8/19/16, via telephone, HCT # 2 reported that HCT # 1 approached her and asked her to go to Resident # 1 ' s room to see if the resident was breathing. She stated she checked the resident ' s pulse and saw no chest rise and hollered for the nurse to come to the room. She recalled that the House Supervisor called the code and when she got to the unit, she told HCT # 2 to go get the crash cart. HCT # 2 said she went to get the crash cart and took it to the resident ' s room. On 8/19/16 at 3:42 PM, HCT #3 stated that Resident# 1 ' s behavior on 6/19/16 was normal. The resident stayed in bed that day and would	F 309	the training by 9/7/16, with the exception of those on leave or temporary employees who were unavailable. Staff members on leave and temporary employees will receive the training upon re-entry to work. Competency Validations were conducted by the Nurse Preceptors, starting 9/8/16 to validate each nurse□s understanding of the class content. Competency validations will be completed by 9/12/16. Nurses who are on leave or unavailable for training will complete the training and competency validation process upon re-entry to work. Training and Competency Validation will be incorporated into Healthcare Worker Orientation for new nurses and will be provided by the Nurse Preceptors starting September 2016. The Staff Development Director will track completion of these requirements and provide a monthly report to the Director of Nursing (DON) of compliance. The DON will review the results and take corrective action as warranted. The report of training compliance will be reviewed monthly by the QI Committee beginning September 2016 x 6 months. CPR Competency Validations for all RNs, LPNs, CNAs were conducted by the BLS instructors beginning 8/30/16. Nursing staff were required to demonstrate knowledge of how to correctly perform CPR, including correct hand placement and correct application of an Ambu-bag. All Competency Validations were completed by 9/9/16 with the exception of employees on leave and temporary	

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F 309	Continued From page 23 refuse meals at times. During lunch, he saw HCT # 1 go into Resident # 1 ' s room and looked out of the room to get HCT # 2 ' s attention. HCT # 3 reported that later he saw several people go into Resident # 1 ' s room and he was looking for Nurse #1, so he looked in the room for her and she told him to get the resident ' s chart and bring it to the room and that the House Supervisor was on the way down to the room. HCT # 3 stated that he was not sure who had called the code, but the resident was never left alone after she was found. He reported that he was CPR certified and that he was aware that residents ' code status was kept on the chart and on a list at the nurse ' s station. In a nursing note by House Supervisor # 1, dated 6/19/16 at 4:00 PM, House Supervisor # 1 revealed that she arrived to the unit at approximately 1:15 PM and found Resident # 1 non-responsive with no heart rated noted per auscultation, no pulse palpitated, no reading on the pulse oximeter, and no blood pressure reading. House Supervisor # 1 ' s note then indicated that CPR was initiated, the AED was used and the code and EMS were called in addition to the on-call doctor. House Supervisor # 1 also documented that she attempted to start an intravenous (IV) line without success. EMS arrived at approximately 1:25 PM and took over the code by continuing CPR without success. It was noted that EMS contacted the doctor and medical examiner, time of death was pronounced at 1:32 PM and received permission to move the body was received at 1:55 PM. A follow up telephone order was received to pronounce expiration at 1:35 PM. In an interview with House Supervisor # 1 at 4:20 PM on 8/18/16, she stated that she was on another floor when Nurse # 1 called her and	F 309	employees. Staff members who were unavailable for training will complete the CPR competency validation upon re-entry to work. A quality assurance process was implemented under the supervision of the Staff Development Director to evaluate that RNs, LPNs and CNAs initiate CPR immediately if the resident is not a DNR. Practice demonstrations will be utilized to assess CPR response. The practice demonstrations will be provided monthly x 3 months, beginning October 2016, then quarterly x one quarter. The results of the monitoring will be reviewed monthly by the DON, with immediate corrective action for any staff member who does not perform satisfactorily. The results of the monitoring will be reviewed monthly by the QI Committee x 6 months. To verify the facility□s CPR training processes, an audit of two CPR classes was conducted by an outside reviewer (BLS instructor) on 9/9/16. Results of the audit will be reviewed by the Director of Standards Management and Staff Development Director on 9/12/16 to determine if any improvements are required prior to the facility□s next scheduled CPR class. A quality assurance process was implemented under the supervision of the Director of Staff Development to include an audit of one CPR class for each BLS instructor quarterly to verify effectiveness of CPR training. Results of the audit will be compiled by the Director of Staff Development and reported to the QI Committee quarterly x 12 months.	

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F 309	Continued From page 24 stated that something was wrong with Resident # 1 and she wasn ' t sure, but she thought the resident was " gone " . House Supervisor # 1 stated she called the code and left the 4th floor to go to the 1st floor to assess Resident # 1. She reported that when she arrived on the unit, Nurse # 1 was at the nurses ' station and she wondered why she was not in the room with the resident, but she didn ' t have time to ask because she was heading straight to the resident ' s room. House Supervisor # 1 reported that she told someone to get the crash cart while she was walking to the resident ' s room and once she entered the resident ' s room she found the resident lying on the bed on her back and other staff that had responded to the code had entered the room and immediately initiated CPR. She stated that while they were administering CPR, she called EMS. She also reported that she tried to start an IV, but was unsuccessful. EMS arrived and took over the CPR and put the resident on their machine, but the resident registered as a flat line. House Supervisor # 1 stated that Resident # 1 was non-responsive, with no respiration, no pulse, cold skin in some place, and skin coloration had begun to change when she entered the resident ' s room. She reported that she had been involved in several codes before and knew when there were no signs of life present and Resident # 1 did not look like there was life present when she entered the room. The House Supervisor stated that the HCT who found the resident should not have left the room, but should have yelled out for help and that Nurse # 1 should have known the resident ' s code status and initiated CPR. She felt that Nurse # 1 panicked as it was her first code and she did not appear to know what to do. House Supervisor # 1 stated that all nursing staff should know the resident ' s code status because	F 309	Per facility policy (NM #1), all direct care nursing employees (e.g. HCTs, LPNs, RNs) are required to complete BLS training as part of New Employee Orientation and annually. The training covers the requirement for HCTs, RNs, and LPNs to initiate CPR if the resident is not a DNR, Call a Code Blue and call 911. A quality assurance process was implemented under the supervision of the Staff Development Director to verify completion of BLS by all required staff members. Completion of training will be verified by the Staff Development Director monthly with results reported to the Director of Nursing for immediate action if warranted. Training compliance will be reported to the QI Committee monthly x 12 months. A Code Blue Response Drill process was initiated under the supervision of the Director of Staff Development on 8/19/16 to evaluate staff response to emergencies. Drills were conducted on 8/19/16, 8/23/16, 8/29/16 and 9/8/16. A schedule for monthly Code Blue Response Drills will be implemented for August, September and October 2016 by the Director of Staff Development, with one drill occurring on each shift monthly. The DON and Staff Development Director will review the results following each drill to determine any additional training needs. Following completion of the October 2016 drills, a formal review of the drill process by the Staff Development Director and Director of Nursing will occur	

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F 309	Continued From page 25 it was given during report at shift change, it was located at the nurses ' station, there was a coded dot on the chart for the DNR residents, and there was a page in the front of each resident ' s chart indicating their advanced directives including their code status. She reported that Nurse # 1 had told her that she tried to call the code herself, but was unable to do so because she did not know how to work the overhead paging system. During a phone interview with House Supervisor # 1 at 4:03 PM on 8/19/16, she stated that she was on the 4th floor when Nurse # 1 called her and said she thought something was wrong with Resident # 1 and she thought the resident might be " gone. " House Supervisor # 1 stated that when she arrived on the 1st floor unit, Nurse # 1 was on the phone at the nursing station and she proceeded to the resident ' s room and found the resident supine in bed. House Supervisor # 1 reported that she asked the resident ' s code status while feeling for a pulse and told staff in the room to get the crash cart. Nurse # 1 entered the room and told the House Supervisor that she had tried to call a code, but was unable. House Supervisor # 1 stated that she then when out of the room and called the code and 911. Staff began responding from other units and asked if the resident was supposed to be given CPR. The House Supervisor informed them that Resident # 1 was supposed to be receiving CPR and the back board was placed under the resident and staff initiated CPR. She reported that she did not call the code prior to arrival on the unit and that no one was doing chest compressions when she arrived on the unit. House Supervisor # 1 informed that it was approximately 8 to 10 minutes from the time she received the call from Nurse # 1 until CPR was initiated. In a follow up phone interview with House	F 309	to determine if the drill process or drill frequency requires revision. Recommendations for any revisions to the drill process will be submitted and approved by the QI Committee. Results of the Code Blue Response drills will be reviewed by the QI Committee monthly x 12 months. A yellow colored sticker with Code Blue paging instructions was added to all telephones in resident care areas on 7/14/16. The process was expanded on 8/26/16 and stickers were added to all telephones in the facility. All Department Managers were instructed to educate their assigned staff members about overhead paging on 8/26/16. A competency validation process for overhead paging was initiated for all facility staff on 8/30/16 and was completed on 9/9/16. The competency validation consisted of each staff member acknowledging awareness of the purpose of the yellowed colored sticker located on the telephone and demonstrating how to correctly overhead page a code blue. Staff members who are on leave will receive training and a competency validation on overhead paging upon re-entry to work. An ongoing monitoring process was initiated, under the supervision of the Assistant Center Director, on 9/09/16 to confirm staff members can correctly overhead page in case of emergencies. Each Department Manager/designee will audit 2 of their assigned staff members weekly x 2 months, then 5 of their staff members monthly x 4 months starting 9/12/16.	

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F 309	Continued From page 26 Supervisor # 1 on 8/19/16 at 5:45 PM, she recalled that she called code blue and EMS before she left the 2nd floor in route to the resident ' s room on the 100 hall. She estimated that the time between receiving Nurse # 1 ' s call and the start of chest compressions (CPR) was approximately 8 to 10 minutes. In an interview with Nurse # 2 at 2:58 PM on 8/18/16, she stated that she was on the 5th floor and the code was called for a resident on the 1st floor. She reported that she and another nurse responded to the code, which took approximately 2 minutes, and there were multiple staff standing in Resident # 1 ' s room when they arrived, but no one was doing CPR on the resident. Nurse # 2 stated that the crash cart was in the resident ' s room when she arrived to the unit, but it was unopened. The nurse who came from the 5th floor with her asked if the resident was a Do Not Resuscitate (DNR) and Nurse # 2 reported that she initiated CPR once she found out the resident was a full code. She stated that they did put the AED on the resident, but there was no heart rhythm. She reported that at some point during CPR, Nurse # 1 did assist with chest compressions, but there had been no one doing CPR prior to her getting to the resident ' s room. She stated that she would have expected to see CPR being done when they entered the room and that nurses should have known the resident ' s code status because it is given at report for all residents on the unit and there are other places where the residents ' code statuses were located including a list at the nurses ' station and an orange dot on the residents ' charts who had a DNR in place. In a follow up interview with Nurse # 2, via telephone, on 8/19/16 at 5:50 PM, she reiterated that when she responded to the code and arrived	F 309	Department Managers/designee will confirm staff awareness of the yellow colored sticker and confirm the staff member can demonstrate how to overhead page. Immediate retraining will be provided by the Department Managers/designee for any identified deficiencies. Audit results will be submitted to the Assistant Center Director and reported monthly to the QI Committee x 6 months. To ensure RNs, LPNs and CNAs have immediate access to each resident□s code status, the Director of Nursing implemented a worksheet on 8/20/16. Staff members receive a worksheet with each resident□s code status during each shift report. The worksheet is retained by the staff member throughout the shift and shredded at the end of each shift. A quality assurance process was implemented under the direction of the DON, to validate that staff members are using the code status worksheets. 6 audits are conducted daily on each shift by the Nursing House Supervisor beginning 9/3/16 and continuing for six months. Staff members are required to confirm awareness of the code status worksheet process and confirm he/she has a worksheet on their person. Results of the audit are forwarded to the DON daily for review and corrective action as warranted. The auditing process was incorporated into the facility QAPI plan, with audit results reviewed monthly by the QI Committee x 6 months.	

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F 309	Continued From page 27 in Resident# 1 ' s room there were no chest compressions being done. She stated that Nurse # 1 stated the resident was not a DNR, so the back board was placed under the resident and CPR was initiated. The House Supervisor was on the phone calling EMS and Nurse # 1 relieved her with the chest compressions while a nurse who is no longer employed at the facility was providing oxygen through the Ambu bag. In an interview with Nurse # 3 on 8/19/16 at 2:53 PM, she stated that she was working on the 2nd floor of the unit when she heard the code. She reported that she put her meds away to prepare to respond to the code when HCT # 2 came to the 2nd floor to retrieve the crash cart. HCT # 2 took the elevator back to the 1st floor while she took the stairs and made it to the unit before the HCT did with the cart. Nurse # 3 reported that when she entered resident ' s room there was staff present, but no CPR was being done. Other nurses responding to the code entered the room and initiated CPR immediately upon entry. Nurse # 3 stated that if a resident was DNR they are listed at the nurses ' station, it is on their medication administration record (MAR), and there is a dot on the chart indicating DNR status. On 8/19/16 @ 6:09 PM, Nurse # 4 reported that she heard the code called overhead and she and another nurse, who is no longer employed at the facility, responded and confirmed that the resident was a full code. The nurse from the 5th floor, Nurse # 2, did chest compressions and AED pads were put on Resident # 1. The House Supervisor entered and tried to start an IV, but could not get it started. EMS entered, confirmed full code status, and took over with the CPR. At 6:42 PM on 8/19/16, Nurse # 5 reported that she was on the 3rd floor with the House Supervisor when the House Supervisor received	F 309	An emergency cart was obtained for the unit where the Code Blue occurred on 8/18/16. An AED was purchased on 8/19/16 and added to the emergency cart. A facility wide review was conducted by the Center Director and Director of Nursing on 8/23/16 to assess if any additional areas, accessible by residents, could benefit from emergency equipment. To ensure quick access to emergency equipment, a requisition was completed to purchase three additional emergency carts and AEDs, to be placed in activity and dining areas outside of the resident units. Three AEDs were received on 9/1/16. Receipt of the emergency carts is pending with a projected delivery date, confirmed by the Business Manager, as 9/23/16. Emergency carts and AEDs are in place for all resident units as of 8/19/16 . The emergency cart and AED for the unit where the Code Blue occurred on 6/19/16, was added to an existing quality assurance process, under the direction of the Director of Nursing, which requires that AEDS are checked every shift to verify they are operational. Results of the emergency equipment auditing will be reviewed monthly by the QI Committee starting September 2016 x 6 months. The facility will continue to review all code blues to determine any opportunities for improvement. Effective 8/20/16, the Director of Standards Management will be immediately notified of all Code Blues. The Director of Standards Management/designee will review the Code Blue to confirm CPR was initiated	

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F 309	Continued From page 28 the call from Nurse # 1. She reported that House Supervisor # 1 immediately left the unit and she heard a code being called over the overhead system a few minutes later. Nurse # 5 stated that when she arrived on the unit, there was a whole group of staff in the room and Nurse # 2 was doing compressions. She reported that she went to get the IV pole. Nurse # 5 stated that she was never aware of a problem with the overhead system and that there was a dot that would be on the chart of residents who were a DNR and there was also a list of DNR resident on the report sheets and the DNR status of all resident on the unit should be specified during shift change. In an interview with the Standards Management Director at 5:15 PM on 8/18/16, she stated that Resident # 1 was found unresponsive in the resident ' s bedroom so it was recorded in the facility ' s incident report as are any incidents involving a code. She reported that the event was reviewed as a part of their patient safety review process and some opportunities for improvement were identified. The facility initiated emergency response retraining for all staff on that unit, a requisition was completed for an additional crash cart to be placed on the unit for the 1st floor since the only crash cart for the unit was located on the 2nd floor, and they put stickers on each phone, on each unit in the facility, that gave step-by-step directions on how to use the overhead paging system used to call an emergency code. The Standards Management Director also stated that the facility had requested funding for additional training for all nursing staff regarding emergency response and codes as well as implementing a program where the facility would start holding mock code drills. In an interview with the Director of Nursing (DON) on 8/18/16 at 7:57 PM, he stated that all nursing	F 309	for any resident who was not a DNR. If there is a delay in CPR, this will be referred to the Center Director and Director of Nursing and a 24 hour report for alleged neglect will be initiated. Results of the code blue reviews will be reviewed monthly by the QI Committee x 12 months. All facility employees will continue to attend Resident Rights Training during New Employee Orientation and annually. In the training, employees are informed of the requirement to report all allegations of abuse, neglect, and exploitation. A monitoring process was implemented under the supervision of the Staff Development Director, to confirm completion of Resident Rights Training by all employees and report compliance to the QI committee monthly, starting September 2016 x 12 months.	

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F 309	Continued From page 29	F 309		

staff were responsible for knowing resident code status and any staff who was trained should initiate CPR. He reported that the facility had implemented sheets of all residents for staff to use to keep on them with their code status and other pertinent information for the duration of their shift and to be shredded at the end of each shift. The DON stated that it was his expectation that staff should not leave the room of an unresponsive resident, they should call out and initiate CPR, if they are trained, and the resident is a full code. The DON reported that all HCTs and nurses were trained and certified in CPR.
From 8:05 PM through 8:25 PM on 8/18/16, observations were made of the stickers that were placed on each phone after Resident # 1 ' s Code Blue on 6/19/16, on each unit, with the step-by-step instructions of how to use the overhead paging system to call a code.
In an interview with the Standards Management Director on 8/19/16 at 2:02 PM, she stated there were orange stickers on the name label on each chart of resident with a DNR status and staff were trained regarding this sticker during orientation. In addition, every shift report staff was to tell what residents were DNR. Facility administration decided all staff should have been re-educated, so they had a meeting on 6/22/16 and again on 8/19/16 to address action items. They started re-education of entire facility staff on night shift on 8/18/16 and asked staff what the orange sticker on the charts meant and asked them to explain how the overhead paging system worked. They also asked staff what they would do if they found a resident unresponsive. There was also a mock code drill done on 8/19/16 in the AM for all nursing staff in the building at the time.
On 8/20/16 at 08:20 AM the DON reported that he felt the nurse panicked and the HCT (HCT #

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F 309	Continued From page 30	F 309		

1) was unsure if she should give CPR and wanted the nurse to verify the resident ' s status before she did anything. Nurse # 1 ran out of the room to call the House Supervisor and was unsure if the overhead paging system was working. He stated that nurses need to know the code status of their residents and there were measures in place for them to know because it had been addressed months prior. The code status was relayed during shift report, there was a dot on the chart for residents with DNR, and a list of DNRs was kept at the nursing station. He reported that the overhead paging system had changed at the end of April and it was discussed in a supervisors ' meeting and an email was sent out alerting staff of the change. The DON stated that staff should have known the code status for Resident # 1 and CPR should have been initiated immediately upon finding the resident unresponsive, but he did not feel the location of the crash cart on the 2nd floor of the unit contributed to the resident expiring.
The Center Director was notified of the immediate jeopardy at 4:57 PM on 8/19/16.
The facility presented a credible allegation on 8/20/16 at 1:39 PM. The credible allegation read: The main resident cited in this Immediate Jeopardy citation has expired. A review of code status for all residents at the facility was completed on 8/20/16 by the Director of Nursing, Assistant Director of Nursing and RN Supervisors. Code status was based on physician orders. Of the 197 residents who are currently at the facility, 120 are full codes and could be at risk for the same deficient practice. The resident who expired had a history of emphysema. The resident was found unresponsive in her bedroom on 6/19/16. There was a delay in calling a Code Blue and a delay in

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F 309	Continued From page 31	F 309		

initiating CPR. The resident expired. Four staff members were directly involved in the situation which included two HCTs and two RNs. A Nurse Preceptor completed retraining of the four staff members, on response to medical emergencies, on 7/27/16. Retraining included review of the facility ' s Medical Emergency Policy (AM 11-15) which states the first person on the scene will summon for help and initiate CPR if resident is not a DNR. The death was reported to the state on 6/20/16.

The following corrective actions were implemented:

A review of the Code Blue was initiated on 6/22/16. The review was conducted by the Director of Standards Management, in conjunction with the Assistant Director of Nursing. The event was discussed in the facility ' s Event Review Committee on 6/22/16. The Event Review Committee is an extension of the facility ' s Quality Improvement Committee. Based on the event analysis, an action plan was developed and forwarded to the Center Director and Director of Nursing. On 8/19/16, the Event Review Committee reviewed the action items and recommended additional items to improve resident care, which included enhanced monitoring processes to validate staff competency.

All staff members on the Alzheimer Unit, where the Code Blue occurred, were retrained on emergency response on 7/27/16 and 7/28/16 by the Nurse Preceptors. The training included a review of the Medical Emergency Policy (AM 11-15) and a power point presentation covering steps for initiating a code blue, review of the emergency paging instructions, AED demonstration and code status information. The training covered the requirement for the staff

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F 309	Continued From page 32	F 309		

member who finds an unresponsive resident to remain with the resident, call for help and immediately start chest compressions if the resident is not a DNR.
Retraining of all facility Nursing Staff by the Nurse Preceptors and Staff Development Nurses, on Emergency Medical Response was initiated on 8/18/16 and continued through 8/20/16. The training included a review of the Medical Emergency Policy (AM 11-15) and a power point presentation covering steps for initiating a code blue, review of the emergency paging instructions, AED demonstration and code status information. The training covered the requirement for the staff member who finds an unresponsive resident to remain with the resident, call for help and immediately start chest compressions if the resident is not a DNR. 210 staff members were trained on 8/18/16, 8/19/16, and 8/20/16. Retraining will continue each shift until all nursing staff are trained, with a target completion date of 8/31/16. Any staff not trained will be trained before working on the hall again.
New Employees will receive training in New Employee Orientation and will complete training prior to having a resident care assignment.
Per facility policy (NM #1), all direct care nursing employees (e.g. HCTs, LPNs, RNs) are required to complete BLS training as part of New Employee Orientation and annually. As part of the training, HCTs, RNs, and LPNs are required to initiate CPR if the resident is not a DNR and call 911. The Staff Development Director/designee tracks employee completion of required training and provides each Department Manager with a report of compliance.
Department Managers are responsible for ensuring their assigned employees complete BLS as required by facility policy.

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F 309	Continued From page 33	F 309		

Mock Code Drills were identified as an enhanced training opportunity for staff on 6/22/16. Planning was initiated and a Mock Code Blue drill was conducted on 8/19/16. A schedule for monthly mock Code Blue drills on each shift, was finalized on 8/19/16. Mock Code Blue drills will be conducted monthly, starting August 2016 on each shift to evaluate staff ' s response to emergencies.

An emergency cart was obtained for Alzheimer 1st floor on 8/18/16. An AED was purchased on 8/19/16 and added to the emergency cart on Alzheimer 1st floor. The emergency cart for 1st floor Alzheimer was added to an existing quality assurance process, under the direction of the Director of Nursing, which requires that AEDS are checked every shift to verify they are operational.

A sticker with Code Blue paging instructions were added to all telephones in resident care areas on 7/14/16. Audits were conducted on 8/18/16 and 8/19/16 to validate nursing staff members (e.g. RNs, LPNS, and HCTs) had knowledge of the paging instructions posted on the telephones and how to call a Code Blue. 174 employees were audited and all employees were able to respond affirmatively.

The facility implemented a process in May 2015 in which code status is reviewed at each shift report and DNR status is noted on the resident ' s medical record, via an orange dot. The orange dot is used to identify residents who are DNR. When a physician order is written for DNR, the orange dot is placed on the name label of the medical record. Physician orders for full code and DNR are reviewed by the nurse. To enhance staff awareness of each resident ' s code status, the Director of Nursing implemented a worksheet on 8/19/16 to be used by staff members during each shift. During shift report, code status will be

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F 309	Continued From page 34	F 309		

verified and written on the worksheet for quick access throughout the shift. The worksheets will be shredded at the end of each shift.
Debriefing of the Code Blue event with the Alzheimer Unit nursing staff was conducted by the Director of Nursing on 7/20/16 and 8/9/16 to review the event and review expectations for emergency response for any future Code Blues.
The Alzheimer Unit Nurse Manager communicated expectations regarding timely response to medical emergencies with the Alzheimer nursing staff, in a staff meeting on 6/27/16. All other facility nursing staff were informed of the expectation for timely response to medical emergencies in a meetings conducted by their Nurse Managers/Nurse Supervisors on 7/15/16, 7/26/16, 7/29/16, 7/30/16 and 8/10/16.
On 8/20/16 at 1:50 PM, the credible allegation was validated. Staff interviews with HCTs and licensed nurses revealed the facility implemented corrective measures, including in-servicing of nursing staff regarding knowing residents ' code statuses and where to find the code statuses, the proper procedure and protocol for calling a Code Blue, and how to respond when a resident is found unresponsive.