		ID HUMAN SERVICES			FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345499	B. WING		C 07/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	RD FALLS HEALTHCARE		4	3200 LITCHFORD ROAD	
Enonior		-	I	RALEIGH, NC 27615	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
		cite as a result of this n conducted 7/13/17. Event			
F 281 SS=D	483.21(b)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET ANDARDS	F 281		8/7/17
	(b)(3) Comprehensive	e Care Plans			
	-	d or arranged by the facility, nprehensive care plan,			
		standards of quality. is not met as evidenced			
	facility failed to accurate	ew and staff interviews, the ately transcribe a medication residents reviewed for lent (Resident #52).		This plan of correction constitutes a written allegation of compliance. Preparation and submission of this p this plan of correction does not const an educine on a submission of this p	
	Findings included:			an admission or agreement by the provider of the truth of the facts alleg the correctness of the conclusions se	
	included dementia wi disturbance, and dep quarterly Minimum Da indicated severe cogr "resident is rarely/new	ression. The most recent ata Set dated 05/05/17 hitive impairment with		forth on the statement of deficiencies plan of correction is prepared and submitted solely because of requirer under state and federal law, and to demonstrate the good faith attempts the provider to improve the quality of of each resident. F281	s. The nent by
	(07/12/17) addressed	plan for Resident #52 end-of-life issues, ion use, and skin integrity		IMMEDIATE ACTION TAKEN Staff Development Coordinator (SDC obtained a clarification order from physician on 7/12/17 for resident #52 Ativan 0.5mg twice a day was clarifie	2.
	A physician 's order of	dated 06/23/17 started		Ativan 0.25mg in the morning and At	
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E.	TITLE	(X6) DATE 08/05/2017

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/17/2017 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345499	B. WING				C 13/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	RD FALLS HEALTHCARE	_		820	00 LITCHFORD ROAD		
	TALLS REALINCARE	-		RA	ALEIGH, NC 27615		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	morning and 0.5 mg p order also discontinue Ativan 0.5 mg po twice This was a response the Pharmacy to atter reduction for Ativan. The order was given the nurse at 1:00 p.m was unchecked for "v The order was transo Administration Recorn 06/23/17: "Ativan 0.5 and "Ativan 0.5 mg po MAR for the months of July (07/01 - 07/11) ro po was administered with the order written 0.25 mg each mornin to receive her previou during this period. In an interview on 07/ Director of Nursing (E error in transcription a correct the error and physician. In an interview on 07/ attending physician s physician orders be for	s (mg) by mouth (po) every po at hour of sleep. The ed the previous order for ce a day (bid) for anxiety. to a recommendation from mpt a gradual dose by telephone and initialed by a. The box on the order form verbal orders read back." Tribed on the Medication d (MAR) as two entries on mg po q a.m." at 9:00 a.m. o q HS po" at 9:00 p.m. The of June (06/23 - 06/30) and eflected that Ativan 0.5 mg each morning in contrast on 06/23/17 to give Ativan g. Resident #52 continued us daily dosage of Ativan (12/17 at 12:44 p.m., the DON) acknowledged the and indicated he would inform the attending	F 2	81	0.5mg in the evening. SDC transcriber the clarified order appropriately on residents Medication administration record. Effective 07/12/2017 resident been receiving Ativan 0.25mg in the morning and Ativan 0.5mg in the ever as ordered by the attending physician IDENTIFICATION OF OTHERS All residents with medication or treatm orders have the potential to be affected 100% audit of current medications for current residents completed on 07/28/2017, 7/31/2017, 8/1/2017, 8/2/2017 and 8/3/2017 by the Director Nursing, Assistant Director of Nursing and Staff Development Coordinator to identify any other residents with medication or treatment orders not transcribed appropriately in medicatio and treatment administration records Physician orders. One other order wa identified as not transcribed per physi order. Resident physician notified of to other identified orders, clarification or obtained by Director of Nursing on 08/01/2017 and transcribed per order Resident administration record. Findir of this audit is documented on "Medic transcription audit tool" located in the facility Survey compliance binder. SYSTEMIC CHANGES Effective 8/07/2017, the new 24-hour chart check form revised by Corporate	has hing hent d. all of per s cian he ders on gs ation	
	errors were unavailat	/13/17 at 1:45 p.m., the DON			Clinical Consultant will be implemented This form will enhance the process of checking accuracy of each transcribed		
L	1						L

Facility ID: 920763

If continuation sheet Page 2 of 29

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 08/17/201 RM APPROVE IO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		TE SURVEY MPLETED
		345499	B. WING			0	C 7/13/2017
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFO	RD FALLS HEALTHCARE	E					
	1			RA	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 281	the nurse receiving the daily orders was revie initialed that the 24-h completed. He stated signed off the orders 06/23/17, however the He shared his expect were transcribed acc transcription that mig during the 24-hour ch In an interview on 07, #2 described the pro- order. She stated tha checked for allergies faxed a copy to the p MAR, and notified the	s for order transcription by ne order. The transcription of ewed by the night nurse who our chart review was I that the night nurse had for Resident #52 on e error was not corrected. tation that physician orders urately and that any errors in ht occur were corrected nart check by the night nurse. (13/17 at 6:14 p.m., Nurse cess of receiving a telephone t she read back the order, if it was a medication order, harmacy, wrote it in the e family if an antibiotic was ed that the night nurse did a eview for accurate	F	281	order in a daily basis. Licensed nur duty during night shift will be respon to complete 24-hour chart check wit duty. 24-Hour chart check is the pro of checking all orders received in the recent 24 hours to ensure accurate proper transcriptions. If any medica treatment order is not transcribed a ordered, night shift nurse will ensur transcribed correctly on the Medica Administration Record or Treatmen Administration Records. 24- Hour of check form will be located in a bind titled 24 Hour report at each nurse's station. Director of Nursing (DON), Assistan Director of Nursing (ADON) and/or Development Coordinator (SDC) w complete 100% education for all lic nurses, to include full time, part tim as needed staff, on the new 24-hou check form. This education will be completed by 08/07/2017. Any licer nurse not educated by 08/07/2017 be allowed to work until educated. education will also be added on new orientation process for all new Licer nurses effective 8/7/2017. On 08/04/2017, Regional Clinical D conducted an education with the ce DON, ADON and SDC about the pr of reviewing new physician orders of changes of orders daily (Monday the Friday). This education emphasized how to identify a root cause when a order is not transcribed appropriate actions to be taken to address any discrepancies in a timely manner.	nsible hile on ocess ue most and ation or s e it is tion t hart er s ht Staff ill ensed e and ir chart This w hires nsed will not This w hires nsed irector enter ocess or rough d on in	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FRINTED: 08/17/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345499	B. WING		C 07/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LITCHFO	RD FALLS HEALTHCARE	1		8200 LITCHFORD ROAD RALEIGH, NC 27615	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 281	Continued From page	e 3	F 28 <sup>-</sup>	1	
				Effective 8/07/2017, the center of administrative team, which inclue ADON, and/or SDC, initiated a p reviewing all new physician order change of orders daily (Monday Friday) and will address any dis in a timely manner. The assigned administrative team member will orders written in the physician of to orders transcribed on the Mere Administration Record (MAR). A identified issues will be address promptly and appropriate action implemented as appropriate by ADON, SDC and/or Registered supervisor. Effective 8/07/2017, week end F Nurse supervisor and/or designat licensed nurse will review, all new or change of orders every Satur Sunday and will address any dis in a timely manner. The assigned administrative team member will orders written in the physician of to orders transcribed on the Mere Administration Record (MAR). A identified issues will be address promptly and appropriate action implemented as appropriate by Registered Nurse supervisor, ar reported to the center's DON time MONITORING PROCESS. Effective 08/07/2017, Director of Assistant Director of Nursing, ar Development Coordinator, will m proper transcription of physician	Ides DON, process for ers or through crepancy ed nurse I compare inder forms dication Any ed is will be the DON, Nurse Registered ated ew orders rday & screpancy ed nurse I compare inder forms dication Any ed is compare inder forms dication Any ed is will be the DON, Nurse Registered ated ew orders rday & screpancy ed nurse I compare inder forms dication Any ed is will be the he nd nely.

Event ID: Q6YI11

Facility ID: 920763

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		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/17/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345499	B. WING		07/13/2017
NAME OF PI	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP COD	
LITCHFOF	RD FALLS HEALTHCARE			8200 LITCHFORD ROAD	
				RALEIGH, NC 27615	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETIO
F 281	Continued From page	RUG REGIMEN IS FREE	F 28	<ul> <li>conducting clinical meeting dathis meeting covers any change resident condition that occurred prior daily clinical meeting, resphysician orders written from meeting, any admission/dischoccurred from the last clinical and/or any incidents or accide occurred from the prior clinical The audit and discussion will physician orders are transcribe to the MARs/TARs. Any issued during this monitoring process addressed promptly. Findings meeting will be documented of clinical report form and filed in meeting binder in Director of I office after proper follow ups a Director of Nursing will review completion of daily clinical rep (M-F) X4 weeks, weekly x 4 w monthly x 3 months.</li> <li>Effective 8/7/2017, Director of report findings of this monitoring or n of this plan monthly X3 month the pattern of compliance is m The QAPI committee can moot to ensure the facility remains substantial compliance.</li> </ul>	ge of ed from the view of prior clinical arges meeting ents il meeting. ensure ed correctly s identified s will be from this on a daily n clinical Nursing are done. the port daily veeks, then f Nursing will ing process ce and committee for nodification is, or until naintained. dify this plan
39-E	483.45(d) Unnecessa				

Facility ID: 920763

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345499	B. WING			C 07/13/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOR	RD FALLS HEALTHCARE	:			3200 LITCHFORD ROAD RALEIGH, NC 27615		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	unnecessary drugs. A drug when used (1) In excessive dose therapy); or (2) For excessive dur (3) Without adequate (4) Without adequate (4) Without adequate (5) In the presence of which indicate the do discontinued; or (6) Any combinations paragraphs (d)(1) through 483.45(e) Psychotrop Based on a comprehe resident, the facility m (1) Residents who had drugs are not given the medication is necessar condition as diagnose clinical record; (2) Residents who us gradual dose reduction interventions, unless	An unnecessary drug is any (including duplicate drug ation; or monitoring; or indications for its use; or f adverse consequences se should be reduced or of the reasons stated in bugh (5) of this section. bic Drugs. ensive assessment of a nust ensure that ve not used psychotropic nese drugs unless the ary to treat a specific ed and documented in the e psychotropic drugs receive ons, and behavioral clinically contraindicated, in	F	329			
	by: Based on record revi	is not met as evidenced iew, resident interview, terviews the facility failed to			IMMEDIATE ACTION TAKEN		

Facility ID: 920763

If continuation sheet Page 6 of 29

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/17/2017 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345499	B. WING		0	C 7/13/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP C	CODE	
		_		8200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	=		RALEIGH, NC 27615		
(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 ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	medication for 1 of 5 and failed to monitor administer insulin acc for 3 of 5 residents (F and Resident #40) th unnecessary medicat Findings Included. 1. a) Resident #52 wa Diagnoses included of disturbance and depr quarterly Minimum Da indicated severe cog "resident is rarely/new checked. She was acc entering the facility. The most recent care 07/12/17 for Residen issues, psychotropic integrity issues. A physician ' s order of Ativan 0.25 milligram morning and 0.5 mg po order also discontinue Ativan 0.5 mg po twice was a response to a Pharmacy to attempt Ativan. The order was given the nurse at 1:00 p.m	t dose of an anti-anxiety residents (Resident #52) blood glucose levels and cording to physicians orders Resident #52, Resident #76 at were reviewed for	F 3		pordinator ion order from esident #52. was clarified to ing and Ativan C transcribed ately on nistration 17 resident had ing in the in the evening g physician. atined resident 17 at 6:30am vas noted to be ng physician omission noted rds related to ucose on the 11:30 a.m , 07/09, 07/11/ 4, 07/07, 07/08, 05, 07/06, and signs and enter's Director tor of Nursing ordinator who failed to or resident #52 nsed nurses pool and ance of e in a timely aff	
		nt on the Medication d (MAR) as two entries on		2. a) Licensed Nurse #2 ol resident #76 blood sugar o		

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/17/2017 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED
		345499	B. WING		0	C 07/13/2017
NAME OF PI	ROVIDER OR SUPPLIER		- <b>·</b>	STREET ADDRESS, CITY, STATE, ZIP CODI	E	
		_		8200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	1		RALEIGH, NC 27615		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	and "Ativan 0.5 mg per MAR for the months of July (07/01 - 07/11) re po was administered with the order written 0.25 mg each mornin to receive her previou during this period. In an interview on 07/ Director of Nursing (E error and indicated he inform the attending p In an interview on 07/ attending physician s physician orders be for The nurse who proce nurse who reviewed i for interviews. In an interview on 07/ acknowledged that the received more medica most recent physiciar reduction due to the of 1. b) Resident #52 wa Diagnoses included of disturbance, and dep quarterly Minimum Da indicated severe cogr "resident is rarely/new	mg po q a.m." at 9:00 a.m. o q HS po" at 9:00 p.m. The of June (06/23 - 06/30) and effected that Ativan 0.5 mg each morning in contrast on 06/23/17 to give Ativan g. Resident #52 continued us daily dosage of Ativan (12/17 at 12:44 p.m., the DON) acknowledged the e would correct the error and ohysician. (12/17 at 6:40 p.m., the hared his expectation that ollowed as written. ssed the order and the night t for errors were unavailable (13/17 at 1:45 p.m., the DON e Resident #52 resident had ation than intended by the n order for a gradual dose error. as admitted 01/27/17. Idementia without behavioral ression. The most recent ata Set dated 05/05/17 nitive impairment with ver understood" being	F 32		attending 2017 on cumentation inistered on 6/1/17 at cumented n order, 1:30 30 pm 5:30 7 at 4:30 7 at 4:30pm, as recorded nsulin der. symptoms ident ued order for cian was ion of umentation ing days 6/8/17 at , 6/19/17 at a shown no ess. On physician to be bed time	
	entering the facility.	Imitted to hospice care upon		3)Resident #40 blood glucose changed by attending physicia 7/14/2017. New order for bloo	an on	
	THE MUST LECENT CALE	plan last updated on			u suyai	

Facility ID: 920763

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		MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · /	MPLETED
			A. BOILDING			С
		345499	B. WING			07/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
		-		8200 LITCHFORD ROAD		
LITCHFU	RD FALLS HEALTHCAR	E		RALEIGH, NC 27615		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 329	Continued From page	e 8	F 32	a		
		t #52 addressed end-of-life	1 52	monitoring before meals and	at hed time	
		medication use, and skin		implemented starting 7/14/20		
	integrity issues.			sliding scale coverage. Licen		
				obtained blood sugar on 7/30		
	Accuchecks for blood	d glucose levels were		6:30am resident blood sugar		
		be performed before meals		243 no insulin administered p	per physician	
		times for the checks were		order of sliding scale.		
		cation Administration Record				
	(MAR) as 6:30 a.m., 9:00 p.m.	11:30 a.m., 4:30 p.m. and		IDENTIFICATION OF OTHEI	RS	
	A physician order for	Novolog insulin to be		All residents with medication	or treatment	
		scale based upon blood		orders have the potential to b	e affected.	
	sugar levels with a st	tart date of 05/08/17 was the		100% audit of current medica	ations for all	
	only anti-hyperglycer	nic agent ordered for		current residents completed		
	Resident #52.			07/28/2017, 7/31/2017, 8/1/2		
				8/2/2017 and 8/3/2017 by the		
		and Daily Blood Sugar		Nursing, Assistant Director of	•	
		onth of July revealed that no vas obtained for Resident		and/or Staff Development Co identify any other residents w		
	-	days and times: 11:30 a.m		medication or treatment orde		
		07/08, 07/09, 07/11/ and		transcribed appropriately in n		
		04, 07/07, 07/08, and 07/09;		and treatment administration		
	9:00 p.m 07/05, 07	/06, and 07/09. The records		Physician orders. One other	order was	
		e partial month of July (07/01		identified as not transcribed p		
		e were no notations of		order. Resident physician no		
		nes on the front or back of		other identified orders, clarific		
	MAR sheet or the co	rresponding worksheet.		obtained by Director of Nursi		
	In an interview on 07	/13/17 at 11:35 a.m., Nurse		08/01/2017 and transcribed p Resident administration reco		
		ovide information on the lack		of this audit is documented o	•	
	-	Accuchecks at 11:30 on six		transcription audit tool" locate		
		dates that he worked. He		facility Survey compliance bir		
	-	mes the resident refused				
	and he didn ' t alway			100% audit of all current resi		
		ck to the resident and tried		orders for blood sugar monito	-	
	-	lged that the resident got		completed on 07/28/2017, 07		
		based on the value and that		08/01/2017, 08/2/2017 and 8		
	is the only coverage	sne received.		the Director of Nursing, Assis	stant Director	

Facility ID: 920763

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345499	B. WING			07/13/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		01110/2011
				8200 LITCHFORD ROAD		
LITCHFOF	RD FALLS HEALTHCARE			RALEIGH, NC 27615		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	Continued From page	e 9	F 32	9		
				of Nursing, and/or Staff Devel	opment	
	2. Resident #76 was	admitted to the facility on		Coordinator to identify any oth	ner residents	
	5/8/17 and her diagno	oses included diabetes.		with blood sugar orders that w		
				adequately monitored, or insu		
		blan dated 5/11/17 for		not administered following the		
		d she was a diabetic and		sliding scale. 9 other resident		
	received insulin cover	rage.		sugar monitoring were identifi blood sugars not being adequ		
	A review of the admis	sion Minimum Data Set		monitored and/or insulin not a	•	
		sident #76 revealed she was		per physician order. Findings		
		d received insulin injections		is documented on the "Blood		
	daily.			audit tool" located in the facilit	-	
	, ,			compliance binder.	, ,	
	A review of the June	2017 physician orders for				
		ed an order to preform		SYSTEMIC CHANGES		
		l glucose levels before				
		0 am, 4:30 pm), at bedtime		Effective 8/07/2017, the new 2		
	· · ·	ster Novolog insulin per		chart check form revised by C		
		e as follows: blood glucose		Clinical Consultant will be imp		
	-	units, 251 to 300 give 6 units,		This form will enhance the pro		
		ts, 351 to 400 give 10 units		checking accuracy of each tra		
	and greater than 401	notity physician.		order in a daily basis. License duty during night shift will be r		
	A review of the medic	al record for Resident #76		to complete 24-hour chart che	•	
		od glucose levels were being		duty. 24-Hour chart check is t		
		and on a form identified as		of checking all orders receive		
		A review of the June 2017		recent 24 hours to ensure acc		
		017 "Daily Blood Sugar" form		proper transcriptions. If any r		
		g: 6/1/17 at 4:30 pm blood		treatment order is not transcri		
	glucose was 208 and	received 2 units of insulin,		ordered, night shift nurse will	ensure it is	
		od glucose was 254 and no		transcribed correctly on the M		
		s given, 6/3/17 at 11:30 am		Administration Record or Trea		
	blood glucose was 34			Administration Records. 24- H		
		n, 6/3/17 at 8:30 pm blood		check form will be located in a		
	-	rded, 6/4/17 at 6:30 am		titled 24 Hour report at each r	IUISE'S	
	blood glucose was 21			station.		
	÷	i, 6/4/17 at 8:30 pm blood , 6/5/17 at 6:30 am blood		Effective 8/7/2017, all License	d nurees will	
		nsulin documented as given,		obtain, document and sign on		

Facility ID: 920763

If continuation sheet Page 10 of 29

					CONSTRUCTION	1	IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	1 Y /	E SURVEY
			A. BUILDING	G			С
		345499	B. WING			0	7/13/2017
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 0	//13/2017
					200 LITCHFORD ROAD		
LITCHFOF	RD FALLS HEALTHCARE			R/	ALEIGH, NC 27615		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETIO
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 329	Continued From page	e 10	F 32	29			
		od glucose not recorded,			to indicate that blood sugar is obtained	d	
		blood glucose not recorded,			and based on blood glucose results		
		ood glucose 254 and no			licensed nurse on duty will administer	the	
	insulin documented a	is given, 6/19/17 at 11:30 am			correct dose of insulin and document		
	-	corded, 6/19/17 at 4:30 pm			such action on individual resident's		
		nd no insulin documented as 30 am blood glucose not			Medication Administration records.		
	-	4:30 pm blood glucose 10t			Effective 8/7/2017, the center will no		
		iented as given, 6/21/17 at			longer utilize "Daily blood sugar" form	to	
	4:30 pm blood glucos				document blood sugar results and insi		
		, 6/30/17 at 4:30 pm blood			administered. Moving forward, effectiv		
		nsulin documented as given			8/7/2017 licensed nurses will docume		
	and 6/30/17 at 8:30 p	m blood glucose not			blood sugar results, and amount of ins	sulin	
	recorded.				administered on each resident's MAR		
					based on physician orders.		
	An interview on 7/12/	17 at 2:40 pm with Resident			On 08/04/2017, Regional Clinical Dire	ctor	
	#76 revealed that the	nurses checked her blood			conducted an education with the center		
		ot sure how often. She stated			DON, ADON and SDC about the proc	ess	
		fused to have her blood			of reviewing new physician orders or		
		hat she had been concerned			changes of orders daily (Monday throu		
		evels were running high; in			Friday). This education emphasized of	n	
		e stated that in the past she ne morning and at night, but			how to identify a root cause when an order is not transcribed appropriately a	and	
		at type of insulin it was			actions to be taken to address any	anu	
		a type of mount it was			discrepancies in a timely manner. The		
	An interview on 7/12/	2017 at 2:49 pm with Nurse			education also emphasized on the		
		een the nurse for Resident			importance of consolidating blood sug	ar	
		he had an order to check her			documentation process by removing o		
	blood glucose four tin	nes a day and received			discontinuing the use of "Daily blood		
		ased on her blood sugar			sugar" form.		
		vasn ' t sure why some of					
		ts were missing, but they			Effective 8/07/2017, the center nursing		
		ne. He stated that Resident			administrative team, which includes D		
		d to have her blood sugar			ADON, and/or SDC, initiated a proces	s for	
	checked.				reviewing all new physician orders or	sh	
	An intonview on 7/19/	2017 at 3:22 pm with Nurse			change of orders daily (Monday throug Friday) and will address any discrepar	-	
		ZUTT AL J.ZZ DITI WILLI NULSE			FILLAVI ALLU WILLAUULESS ALLV UISCIEDAL	IGV	1

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		MEDICAID SERVICES	a		OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	i	
		345499	B. WING		С
		545433		STREET ADDRESS, CITY, STATE, ZIP CODE	07/13/2017
NAME OF P	ROVIDER OR SUPPLIER				
LITCHFOR	RD FALLS HEALTHCARE	E		8200 LITCHFORD ROAD RALEIGH, NC 27615	
					071011
(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 SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI
F 329	Continued From page	e 11	F 32	9	
		ated that the resident is a		administrative team member will	compare
	diabetic and received			orders written in the physician or	
	coverage. She stated	-		to orders transcribed on the Med	
		aily. She stated that she		Administration Record (MAR). Ar	ıy
	wasn 't sure why the	re were errors and		identified issues will be addresse	d
	omissions in Residen	t #76 ' s blood sugars and		promptly and appropriate actions	will be
		she had completed them		implemented as appropriate by the	
		essed she hadn ' t because		ADON, SDC and/or Registered N	lurse
	the MAR was a "mes	s".		supervisor.	
	An interview on 7/12/	17 at 3:31 pm with the DON		Effective 8/07/2017, week end Re	egistered
		lity had initially used the		Nurse supervisor and/or designation	-
		orm because the nurses had		licensed nurse will review, all new	
	complained that there	e wasn ' t enough room on		or change of orders every Saturd	ay &
	the MAR to documen	t the blood glucose result		Sunday and will address any disc	
		sulin given in the little blocks.		in a timely manner. The assigned	
		made some adjustments to		administrative team member will	-
		asier for them to document,		orders written in the physician or	
		tinued to use the other form.		to orders transcribed on the Medi	
		his expectation that the		Administration Record (MAR). Ar identified issues will be addresse	
	-	ood sugar checks at the ninister the sliding scale			
	insulin coverage base			promptly and appropriate actions implemented as appropriate by the	
	results.	su on the blood sugar		Registered Nurse supervisor, and	
				reported to the center's DON time	
		17 at 2:30 pm with the			
		nt #76 revealed he was very		Director of Nursing, Assistant Dir	
		ent. He stated that he		Nursing and/or Staff Developmer	
		rs to be checked and the		Coordinator will complete 100% e	
		ling scale insulin to be		for all licensed nurses, to include	
	administered accordin	ng to his orders.		part time and as needed staff, on medication and treatment admini	
	3. Resident #40 was	admitted 05/20/15		This education will emphasize on	
		nemiplegia following a		importance of documenting all ca	
	cardiovascular accide			rendered to each resident to inclu	
		tes mellitus Type 1, chronic		documentation on the medication	
		osychotic disorder with		administration records for blood s	
	hallucinations.			monitoring per physician order, ir	-
				administration based on ordered	

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	D: 08/17/2017 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345499	B. WING		07	C 7/ <b>13/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	)E	
		_		8200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	-		RALEIGH, NC 27615		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 329			F 32	29 scale and documenting the co the treatment on the Treatmen Administration Record as ord Licensed nurses were also ec about their responsibility to cr their MARs/TARs during shift signed off on the Daily MAR/ tool as monitoring process to compliance by validating that documentation is complete be handing over residents respoi incoming licensed nurse. This will be completed on 8/7/2017 licensed nurse not educated to 08/07/2017 will not be allowed until educated. This educatio added on new hires orientation for all new Licensed nurses e 8/7/2017.	nt ered. ducated ross check change and TAR audit ensure their efore nsibilities to s education 7. Any by d to work on will also be on process	
	in the Medication Adr as 6:30 a.m., 11:30 a and 8:30 p.m. Reside insulin 74 units every and Humalog Kwikpe (ordered 03/03/17). A review of the May, revealed that Accuch conducted five days i and 05/26) and no da There were no notatio on the missing days. In an interview on 07/ #2 indicated that she May and did not work	or the checks were recorded ninistration Record (MAR) .m., 2:00 p.m., 4:30 p.m., ent #40 received Humulin N morning (ordered 02/15/17) en 10 units with meals June, and July 2017 MAR ecks for 2:00 p.m. were n May (05/01 - 05/03, 05/25, ays in either June or July. ons of refusals for that time /13/17 at 6:14 p.m., Nurse did not work on the unit in a the first shift on the days for of the 2:00 p.m. Accucheck		MONITORING PROCESS Moving forward, effective 08/d Director of Nursing, Assistant Nursing, and/or Staff Develop Coordinator, will monitor prop transcription of physician order conducting clinical meeting da this meeting covers any chan resident condition that occurre prior daily clinical meeting, re physician orders written from meeting, any admission/disch occurred from the last clinical and/or any incidents or accider occurred from the prior clinical The audit and discussion will physician orders are transcrib	Director of oment ber ers by aily (M-F), ge of ed from the view of prior clinical harges meeting ents al meeting. ensure	

Facility ID: 920763

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 08/17/2017 RM APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345499	B. WING			07	C 7/13/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		-		820	0 LITCHFORD ROAD		
	RD FALLS HEALTHCARE	<u>-</u>		RA	LEIGH, NC 27615		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	refused testing of her documented it on the note, and notified the that if the resident ha	ted that when Resident #40 blood glucose, she MAR, wrote a progress physician. She indicated d multiple refusals she pervisor or physician to see	F		to the MARs/TARs. Any issues identi during this monitoring process will be addressed promptly. Findings from the meeting will be documented on a dai clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done Director of Nursing will review the completion of daily clinical report dail (Monday - Friday) for 4 weeks, week weeks, then monthly x 3 months. Moving forward, effective 08/07/2017 each licensed nurse will be responsite sign off on the Daily MAR/TAR audit 1 This audit tool should be signed off be each shift indicating that they have documented on their MARs/TARs for resident. By signing, the licensed nu acknowledges that their documentatic complete, any omission or discrepan- especially for ordered blood glucose insulin orders will be addressed prom This monitoring process will take plac daily (Monday - Friday) for 30 days, weekly x 30 days then monthly for the months or until the pattern of complia is maintained. Effective 8/7/2017, During the daily c meeting (Monday - Friday), the Director of Nursing, Assistant Director of Nursi and/or Staff Development Coordinato be responsible for checking the Daily MAR/TAR Audit tool to ensure each s from the previous day completed and off their MARs/TARs. Any discrepand noted will be addressed and involved nurse will be counseled following the	is ly le. y y x 4 y x 4 y each tool. y each rse on is cies or uptly. ce ree ince linical ctor ing or will shift sign ies	

Event ID: Q6YI11

Facility ID: 920763

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STATEMENT	S FOR MEDICARE & DEFICIENCIES	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	OMB NO	M APPROVE <u> D. 0938-039</u> E SURVEY PLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG			
		345499	B. WING _				C / <b>13/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFO	RD FALLS HEALTHCARE				200 LITCHFORD ROAD		
	-			R	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329 F 371 SS=E	STORE/PREPARE/SI (i)(1) - Procure food find considered satisfactor authorities. (i) This may include for from local producers, and local producers, and local laws or regulation of facilities from using progradens, subject to constant safe growing and food (iii) This provision does for the provision does facilities from using programs, subject to constant safe growing and food (iii) This provision does for the	D PROCURE, ERVE - SANITARY rom sources approved or ry by federal, state or local bod items obtained directly subject to applicable State ulations.		329	center protocol. Once they have verifie the audit tool is completed, they will sig off indicating the completion of the MARs/TARs. This monitoring process of take place daily (Monday - Friday) for 3 days, weekly for 30 days then monthly three months or until the pattern of compliance is maintained. Effective 8/7/2017, Director of Nursing report findings of this monitoring proce to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly for three months, until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	gn will 30 for will ss for on	8/7/17

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345499	B. WING		C 07/13/2017	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LITCHFOF	RD FALLS HEALTHCARE			8200 LITCHFORD ROAD RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 371	<ul> <li>accordance with profeservice safety.</li> <li>(i)(3) Have a policy refoods brought to reside visitors to ensure safethandling, and consum This REQUIREMENT by:</li> <li>Based on observation facility failed to allow of maintain insulated plate condition and failed to equipment.</li> <li>Findings Included: <ol> <li>An observation of the pm with the Dietary N</li> <li>a) 25 meal trays were cart ready to be used meal</li> <li>b) 27 insulated plate of together wet on the stafe to service of the supper control of the supper of the supper An interview on 7/9/11 revealed that the dish</li> </ol> </li> </ul>	distribute and serve food in essional standards for food garding use and storage of lents by family and other e and sanitary storage, hption. is not met as evidenced in and staff interviews the dishware to air dry, failed to the chargers in good o maintain clean kitchen he kitchen on 7/9/17 at 5:20 lanager (DM) revealed: e stacked together wet on a for service of the supper chargers were stacked team table ready to be used ber meal lates were stacked together e ready to be used for meal 7 at 5:35 pm with Dietary the dishes should be dried eing put away. 7 at 5:37 pm with the DM es should be allowed to air	F 37	<ul> <li>IMMEDIATE ACTION TAKEN</li> <li>1. A. On 07/09/2017, Certified Dietary Manager removed 25 meal trays that were stacked together wet on the cart they could not be used for the service the supper meal. Meal trays re-washed and were allowed to air dry.</li> <li>B. On 07/09/2017, Certified Dietary Manager removed 27 insulated plate chargers that were stacked together w on the steam table so they could not b used for the service of the supper meal Plate chargers re-washed and were allowed to air dry.</li> <li>2. On 07/09/2017, Certified Dietary Manager removed 14 insulated plate chargers that were heavily scratched so they could not be used for service of meals. Certified Dietary Manager Discarded 14 insulated plate chargers 07/09/2017 and were replaced.</li> <li>3. A. On 07/09/2017, Certified Dietary Manager cleaned the shelving unit use</li> </ul>	of d et e l. o on	
		away. She stated that the		for the juice machine to remove the sti build-up of substances.		

Facility ID: 920763

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/17/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345499	B. WING				C / <b>13/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFO	RD FALLS HEALTHCARE	E			200 LITCHFORD ROAD ALEIGH, NC 27615		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From page	e 16	F	371			
	<ul> <li>pm with the DM reveal</li> <li>14 insulated plate chascratched with portion on the steam table rethe supper meal.</li> <li>An interview on 7/9/1 revealed that the dam replaced.</li> <li>3. An observation of tipm with the DM reveal</li> <li>a) A shelving unit use equipment had a heasubstances</li> <li>b) The filters in the hoge grease and dust</li> <li>An interview on 7/9/1 revealed that the shemachine needed to badd this to the cleaning that the hood filters hweeks ago and that the again.</li> <li>An interview on 7/13/Administrator revealed be air dried and that a be discarded and rep</li> </ul>	argers were heavily ns of plastic peeling off were ady to be used for service of 7 at 5:40 pm with the DM naged plate bases should be the kitchen on 7/9/17 at 5:45 aled:			<ul> <li>B. On 07/09/2017, Certified Dietary Manager cleaned the filters in the hod system to remove build-up of grease dust.</li> <li>IDENTIFICATION OF OTHERS</li> <li>All residents have potential to be affer</li> <li>On 07/09/2017, Certified Dietary Maraudited 100% of all meal trays to ensino other dishes were stacked togethe wet prior to the service of the supper meal. Results of this audit revealed n other meal trays were stacked togethe wet. This audit is documented on "Dis Sanitation and quality audit" tool locat the facility compliance binder.</li> <li>On 07/09/2017, Certified Dietary Mar completed 100% audit of all insulated plate chargers used to serve resident meal, to ensure no other insulated pl chargers were stacked together wet to the service of the supper meal, no other insulated plate chargers were n stacked together wet. Results of this is documented on "Dishes Sanitation quality audit" tool located in the facilit compliance binder.</li> <li>On 07/09/2017, Certified Dietary Mar completed 100% audit of all insulated plate chargers used to serve resident meal, to ensure no other insulated pl chargers were stacked together wet to the service of the supper meal, no other insulated plate chargers were n stacked together wet. Results of this is documented on "Dishes Sanitation quality audit" tool located in the facilit compliance binder.</li> <li>On 07/09/2017, Certified Dietary Mar completed 100% audit of all insulated plate chargers used to serve resident meal to identify if any other insulated chargers is in poor condition evident the avy scratches. Three other insulated plate charger identified as being heav</li> </ul>	and cted. lager ure er shes ted in lager s ate prior oted audit and y lager s plate by ed	

Event ID: Q6YI11

Facility ID: 920763

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/17/2017 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345499	B. WING				C / <b>13/2017</b>
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
LITCHFOR	RD FALLS HEALTHCARE	:			200 LITCHFORD ROAD ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From page	2 17	F	371	scratched. Identified insulated plate charger was removed and discarded. Results of this audit is documented o Dishes Sanitation and quality audit" to located in the facility compliance bind On 07/09/2017, Certified Dietary Mar audited other surface areas used to s resident used items to ensure no othe areas are noted with sticky buildup substance or not in a clean and sanita form. Results of this audit revealed no other surface areas had a sticky build substances. On 07/09/2017, Certified Dietary Mar audited hood to ensure it was clean a free of build-up grease and dust. Res of this audit revealed the hood to be fo of build-up grease and dust. On 7/31/2017 Licensed Dietician, contracted to provide services for the facility, completed a detailed sanitatio inspection to ensure the center store, prepare, distribute and serve food in accordance with professional standar for food service safety. No other issu identified on the station inspection. The sanitation inspection form located in facility compliance binder. SYSTEMIC CHANGES Moving forward, Effective 8/7/2017 quality check process will be initiated ensure only dishware that are dry, in	n ool ler. hager store er ary bup hager and sults free on rds les his on the	
	7(02-99) Previous Versions Obs	olate Event ID: 06VI			repair and free of heavy scratches are	e	at Page 18 of 20

Event ID: Q6YI11

Facility ID: 920763

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ONTENDED OF DEFICIENCIES AND PLAN OF CORRECTION         (M) PERMORPHIENCULA IDENTIFICATION NUMBER:         OCIDENTITION A BULDING IDENTIFICATION NUMBER:         (PC) WLITHE CONSTRUCTION A BULDING IDENTIFICATION NUMBER:         (PC) WLITHE CONSTRUCTION A BULDING IDENTIFICATION NUMBER:         (PC) WLITHE CONSTRUCTION A BULDING IDENTIFICATION NUMBER:         (PC) WLITHE CONSTRUCTION IDENTIFICA		-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 08/17/2017 ORM APPROVED 3 NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER         States         Contract of the second control to a good repair. Any charter second control to a good repair is placed in a dish rack. The second control agood repair will be removed out of circulation immediately. Dietary manager will re-inspect the dishes removed out of circulation control agood repair will be control to agood repair. Any charter second control to agood repair will be control to agood repair. Any charter second control to agood repair will be control to agood repair. Any charter second control to agood repair will be control to agood repair. Any charter second control to agood repair will be control to agood repair will be control to agood repair will be conto the s	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, <i>,</i>			(X3)	DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER         STREE LADDRESS CITY STALE 2P CODE           LITCHFORD FALLS HEALTHCARE         200 LITCHFORD RAD           INVELSION TO PROVIDE STALLS PRODUCES         INVELSION TO PROVIDE STALLS CITY STALE CODE CORRECTION           PREFIX         INVELSION FOR RADO CORRECTION         COMPLETION           PREFIX         INVELSION FOR ANO CORRECTION ON STORMANTICAN         PREFIX         PROVIDER'STALA OF CORRECTION         COMPLETION           F 371         Continued From page 18         F 371         Used to serve food to our residents. The first quality check point will be done by a dictary staff will ensure no dishware with heavy soratches or not in a good repair is placed in a dist rack. The second quality check point will be done by a dictary staff will ensure no dishware with heavy soratches or not in a good repair is placed in a distract. The second quality check point will be removed out of circulation immediately. Direlary and at the beginning of the tray line. Direlary dist at the beginning of the tray in a good repair will be removed out of service and determine the proper action not limited to replacing the dishes. Certified Dietary manager revised the kitchen cleaning schedule to right will be dispensing equipment thood system. This new revised schedule will be used effective 8/07/2017. the diaty staff will ensure as schedule. Moving forward, effective 8/07/2017, the diaty staff will ensure the methy proved to the schedule. Moving forward, effective 8/07/2017, the diaty staff will lice with the schedule. Moving forward, effective 8/07/2017, the diaty staff will lice with the orden schedule. Moving forward, effective 8/07/2017, the diaty staff will lice with mean (the diny revised cleaning schedule). Moving forward, effect			345499	B. WING				
LITCHORD FALLS HEALTHOARE     RALEIGH, NC 27615       (M) ID PREENX TAC     SUMMARY STATEMENT OF DEFICIENCIES ECAL DEPICIENCY WAST DE RECORD OF YALL ACCURRENT AND TO APPROPRIATE SECURITION APPROPRIATE SECURITION APPROPRIATE SECURITION APPROPRIATE DEFICIENCY     PROVIDERS PLANOF CORRECTION (CROSS REFERENCE) ACTION APPROPRIATE DEFICIENCY     000 (CROSS REFERENCE) (CROSS REFERENCE)     000 (CROSS REFERENCE)     0000 (CROSS REFERENCE)	NAME OF P	ROVIDER OR SUPPLIER	l		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
OND PRET/INC         BUMMARY SINTEMENT OF DETERDINGES (A) UNCLOSE OF ALL (A)	LITCHFO	RD FALLS HEALTHCARE						
Prigrix Tx0         LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Precint Tx0         Cold Conserve food to our residents. The first quality check point will be done by a dietary staff with oremove clean dishes from a dishwashing machine. That dietary staff will nesure no dishware with heavy scratches or not in a good repair is placed in a dish rack. The second quality check point will take place at the beginning of the line will remove any dishware with heavy scratches on to in a good repair. Any dishes not in a good repair. Any dishes due the beginning of the line will remove any dishware with heavy scratches or not in a good repair. Any dishes due is a due in a good repair. Any dishes due is a due in the beginning of the line will be used feature due in a good repair. Any dishes due on the stealing and for the second due on the stealing and for the due on the shelving unit for the due on the shelving unit for the due due on the shelving unit for the due on the shelving unit for the due on the shelving unit		-			R	ALEIGH, NC 27615		
<ul> <li>used to serve food to our residents. The first quality check point will be done by a dietary staff who remove clean dishes from a dishwashing machine. That dietary staff will ensure no dishware with heavy scratches or not in a good repair is placed in a dish rack. The second quality check point will take place at the beginning of the tray line. Dietary aide at the beginning of the line will remove any dishware with heavy scratches or not in a good repair. Any dishes not in a good repair will be removed out of circulation immediately. Dietary manager will re-inspect the dishes removed out of service and determine the proper action not limited to replacing the dishes.</li> <li>Certified Dietary manager revised the kitchen cleaning schedule on 7/9/2017 to include a shelving unit used for juice dispensing equipment and filters in the hood system. This new revised schedule will be used effective 8/07/2017. Moving forward, effective 08/07/2017, the dietary staff will leave the meal trays on the dish case shell will be used effective 08/07/2017, the dietary staff will leave the meal trays on the dish sum will be cased by well by each still are part of the stary staff will leave the meal trays on the dish rack to make a shift per the daily revised cleaning schedule.</li> </ul>	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	x	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
the dish racks until air dry after putting them through the dish machine for	F 371	Continued From page	e 18	F	371	used to serve food to our residents first quality check point will be done dietary staff who remove clean dish from a dishwashing machine. That staff will ensure no dishware with h scratches or not in a good repair is in a dish rack. The second quality of point will take place at the beginnin the tray line. Dietary aide at the begin of the line will remove any dishware heavy scratches or not in a good repair will removed out of circulation immedia Dietary manager will re-inspect the removed out of service and determ proper action not limited to replacin dishes. Certified Dietary manager revised f kitchen cleaning schedule on 7/9/2 include a shelving unit used for juid dispensing equipment and filters in hood system. This new revised sch will be used effective 8/7/2017. Moving forward, effective 08/07/20 dietary staff will wipe down the she unit for the juice dispensing equipn thoroughly each shift per the daily cleaning schedule. Moving forward effective 08/07/2017, the filters in th hood system will be cleaned bi-weat the revised cleaning schedule. Moving forward, effective 08/07/20	e by a hes dietary eavy placed check g of ginning e with epair. be tely. dishes ine the og the he 017 to re the he dule 17, the lving hent revised , ne ekly per 17, the	
						the dish racks until air dry after put them through the dish machine for	ting	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY				
	CORRECTION	IDENTIFICATION NUMBER:	· · /		COMPLETED				
					С				
		345499	B. WING		07/13/2017				
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
LITCHFOF	D FALLS HEALTHCARE	E		8200 LITCHFORD ROAD					
				RALEIGH, NC 27615					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIN				
F 371	Continued From page	e 19	F 371						
				stored for usage at the needed	time.				
				Moving forward, effective 08/0	7/2017, the				
				dietary staff will use the drying	rack to				
				place the insulated plate charg					
				air dry after putting them throug machine for cleaning. Once dr					
				insulated plate chargers will be					
				usage at the needed time.					
			Moving forward, effective 08/07/201						
				Registered Dietician will compl					
				sanitation inspection monthly to inspecting the quality of dishwa					
				for residents (i.e. insulated plat					
				chargers). The Registered Diet					
				also inspect the filters in the ho	-				
				for grease and dust during the					
				Kitchen Sanitation Audit. Any r findings of dishes not in good r					
				cleanliness of hood filters will b	-				
				to the Certified Dietary Manage					
				Administrator promptly. This in					
				will be documented on the "Kite					
				Sanitation audit" tool and will b	•				
				the facility Quality Assurance a Performance Improvement info					
				renomance improvement inic					
				Licensed dietician and/or Admi	nistrator				
				completed an in-service educa					
				7/31/2017 with the Certified Die					
				Manager to stress the importar allowing dishes to air dry and t					
				check process that will assure					
				in good repair are removed from					
				circulation promptly and to ens	sure the				
				center continue to store, prepa					
				distribute and serve food in acc					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 08/17/2017 ORM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	DATE SURVEY COMPLETED
		345499	B. WING				C 07/13/2017
NAME OF P	ROVIDER OR SUPPLIER	1	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOR	RD FALLS HEALTHCARE			-	200 LITCHFORD ROAD		
		-		R	ALEIGH, NC 27615		1
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	Continued From page	e 20	F	371			
					service safety.		
					On 07/09/2017, Certified Dieta conducted individualized educa involved employees regarding stacking dishes wet before the completely dry.	ation with not y are	
					Certified Dietary Manager com 100% education with dietary st include full time, part time and staff. This education included washing dishes, they must be	aff to as needed when stacked to	
					air dry and cannot be stacked of Also, when notice the insulated chargers are found heavily scru- they should be removed from of The shelving unit for the juice of equipment should be wiped do	d plate atched, circulation. dispensing wn after	
					each shift per revised cleaning and the filters in the hood syste be monitored for grease and di then cleaned per cleaning sche as needed. This education will completed by 08/07/2017, any	em should ust, and edule and be	
					not educated by 08/07/2017 will allowed to work until educated education will be added on new orientation process for all dieta effective 08/07/2017	. This w hire	
					MONITORING PROCESS		
					The Certified Dietary Manager designated staff will audit the n and insulated plate chargers to they are not stacked wet daily	neal trays o ensure x4 weeks,	
					weekly x4 weeks, then monthly	y until	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		345499	B. WING		C 07/13/2017			
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
	D FALLS HEALTHCAR	=	8	3200 LITCHFORD ROAD				
				RALEIGH, NC 27615				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 COMPLETI			
F 371	Continued From page	e 21	F 371		nd/or ulated e not f plastic 4 weeks, until ined for nd/or elving unit eaned s, and mpliance ve nd/or ers in the e been nen nce is months.			
				three consecutive months. The Dietary Manager will report t summary findings of these audits Quality Assurance and Performa	s to			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/17/2017 MAPPROVED O. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		345499	B. WING		07	C 7/ <b>13/2017</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 8200 LITCHFORD ROAD RALEIGH, NC 27615	CODE	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	Continued From page	22	F 371	Improvement Committee m months or until a pattern of achieved.		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLE LE	TE/ACCURATE/ACCESSIB	F 514	L .		8/7/17
	standards and practic	h accepted professional ces, the facility must ords on each resident that				
	(i) Complete;					
	(ii) Accurately docum	ented;				
	(iii) Readily accessible	e; and				
	(iv) Systematically or	ganized				
	(5) The medical recor	d must contain-				
	(i) Sufficient informati	on to identify the resident;				
	(ii) A record of the res	sident's assessments;				
	(iii) The comprehensi provided;	ve plan of care and services				
	(iv) The results of any and resident review e determinations condu					
	(v) Physician's, nurse professional's progres	's, and other licensed ss notes; and				
	(vi) Laboratory, radiol	ogy and other diagnostic				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/17/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345499	B. WING			C 13/2017
NAME OF PF	ROVIDER OR SUPPLIER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	
			82	200 LITCHFORD ROAD		
LITCHFOR	D FALLS HEALTHCARE		R	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	Continued From page services reports as re		F 514			
	This REQUIREMENT by: Based on record revi facility failed to mainta documentation for 2 o #104 and Resident #5 pressure ulcers. Finding Included: 1. Resident #104 was 3/27/15 and his diagn contractures and Alzh A significant change r dated 6/24/17 for Res an unstageable press dependent on staff for (ADL ' s) and had sev A care plan dated 7/11 revealed he had a pre hip / greater trochante that included skin care physicians order.	is not met as evidenced ew and staff interviews the ain accurate treatment of 3 residents (Resident 52) that were reviewed for admitted to the facility on oses included malnutrition, eimer 's disease. ninimum data set (MDS) ident #104 revealed he had ure ulcer, was totally activities of daily living erely impaired cognition.		IMMEDIATE ACTION TAKEN 1.On 07/15/2017, the Assistant Din Nursing audited clinical record to e the facility had the correct treatme orders in place for Resident #104. Results from this audit revealed th had the correct orders in place for Resident #104. On 07/15/2017, th Assistant Director of Nursing comp the treatment and documented on treatment record for resident #104 Resident #104 shown no deteriorar wound noted, resident shown no s symptoms of any distress. 2.On 07/15/2017, a Registered Nu audited clinical record to ensure th facility had the correct treatment o place for Resident #50. Results fr audit revealed the facility had the o orders in place for Resident #50. 07/15/2017, Registered nurse #1 completed the treatment and docu on the treatment record for resider Resident #50 shown no deteriorati	ensure efacility efacility e oleted the tion of igns or rse #1, e rders in om this correct On mented it #50.	
	cleanse right hip / gre with normal saline, pa and cover with mepile needed.	ater trochanter area wound t dry, apply santyl ointment x. Change daily and as		wound noted, resident shown no s symptoms of any distress. IDENTIFICATION OF OTHERS		
	revealed a treatment of cleanse right hip / gre	2017 treatment (TAR) for Resident #104 order dated 6/19/17 to ater trochanter area wound t dry, apply santyl ointment		100% audit of current treatment administration records for all curre residents completed on 07/28/201 07/31/2017, 08/01/2017, 08/2/201 8/3/2017 by the Director of Nursing	7, 7 and	

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			a			. 0938-03
TATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA       ND PLAN OF CORRECTION     IDENTIFICATION NUMBER:		(X2) MULTIP	. ,	(X3) DATE SURVEY COMPLETED		
			A. BUILDING	;		
		345499	B. WING			, 13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		13/2017
	NOVIDER OR OUT FIER			8200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	E		RALEIGH, NC 27615		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETIC DATE
F 514	Continued From page	e 24	F 51	4		
	-	ex. Change daily and as		Assistant Director of Nu	ursing, and Staff	
		o documentation (nurses		Development Coordinat		
		nent had been completed on		other residents with ina		
	6/21, 6/22, 6/23, 6/29	•		incomplete treatment de	ocumentation. 63	
				other residents noted w	ith incomplete	
		17 at 11:27 am with Nurse		treatment documentation		
		had been Resident #104 ' s		of wounds noted related		
	nurse and responsible			Findings of this audit is		
	-	sure ulcer on 6/21, 6/22 and felt like she had done the		the Treatment Record a		
		have forgotten to sign the		the facility survey comp		
	TAR.	lave longottern to sight the		SYSTEMIC CHANGES		
				Effective 8/7/2017, all li		
	An interview on 7/12/	17 at 11:39 am with Nurse		obtain, document and s		
	#6 revealed that on 6	/30/17 the med tech that		Treatment Administratio	-	
	was assigned to Resi	dent #104 asked her to		indicate that resident tre	eatment is	
	complete the treatme	nt for his pressure ulcer.		completed based on ph	ysician orders.	
		ound was on his hip and she				
		pleted the treatment, but		Effective 8/07/2017, the	9	
	had not signed the TA	AR.		administrative team, wh	-	
	The pure that was a			ADON, and/or SDC, init	-	
		ssigned to complete the Resident #104 on 6/23 was		reviewing all new physic change of orders daily (		
	unavailable for an inte			Friday) and will address		
				in a timely manner. The		
	An interview on 7/12/	17 at 3:51 pm with the		administrative team me	-	
		DON) revealed he expected		orders written in the phy	-	
		be completed as ordered by		to orders transcribed or		
	the physician and doo	cumented as being		Administration Record (	(TAR). Any	
	completed on the TAF	ર.		identified issues will be		
				promptly and actions w	-	
		17 at 6:36 pm with the		as appropriate by the D		
		nt #104 revealed it was his		and/or Registered Nurs	e supervisor.	
	expectation that wour				ok and Dogistarad	
		<ol> <li>He stated that the facility the wound care nurse</li> </ol>		Effective 8/07/2017, we Nurse supervisor and/o	-	
		have contributed to the		licensed nurse will revie		
	treatments not being			or change of orders eve		
				Sunday and will addres		

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		MEDICAID SERVICES				NO. 0938-03
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	J		С
		345499	B. WING			07/13/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
		_		8200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	=		RALEIGH, NC 27615		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 514	Continued From page	e 25	F 51	4		
				in a timely manner. The ass	signed nurse	
	2. Resident # 50 was	s admitted to the facility on		administrative team member	-	
		s included insomnia, muscle		orders written in the physici	•	
	weakness and dysph			to orders transcribed on the		
				Administration Record (TAF	R). Any	
	A review of Minimum	Date Set (MDS) dated		identified issues will be add	ressed	
	4/30/17 revealed Res	sident #50 had an		promptly and actions will be	e implemented	
	unstageable pressure			as appropriate by the Regis		
		or activities of daily living		supervisor, and reported to	the center's	
	(ADL's). However she eating.	e only needed set up for		DON timely.		
	eating.			Director of Nursing, Assista	nt Director of	
	A care plan dated 6/1	11/17 for Resident #50		Nursing and/or Staff Develo		
		unstageable pressure ulcer		Coordinator will complete 1	•	
		heal (unstageable due to		for all licensed nurses, to in		
	slough/eschar). Interv	vention that included skin		part time and as needed sta	aff, on	
	care and treatment p	er physicians order.		medication and treatment a	dministrations.	
				This education will emphas	ize on the	
		7 physician orders for		importance of documenting	all care	
		ed that right bottom of heel		rendered to each resident to	o include	
	need to be clean with	n silvasorb gel daily to assist		documentation on the Treat	ment	
	with odor debridemer	nt. Change daily and as		administration records for a		
	needed.			rendered per physician orde		
				nurses will also be educate		
	A review of the May 2			responsibility to cross check		
		(TAR) for Resident # 50		MARs/TARs during shift cha		
		eable pressure ulcer to right		signed off on the Daily MA		
		ange daily and as needed.		tool as monitoring process to		
		entation (nurses initials) that		compliance by validating the		
	5/26, 5/27 and 5/28.	en completed on 5/23, 5/25,		documentation is complete, accurate before handing ov		
	5/20, 5/27 anu 5/20.			responsibilities to incoming		
	A review of June 201	7 treatment administration		nurse. This education will b		
		ident #50 revealed that the		by 08/07/2017. Any license		
		e ulcer to the right heel		educated by 08/07/2017 will		
		e daily and as needed. There		allowed to work until educa		
		on (nurses initials) that the		education will also be adde		
		completed on 6/9, 6/16, 6/19		orientation process for all n		
	and 6/20.			nurses effective 8/7/2017.		

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	-	ID HUMAN SERVICES				FORM	APPROVED	
STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING				LETED	
		345499	B. WING			C 07/13/2017		
NAME OF PROVIDER OR SUPPLIER				s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 017		
LITCHFORD FALLS HEALTHCARE				8	200 LITCHFORD ROAD			
		•		F	RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY)			
F 514	Continued From page	26	F	514				
	AM revealed that she nurse and responsible treatment for her press 5/26 and 6/9, and 6/1 done the treatment ar TAR. An interview with Nurse AM he revealed that he and treatment Reside and 6/20 pressure uld the TAR. An interview on 7/12/2 Director of Nursing (D wound treatment to be the physician and door completed on the TAF An interview on 7/12/2 physician for Residem expectation that wour completed as ordered had some turnover in	w with Nurse # 5 on 7/12/17 at 11:40 ed that she had been Resident #50 responsible for completing the or her pressure ulcer on 5/23, 5/25, /9, and 6/16. She stated that she had eatment and just forgotten to sign the w with Nurse #1 on 7/12/17 at 11:53 ealed that he had completed the care ent Resident #50 on 5/27, 5/28, 6/19 ressure ulcer and just forgotten to sign w on 7/12/17 at 3:51 PM with the Nursing (DON) revealed he expected timent to be completed as ordered by an and documented as being on the TAR. w on 7/12/17 at 6:36 PM with the for Resident #50 revealed it was his in that wound treatment were as ordered. He stated that the facility turnover in the wound care nurse d that may have contributed to the		F 514 MONITORING PROCESS. Moving forward, effective 08/07/201 each licensed nurse will be respons sign off on the Daily MAR/TAR audi This audit tool should be signed off each shift indicating that they have documented on their MARs/TARs for resident. By signing, the licensed n acknowledges that their documenta complete, any omission or discrepa especially for ordered blood glucose insulin orders will be addressed pro This monitoring process will take pla daily (Monday - Friday) for 30 days, weekly x 30 days then monthly for th months or until the pattern of compli is maintained. Effective 8/7/2017, During the daily meeting (Monday - Friday), the Dire of Nursing, Assistant Director of Nur and/or Staff Development Coordinat be responsible for checking the Dail MAR/TAR Audit tool to ensure each from the previous day completed an off their MARs/TARs. Any discrepar noted will be addressed and involve nurse will be counseled following th- center protocol. Once they have ve the audit tool is completed, they will off indicating the completion of the MARs/TARs. This monitoring process take place daily (Monday - Friday) for 30 days then mont		ool. each se n is ies r otly. e e e ce nical or ng will sign es ed gn will 30		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345499	B. WING		C 07/13/2017		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0110/2011		
LITCHFO				8200 LITCHFORD ROAD			
				RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 514	Continued From page	e 27	F 514	1			
	FIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)			Moving forward, effective 08/07/ Director of Nursing, Assistant Di Nursing, and/or Staff Developme Coordinator, will monitor proper transcription of physician orders conducting clinical meeting daily this meeting covers any change resident condition that occurred prior daily clinical meeting, revie physician orders written from pri meeting, any admission/dischar occurred from the last clinical m and/or any incidents or accident occurred from the prior clinical m The audit and discussion will en physician orders are transcribed to the MARs/TARs. Any issues i during this monitoring process w addressed promptly. Findings fm meeting will be documented on clinical report form and filed in c meeting binder in Director of Nu office after proper follow ups are Director of Nursing will review th completion of daily clinical repor (Monday - Friday) for 4 weeks, w weeks, then monthly x 3 months Effective 8/7/2017, Director of N report findings of this monitoring to the facility Quality Assurance Performance Improvement Com any additional monitoring or mon of this plan monthly for three mon until the pattern of compliance is maintained. The QAPI committe modify this plan to ensure the fa	irector of ent by / (M-F), of from the w of ior clinical ges eeting s neeting. sure correctly dentified vill be om this a daily linical rsing e done. ne t daily weekly x 4 s. lursing will p process and mittee for dification onths, or s e can		

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/17/2017 RM APPROVED IO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		345499	B. WING _		C 07/13/2017		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
	RD FALLS HEALTHCARE	-		8200 LITCHFORD ROAD			
		-		RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG		(X5) COMPLETION DATE		

Facility ID: 920763

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