### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345499

**Date Survey Completed:** 06/25/2015

**Name of Provider or Supplier:** Litchford Falls Healthcare

**Address:** 8200 Litchford Road, Raleigh, NC 27615

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**Summary Statement of Deficiencies:**

<table>
<thead>
<tr>
<th>ID</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>The facility was found to be in compliance with the Medicare/Medicaid Long Term Care Regulations 42 CFR Part 483, Sub Part B during a recertification survey.</td>
</tr>
</tbody>
</table>

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**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

**Date:** 06/29/2015

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*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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**Event ID:** TRQJ11

**Facility ID:** 920763

**If continuation sheet Page:** 1 of 1