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	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longleaf Neuro-Medical Treatment Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and Medical Director interview, the facility failed to provide care and services in accordance professional standards of practice when staff moved and repositioned the resident after a fall prior to nursing assessment for 1 of 3 resident reviewed for accidents (Resident #1). Findings included:A review of the records showed Resident #1 was admitted to the facility on [DATE] with diagnoses that included major neurocognitive disorder due to vascular disease with behavioral disturbance, and disorganized schizophrenia. Resident #1 was not available for interview because she was hospitalized at the time of the investigation. A review of the care plan dated 7/9/2025 showed problems, goals, and interventions that included providing socialization through staff review, cueing and reorientation as needed, assessing for mood changes, administering medications as ordered, assisting with personal hygiene, monitoring for continence patterns, implementing fall prevention measures related to dementia, poor safety awareness, aggression, and medication which placed the resident at risk for further falls/injury.A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact. The MDS documented that Resident #1 used a wheelchair for mobility and required extensive to total assistance with activities of daily living (ADL), including toileting hygiene, bathing, personal hygiene, and transfers. Resident was coded as dependent for sit-to-stand transfers and required substantial/maximal assistance for chair/bed-to-chair transfers. Toilet transfers were not attempted due to medical condition or safety concerns but indicated Resident #1 was always incontinent with bladder and bowel. The MDS coded the resident as having no falls since admission, reentry, or prior assessment.A nursing note documented by Nurse #1 dated 5/5/2026 at 6:20 pm stated that on 5/4/2026 Nurse #1 was called to Resident #1 room by Health Care Technician (HCT) (did not specify which HCT). Nurse #1 documented that upon arriving, resident was lying on back with mechanical lift pad already underneath her.An interview with HCT #1 on 5/6/2026 at 12:50 pm revealed she entered the Resident #1 room with HCT #2 on 5/4/2026 between 2:50 pm and 3:00 pm, after Resident #1 returned from activities because resident repeatedly stated she was wet. HCT #1 stated they were changing Resident #1 in her room, with the walker facing the bed. HCT #1 stated she stood on one side and HCT #2 stood on the other side, and they assisted the resident to stand from the wheelchair using the walker to hold herself up. HCT #1 stated they removed Resident #1 wet incontinent brief and put a dry incontinent brief onto resident. HCT #1 recalled that resident was wearing a silky like gown and once they had the brief on, all they had to do was drop the gown. HCT #1 stated that once they dropped the gown, resident said, I'm falling, and began going down. HCT #1 stated she did not recall the exact placement of the wheelchair but stated it was not far away. HCT #1 stated they attempted to move the wheelchair underneath the resident, but the resident sat on the edge of the wheelchair. HCT #1 stated she and HCT #2 recognized the wheelchair was not positioned far enough back and attempted to pull the resident further onto the wheelchair cushion using the gait belt but were unable to move the resident. Resident #1 fell to her knees from the seat of the wheelchair and then fell to the side at an awkward angle. HCT #1 stated the resident landed with one leg, she could not recall which leg but thought it may have been the left, underneath the bed. HCT #1 stated she and (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HCT #2 used the gait belt to pull Resident #1 from underneath the bed and then obtained a mechanical lift pad. HCT #1 stated she and HCT #2 rolled the resident from side to side to place the mechanical lift pad underneath her and then HCT #1 went to get the nurse while HCT #2 stayed with the patient. HCT #1 did recall that patient immediately began complaining of knee pain after the fall. In an interview with HCT #2 on 5/14/2026 at 2:15 pm she stated that on 5/4/2026 she and HCT #1 entered Resident #1's room after resident returned from activities. She could not remember the exact time but thought it may have been a little after 3:00 PM. They went into the room to change the resident because the resident kept saying that she was wet. HCT #2 stated that they frequently changed resident in her room from the wheelchair. HCT #2 stated that after resident was changed, she attempted to sit before they put the wheelchair fully back under her. HCT #2 stated that resident sat on the edge of the seat of the wheelchair and then began falling forward to her knees. They did attempt to keep resident on the wheelchair, but resident weighed over 250 pounds, so they were not able to keep her from falling. Once she fell, she was under the bed a little bit, so they used the gait belt to pull her from under the bed. HCT #2 stated they got the mechanical lift pad from outside of the room and rolled resident two times to put the pad under her. HCT #2 stated they did this because they knew that they would need the mechanical lift to get patient up off the floor. HCT #2 stated she stayed with resident while HCT #1 got the nurse. HCT #2 stated that she did not recall Nurse #1 doing any range of motion checks with the resident or resident refusing. HCT #2 stated that once Nurse #1 said it was ok, they used the mechanical lift to pick resident up off floor and placed her on the bed. In an interview with Nurse #1 on 5/6/2026 at 12:31 pm she stated that on 5/4/2026 sometime after 3:00 pm, Health Care Technician (HCT) #2 came and got her saying that Resident #1 was on the floor. When she arrived in the room, Resident #1 was lying on floor, on a mechanical lift pad. She stated that Resident #1 would not allow nurse to check her range of motion (ROM) but was complaining of knee pain. Nurse #1 stated that there were no visible signs of injury. She stated that since resident was complaining of knee pain, an x-ray was ordered and it showed a fracture. Resident #1 was sent out to the hospital once the x-ray confirmed a fracture. A physician progress note dated 5/5/2026 at 10:15 am documented the resident sustained an assisted fall after attempting to sit down prior to seating being in place. The resident complained of left knee pain following the fall.Records further showed that on 5/5/2026 an x-ray of left knee showed fracture of the distal femoral shaft (break in the lower portion of the thighbone just above the knee) with malalignment.A review of records revealed that resident was discharged from the facility on 5/5/2026 and admitted to the hospital.An interview with the Medical Director was conducted on 5/14/2026 at 2:25 pm. The Medical Director stated that if a resident falls, the HCT should get the nurse, and the nurse should do a clinical assessment before attempting to move the resident. However, if there are extenuating circumstances such as HCT does not feel resident is safe, she would expect HCT to move resident to a more secure location. The Medical Director stated that in the case of Resident #1, the HCT's should have gotten the nurse to access for injuries before they moved the resident.On 5/14/2026 at 2:45 pm an interview with the Director of Nursing (DON) revealed her expectation was if a resident falls, unlicensed staff should get licensed staff before attempting to move the resident. The DON stated that HCT #1 and HCT #2 should not have rolled the resident to put the mechanical lift pad under her prior to the nurse evaluating the resident for injuries.In an interview with Care Director on 5/14/2026 at 2:51 pm she stated that per the facility policy, if resident falls, they should not be moved until assessed by a Registered Nurse (RN). If it was an assisted fall, then the assessment could be done by a Licensed Practical Nurse (LPN). The Care Director stated that HCT #1 and HCT #2 should not have moved the resident until the resident was evaluated by a nurse. She stated that the HCT's were anticipating having to get the resident up with the mechanical lift but should have waited for nurse to examine resident for injuries.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide care in a safe manner. During incontinence care a resident fell while standing and sustained a fracture of the left distal femoral shaft (break in the lower portion of the thighbone just above the knee) with malalignment. This practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 was admitted to the facility on [DATE] with diagnoses that included major neurocognitive disorder due to vascular disease with behavioral disturbance and disorganized schizophrenia. Resident #1 was not available for interview because she was hospitalized at the time of the investigation.The care plan dated 7/9/2025 and revised 3/26/2026 documented Resident #1 was at risk for falls/injury related to dementia, poor safety awareness, aggression, and medication use. Interventions included implementing fall prevention measures, assisting the resident with personal hygiene, queueing and reorientation as needed, and monitoring behaviors and safety concerns. Staff were also to provide assistance with transfers and activities of daily living (ADL) as needed. A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #1 was cognitively intact. The MDS documented that Resident #1 used a wheelchair for mobility and required extensive total assistance with activities of daily living (ADL), including toileting hygiene, bathing, personal hygiene, and transfers. Resident was coded as dependent for sit-to-stand transfers and required substantial/maximal assistance for chair/bed-to-chair transfers. Toilet transfers were not attempted due to medical condition or safety concerns but indicated Resident #1 was always incontinent with bladder and bowel. The MDS coded the resident as having no falls since admission, reentry, or prior assessment. The MDS recorded weight was 125 pounds, height was 5 feet 3 inches and resident was not on any blood thinners.An interview with Health Care Technician (HCT) #1 on 5/6/2026 at 12:50 pm revealed she entered the Resident #1 room with HCT #2 on 5/4/2026 between 2:50 pm and 3:00 pm, after Resident #1 returned from activities because resident repeatedly stated she was wet. HCT #1 stated they were changing Resident #1 in her room, with the walker facing the bed. HCT #1 indicated that this was the way they always changed the resident if she was up and out of bed. HCT #1 stated she stood on one side and HCT #2 stood on the other side, and they assisted the resident to stand from the wheelchair using the walker to hold herself up. HCT #1 stated they removed Resident #1's tabbed wet brief and put a dry tabbed brief on. HCT #1 recalled that resident was wearing a silky like gown and once they had the brief on, all they had to do was drop the gown. HCT #1 stated that once they dropped the gown, resident said, I'm falling, and began going down. HCT #1 stated she did not recall the exact placement of the wheelchair but stated it was not far away. HCT #1 stated they attempted to move the wheelchair underneath the resident, but the resident sat on the edge of the wheelchair. HCT #1 stated she and HCT #2 recognized Resident #1 was not positioned far enough back in the wheelchair and attempted to pull the resident further onto the wheelchair cushion using the gait belt but were unable to move the resident. Resident #1 fell to her knees from the seat of the wheelchair and then fell to the side at an awkward angle. HCT #1 stated the resident landed with one leg, she could not recall which leg but thought it may have been the left, underneath the bed. HCT #1 stated she and HCT #2 used the gait belt to pull Resident #1 from underneath the bed and then obtained a mechanical lift pad. HCT #1 stated she and HCT #2 rolled the resident from side to side to place the mechanical lift pad underneath her and then HCT #1 went to get the nurse while HCT #2 stayed with the patient. HCT #1 did recall that patient immediately began complaining of knee pain after the fall.In an interview with HCT #2 on 5/14/2026 at 2:15 pm she stated that on 5/4/2026 she and HCT #1 entered Resident #1 room after resident returned from activities. She could not remember the exact time but thought it may have been a little after 3:00 pm. They went into the room to change the resident because the resident kept saying that she was wet. HCT #2 stated that they (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	frequently changed resident in her room from the wheelchair. HCT #2 stated that after resident was changed, she attempted to sit before they put the wheelchair fully back under her. HCT #2 stated that resident sat on the edge of the seat of the wheelchair and then began falling forward to her knees. They did attempt to keep the resident on the wheelchair, but they were not able to keep her from falling. Once she fell, she was under the bed a little bit, so they used the gait belt to pull her from under the bed. HCT #2 stated they got the mechanical lift pad from outside of the room and rolled resident two times to put the pad under her. HCT #2 stated they did this because they knew that they would need the mechanical lift to get patient up off the floor. HCT #2 stated she stayed with resident while HCT #1 got the nurse. HCT #2 stated that she did not recall Nurse #1 doing any range of motion checks with the resident or resident refusing. HCT #2 stated that once Nurse #1 said it was ok, they used the mechanical lift to pick resident up off floor and placed her on the bed.A nursing note (Nurse #1) dated 5/5/2026 at 6:20 pm stated that on 5/4/2026 Nurse #1 was called to Resident #1 room by Health Care Technician (HCT). Nurse #1 stated that upon arriving, resident was lying on back with mechanical lift pad already underneath her.In an interview with Nurse #1 on 5/6/2026 at 12:31 pm she stated that on 5/4/2026 sometime after 3:00 pm, Health Care Technician (HCT) #2 came and got her saying that Resident #1 was on the floor. When she arrived in the room, Resident #1 was lying on floor, on a mechanical lift pad. She stated that Resident #1 would not allow nurse to check her range of motion (ROM) but was complaining of knee pain. Nurse #1 stated that there were no visible signs of injury. She stated that since resident was complaining of knee pain, an x-ray was ordered and it showed a fracture. Resident #1 was sent out to the hospital once the x-ray confirmed a fracture.A physician progress note dated 5/5/2026 at 10:15 am documented the resident sustained an assisted fall after attempting to sit down prior to seating being in place. The resident complained of left knee pain following the fall. Records further showed that on 5/5/2026 an x-ray of left knee showed fracture of the distal femoral shaft with malalignment.A review of records revealed that resident was discharged from the facility on 5/5/2026 and admitted to the hospital.The Director of Nursing (DON) stated in an interview on 5/14/2026 at 2:45 pm that nursing staff frequently changed Resident #1 from her wheelchair. The DON stated that it would have been better for staff to get the Resident into the bathroom for incontinence care, but Resident #1 does not always cooperate. The DON agreed that residents should not fall during incontinence care or while staff were providing care.In an interview with Care Director (facility Director) on 5/14/2026 at 2:51 pm she stated that during the facility investigation it was found that Resident #1 needed to be changed. HCT #1 and HCT #2 entered resident's room, put a gait belt on resident, put the walker in front of resident and asked her to stand up. Resident #1 was able to stand with no issue, but when she went to sit back down in the wheelchair, she sat too close to the edge of the wheelchair. The HCT's attempted to slide her back into the wheelchair utilizing the gait belt but were unable to and resident fell out of the chair to her knees. At the time of the fall Resident #1's mobility was plus two assist with transfers with gait belt and rolling walker. An interview with the Medical Director was conducted on 5/14/2026 at 2:25 pm. The Medical Director stated that she was aware that Resident #1 had a fall from her wheelchair on 5/4/2026. The Medical Director indicated she had some concerns about the way the incident was documented in that there were no nurses' notes detailing the incident. The Medical Director stated it was okay for staff to change residents from their wheelchair, but it must be done in a safe manner.