

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Longleaf Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4761 Ward Boulevard Wilson, NC 27893	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff and physician interviews, the facility did not provide care in a safe manner when 1.) Resident #3 fell to the floor from a mechanical lift (a device that uses electric or hydraulic power to safely transfer patients who have limited mobility) during a transfer from the bed to a chair sustaining a 4-centimeter posterior (at the back or rear of something) scalp laceration (cut or tear in the skin of the scalp) requiring evaluation in the emergency room and wound closure with 7 staples and 2.) Resident #4 fell out of a shower bed requiring evaluation in the emergency room sustaining an occipital hematoma (a collection of blood in or around the back part of the brain), a 2 x 2 centimeter (cm) reddened area to the left elbow, and an abrasion (superficial skin injury) to the left buttocks. This deficient practice affected 2 of 3 residents reviewed for accidents (Resident #3 and Resident #4).The findings included:</p> <p>1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included severe vascular dementia with agitation (characterized by restlessness, distress, and potentially aggression, often stemming from the person's inability to communicate needs or understand their environment) and a movement disorder (a neurological condition that affects the ability to control physical movements, causing either too much or too little movement, impacting coordination, gait, posture, and sometimes speech or swallowing).</p> <p>A review of Resident #3's Physician's order dated 11/30/2020 revealed her mechanical lift order was updated from a 1 person assist to a 2 person assist for transfers.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively impaired. Resident #3 was dependent on staff for eating, oral hygiene, toileting hygiene, showering/bathing herself, upper and lower body dressing, personal hygiene, putting on/taking off footwear, rolling left and right, chair/bed to chair transfer, and tub/shower transfer.</p> <p>A review of Resident #3's Physician's orders revealed she was not receiving any anti-coagulant (blood thinning) medication.</p> <p>A nursing progress note dated 11/24/25 indicated Nurse #1 was summoned by Health Care Technician (HCT) #2 to Resident #3's room and found Resident #3 lying on floor on her back with bright red bleeding to back of her head. Calls were placed to 911, the Physician and the House Supervisor.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A written witness statement dated 11/24/25 from HCT #1 was reviewed. In the witness statement, HCT #1 indicated on 11/24/25 she was assigned Resident #3. HCT #1 stated she got Resident #3 dressed, put the lift pad (sling: A fabric harness or pad placed under and around the patient's body to support their weight during the transfer. The sling attaches to the lift's spreader bar or hooks) under her and went to get help to transfer her with the mechanical lift. HCT #1 saw HCT #2 and asked her to help. HCT #1 stated they went in and secured Resident #3's sling onto the lift and she was lifted in the air. HCT #1 moved the mechanical lift to place Resident #3 in a chair, and Resident #3 fell out of the lift.</p> <p>Multiple telephone attempts were made to interview Health Care Technician (HCT) #1 who was assigned to Resident #3 on 11/24/25 but were unsuccessful as she was no longer employed at the facility.</p> <p>A written witness statement dated 11/24/25 from HCT #2 was reviewed. HCT #2 indicated prior to leaving her completed shift, she was called by HCT #1 to assist with a transfer for Resident #3. HCT #2 stated upon entering Resident #3's room, Resident #3 was hooked up to the mechanical lift and raised off the bed. HCT #2 stated when HCT #1 moved the mechanical lift out and turned it, the right shoulder strap came undone, and Resident #3 fell.</p> <p>On 12/5/25 at 11:34 AM an attempt was made to interview HCT # 2 by telephone; however, she declined to talk to this surveyor about the incident.</p> <p>A telephone interview was conducted with Nurse #1 on 12/8/25 at 8:43 AM. She stated she was in the hallway at approximately 7:35 AM (on 11/24/25) conducting visual checks of the residents when a HCT (HCT #1) stuck her head out from a doorway and asked an HCT (HCT #2) to help her. The HCTs were in the room for a few seconds and HCT #2 asked her to come into Resident #3's room. She stated Resident#3 was lying with her head facing the door and had blood-soaked hair on the back of her head. Nurse #1 stated Resident #3 was alert and awake with her eyes open. Nurse #1 stated she asked what happened and HCT #1 said (implied) Resident #3 jumped out of the sling, which was not the resident's typical behavior. Nurse #1 stated she alerted the House Supervisor, the Physician, and 911 and stayed with Resident #3. Nurse #1 further stated that using the mechanical lift required a minimum of 2 people; 1 person for lift, 1 person for the resident's head, correct placement of the pad, attaching the pad to the 4 points on the mechanical lift, and making sure everything was secured before moving a resident.</p> <p>The hospital record for Resident #3 included a hospital history and physical note dated 11/24/2025 which indicated Resident #3 sustained a witnessed fall from a mechanical lift to the floor resulting in a 4-centimeter posterior scalp laceration requiring evaluation in the emergency room and wound closure with 7 staples. A computed tomography (CT) scan (a noninvasive imagining procedure that uses x-rays to create detailed images of the body) of Resident #3's head, neck, lumbar spine (the lower back section of the spine) and pelvic girdle (basin-shaped ring of bones (two hip bones, sacrum, coccyx) that connects the spine to the legs) revealed no abnormal findings. An x-ray completed on Resident #3's chest revealed no relevant findings. Resident #3 was discharged back to the facility on [DATE] with instructions to remove her staples in 7 to 10 days.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted with Nurse #2 on 12/5/25 at 12:55 PM. He stated that morning (11/24/25) at start of his shift he was in the medication room and a HCT (HCT #2) came and asked him for a flashlight. He stated he went to Resident #3's room and saw her on her back positioned next to the mechanical lift. Nurse #2 stated he asked HCT #1 what happened and HCT #1 stated she did not operate the mechanical lift by herself.</p> <p>A telephone interview was conducted with the House Supervisor #1 on 12/5/25 at 12:38 PM. House Supervisor #1 stated she received a call at the start of her shift that Resident #3 fell. Upon her arrival to Resident #3's room, Resident #3 was on the floor with her head facing door. House Supervisor #1 stated the physician was present and she stayed on the floor with her, attending to Resident #3's bleeding head, and stabilized her head until emergency services (EMS) arrived. House Supervisor #1 stated she asked HCT #1 what happened and HCT #1 told her she was not sure how the resident fell. HCT #2 informed House Supervisor #1 that Resident #3 was already attached to the mechanical lift when she arrived in the room.</p> <p>A telephone interview was completed on 12/5/25 at 1:07 PM with Physician #1. The Physician stated he was called about Resident #3's fall and went to assess her. Physician #1 stated Resident #3 and was on the ground with a laceration on back of her head, he asked staff not to move her until EMS arrived. Physician #1 further stated it was his expectation that staff identify any issues with a resident transfer prior to the move. He stated he expected staff to operate mechanical lifts as they were trained.</p> <p>An interview was completed on 12/8/25 at 12:05 PM with the interim Director of Nursing (DON). The DON revealed it was her understanding that HCT #1 put Resident #3 on the (lift) pad, hooked the pad to the mechanical lift, raised Resident #3 off the bed but did not move her. HCT #1 called for help, HCT #2 came to help her, and they began to move the mechanical lift. The interim DON stated one of the slings went down and Resident #3 fell to the floor. She stated HCT #1 was immediately taken off the unit and both HCTs were taken off patient care until the investigation was completed. The interim DON further stated she had HCT #1 and HCT #2 reenact what happened due to conflicting statements. The interim DON stated after the reenactment, HCT #1 was terminated due to inconsistencies in the 2 HCTs statements. The interim DON stated it was her expectation that staff followed the mechanical lift protocol, 2 staff members were always required for a lift, staff should inspect the mechanical lift prior to using, inspect the sling to ensure it was the correct size and was in good condition, the sling was correctly placed on the resident, and the sling was secured to the correct sections of the loops on the mechanical lift. She further stated once the sling was looped, staff were to ensure the hooks were closed.</p> <p>During an interview on 12/8/28 at 3:36 PM the Administrator stated her expectation was that staff followed the policy when they used a mechanical lift which included 2-person assistance.</p> <p>2. Resident #4 was admitted to the facility on [DATE] with diagnoses which included progressive neurological condition, cervical spinal stenosis (the narrowing of the spinal canal in the neck, compressing the spinal cord and nerve roots), and communication deficit disorder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. Resident #4 was non-verbal and non-ambulatory with impairment of range of motion on bilateral upper/lower extremities. Resident #4 was totally dependent on staff for all her activities of daily living (ADL) and transfers. Resident #4 was not prescribed anticoagulant (blood thinning) medication.</p> <p>Review of Resident#4's care plan dated 4/9/25 revealed a goal for total care with all activities of daily living (ADL) as resident was unable to participate in her ADL with interventions which included the use of a shower bed, all procedures explained to her with encouraged compliance, and if resident is agitated, she may require additional staff for safety. The care plan also had a goal of at risk for falls with interventions which included notifying guardian of any falls/injuries, increased observation during periods of agitation, and frequent observation as resident is unable to use call bell system.</p> <p>A progress note dated 9/5/25 completed by Health Care Technician (HCT) #4 documented she gave Resident #4 a shower on the shower bed. HCT #4 documented when she started to lower the head of the shower bed Resident #4 began to squirm and her body proceeded to slide down to the end of the shower bed. She started calling out for help as Resident #4 was sliding off the shower bed. Resident #4 landed on her buttocks on the left side. HCT #4 called for the nurse to explain what happened.</p> <p>During a telephone interview on 12/8/25 at 4:00 pm with HCT# 4, she stated she had given showers to Resident #4 in the past without difficulties and gave Resident #4 a shower on the shower bed on 9/5/25. HCT #4 further stated she started Resident #4's shower the head of the shower bed was raised to allow for the water to flow down the shower bed to the drain at the bottom of the shower bed. HCT #4 indicated the water would not drain unless the head of the shower bed was raised. HCT #4 further stated she explained to Resident #4 that she was going to lower the head of the shower bed and when she started to lower the head of the shower bed, Resident #4 started moving and squirming around, began to slide down the shower bed, and fell off the shower bed at the opening at the end of the shower bed. HCT #4 explained she yelled out for help but Resident #4 was on the floor when help arrived at the shower room. HCT #4 indicated she could not stop Resident #4 from sliding off the shower bed, as it happened so fast. HCT #4 further indicated she reported the incident to the floor nurse, and the floor nurse reported the incident to the Unit Manager. HCT #4 stated the Unit Manager made the Physician aware. HCT #4 recalled the Physician came to the unit and assessed Resident #4 and gave orders to send her to the Emergency Department (ED) for evaluation. The interview further revealed HCT #4 did not know if the HOB was supposed to be raised or flat during a shower. HCT #4 stated she received training on the use of the shower beds but did not recall if the HOB was supposed to be raised or flat.</p> <p>During an interview with HCT #5 on 12/8/25 at 1:52 pm, she stated she thought it was the residents' preference for the HOB to be raised. When questioned about the non-verbal residents' preference she stated the HCT would make the choice to have the HOB raised or flat on the shower bed.</p> <p>A progress note dated 9/5/25 completed by Nurse #5 documented she was called to the shower room and found Resident #4 lying on the floor on her back. Resident #4 was parallel to the shower bed. Upon assessment she palpated (examine a part of the body by touch) a knot on the back of her head with no bleeding noted. Nurse #5 called the Unit Manager as well as the Physician. Orders were placed to send Resident #4 to the ED for evaluation. No vital signs were documented in the progress note.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 12/8/25 at 3:15 pm with Nurse #5, she stated she was called to the shower room to assess Resident #4 after she fell off the shower bed on 9/5/25. Nurse #5 indicated Resident #4 was lying unclothed on the shower room floor. Nurse #5 further stated HCT #4 reported to her that Resident #4 slid off the shower bed through the open area at the bottom of the shower bed onto the floor. Nurse #5 explained she assessed Resident #4 and palpated a knot on the back of Resident #4's head. Nurse #5 further explained she called the Unit Manager and the Physician. Nurse #5 stated Resident #4 was sent to the ED for evaluation.</p> <p>The Unit Manager (UM) was interviewed on 12/8/25 at 2:20 pm. The UM stated she was made aware of Resident #4's fall by Nurse #5. The UM further stated when she walked in the shower room, she found Resident #4 on the floor on her left side. The UM indicated during an assessment of Resident #4 she palpated a raised area on the back of Resident #4's head, a 2 x 2 cm reddened area was visually noted to the left elbow, and a superficial abrasion noted to the left buttock area. The UM explained Resident #4 was not moved; however, she covered Resident #4 with a blanket for privacy and placed a pillow under her head prior to Emergency Medical Technicians (EMTs) arrival at the facility. The UM stated HCT #4 explained she was giving Resident #4 a shower on the shower bed. When she lowered the head of the shower bed Resident #4 started moving and squirming around, slid down the shower bed, and fell off the shower bed through the opening at the end of the shower bed.</p> <p>A progress note dated 9/5/25 completed by Physician #2 documented he received a call from the UM reporting that Resident #4 had fallen from the shower bed. Physician #2 arrived approximately 2 minutes later, and Resident #4 was on the floor wet with a towel under her head. Resident #4 was moving her right side and her head and neck. Resident #4 was non-verbal and it was difficult to tell her level of consciousness. Physician #2 documented the nursing staff attempted to obtain vital signs but were unsuccessful. Physician #2 obtained systolic blood pressure (BP) manually and was 174, oxygen saturation initially was 93 to 94 percent (%), heart rate 120 and respiratory rate between 16 and 18 breaths per minute. (Normal vital sign ranges: BP under 120/80 mmHg (millimeters of mercury), Heart Rate 60 to 100 beats per minute, Respiratory rate 12-20 breaths per minute and oxygen saturation 96% to 99%). An abrasion was noted to her left elbow, a bruise to her left hip, and no open wound or bleeding noted from the scalp. Resident #4 was transported to the ED for further evaluation.</p> <p>In a telephone interview with Physician #2 on 12/8/25 at 2:41 pm, he stated he was notified of Resident #4's fall and when he went into the shower room, everything was slippery and wet. Physician #2 further stated he gave orders for Resident #4 to be sent to the ED for evaluation. When asked was this fall preventable, he replied the shower bed should have side rails all around the shower bed.</p> <p>Review of Resident #4's hospital Discharge summary dated [DATE] revealed Resident #4 was brought to the ED by Emergency Medical Systems (EMS) at approximately 9:42 am. Resident #4's past medical history revealed she was bed-bound with left side extremity contracture (a condition of shortening and hardening of muscles, tendons or other tissues often leading to restricted joint mobility). She was evaluated for occipital hematoma (collection of blood at the back of the head) after a fall from a shower bed at the facility. A Computed Tomography (CT) scan of the Spine (which is a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of spine) was completed with no acute fracture noted. A CT scan of the head was completed which showed no skull fracture. Clinical Impression: closed [NAME] injury. Resident #4 was discharged back to the facility on 9/5/25 with no new orders.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>On 12/8/25 at 2:45 pm an observation was made of the facility's shower bed used for Resident #4. The shower bed was approximately 3 feet tall and approximately 78 inches in length on a metal frame with locking wheels. At the head of the shower bed on the left side was a lever used for raising and lowering the head of the shower bed. Along the sides of the shower bed there were side rails which were located in the middle of the shower bed leaving approximately 24 inches of space at the head of the shower bed and at the bottom of the shower bed. The shower bed had a hole at the bottom in the middle of the shower bed used to drain the water.</p> <p>During an interview with the Director of Nursing (DON) on 12/8/25 at 3:38 pm, she stated she was out when Resident #4 fell from the shower bed and heard about it from staff when she returned to work but could not recall the date. The DON noted she reviewed Resident #4's Electronic Medical Record (EMR). The DON indicated the shower beds were new and were received in December 2024. A video training course was provided for the staff on how to use the shower bed. The DON explained 2 staff members may be necessary when using the shower bed, and the head of the shower bed should not be raised to ensure the safety of the residents to prevent this from happening again. DON stated the HCT's were in-serviced on patient care and use of the shower bed to keep HOB flat. The interview further revealed Resident #4's care plan was revised for her to be provided with bed baths and no showers.</p>		