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 09/28/2023

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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/26/23 through 09/28/23. Event ID# MDJ11. The following intakes were investigated NC00206667 and NC00207352. 1 of the 6 complaint allegations resulted in deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and Physician interviews, the facility failed to provide care in a safe manner which resulted in a fall from the bed and a hospitalization for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on 11/06/2006 and diagnoses included Traumatic Brain Injury with memory loss and left sided hemiparesis, contracture of the left elbow, glaucoma, memory impairment, and neuropathy. Review of quarterly Minimum Data Set (MDS) dated 06/29/23 revealed Resident #1 was moderately cognitively impaired and needed	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/11/2023

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 09/28/2023

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
F 689	Continued From page 1	F 689		

extensive assistance to total dependence on staff for all activities of daily living. However, Resident #1 was able to feed herself with set up help. Resident #1 needed two plus staff for bed mobility, transfers, turning and reposition.

A review of Resident #1's care plan dated 06/22/23 indicated Resident needed two plus staff to provide care. Further review of the care plan revealed Resident #1 was at risk for falls injury due to weakness, impaired mobility, incontinence, potential side effects from medication, poor safety awareness, and had a fall on 08/26/23 with pain to lower back.

An interview with NA #1 on 09/27/23 at 11:30am was made. NA #1 indicated on 08/26/23 he was providing care for Resident #1 and was turning her when she began to slide off the bed. NA #1 indicated he did not have a second staff member with him, and he caught her fall and lowered Resident#1 to the floor. He indicated she never hit her head or her body on the floor. NA #1 indicated after that incident he was re-educated on Resident # 1's care and treatment. NA #1 indicated he knows now to look at the resident's care card to make sure if two staff are needed, to go and get help.

Review of the incident report dated 08/26/23 read in part "Review of the post-incident action note dated 08/26/23 at 5:10pm indicated the Nurse interviewed the NA and the NA stated he was turning Resident #1 when Resident #1 had begun to slide off the bed. The NA assisted resident to the floor from the bed."

Review of nursing progress note dated 08/26/23 read in part, at 5:10pm the Medication Aide

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 09/28/2023

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
F 689	Continued From page 2	F 689		

(Nurse Aide #1)alerted the Nurse that Resident #1 was on the floor. The Nurse walked in the room and observed the Resident on the floor in a supine position alongside of the bed. The Nurse asked what happened and Resident stated, " I fell to the floor." The Nurse assessed the upper extremity and Resident began to scream. Resident was made comfortable on the floor while the nurse called 911 and received an order to send Resident out to be evaluated and treated . The resident's responsible party was notified and made aware. Resident was transported to hospital.

An interview with Nurse #2 was conducted on 09/28/23 at 10:30am. Nurse #2 indicated NA #1 reported, Resident #1 had a fall. Nurse #2 indicated she assessed Resident #1 after the fall on 08/26/23.

An emailed statement was received from Nurse #2 on 9/28/23. See email below:

As we shared on the phone, "At 5:10pm, NA #1, came to where I was working on West Hall to tell me I was needed on East Hall as Resident #1 was on the floor. I went directly to the room. When I entered, I noticed Resident #1's bed was positioned high; she has a tendency to raise it high. I saw that she was lying on the floor on her back. NA #1 was trying to explain what happened, but I went directly to Resident #1 to assess. I started to move her arm first to assess for any injury. She said, "Ow. Ow. That hurts." So, I stopped the assessment and called 911.
I never completed the assessment past her arm. Resident #1 never complained that her back or her hips hurt. Instead, she kept asking to get off the floor. We explained that it was better to wait

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 09/28/2023

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
F 689	Continued From page 3	F 689		

for EMS. 10-15 minutes later, EMS arrived along with Resident #1's [family member]."

A review of the discharge summary from the hospital dated 08/31/23 revealed "Resident #1 presented to the hospital after a fall at the skilled nursing facility. The CT scan (A computerized tomography (CT) scan combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside the body) showed a possible left sacral fracture of undetermined age. Neurosurgery was consulted and they suggested a total spine MRI (Magnetic resonance imaging, or MRI, is a noninvasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles and blood vessels) and a plan for kyphoplasty (a minimally invasive procedure used to treat vertebral compression fractures by inflating a balloon to restore bone height then injecting bone cement into the vertebral body.) if needed. The MRI obtained demonstrated evidence of a possible sacral fracture that was already seen on CT scan. No further neurosurgical evaluation was warranted. Orthopedics was consulted for sacral fracture findings. Patient has limited mobility at baseline."

An interview was conducted with Resident #1 on 09/27/23 at 10:00am, Resident #1 was able to answer some questions about how she was feeling today and if she had any concerns with her stay. However Resident #1 was not able to recall any falls or incidents during her stay at the facility.

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 09/28/2023

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
F 689	Continued From page 4	F 689		

An interview with the facility Physician via phone was conducted on 09/27/23 at 1:20pm, and he indicated he was aware of Resident #1's fall that occurred in August, and the information from the hospital of a possible sacral fracture. He indicated because of Resident's size and the information from staff interviewed of catching the Resident and lowering her to the floor she would not have a fracture.

During an interview with the Director of Nursing on 09/27/23 at 3:20 pm she indicated that it was her expectation that employees follow plan of care of the resident, including using the level of assistance needed to provide the care, noted in the resident's care summary. The DON stated, "the employee did not cause the resident any harm."

During the interview with the Administrator on 09/27/23, at 3:25pm it was indicated, it was the expectation of the administrator for all care staff to follow the resident's plan of care including using level of assistance determined by nursing in the resident care summary; however, there was no harm caused in this incident.

The facility provided the following corrective action plan with a completion date of 8/30/23.

8/26/23 Nurse Aide (NA) #1 was providing incontinent care to Resident #1 and resident fell from the bed.

On 8/26/23 at approximately 5:10 pm Med Aid (Nurse Aide #1) alerted staff that resident was on the floor. Nurse in to assess. Resident stated, "I fell to the floor." C/o pain to neck and lower back.

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 09/28/2023

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
F 689	Continued From page 5	F 689		

Resident c/o pain with ROM. Order obtained to transfer to local Emergency Department for evaluations and treatment. Responsible Party and Physican notified.

Problem Identified:

Root Cause: The resident was 2 persons assist for bed mobility; NA failed to obtain another NA to help with turning the resident to provide incontinent care.

On 08/26/23 the resident care summary for the affected resident was verified to reflect 2 persons assist.

On 08/23/23 The RN Supervisor re-educated all nursing staff on the resident's care summary and the importance of checking the resident care summary to see if the resident is 1 or 2 persons assist when turning or repositioning a resident.

1. Corrective Action
8/26/23
At approximately 5:30 pm the resident was transferred to Wake Med.

8/26/23
A witness statement was obtained from the employee involved. The employee was reeducated and disciplined per policy.

8/26/23 at 8:48pm
Wake Med ordered a CT scan of the head and C-pine which demonstrated no acute findings. The CT of the chest and abdomen demonstrates a possibly acute left sacral fracture with a chronic appearing left pubic ring fracture. There was

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 09/28/2023

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
F 689	Continued From page 6 notably and moderated compression deformity of L1 possibly chronic. Ortho recommended an MRI. An MRI was obtained that did not show evidence of fracture. It demonstrated evidence of possibly chronic sacral fracture that was already seen on a prior CT scan. Ortho was consulted for findings and stated patient has limited mobility at baseline. Resident is able to sit up in bed. When up out of bed, she is assisted around via wheelchair with her baseline left-sided deficits remaining stable. No recommendation was made for further inpatient work-up as the resident was discharged back to Litchford Falls in stable condition. 8/26/23 Director of Nursing reviewed resident care summary for the affected resident to verify resident was a two-person assist. RN Supervisor re-educated all nursing staff on the resident's care summary and the importance of checking the resident care summary to see if the resident is a one or 2-person assist when turning or repositioning a resident. Nurse Aide #1 was reeducated by the Director of Nursing on checking the resident care summary prior to providing care to any resident. 2. Other Affected Residents 8/28/23 The Director of Nursing, Restorative Nurse Aide, and Therapy Director reviewed all resident care summaries for accuracy on the amount of assistance needed with bed mobility, no problems identified.	F 689		

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 09/28/2023

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
F 689	Continued From page 7	F 689		

Staff Development Coordinator educated the nursing staff (CNA and licensed nurses) to refer to the resident's care summary prior to providing care to any resident.

The Director of Nursing, Staff Development Coordinator, or Unit Manager educated the nursing staff on how to perform bed mobility using one-person and two-person assist.

9/1/23
Resident readmitted to facility. Resident c/o of pain & was given medication that was effective.

3. Systemic Changes
Beginning 8/29/2023, education will be provided to all new hires who provide direct care to refer to the resident's care summary during orientation and/or prior to being assigned to any resident.

Beginning 8/29/2023, the Director of Nursing, Unit Manager, and Staff Development Coordinator will ensure all new admission's Resident Care Summary is completed indicating a resident's level of assistance.

4. Monitoring Procedure
Director of Nursing or designee will audit all new admission's care guides daily in daily clinical meeting to ensure accurate bed mobility assistance is reflected in the resident's care summary daily, Monday through Friday.

" Daily X 1 week
" 3 X week X 1 week
" Biweekly X 2 Weeks
" 1 X week X 2 Months
" Monthly X 2 Months

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 09/28/2023

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
F 689	Continued From page 8	F 689		

The Unit Manager, Staff Development Coordinator, and Director of Nursing will randomly select CNAs to ensure staff are using the correct number of certified nursing assistants when providing incontinent care to residents.

" 3 NA Daily X 1 week
" 3 NA 3 X week X 2 weeks
" 3 NA 2 X week X 2 Weeks
" 3 NA 1 X week X 2 weeks
" 3 NA 1 X Month for 3 months

Director of Nursing or Designee 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 for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

Compliance Date 8/30/2023

The Corrective Action Plan was validated on 09/28/23 and concluded the facility had implemented an acceptable corrective action plan on 08/30/23. As part of the validation process, the plan of correction was reviewed and verified through the review of audit sheets, the in-service records, and staff interviews. Observations were conducted on 09/26/23-though 09/28/23 of staff completing care to residents according to the care plan of 2 plus staff members during residents' care and treatment. QAPI committee minutes reviewed, and staff training and education was reviewed at that time.

Interviews were conducted with staff that was

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 09/28/2023

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
F 689	Continued From page 9 involved with the fall on 08/26/23 and they indicated they had received in-servicing and education on the provision of safe care with residents who needed 2-person or more staff to provide care for residents in the facility. On 09/28/23 there was sufficient evidence to support the facility's Corrective Action Plan was implemented and carried out by 08/30/23. The validation process verified the facility' date of compliance of August 30, 2023.	F 689		