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 02/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 2/15/2018. Intakes NC00133384, NC00133366, and NC00133361.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of physical restraints for 2 of 7 residents reviewed (Residents #158 and #49). The findings included: 1-Resident #158 was admitted to the facility on 8/7/2015 with diagnoses which included Huntington's disease and a history of Psychosis. Review of the medical record revealed a Positioning Review dated 12/22/2017 completed by the facility Occupational Therapist (OT). The Positioning Review revealed the resident had decreased safety awareness and decreased coordination. The Review further revealed the tabletop allowed for upright alignment and did not restrict the resident's access or functional status. Review of the quarterly MDS assessment dated 1/24/18 indicated Resident #158 was moderately cognitively impaired and required extensive to total assist with all activities of daily living (ADLs). Resident #158 was assessed with impairment on	F 641	Response for Tag F 641 The facility maintains that an assessment, which accurately reflects the resident' s status, was completed. The use of the lap tray by Resident #158 was assessed on 2/14/18 by the MDS Nurse and deemed a restraint. A physicians order for use of the restraint for Resident #158 was obtained and implemented on 2/14/18. The use of the seatbelt by Resident #49, was assessed on 2/14/18 by the MDS Nurse and deemed a restraint. A physicians order for use of the restraint for Resident # 49 was obtained and implemented on 2/14/18. The coding on Section P of the 1/24/18 MDS Assessment for Resident #158 was corrected to reflect the use of a physical restraint. The coding on Section P of the 11/29/17 MDS assessment for Resident #49 was corrected to reflect use of a physical restraint. Corrected MDS assessments for Resident #158 and Resident #49 were submitted and accepted by CMS on 2/26/18.	3/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/27/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 both sides of his upper extremities. The MDS indicated the resident had no physical restraints. Review of the signed Physician orders for 2/1/2018 through 3/1/2018 revealed an order for a tabletop with wheelchair for positioning intervention, upright trunk positioning and support due to involuntary movements. Review of Resident #158's Care Plan updated on 2/7/2018 revealed a problem with ADLs and falls which included the intervention of a wheelchair with a tabletop per MD orders for both areas. An observation was conducted of Resident #158 on 2/13/18 at 9:58 AM. The resident was in his room, sitting in a wheelchair with a lap tray attached to the chair by hook and loop straps which were secured in the back of the chair. The resident was sitting quietly and still with his eyes closed and his hands on the tray. There were no objects on the tray. An observation was made of Resident #158 on 2/14/2018 at 8:35 AM. The resident was in the wheelchair with the lap tray secured in the same position as the previous day. The resident was sitting still in the wheelchair with his hands on the lap tray and was watching the staff member in his room. There were no objects on the tray. Nursing Assistant (NA) # 1 was in the room with the resident. An interview was conducted with MDS Nurse #1 on 2/14/2018 at 11:08 AM. MDS Nurse #1 confirmed she was the MDS nurse assigned to Resident #158. MDS Nurse #1 indicated she was aware of the tray table used for the resident when he was up in the wheelchair. MDS Nurse #1	F 641	The following corrective actions were implemented: 1. On 2/14/18, a reassessment of all residents who were using a positioning device was conducted by the facility□'s MDS Nurses. Devices which met the CMS restraint definition were deemed restraints and physician orders were obtained on 2/14/18 for use of the restraints. 2. Coding corrections were completed by the MDS Nurses for all residents who were using a device, which met the CMS definition of physical restraint, during the observation period of their last MDS assessment. Corrected MDS assessments will be submitted to CMS by 3/1/18. 3. Effective 2/16/18, the coding of Section P of the MDS assessment was reassigned from the Occupational Therapist/Physical Therapist to the MDS Nurses. 4. Effective 3/1/18, a new process, developed with input from the Center Director, Medical Director and Director of Nursing, will be implemented for review of positioning and restraint devices. The MDS Nurses will review any device recommended by the OT/PT to confirm if it meets the CMS restraint definition. The MDS Nurse will communicate the MDS coding decision to the Treatment Team. 5. A class was developed on Accuracy of Assessment. The class addressed the RAI requirements, the importance of	

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Continued From page 2

reported the resident used the tray to keep his remote control and other items on so he could reach them. MDS Nurse #1 stated the tray was not used as a restraint as therapy observed the resident and made the decision. MDS Nurse #1 reported the therapists were the experts and if they inform her a device is not a restraint, she doesn't code it as a restraint. MDS Nurse #1 indicated she relied on the therapist to make the decision.

An interview was conducted on 2/14/2018 at 11:22 AM with the Occupational Therapist (OT) who completed the Positioning Review assessment of Resident #158. The OT confirmed she completed the Positioning Review for the resident. The OT indicated the resident periodically flexed and extended his trunk and without a positioning device he would be a risk to himself for falling. The OT indicated the lap tray did not restrict normal movement for the resident and therefore it was not a restraint. The OT stated the tray was a safety intervention.

An interview was conducted with NA #1 on 2/14/2018 at 11:51 AM. NA #1 confirmed she worked with resident #158 almost every day. NA #1 reported she attached the tabletop to the resident's wheelchair each time he was in the chair. NA #1 indicated the resident was unable to remove the tray as it is secured on the back of the chair. The NA further indicated the tray kept the resident from sliding from the wheelchair to the floor and was for the safety of the resident.

An interview was conducted with the Director of Nursing (DON) on 2/14/2018 at 4:06 PM. The DON indicated he understood the definition of a restraint and the tabletop appeared to meet the

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accurate coding on the MDS assessments, and CMS regulations for use of physical restraints. All the MDS Nurses attended the class, presented by the Director of Standards Management, on 2/23/18. Classes were scheduled for treatment team members beginning 2/26/18. All treatment team members, with the exception of one staff member who is on leave, completed the Accuracy of Assessment class by 2/27/18. Completion of training is evidenced by their signature on the class training roster.

6. A quality assurance process was implemented under the direction of the Director of Nursing (DON) to confirm that physical restraints are coded accurately on the MDS assessment. Beginning 3/1/18, the MDS Nurse Supervisor will review each time a device is recommended by OT/PT, to determine if the device should be coded as a restraint. With each MDS assessment, the MDS Nurse Supervisor will
verify that Section P: Restraints and Alarms has been coded accurately. The MDS Nurse Supervisor will complete a Physical Restraint Audit Form and submit the form weekly x 6 months to the Director of Nursing for review and corrective action as needed. The audit findings will be compiled by the Director of Standards Management/designee and reported monthly x 6 months to the QI Committee for review or additional action.

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F 641	Continued From page 3 definition. The DON stated the expectation was for all assessments to be coded accurately. 2-Resident #49 was admitted to the facility on 1/24/2012 with diagnoses which included Huntington's disease and Dementia. Review of the quarterly MDS assessment dated 11/29/17 indicated Resident #49 was rarely/never understood and required extensive to total assist with all activities of daily living (ADLs). Resident #98 was assessed as having no functional limitation of upper or lower extremities. The MDS indicated the resident had no physical restraints. Review of the medical record revealed a Positioning Review dated 11/30/2017 completed by the facility Occupational Therapist (OT). The Positioning Review indicated the Resident #49 used a seatbelt while in the wheelchair. The review reported the resident had constant movement with the inability to reposition himself. The review indicated there were no adverse reactions with the use of the positioning device and the plan was to continue the seatbelt for positioning intervention. Review of Resident #49's Care Plan updated on 12/13/2107 revealed a problem with falls due to spastic movements of upper and lower extremities at times, a history of transferring unassisted at times and poor safety awareness. Interventions included a seatbelt with high-back wheelchair per MD orders.	F 641		

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F 641	Continued From page 4 Review of the signed Physician orders for Resident #49 from 2/1/2018 through 3/1/2018 revealed an order for a seatbelt to wheelchair for positioning intervention. An observation was made of Resident #49 on 2/13/2018 at 9:47 AM. The resident was sitting in a high back wheelchair with a seat belt attached to the chair and secured around the resident's waist with a buckle. The resident was sitting in the day room quietly and did not make any movements during the observation. An observation was made of Resident #49 on 12/14/2018 at 8:01 AM. The resident was sitting in a straight back folding chair in his room with an over bed table in front of him which held his breakfast tray. The resident was sitting still in the chair. Nursing Assistant #2 entered the resident's room and sat down beside him and assisted with his breakfast. An observation was made of Resident #49 on 2/14/2018 at 2:35 PM. The resident was sitting in a high back wheelchair with a seat belt attached to the chair and secured around the resident's waist with a buckle. The resident was seated in the hall outside of his room. An interview was conducted with NA #2 on 2/14/2018 at 2:39 PM. NA #2 confirmed she worked with resident #158 almost every day. NA #1 reported she buckled the resident's wheelchair seat belt whenever she got him up. NA # 2 indicated the resident was not able to unbuckle the seat belt when he was in the wheelchair. NA #2 indicated the seatbelt was for the resident's safety so he would not fall and to keep him positioned in the chair.	F 641		

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F 641	Continued From page 5 An interview was conducted with MDS Nurse #1 on 2/14/2018 at 3:40 PM. MDS Nurse #1 confirmed she was the MDS nurse assigned to Resident #49. MDS Nurse #1 indicated she was aware of the seatbelt used for the resident when he was up in the wheelchair. MDS Nurse #1 reported the resident used the seatbelt per the Occupational Therapy recommendations as the resident was non ambulatory and required extensive assistance with transfers. MDS Nurse #1 stated the seatbelt was not used as a restraint as therapy observed the resident and made the decision. MDS Nurse #1 reported the therapists were the experts and if they inform her a device is not a restraint, she doesn't code it as a restraint. MDS Nurse #1 indicated she relied on the therapist to make the decision. An interview was conducted with the Director of Nursing (DON) on 2/14/2018 at 4:06 PM. The DON indicated he understood the definition of a restraint and the tabletop appeared to meet the definition. The DON stated the expectation was for all assessments to be coded accurately.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		3/9/18

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F 761	Continued From page 6 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure 2 of 10 medication carts (4th floor north, 2nd floor north). Findings included: 1. On 2/15/18 at 8:20 AM, the 4th floor north medication cart was observed parked outside of room 402. The lock mechanism was observed in the unlocked position. No residents or staff were observed in the hall. No staff were visible in room 402 from the hall. On 2/15/18 at 8:29 AM Nurse #1 was observed exiting room 402. The nurse demonstrated the cart was unlocked by opening the top drawer on each side of the cart. The nurse stated it was dangerous to leave the cart unlocked because residents could help themselves to whatever they like. The shift supervisor of the 4th floor was	F 761	Response for Tag F761 The facility maintains that drugs and biologicals used in the facility are stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The following corrective actions were implemented: 1. All the medication carts were checked by a Nurse Preceptor on 2/16/18 to confirm the locks work properly. 2. The Medication Administration Policy (NM-M-2) and Medication Room, Cart and Key Policy (NM #4) were reviewed by the Director of Nursing and Director of Standards Management on 2/16/18. Revisions were made to enhance the language about keeping the medication	

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interviewed on 2/15/18 at 8:37 AM. The supervisor stated she would expect the nurse to lock the medication cart when it was out of sight of the nurse.

An interview with the Director of Nursing (DON) was conducted on 2/15/18 at 4:02 PM. The DON stated it was his expectation that the nurses would keep their medication carts locked when out of their view.

2. On 2/15/18 at 9:34 AM, the 2nd floor north medication cart was observed parked in the hall across from room 232. The lock mechanism was observed in the unlocked position. The nurse was observed in going into room 232 and shutting the door.

On 2/15/18 at 9:37 AM Nurse #2 came out of room 232 and immediately activated the lock mechanism. When the nurse was asked if the medication cart had been unsecured, she stated she should have locked the cart before going into the room. The nurse stated the medication cart should be locked so others cannot get into it.

An interview with the 2nd floor unit manager was conducted on 2/15/18 at 11:12 AM. The unit manager stated it would be her expectation of the nursing staff to lock the medication cart when out of their view.

An interview with the Director of Nursing (DON) was conducted on 2/15/18 at 4:02 PM. The DON stated it was his expectation that the nurses would keep their medication carts locked when out of their view.

F 761

carts locked at all times when unattended. The policy revisions were approved by the QI Committee members on 2/20/18.

3. An education packet on medication storage was developed by the Director of Nursing, Nurse Preceptor, and Director of Standards Management. The packet included a memo from the DON summarizing the medication storage requirements, a copy of the Medication Administration Policy, a copy of the Medication Room, Cart and Key Policy and a flyer showing how to properly lock the medication cart. The education packet was distributed on 2/21/18, along with instructions from the DON for all nurses to complete the education packet by 3/9/18. Nurses will confirm review and understanding of the material by signing the training roster by 3/9/18.

4. A yellow reminder sticker with the wording "keep locked when unattended" was added to each medication cart on 2/20/18 by the Nurse Preceptor.

5. A quality assurance process was implemented under the direction of the Director of Nursing to audit that nurses are locking their medication carts when unattended. Beginning 2/23/18, a RN (e.g. Staff Development Nurse, Nurse Preceptor, Nursing House Supervisor or other designated RN) will complete one observation daily on each nursing unit. The RN will make rounds while the medication pass is being conducted to confirm the nurses are locking their

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F 761	Continued From page 8	F 761	assigned medication carts. Audits will be conducted daily x 1 month, then weekly x 5 months. In addition, weekly audits of medication storage areas will be conducted by the Shift Supervisor on each shift on each nursing unit. Weekly medication storage audits will be conducted x 6 months. Audits will be submitted daily/weekly to the DON for review and corrective action as needed. The audit findings will be compiled by the Director of Standards Management/designee and reported monthly x 6 months to the QI Committee for review or additional action.	