	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345555	B. WING		C 09/12/2019			
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	03/12/2013			
			3	830 BLUE RIDGE ROAD				
HILLCRES	T RALEIGH AT CRABT		R	ALEIGH, NC 27612				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
E 000	Initial Comments		E 000					
F 000	survey was conducte	ID # W84111.	F 000					
	A recertifucation and conducted from 9/9/1	complaint survey was 9 through 9/12/19.						
	1 of the 2 complaint a substantiated resultin	g in a deficiency.						
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	lents	F 641		10/10/19			
	resident's status. This REQUIREMENT	of Assessments. at accurately reflect the is not met as evidenced						
	facility failed to accur Data Set (MDS) asse restorative nursing se sampled residents re	ervices provided for 2 of 3 viewed for range of motion esident #44) and failed to I resident going to an		This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or th one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	n			
	The findings included	:		[F 641] Accuracy of Assessments				
	1/29/19 from a hospit diagnoses included d muscle weakness, ar	ementia, generalized ad a history of cellulitis (a		Address how corrective action will be accomplished for those residents found have been affected by the deficient practice;	i to			
	bacterial skin infectio	n) of her right lower limb.		On 09/12/2019 the MDS Nurse correct	ed			

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/16/20 RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345555	B. WING		0	C 9/12/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
HILLCRES	T RALEIGH AT CRABT	REE VALLEY) BLUE RIDGE ROAD _EIGH, NC 27612		
				KAL	•	TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 641	Continued From page	e 1	F	641			
	A review of the reside				Resident #39⊡s MDS assessmen	t so that	
	"Restorative Care" fro	om July 2019 was		i	it reflected involvement in the prop	ber	
		is for completion of the form			restorative program. The informat		
	were as follows: "Us program, Document	e one page for each the restorative program,			then submitted to CMS by the MD Nurse.	S	
		problem, document the goal		'			
	in measurable and qu				On 10/03/2019 the MDS Nurse co	rrected	
		ntions. Record restorative			Resident #44⊡s MDS assessmen		
		ing the grid. Enter initials			it reflected involvement in the prop	ber	
	-	plete a weekly evaluation by			facility restorative program. The	0.10	
	-	dent 's response and			information was then submitted to	CMS	
	progress towards goa	be written by the Restorative			by the MDS Nurse.		
		y the Licensed Nurse or they			On 09/11/2019 the MDS nurse co	rected	
		Licensed Nurse." Upon			Resident #94□s MDS assessmen		
	review, the record inc	dicated Resident #39 began		i	it reflected the correct discharge lo	ocation.	
		om the restorative nursing			The information was then submitte	ed to	
		She received at least 15			CMS by the MDS Nurse.		
		e nursing services on each of					
	•	uring the remainder of July:			Address how the facility will identif	-	
		6/19, 7/18/19, 7/21/19, 4/19, 7/26/19, 7/29/19,			residents having the potential to b affected by the same deficient pra		
	7/30/19, and 7/31/19				anected by the same dencient pra	clice,	
	,				On 09/12/2019 the DON⊡s desigr	nee	
		sident #39 ' s Restorative			began auditing 10% of MDS subm		
	Care records from Ju	lly 2019 included the			last quarter (July, August, Septem		
	following, in part:				2019) MDS assessment to ensure		
		ility or sitting balance at risk for decreased bed			coding for restorative program and		
		balance if she does not			accurate discharge locations, if en were found they were corrected a		
	perform these tasks r				resubmitted by the MDS nurse.		
		plete rolling side to side in					
		petitions and supine times			Audits will be completed by Octob	er 10,	
		t. Or, patient to complete		:	2019.		
		eri-chair forward reaching					
		mity 5 times 10 repetitions			Address what measures will be pu		
	each.	with potiont on rolling side			place or systemic changes made t		
		with patient on rolling side pine with sit; or, if patient in			ensure that the deficient practice v	viil not	

Facility ID: 20120054

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 10/16/20 M APPROVI D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		345555	B. WING				/12/2019
NAME OF PR	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRES	T RALEIGH AT CRABT	REE VALLEY			330 BLUE RIDGE ROAD ALEIGH, NC 27612		
	4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTI		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETIO DATE
F 641	Continued From page	<u>م</u>	E E	641			
		complete forward reaching					
	with upper extremities				Random audits of MDS documents	bv	
	••	tes were written by the			DON/designee will be performed we	-	
	Restorative Aide on 7				for 4 weeks, then bi-weekly x 2 mon		
	7/28/19.				and monthly x 6 months to ensure c	-	
		ursing Evaluation was			is consistent with Residents actua		
	signed by the Restora				condition and treatment. Upon disco	•	
	of care was appropria	dicated the resident 's plan			of errors, frequency of audits will be increased until we have two consec		
	Restorative Program				audits with no error. The DON/desi		
	Program: Range of				will be responsible to ensure	9.100	
	• •	at risk for decreased ROM			implementation of the acceptable pl	an of	
	and strength if she is -Goal: Patient will cor	not exercised regularly. nplete seated in the			correction.		
		bed active/active assist			On 09/12/2019 the MDS nurse note		
		lateral lower extremities with			have made the errors received in-se		
	-	s each. Active ROM means			education regarding accurately com		
		n exercise to move a joint e or effort of another person			the MDS and avoiding errors. It was discovered the MDS errors were ma		
		inding the joint. Active			due to human error. The MDS nurs		
		the use of the muscles			made these errors has been an MD		
		to perform the exercise but			nurse for several years and has not	-	
	requires some help freequipment.	om the therapist or			this happen prior.		
		nt will complete bilateral			Indicate how the facility plans to mo	nitor	
		e/active assist ROM exercise			its performance to make sure that		
	all planes 2 times 10	-			solutions are sustained;		
		tes dated 7/14/19, 7/21/19, tten by Restorative Aide #2.			This plan of correction will be review	und in	
		rsing Evaluation was signed			the next regularly scheduled Quality		
	-	irse and dated 8/1/19. The			Assurance meeting October 23, 201		
	-	esident 's plan of care was			and the dates to determine continua		
	appropriate; no chang	-			monitoring reports are subject to the	e vote	
	Program were recom	mended.			of this interdisciplinary committee.		
		#39 's Restorative Care					
	records from August 2	2019 was also completed					1
	-	ted the resident continued to					

Facility ID: 20120054

If continuation sheet Page 3 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345555	B. WING				C / 12/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST RALEIGH AT CRABTE	REE VALLEY			3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	minutes of services w provided on 8/1/19 (th back period for the m Set or MDS assessm The resident ' s most (MDS) assessment w MDS dated 8/1/19. T #39 had intact cogniti making. She required extensive assistance locomotion on the uni resident was totally du transfers, toileting, an Section O of the MDS indicate the resident H facility ' s restorative for 7-day look back period A review of Resident plan included a Proble increased risk of a de (Problem onset: 8/9/1 An interview was con PM with Restorative A facility ' s Restorative interview, RA #2 repo services from the rest and was typically part stated restorative nur offered 6 days a weel generally included 2 s upper and lower extre- bed or sitting in a char	he month. At least 15 rere documented as ne last day of the 7-day look ost recent Minimum Data ent). recent Minimum Data Set as a Significant Change the MDS revealed Resident ve skills for daily decision d supervision for eating, from staff for bed mobility, t, and dressing. The ependent on staff for id personal hygiene. S assessment did not had been involved in the nursing program within the d. #39 ' s comprehensive care em/Need related to her crease in range of motion 9). ducted on 9/11/19 at 2:35 Aide (RA) #1, RA #2, and the Nurse. During the rted Resident #39 received torative nursing program t of her assignment. She sing services were routinely k for this resident and sets of 10 exercises for her emities either while lying in ir.	F	641			

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If continuation sheet Page 4 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345555	B. WING				C 12/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HILLCRES	ST RALEIGH AT CRABTE	REE VALLEY			3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 641	nurse was asked to re #39 's MDS dated 8/ MDS was coded corre Restorative Nursing s resident, the nurse sta An interview was con AM with the facility 's the interview, the MD Section O of Residen be inaccurate. She re accordance with the g An interview was con AM with the facility 's During the interview, ' coding of the restorat MDS assessments we asked, the DON state the MDS to be accura 2) Resident #44 was 11/24/17 with reentry His cumulative diagno intracranial hemorrha vegetative state. A review of Resident dated 7/6/18 was con referred to the restorat Range of Motion (RO category and services active assist ROM (A extremity, AAROM rig AAROM bilateral lowe assisted ROM refers	During the interview, the eview Section O of Resident 1/19. When asked if the ectly to reflect the services provided for this ated it was not. ducted on 9/12/19 at 8:59 MDS Coordinator. During S Coordinator reported t #39 's MDS was found to eported it was modified in guidelines. ducted on 9/12/19 at 11:22 5 Director of Nursing (DON). the concerns identified with ive nursing program on the ere discussed. When ad her expectation was for ate. admitted to the facility on on 8/23/17 from a hospital. bess included a history of an ge and a persistent #44 's Restorative Referral ducted. The resident was ative nursing program for M). The restorative is were noted to include: 1) AROM) right upper ght lower extremity, and er extremities. Active to the use of the muscles to perform the exercise but	F	641			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/16/2019 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345555	B. WING			_		/12/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
	ST RALEIGH AT CRABTE				3830 BLUE RIDGE ROAD				
HILLORE	DI KALEIGH AI CRADIP				RALEIGH, NC 27612				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRI/ EFICIENCY)		(X5) COMPLETION DATE	
F 641	upper extremity and F Passive ROM refers to through the range of to the patient. Further review of Ress revealed a Rehabilitation Registered Occupation dated 7/18/19. The s observations/concern currently dependent of all of his Activities of If functioning at baselin A review of the reside "Restorative Care" fro conducted. Direction were as follows: "Use program. Document describe the specific in measurable and qu document the interven minutes of service us and signatures. Com documenting the reside progress towards goa progress notes may b Aide and cosigned by can be written by the review, the records in received at least 15 m services on each day with the exception of	assive ROM (PROM) left PROM right lower extremity. to the movement of a joint motion with no effort from sident #44 ' s records tion Screen dated 2/5/19 resident was noted to be e. The resident ' s most Screen was completed by a onal Therapist (OTR) and creen ' s is noted the patient was on staff for assistance with Daily Living (ADLs) and was e. ent ' s record entitled, om July 2019 was s for completion of the form e one page for each the restorative program, problem, document the goal uantifiable terms, and ntions. Record restorative ing the grid. Enter initials uplete a weekly evaluation by dent ' s response and als on the back. The pe written by the Restorative y the Licensed Nurse." Upon	F	64	1				

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	-	ID HUMAN SERVICES				FO	TED: 10/16/2019 DRM APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	NO. 0938-0391 ATE SURVEY DMPLETED
		345555	B. WING				C 09/12/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ILLCREST RALEIGH AT CRABTREE VALLEY			38	330 BLUE RIDGE ROAD		
HILLCRE	ST RALEIGH AT CRABTE			R	ALEIGH, NC 27612		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641	Continued From page	9 6	F	641			
	Care records from Ju following, in part: Program: AAROM -Problem: Patient is a and contracture deve -Goal: Patient will tole assist right should fle: or joint)/extension (a si increases the angle b flexion/extension, wris -Interventions: Right repetitions in all availa extension and hip flex PROM left upper extr flexion/abduction (the other part away from body)/adduction (the part toward the midlin repetitions each. -Weekly Progress No 7/21/19, and 7/28/19 Aide #2. The progress "Resident participated exercise 10 reps (rep (bilateral) LE (lower e extremity) in all plane The progress note da participated 4 days of PROM B (bilateral) LB planes to prevent con The progress note da participated 6 days of (bilateral) UE and LE. planes to prevent con The progress note da	at risk for decline in strength lopment. erate 10 repetitions of active xion (the bending of a limb straightening movement that etween body parts), elbow st finger flexion/extension. upper extremity 10 able planes. Right knee kion times 10 repetitions; emity and hip movement of a limb or the midline of the movement of a limb or other te of the body) times 10 tes dated 7/7/19, 7/14/19, were written by Restorative es note dated 7/7/19 read, d 4 days of his restorative etitions) on PROM B xtremity) and UE (upper s to prevent contractures." ted 7/14/19 read: "Resident i his restorative program in E and UE 10 reps in all tractures." ted 7/21/19 read: "Resident i his restorative program in B . PROM 10 reps in all tractures." ted 7/28/19 read: "Resident i his restorative exercise in					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/16/2019 // APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				LETED
		345555	B. WING				C 12/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRES	ST RALEIGH AT CRABTR	REE VALLEY			830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 641	Continued From page	e 7	F (641			
	contractures."						
	-	ursing Evaluation was					
		ative Nurse and dated dicated the resident ' s plan					
	of care was appropria	ite; no changes to the					
	Restorative Program	were recommended.					
		recent Minimum Data Set as an annual MDS dated					
		evealed Resident #44 had					
	severely impaired cog						
	-	was totally dependent on /ities of Daily Living (ADLs).					
		S assessment reported the					
	following restorative r						
		t 15 minutes a day in the last ve ROM on 6 out of the last					
	7 days.						
		#44 's comprehensive care					
		owing area of focus, in part:					
		ROM; the resident was at rength and contracture					
	development. (Proble						
		ducted on 9/11/19 at 2:35 Aide (RA) #1, RA #2, and the					
	facility 's Restorative						
	interview, RA #2 repo	orted Resident #44 was					
	interview, RA #2 reported Resident #44 was typically part of her assignment. She stated restorative nursing services were routinely offered						
		ervices were routinely offered s resident. Upon further					
		Restorative Nurse reported					
	the resident received	PROM for all joints in his					
	upper and lower extre	emities.					
	An interview was con	ducted on 9/11/19 at 3:36					
		#2 (who also served as the					
	Restorative Nurse).	During the interview, the					

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 10/16/2019 FORM APPROVED IB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION) DATE SURVEY COMPLETED
		345555	B. WING				C 09/12/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CO	DE	
HILLCRES	T RALEIGH AT CRABT			383	0 BLUE RIDGE ROAD		
	-			RA	LEIGH, NC 27612		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 641	#44 's MDS dated 7/ MDS Nurse #2 was a correctly to reflect the services provided for of the MDS and base information, she repo- been coded to indicat PROM (not AROM). An interview was com AM with the facility 's the interview, question services received from program and coding of were discussed. Acc Coordinator, an interv 9/12/19 at 9:10 AM w having completed the #44 on 7/18/19. Duri #44 's Restorative R Screenings were revit the AAROM (active a restorative care plan She stated the reside PROM services at thi An interview was com AM with the facility 's	eview Section O of Resident 26/19. During the interview, isked if the MDS was coded a Restorative Nursing this resident. Upon review d on the restorative program rted the MDS should have te the resident received ducted on 9/12/19 at 8:59 a MDS Coordinator. During ins regarding the type of m the restorative nursing of the MDS assessment companied by the MDS view was conducted on vith the OTR identified as a last evaluation of Resident ing the interview, Resident eferral and Rehab ewed. The OTR reported ssisted ROM) on the initial was no longer appropriate. Int was only able to receive is point in time. ducted on 9/12/19 at 11:22 a Director of Nursing (DON). the concerns identified with ive nursing program	F	641			
	discussed. When as expectation was for the 3. Resident #94 was	ked, the DON stated her he MDS to be accurate. admitted to the facility on oses of chronic diastolic					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE	
		345555	B. WING _				C 12/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRES	T RALEIGH AT CRABT				330 BLUE RIDGE ROAD		
				R	ALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	9	F6	641			
		Date Set (MDS) dated Section A that Resident o acute hospital.					
		11/ 2019 at 3pm revealed s discharged to an Assisted on 7/19/2019.					
	coding all MDS asses reported the MDS for						
	9/12/2019 at 2:30 pm expectation that MDS error.	's were completed without					
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)(eet Professional Standards (i)	F6	658			10/10/19
	as outlined by the cor must- (i) Meet professional s This REQUIREMENT by:	d or arranged by the facility, nprehensive care plan, standards of quality. is not met as evidenced					
	facility failed to compl ordered medication (F 1 of 6 residents (Resi were reviewed.	ew and staff interviews, the etely transcribe a physician Prednisone 5 milligrams) for dent #1) whose medications			This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of		
	Findings included:				Correction is submitted to meet requirements established by state and		

Event ID: W84111

Facility ID: 20120054

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED C 09/12/2019		
		345555	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				383	0 BLUE RIDGE ROAD		
HILLCRES	IILLCREST RALEIGH AT CRABTREE VALLEY			RA	LEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From pag	- 10					
F 050		ge summary dated 8/29/19	F 6		federal law.		
	have changed-Predn	ue these medications which			[F 658] Services Provided Meet		
		ablets (30mg total) by mouth			Professional Standards		
		, then 2 tabs (tablets) (20mg)			Address how corrective action will be		
		1 (10mg) daily for 3 days,			accomplished for those residents foun	id to	
	then back to 5mg do				have been affected by the deficient		
	-				practice;		
	Resident #1 was adn	mitted to the facility on					
		5 day MDS (Minimum Data			On 9/11/2019 Resident #1 was		
		esident assessment) dated			discharged from the facility and did no	ot	
		ident #1 was cognitively			return.		
		uate vision, hearing and clear					
		stance was required for all			Address how the facility will identify ot	her	
	-	ing and active diagnoses			residents having the potential to be		
	included, but were no bronchiectasis, and r				affected by the same deficient practice		
					On 9/11/2019, the DON's designee be	•	
		tian orders dated 8/29/19			auditing all Resident charts to ensure		
	· · ·	sone 10mg-3 tabs po (by) 2 days; Prednisone 10mg			other prednisone tapering was missed		
	, , ,	o daily x 3 days; Prednisone Tomg			Any discrepancies found will be correct immediately and proper communication		
		daily x 3 days; Prednisone			will take place. The audit will be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	5mg tab-1 tab po dai				completed by 10/10/2019.		
	Review of the MAR of	dated 8/29/19 through			All Nurses will be educated by		
	-	, "Prednisone 10mg-3 tabs			DON/designee as to proper procedure	9	
		(times) 2 days; Prednisone			and implementation of review and		
		Omg) po daily x 3 days;			verification of Medication Administration	on	
		bs-1 tab po daily x 3 days;			Records.		
	Prednisone 5mg tab-	-1 tab po daily."			The interaction (101) and the		
		ation Administration Descard			The in-service will be completed by		
		ation Administration Record			10/10/2019.		
		through 9/30/19 revealed bs-2 tabs (20mg) was			Address what measures will be put int	0	
	-	19, and 9/3/19. Prednisone			place or systemic changes made to	.0	
		mg) was received 9/4/19,			ensure that the deficient practice will r	not	
		lo other doses of Prednisone			recur;	101	
		en 9/7/19 and 9/12/19. The					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/16/2019 M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345555	B. WING _			C 09/12/2019		
	ROVIDER OR SUPPLIER	REE VALLEY		38	REET ADDRESS, CITY, STATE, ZIP CODE 30 BLUE RIDGE ROAD ALEIGH, NC 27612			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	MAR was not set up tab po daily. A review of hospital merevealed Resident #1 Emergency Departme 2 day history of short non-productive cough weakness. The hospital "Patient's chronic Pre- at SNF (Skilled Nursi dose of 5mg (milligra Resident #1 was not the investigation, how conducted with a fam at 12:00PM. She stat Prednisone was not i submitted by the facil of transfer on 9/11/19 An interview was com 9/12/19 at 12:25PM. hospital discharge su otherwise from our fa are checked twice at different staff membe verify (Resident #1's) On 9/12/19 at 12:45F attempted with Nurse verification nurse for medications. A voiced returned. An interview was com Nursing on 9/12/19 at	for Prednisone 5mg tab-1 ecords dated 9/11/19 was brought to the ent on 9/11/19 for a reported ness of breath with a n and increased generalized ital record revealed a 9/11/19 which read, in part, ednisone was NOT continued ng Facility). Resume usual ms). in the facility at the time of vever, an interview was illy member (FM) on 9/12/10 red the chronic dose of ncluded on the MAR lity to the hospital at the time o.	F6	558	Random audits of Medication Administration Records will be perfor by DON/designee weekly x 4 weeks, bi-weekly x 2, and monthly x 1 to ens policy and procedures are followed relating to verification of Medication Administration Records and ensuring accurate transcription has occurred. Indicate how the facility plans to mon its performance to make sure that solutions are sustained; This plan of correction will be reviewe the next regularly scheduled Quality Assurance meeting October 23, 2019 the dates to determine continuation of monitoring reports are subject to the of this interdisciplinary committee.	then ure itor ed in 9 and of		

If continuation sheet Page 12 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	JLTIPLE CONSTRUCTION DING			SURVEY PLETED
		345555	B. WING				0 12/2019
NAME OF P	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
HILLCRES	ST RALEIGH AT CRABTR	REE VALLEY			3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE SC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE
F 658 F 761 SS=D	We verify the medical them then we fill out a MAR, physician order summary are all faxed end of the month eac charts to review. They record on hand again accuracy. The medica nurses for accuracy. I be transcribed correct accuracy. We are a re we have such a high that's no excuse. The accurate. I don't know Prednisone wasn't piot (Nurse #4)." Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle: appropriate accessor instructions, and the e applicable. §483.45(h) Storage o §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The face locked, permanently according to the second second second second second second second second second second second second second second second second second seco	tions with the physician and a physician order sheet. The r sheet and discharge d to our pharmacy. At the h nurse is assigned specific y check the medication st the orders on the chart for ations are checked by 2 My expectation is for them to tly and checked for eally busy facility because patient turnover ratio, but medications should be why the missed 5mg cked up on the MAR by d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized		761			10/10/19

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	-	ID HUMAN SERVICES				FOR	D: 10/16/201 APPROVE: 0.0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345555	B. WING			09	C / 12/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
HILLCRES	ST RALEIGH AT CRABTE	REE VALLEY			330 BLUE RIDGE ROAD ALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 761	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 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, staff interviews and record reviews, the facility failed to discard expired medications on 1 of 4 medication carts observed (PP Hall Med Cart 1); and failed to store medications as indicated by the manufacturer on 2 of 4 medication carts observed (TG Hall Med Cart 1 and TG Hall Med Cart 2). The findings included: 1-a) In the presence of Nurse #1, an observation was conducted of the PP Hall Med Cart 1 on 9/10/19 at 12:00 PM. The observation revealed an opened vial of Lantus insulin dispensed by the pharmacy on 8/6/19 and labeled for use by Resident #91 was stored on the medication cart. The insulin vial was dated as having been opened on 8/6/19; no shortened expiration date was written on the vial. At the time of the observation, Nurse #1 reported the opened vial of insulin was expired and needed to be discarded. The shortened expiration date for the opened vial of insulin was 		F	761	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submiss of the Plan of Correction is not an admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 761] Label/Store Drugs and Biolog Address how corrective action will be accomplished for those residents four have been affected by the deficient practice; On 9/10/2019 the cited deficiency regarding resident #91 and #70 was corrected immediately by having Nurs discard insulin and ordered new insuli vial on 9/10/2019. On 9/10/2019 the cited deficiency	e ion nat icals id to e #1 n	
	insulin vial should hav after opening.	9. Nurse #1 stated the ve been discarded 28 days			regarding residents # 39 and #25 was corrected immediately by having Nurs removing and discarding eye drops ar ordered new eye drops.	e #3	
	A review of the manufacturer 's storage instructions indicated once opened (in use), vials of Lantus insulin should be used within 28 days.				On 09/11/2019 dividers were ordered, these dividers were installed on 09/15/2019 and will ensure eye drops		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG		C	
		345555	B. WING			0	9/12/2019
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	ST RALEIGH AT CRABT			383	0 BLUE RIDGE ROAD		
THELONE				RA	LEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From page	e 14	E T	761			
	A review of Resident	#91's physician orders			could be stored upright.		
	Lantus insulin (initiate			Address how the facility will identify o residents having the potential to be	ther		
	An interview was con AM with the facility ' s			affected by the same deficient practic	e;		
	Upon inquiry, the DO			On 9/10/2019 the pharmacy consulta			
		ulin when it was opened and			observed medication carts on Carolin		
		priately. She acknowledged			Shores and confirmed all insulins wer	е	
		halog insulins had shortened			dated appropriately and no issues	A 11	
	discarded 28 days af	e opened and needed to be			identified with storage of eye drops. A nurses in-serviced by the pharmacy	H II	
	uiscalueu 20 uays al	ter opening.			consultant/nurse supervisor on prope	r	
	An interview was con	nducted on 9/12/19 at 1:25			storage of insulin and eye drops.	•	
		s consultant pharmacist.			In-services will be completed by		
	-	the medication storage			10/10/2019.		
	•	om observations were					
	discussed. When as	ked, the pharmacist reported			Address what measures will be put in	to	
		ulins to be dated with a			place or systemic changes made to		
	-	date. She also stated			ensure that the deficient practice will	not	
		insulin would need to be			recur;		
	discarded when expli	red (28 days after opening).			Dendem audite of C mod conta for an		
	1 b) In the procence.	of Nurse #1, an observation			Random audits of 6 med carts for pro storage and disposal of insulin and pr	-	
		e PP Hall Med Cart 1 on			storage of eye drops will be conducte		
	9/10/19 at 12:00 PM.				the nurse supervisors/designee for a	aby	
		aled an opened vial of			period of weekly x 4 weeks, bi-weekly	/ x 2	
		ensed by the pharmacy on			months, to ensure there is no expired		
		or use by Resident #79 was			medication on the cart and medication		
		tion cart. The insulin vial			stored properly. The DON/designee	will	
		been opened on 8/4/19 with			be responsible for implementing the		
	-	on date of 9/2/19 written on			acceptable plan of correction.		
		of the observation, Nurse #1			Indicate how the facility stars to	itor	
		vial of insulin was expired carded. She stated the			Indicate how the facility plans to mon	ILOF	
		ve been discarded 28 days			its performance to make sure that solutions are sustained;		
	after opening.	ve been discarded 20 days			solutions are sustained,		
	siter opening.				This plan of correction will be reviewed	ed in	
	A review of the manu	facturor ' e storago			the next regularly scheduled Quality		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1)			(X2) MULTIP	LE CONSTRUCTION	(X3) DA	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
	345555		B. WING		0	9/12/2019	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE		
				3830 BLUE RIDGE ROAD			
				RALEIGH, NC 27612			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 761	Continued From page	e 15	F 76	1			
		opened vials of Humalog		Assurance meeting Octob	er 23, 2019 and		
	insulin should be use			the dates to determine cor	ntinuation of		
				monitoring reports are sub	•		
		ent's physician orders		of this interdisciplinary con	nmittee.		
	revealed Resident #79 had a current order for Humalog insulin (initiated on 8/1/19).						
	An interview was con	ducted on 9/12/19 at 11:15					
	AM with the facility ' s	Director of Nursing (DON).					
		N reported nursing staff was					
		Ilin when it was opened and					
	both Lantus and Hur	priately. She acknowledged					
		date once opened and					
		ed 28 days after opening.					
		ducted on 9/12/19 at 1:25					
		s consultant pharmacist.					
		the medication storage om observations were					
		ked, the pharmacist reported					
		ulins to be dated with a					
		date. She also stated					
		insulin would need to be					
	discarded when expir	ed (28 days after opening).					
	2) Accompanied by N	lurse #2, an observation of					
	the TG Hall Med Carl						
		A bottle of 0.5% Lotemax					
		on (a steroid-containing eye					
		the pharmacy on 6/3/19 for					
		served to be lying down on of the medication cart. The					
		op container in the med cart					
	was shown to the nur						
	manufacturer labeling						
	indicated the medical	tion needed to be stored in					
	an upright position.						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345555		345555	B. WING				C / 12/2019
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST RALEIGH AT CRABTE				3830 BLUE RIDGE ROAD		
				F	RALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 761	The manufacturer reco of Lotemax ophthalmi bottle of eye drops sh position. A review of Resident included a current or ophthalmic suspension An interview was con AM with the facility 's When asked about th suspension eye drops be stored in (an) uprig An interview was con PM with the facility 's During the interview, concerns identified fro discussed. Upon inquishe would expect oph stored in an upright p 3) Accompanied by N the TG Hall Med Cart 9/10/19 at 12:13 PM. bottle of 0.1% fluorom suspension (a steroid observed to be lying of of the med cart. The efform the pharmacy of Resident #25. Manuf bottle of the eye drop upright position." An Nurse #3 at the time of the eye drops were ly drawer of the med car confirmed the instruct	ommendations for storage c suspension indicated the ould be stored in the upright #39's physician orders ler for 0.5% Lotemax in (initiated 2/11/19). ducted on 9/12/19 at 11:15 Director of Nursing (DON). e storage of ophthalmic s, the DON stated, "It should ght position." ducted on 9/12/19 at 1:25 consultant pharmacist. the medication storage om observations were uiry, the pharmacist reported thalmic suspensions to be osition. urse #3, an observation of 2 was conducted on During the observation, a netholone ophthalmic -containing eye drop) was down on its side in a drawer eye drops were dispensed in 9/2/19 and labeled for acturer labeling on the s read in part, "Store in an interview conducted with of the observation confirmed ing down on its side in the	F	761			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/16/2019 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345555	B. WING			/12/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • •	
HILLCRES	T RALEIGH AT CRABTE	REE VALLEY		3830 BLUE RIDGE ROAD		
				RALEIGH, NC 27612		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 761	Continued From page	e 17	F 76	31		
	pharmacy sticker) ind to be stored in an upr	licated the container needed ight position.				
	for the storage of fluo	facturer recommendations rometholone ophthalmic the bottle of eye drops n upright position.				
		#25's physician orders der for 0.1% fluorometholone on.				
	AM with the facility 's When asked about th	ducted on 9/12/19 at 11:15 b Director of Nursing (DON). e storage of ophthalmic s, the DON stated, "It should ght position."				
	PM with the facility 's During the interview, concerns identified fro discussed. Upon inqu	ducted on 9/12/19 at 1:25 consultant pharmacist. the medication storage om observations were uiry, the pharmacist reported nthalmic suspensions to be				
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2)	ent Activities	F 86	57		10/10/19
	§483.75(g) Quality as	ssessment and assurance.				
	action to correct ident					
		ns, record review, staff and e facility ' s Quality		This plan of correction constitute written allegation of compliance f		

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		MEDICAID SERVICES					NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			C	
345555		B. WING					
NAME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	<u> </u>	09/12/2019	
					E RIDGE ROAD		
HILLCRES	ST RALEIGH AT CRABTE	REE VALLEY			I, NC 27612		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION
F 867	Continued From page	e 18	F 86	7			
		formance Improvement			encies cited. However, submiss	sion	
		iled to maintain implemented			Plan of Correction is not an		
		tor the interventions that		admis	ssion that a deficiency exists or	that	
	were put in place follo	-			vas cited correctly. This Plan of		
		mplaint survey of 9/07/2018.			ection is submitted to meet		
	This was for 1 recited			rements established by state an	d		
	accuracy of assessme		tedera	al law.			
was re-cited during the complaint survey of 9/1 failure of the facility dur record showed a patter to sustain an effective of				IE 86	7] QAPI/QAA Improvement Activ	vities	
				-	ess how corrective action will be		
		ern of the facility 's inability		accor	nplished for those residents fou	nd to	
			have practi	been affected by the deficient ce;			
	Findings included:						
	This tag is cross refe	rred to:		Resid	(12/2019 the MDS Nurse correc lent #39's MDS assessment so		
					ected involvement in the proper		
		n staff interviews and record			rative program. The information	i was	
		iled to accurately code the IDS) assessment to reflect		CMS.	submitted by the MDS Nurse to		
		g services provided for 2 of					
		reviewed for range of motion		On 10	0/03/19 the MDS Nurse correcte	ed	
		esident #44) and failed to		Resid	lent #44's MDS assessment so	that	
	reflect the discharged			it refle	ected involvement in the proper		
	assisted living facility	(Resident #94).			y restorative program. The		
	During a ll life				nation was then submitted by M	DS	
	-	tion and complaint survey of		Nurse	9.		
		was cited for failure to IDS assessment to reflect		0n 00	9/11/2019 the MDS nurse correc	hete	
		and medications received			lent #94's MDS assessment so		
		viewed for unnecessary			ected the correct discharge loca		
	medications (Resider	5			-		
					0/4/2019 the QAA committee wa		
		vith the Administrator on			ed via email that accurate comp		
	-	she revealed it was her			OS assessments and compliance		
	expectation that MDS withour error.	s's would be completed			-641 would be re-entered into the da for the meeting set for Octob		
				-	019.		

Event ID: W84111

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8		FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
				09/12/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HILLCREST RALEIGH AT CRABI		3	830 BLUE RIDGE ROAD	
		F	RALEIGH, NC 27612	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 867 Continued From page	je 19	F 867	Address how the facility will identifing residents having the potential to be affected by the same deficient praction of 09/12/2019 the DON's designed began auditing last quarter (July, A September 2019) MDS assessment ensure proper coding for restorative program and accurate discharge locations, if errors were found they corrected and MDS was resubmitted MDS nurse. Audits will be compled October 10, 2019. On October 23, 2019, the QAA Conwill review the September 12, 2019 deficiency and plan of correction c to address the same. The QAA committee will keep this concern reference F641 on the agenda for than one year. Address what measures will be pupplace or systemic changes made t ensure that the deficient practice w recur; Random audits of MDS documentation of the set of a set of the set of t	e ctice; re August, hts to re vere ed by te by mmittee 0 F641 reated no less t into o vill not ation by veekly nths coding covery e cutive

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345555		(X2) MULTIPL A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		B. WING	C 09/12/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •
HILLCREST RALEIGH AT CRABTREE VALLEY				3830 BLUE RIDGE ROAD RALEIGH, NC 27612	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 867	Continued From pa	ge 20	F 867	7	
				On 09/12/2019 the MDS nurse no have made the errors received in education regarding accurately or the MDS and avoiding errors. The nurse that made these errors has MDS nurse for several years and had this happen prior. The QAA committee will review a conduct interviews with the DON/ nurse to ensure compliance and determine if additional audits or tr are necessary. The QAA commit review these systematic changes quarterly for no less than one yea ensure this deficient practice doe occur. Indicate how the facility plans to r its performance to make sure tha solutions are sustained; This plan of correction will be rev the QAA Committee in the next re scheduled Quality Assurance me October 23, 2019 and the dates t determine continuation of monitor reports are subject to the vote of interdisciplinary committee but wi for no less than one year. The Q committee will also review the res the random audits conducted the 9/23, 09/30, 10/7 and 10/14.	-service ompleting ie MDS is been an has not udits and MDS raining tee will ar to s not monitor t iewed by egularly eting o rring this II remain AA sults of

Facility ID: 20120054

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