PRINTED: 05/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING ______ B. WING ______	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITCHFORD FALLS HEALTHCARE	8200 LITCHFORD ROAD RALEIGH, NC 27615

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 4/9/19 through 4/12/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #41MJ11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 4/12/19. Event ID #41MJ11.	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 and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for behaviors and weight loss program for 2 of 22 residents reviewed for MDS accuracy (Resident #86 and Resident #29). The findings included: 1. Resident #86 was admitted to the facility on 12/13/17 with diagnoses that included hypertension and diabetes mellitus. Review of a progress note dated 1/19/19 revealed Resident #86 attempted to throw the controls to his bed at a staff member. Review of a progress note dated 1/20/19 indicated Resident #86 threw pillows at a staff member.	F 641	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. IMMEDIATE ACTION TAKEN The MDS assessment for resident #86 ARD 01/20/2019 was modified on 04/19/2019 to reflect displaying physical	5/6/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/03/2019

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 Review of Resident #86's minimum data set (MDS) assessment dated 1/20/19 revealed Resident #86 was assessed in Section E, question E200A as not having physical behaviors directed towards others during the 7 day look back period of the assessment. During an interview on 4/11/19 at 3:29 PM with the Social Worker she stated Resident #86 displayed physical behaviors directed towards others during the 7 day look back period of the assessment and question E200A was coded incorrectly. During an interview with the Administrator on 4/12/19 at 10:30 AM who indicated it is her expectation MDS assessments are coded completely and accurately. 2. Resident #29 was admitted to the facility with diagnoses that included: Unspecified Dementia without Behavioral Disturbance, Abnormal Posture, Contracture Right Knee and Abnormalities of Gait and Mobility among others. Review of the MDS assessment for resident #29 dated 07/27/18 revealed the resident was coded in section K 0300 Weight Loss as being on a physician prescribed weight loss regime. Review of the physician ' s orders for July 2018 revealed resident #29 was prescribed a diet of pureed double portions of fortified foods, a nutritional supplement of Medpass 2.0, 120 milliliters three times per day and a vitamin, Decuvite 1 by mouth daily for wound healing.	F 641	behaviors on the look back period per RAI guidelines in section E of MDS by MDS Nurse #1 the modified MDS assessment was transmitted on 04/23/2019 by MDS nurse #1. The MDS assessment for resident #29 ARD 07/27/2018 will be modified on 04/19/2019 to reflect resident no on a prescribed weight loss regime on the look back period per RAI guidelines in section K of MDS by MDS Nurse #1 the modified MDS assessment was transmitted on 04/23/2019 by MDS nurse #1. IDENTIFICATION OF OTHERS 100% audit for current residents most recent MDS assessment was completed by the Director of Social Services on 04/18/2019 to determine if any other residents displayed physical behaviors in the look back period was coded appropriately per RAI guidelines in section E of MDS 3.0. The results of the audit revealed two other residents were coded inaccurately per RAI guidelines in section E of MDS 3.0. Findings of this audit is documented on “Section E Coding Audit” located in the facility compliance binder. 100% audit for current residents most recent MDS assessment was completed by the Dietary Manager on 04/17/2019 to if other residents with no prescribed weight loss regime was coded accurately in section K of MDS 3.0. The results of the audit indicated no other	

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F 641	Continued From page 2 No physician orders for a weight loss regime were found in resident #29 ' s record. During an interview on 04/11/19 at 08:30 AM the dietary manager indicated that she had coded section K 0300 of resident #29 ' s MDS assessment incorrectly as resident #29 was not prescribed a weight loss regime. She further indicated that she would correct this.	F 641	residents coded inaccurately per RAI guidelines in section K 0300 of MDS 3.0. Findings of this audit is documented on "Section K Coding Audit" located in the facility compliance binder. SYSTEMIC CHANGES Effective 05/06/2019, residents who display physical behavior and not on a prescribed weight loss regime will be coded in MDS 3.0 per RAI guidelines. On 04/26/2019, MDS consultant from the contracted Management and Consulting Company will conduct re-education to Director of Social Services and Dietary Manager on accurate coding of MDS using Resident Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS, specifically related to section E 200A and Section K 0300 of MDS 3.0 assessment. Effective 05/06/2019, education on the accurate coding of MDS will be added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (DM). This education will also be provided annually for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (CDM). MONITORING PROCESS Effective 05/06/2019, prior to submission, MDS Nurse #1 will review section E 200A and Section K 0200 of MDS 3.0 0300 completed by Director of Social Services	

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F 641	Continued From page 3	F 641	and Dietary Manager to ensure that documented displayed physical behaviors and residents no prescribed weight loss regime is coded accurately per RAI guideline respectively. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Any inaccurate coding identified will be noted and corrected before submission by MDS nurse #1. Findings of this monitoring process will be documented on MDS accuracy monitoring tool located in the facility compliance binder. Effective 05/06/2019, MDS nurse #1 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 05/06/2019, the Executive Director and MDS Nurse #1will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard potentially hazardous opened food items stored in 1 of 1 walk-in refrigerator by their expiration date. The findings included: An observation of the walk-in refrigerator on 4/9/19 at 10:20 AM with the Dietary Manager revealed one container of left over chicken and pastry labeled with a use by date of 3/27/19 and one container of a liquid labeled broth with a use by date of 3/31/19. During the observation on 4/9/19 at 10:20 AM the Dietary Manager stated the food items should have been discarded by the use by date written	F 812	IMMEDIATE ACTION TAKEN On 04/09/2019, the Dietary Manager discarded the container of leftover chicken and pastry labeled with a use by date of 03/27/2019. IDENTIFICATION OF OTHERS All residents have potential to be affected. On 04/09/2019, the Dietary Manager audited the kitchen to ensure opened food items were discarded by their expiration date. This audit revealed no other opened food items were past their expiration date. SYSTEMIC CHANGES	5/6/19

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F 812	Continued From page 5 on the labels on the containers of the food items.	F 812	Moving forward, effective 05/06/2019, the dietary staff will discard opened food items by their expiration date. Moving forward, effective 05/06/2019, the dietary manager will designate staff to use the Food Storage Expiration Schedule to monitor for expired food daily. On 04/15/2019, the Registered Dietician completed an education with the Certified Dietary Manager regarding food storage and discarding open food items by their expiration date. On 04/15/2019, the Certified Dietary Manager completed 100% education with dietary staff to include full time, part time and as needed staff. This education included food storage and discarding opened food items by their expiration date. This education will be completed by 05/06/2019, any dietary staff not educated by 05/06/2019 will not be allowed to work until educated. This education will be added on new hire orientation process for all dietary staff effective 05/06/2019. MONITORING PROCESS Effective 05/06/2019, the Certified dietary Manager and/or Administrator will monitor compliance of discarding outdated food items by their expiration date daily (Monday - Friday) for 4 weeks, weekly for 4 weeks, then monthly until substantial compliance is maintained for three consecutive months. Effective 05/06/2019, MDS nurse #1 will	

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F 812	Continued From page 6	F 812	report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 05/06/2019, the Executive Director and Dietary Manager will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	