	-	ID HUMAN SERVICES				FP	FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u></u> ON	/IB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
		345555	B. WING				C 01/04/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				:	3830 BLUE RIDGE ROAD		
HILLCRES	ST RALEIGH AT CRABTE				RALEIGH, NC 27612		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580 SS=D	CFR(s): 483.10(g)(14) §483.10(g)(14) Notifie (i) A facility must imme consult with the resid consistent with his or- representative(s) whe (A) An accident involve- results in injury and h physician intervention (B) A significant chan- mental, or psychosoco- deterioration in health- status in either life-thu- clinical complications (C) A need to alter tree a need to discontinue- treatment due to adve- commence a new form (D) A decision to tran- resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informati- is available and provi- physician. (iii) The facility must ar- resident and the reside- when there is- (A) A change in room- as specified in §483.1 (B) A change in reside- State law or regulatio- (e)(10) of this section- (iv) The facility must ar- state law or regulatio- (e)(10) of this section- (iv) The facility must ar- resident and the reside- state law or regulatio- (e)(10) of this section- (iv) The facility must ar- state law or regulatio- (iv) The facility must ar- (iv) The facility must ar- state law or regulatio- (iv) The facility must ar- (iv) The facility must ar- (cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident as the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph	F	580			2/1/18
	phone number of the representative(s).						
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	2F		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

01/15/2018

PRINTED: 02/05/2018

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.

Electronically Signed

	MENT OF HEALTH AN S FOR MEDICARE & I				FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345555	B. WING		C 01/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
HILLCRES	ST RALEIGH AT CRABTR	EE VALLEY		3830 BLUE RIDGE ROAD RALEIGH, NC 27612	
(X4) ID PREFIX TAG	(EACH DEFICIENC)				BE COMPLETION
F 580	Continued From page	ntinued From page 1 F 580		80	
	that is a composite dis §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi facility failed to notify new pressure ulcers f for pressure ulcer (Re Findings included: Resident #1 was adm 5/19/17 with the diagr Peripheral Vascular D Resident's #1 Quarter 8/21/17 revealed the to cognitively impaired a assistance with bed m personal hygiene. The pressure ulcer that was unstageable pressure entry. The resident has device for the bed, nu interventions and was care.	83.10(g)(15) Imission to a composite distinct part. A facility at is a composite distinct part (as defined in 83.5) must disclose in its admission agreement physical configuration, including the various cations that comprise the composite distinct rt, and must specify the policies that apply to om changes between its different locations der §483.15(c)(9). is REQUIREMENT is not met as evidenced : ased on record review and staff interviews, the cility failed to notify the physician and family of w pressure ulcers for 1 of 3 residents reviewed pressure ulcer (Resident #1). ndings included: esident #1 was admitted to the facility on 19/17 with the diagnoses of dementia, ripheral Vascular Disease and malnutrition. esident's #1 Quarterly Minimum Data Set dated 21/17 revealed the resident was severely gnitively impaired and required extensive sistance with bed mobility, dressing, and rsonal hygiene. The resident had one stage 2 essure ulcer that was present on entry and one stageable pressure ulcer that was present on try. The resident had a pressure reducing vice for the bed, nutrition and hydration erventions and was receiving pressure ulcer		 This plan of correction constitutes Hillcrest Raleigh at Crabtree, LLC's (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F580 Address how corrective action will the accomplished for those residents four have been affected by the deficient practice. The DON was notified during the complaint survey that the nurse failed communicate with the physician and family regarding discovery of new work found on Resident #1 on 11/28/17. Resident #1 was discharged from the facility on 12/7/17. Address how corrective action will the accomplished for those residents have potential to be affected by the same 	be d to to unds

Facility ID: 20120054

If continuation sheet Page 2 of 16

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB I	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	1 Y	ATE SURVEY
		345555	B. WING				C
	ROVIDER OR SUPPLIER	545555			REET ADDRESS, CITY, STATE, ZIP CODE	(01/04/2018
					30 BLUE RIDGE ROAD		
HILLCRE	ST RALEIGH AT CRABT	REE VALLEY			ALEIGH, NC 27612		
(X4) ID			ID				(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
F 580	Continued From page	e 2	F 58	30			
		1/28/17 revealed the resident ne outside of her left and			deficient practice.		
	right foot that "looks I				The DON audited 100% of all resider	nts	
					with wounds for notification		
	-	11/28/17 revealed the			documentation to the physician and		
		a new lesion forming, pink tinge at the center, Zinc			responsible party. For instances when there was no documentation	re	
		On the patient's right foot is			demonstrating communication with		
		on, zinc paste applied and			physician and responsible party regard	lina	
	the patient tolerated t				a particular wound, notification occurre		
					and was appropriately documented .	-	
	The resident went to	the hospital on 12/7/17.			The facility will implement new		
					documentation procedures, and update		
		d 12/8/17 revealed that the			education of staff in regards to notification		
	-	y tract infection, 2 right Deep			of changes to physician and responsib	le	
		foot, one laterally that			party. All nurses will receive updated		
		cm and one anteriorly that			education on procedures for notificatio		
		cm. The resident also had a			changes in regards to communicating	with	
		le pressure ulcer to her foot n x 2.5 cm and a mid- lateral			the physician. This education will be conducted by the DON/designee.		
		e ulcer to her left foot that			conducted by the DON/designee.		
		m. There was also a left			3. Address what measures will be put	into	
		ch-able area that measured			place or systemic changes made to		
		acral pressure ulcer that			ensure that the deficient practice will n	ot	
		cm x 0.3 cm. The resident			occur.		
		vet gangrene to the right					
		ated that the resident's			The facility will update education of st	taff	
	family had a difficult t				in regards to notification of changes to		
		as not aware of the wound			physician and responsible party. All		
	(of right foot) prior to	today.			nurses will be educated on procedures	s for	
					notification of changes in regards to		
		se was interviewed on			communicating with the physician. Th	IS	
	12/29/17 at 11:21 AM				education will be conducted by the		
		ote in note that the resident he left foot and one forming			DON/designee. Communication documentation in		
		vas an darken open lesion.			resident charts will be audited/monitor	ed	
	-	the nurse found 2 lesions			by the DON/designee weekly x4 week		
		e to both areas. She stated			bi-weekly x2 weeks and monthly x 1	Ξ,	
		ote, it did not state who was			month.		

Facility ID: 20120054

STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DAT	O. 0938-039 E SURVEY IPLETED	
				3		С	
		345555	B. WING			1/04/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HILLCRES	ST RALEIGH AT CRABT	REE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 580	Continued From page	e 3	F 58	30			
	notified about the wo						
				4. Indicate how the facility plan	is to		
	-	was contacted on 12/29/17		monitor its performance to mal			
		ed that he was Resident's #1 e stated he was not notified		solutions are sustained. The fa develop a plan for ensuring that			
		ounds until she went to the		is achieved and sustained. Th			
		He was told she was sent to		be implemented and the correct			
		sible stroke. When she got		evaluated for its effectiveness.			
	the hospital, he was r	notified of the wounds. He		of Correction is			
		notified by the physician at					
		resident's wounds. He stated		Monitoring of these changes			
		e for 3 weeks on a trip but		specifically, the communication	-		
	any changes to Resid	to still contact him about dent #1.		to the physician and responsib concerning change of condition performed by the DON/designed	ns will be		
	Nursing Assistant #1	was interviewed on 12/29/17		x4, bi-monthly x2 months, and	-		
	-	ed that the resident required		The facility QA committee and	,		
		ve the resident showers.		administrator/designee will rev			
		in November, 2017, the		monitoring results during QA m	•		
		oted on the lower part of her		DON/designee will be respons	ible for		
	-	added that the resident wore		monitoring and reporting.			
		. She stated she reported nurse. She stated that one					
		pleeding a little and she told					
		e put a bandage on it and					
		not sure who the nurse called					
		bout the treatment. She also					
		not remember the name of					
	the nurse working that had documented the	at day. She stated that she new area.					
		ewed on 12/29/17 at 4:28					
		she had only cared for					
		ne time was in November, t had a sacral wound. She					
		e also 2 red spot on the					
		It foot and she put zinc oxide					
		area open. She stated that					
	when he NA was clea	aning the resident, the NA					

If continuation sheet Page 4 of 16

DEPARTMENT OF HE CENTERS FOR MEDI	FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			C
		345555	B. WING				04/2018
NAME OF PROVIDER OR SUF	PLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
HILLCREST RALEIGH A		REE VALLEY			830 BLUE RIDGE ROAD		
				R	RALEIGH, NC 27612		
PREFIX (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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
went and as areas were p resident did that was rela- she told the she was the that they con- day. She sta- all because She added t black spot o foot wound. remember s had a "black The day shif attempted to The Medical 12/29/17 at p familiar with the facility al was really p He stated th there were s sacrum. The to the residen another facil because she and was in a did have a w not know ab until till she expected an wound. He s	that she sessed the poinkish are not have ated to the nurse duil regular in municate the she of it was not hat the regular in the right She state pecifically spot" in it the state pecifically spot" in it this reside nd at the poor and s at when s owne would the state poor and s at when s owne would the state poor and s at when s owne would the state poor and s at when s owne would the state the state pecifically the state the state pecifically the state pecifically the state pecifically the state pecifically the state pecifically the state pecifically the state the state pecifically the state the state pecifically the state the state the state the state the state the state the state the state	noticed the wounds so she nem. She stated that the nd were circular. The any pain that she knew of ose spots. She stated that ring the hand off because nurse for that resident and te to the doctor during the did not contact the family at t urgent and it was at night. esident did have a very small t outside aspect of the right ed that she could not y if the resident's left foot	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345555	B. WING				04/2018
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HILLCRES	ST RALEIGH AT CRABTE	REE VALLEY		3 R			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580	Continued From page	5	F	580			
	12/29/17 at 6:46 PM. nurse's responsibility changes on the hall. rounded weekly to as changes occurred. If then the nurse should family (unless the res and get orders for treat the new area/wound a make the calls. The Unit Nurse Mana 12/19/17 at 7:14 PM. was a bit lethargic at she was sent to the h to take any chances s He stated he did not H resident had and had changes before. If the they would call the do implement wound car contacted if there was The Administrator wa 7:19 PM. She stated the with this resident besit was filed. The resider about Resident's #1 co offered to meet with the times after the grieval that she did not know resident had went she her expectation was to notify the Resident's the	ng was interviewed on She stated that it was for doing the dressing The wound care nurse sess the wounds or if any a resident got a new wound d notified the doctor and ident is alert and oriented) atment. The nurse that finds and would be the one to ger was interviewed on He stated that Resident #1 the nursing station (the day ospital) and they didn't want so they sent the resident out. Know how many wounds the never done her dressing ere was a new wound then octor and each nurse would te. The family was also is any change of regimen. Is interviewed on 12/29/17 at that there was no concerns ide the one grievance that nt's family was unrealistic condition. She stated she he resident's family three nce was filed. She stated i how many wounds the e left the facility. She stated o follow their policy and representative and the d and for the wound care					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/05/2018 M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345555	B. WING			C 01/04/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				3	830 BLUE RIDGE ROAD			
HILLOKE	ST RALEIGH AT CRABT			F	RALEIGH, NC 27612			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 686	6 Continued From page 6		│ F	686				
F 686		event/Heal Pressure Ulcer		686			2/1/18	
SS=D	CFR(s): 483.25(b)(1)			000			2/1/10	
	§483.25(b) Skin Integ §483.25(b)(1) Pressu							
	Based on the compre							
	resident, the facility must ensure that-(i) A resident receives care, consistent with							
	professional standards of practice, to prevent							
	-	does not develop pressure						
		vidual's clinical condition						
	demonstrates that the	ey were unavoidable; and						
		essure ulcers receives						
		and services, consistent						
	with professional star							
		vent infection and prevent						
	new ulcers from deve							
	by:	Γ is not met as evidenced						
	-	iew and staff and physician's			This plan of correction constitutes			
		failed to provide pressure			Hillcrest Raleigh at Crabtree, LLC's			
	· · ·	dent's sacrum and to a new			(Hillcrest's) written allegation of			
	pressure ulcers on th	e left lateral foot and a Deep			compliance for the deficiencies cited.			
		ght lateral foot for 1 of 3			However, submission of the Plan of			
		or pressure ulcers (Resident			Correction is not an admission that a			
	#1).				deficiency exists or that one was cited			
	Ein die en in durde de				correctly. This Plan of Correction is			
	Findings included:				submitted to meet requirements established by state and federal law.			
	1a. Resident #1 was	admitted to the facility on						
	5/19/17 with the diag	-			F686			
		Disease and malnutrition.			1. Address how corrective action will be	9		
					accomplished for those residents found	l to		
		rly Minimum Data Set dated			have been affected by the deficient			
		resident was severely			practice.			
		and required extensive						
		nobility, dressing, and			The DON was notified during the	•		
		e resident had one stage 2 as present on entry and one			complaint survey that the nurse failed to	0		
	pressure uncer trial W	as present on entry and one			provide treatment to "new lesions" for			

Facility ID: 20120054

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/05/20 FORM APPROV OMB NO. 0938-03
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345555	B. WING		C 01/04/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE
				3830 BLUE RIDGE ROAD	
HILLCRES	ST RALEIGH AT CRABT			RALEIGH, NC 27612	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 686	Continued From page	o 7	F 68	e	
1 000			F 00		ident #1
		e ulcer that was present on		11/28/17 thru 12/7/17 to Res	
	device for the bed, nu	ad a pressure reducing		Resident #1 was discharged facility on 12/7/17.	from the
		s receiving pressure ulcer			
	care.			2. Address how corrective ac	ction will be
	Resident #1 had a ca	are plan in place for pressure		accomplished for those resid	
		(17). The Resident's care		potential to be affected by the	e same
		d on 11/10/17 and stated that		deficient practice.	
		crum pressure ulcer that			
	presented as a stage	93.		The DON audited 100% of	
				for wounds and treatment or	-
	·	pressure ulcer care (no date)		undocumented wounds found	
	hypergel daily and co	ther than heels" to "apply		documented and treatment of place; there were no other in	-
		ing orders also revealed to		where wounds were identifie	
	-	ders as appropriate and to		corresponding treatment was	
	document interventio			documented. The facility will	
				documentation procedures, a	
	From 10/19/17 throug	gh 11/28/17, it was only		education of staff in regards	
	documented that the	resident had a pressure		orders and documentation of	
	ulcer to her sacrum.			All nurses will be educated o	•
				for treatment orders and doc	
	A shower sheet skin	-		This education will be condu	cted by the
		1/28/17 revealed the resident he outside of her left and		DON/designee.	
	right foot that "looks l			3. Address what measures w	vill be put into
				place or systemic changes m	
	A nursing note dated	11/28/17 revealed the		ensure that the deficient prac	
		d a new lesion forming, pink		occur.	
	in color with blackish	tinge at the center, Zinc			
		"On the patient's right foot is		The facility will update educ	
		on, zinc paste applied and		in regards to skin assessmer	
	the patient tolerated t	the treatment well."		orders and wound care docu	
	Thorowsers a tract	a ant ardara franciska		All nurses will be educated o	
	There were no treatm			for skin assessments, treatm	
1		the "new lesions" from ident #1 discharge on		and wound care documentat education will be conducted	
1 1					
		ders during this time were for		DON/designee.	by the

Facility ID: 20120054

STATEMENT (S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		345555	B. WING			C 01/04/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/04/2010	
				3830 BLUE RIDGE ROAD			
HILLCRES	T RALEIGH AT CRABT	REE VALLEY		RALEIGH, NC 27612			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	documentation in Reprovided to these are The resident went to Hospital records date resident had a urinar Deep Tissue Injuries DTI to the right foot r (cm) x 6 cm and the cm x 2 cm. The resid unstageable pressure measured 2.5 cm x 2 unstageable pressure measured 1 cm x 1 c medial abraded bland cm x 1 cm and a sac measured 8 cm x 5.5 The wound care nurs 12/29/17 at 11:21 AM 11/28/17, a nurse wro had a new lesion to t to the right foot that w The note stated that and applied zinc pass resident already had on a previous order (only), which was app pulled the shower sh Assistant noted the a stated she wouldn't r the (new) areas but t appropriate order. H	ent sacrum. There was no sident #1 chart that care was eas. the hospital on 12/7/17. ed 12/8/17 revealed that the y tract infection and 2 right (DTI) on her foot. The lateral neasured 7.5 centimeters anterior DTI measured 2.8 lent also had a left lateral e ulcer to her foot that 2.5 cm and a mid- lateral e ulcer to her left foot that cm. There was also a left chable area that measured 3 ral pressure ulcer that 5 cm x 0.3 cm. se was interviewed on <i>A</i> . She stated that on ote in note that the resident the left foot and one forming was a darkened open lesion. the nurse found 2 lesions te to both areas. The skin prep in place to her feet (per order it was for heels propriate. She stated that she eets and the Nursing areas on there too. She not have put the zinc oxide on that the skin prep was the lowever, there were standing ulcer care that was the	F 68	 documentation in resident cha audited/monitored by the DON weekly x4 weeks, bi-weekly x2 monthly x 1 month. 4. Indicate how the facility plan monitor its performance to ma solutions are sustained. The fa develop a plan for ensuring the is achieved and sustained. Th be implemented and the corre evaluated for its effectiveness of Correction is Monitoring of these changer specifically, skin assessments orders and wound care docum be performed by the DON/des weekly x4, bi-monthly x2 mont monthly x1. The facility QA cc and administrator/designee wit monitoring results during QA r DON/designee will be response monitoring and reporting. 	I/designee 2 weeks and 2 weeks		
		was interviewed on 12/29/17 ed that the resident required					

Facility ID: 20120054

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M			FORM	APPROVED 0. 0938-0391			
STATEMENT OF DEFICIENCIES ()	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			LETED	
	345555	B. WING				_ 04/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
HILLCREST RALEIGH AT CRABTRE	E VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ION SHOULD BE COMPLETIO THE APPROPRIATE DATE		
ankle. She also added "bunnies" on her feet. S the new areas to the nu- time the wound was ble the nurse. The nurse p cleaned it. She was not about the wound or abo added that she could no the nurse working that a had documented the ne Nurse #1 was interview PM. She stated that she Resident #1 twice. One 2017 and the resident h stated that there were a outside of the resident f stated that there were a outside on them and left that when the NA was on NA had told her that she she went and assessed areas were pinkish and resident did not have al that was related to thos there were standing or spots" then you put Zin added that the resident black spot on the right of foot wound. She stated remember specifically i had a "black spot" in it. The day shift nurse tha attempted to be interview Nurse #6 (who worked	e the resident showers. November, 2017, the red on the lower part of her that the resident wore She stated she reported urse. She stated that one reeding a little and she told out a bandage on it and t sure who the nurse called out the treatment. She also not remember the name of day. She stated that she rew area. wed on 12/29/17 at 4:28 re had only cared for the time was in November, had a sacral wound. She also 2 red spot on the legs and she put zinc the area open. She stated cleaning the resident, the ne noticed the wounds so d them. She stated that the d were circular. The my pain that she knew of se spots. She stated that der for if there are "red nc oxide ointment on it. She t did have a very small outside aspect of the right d that she could not if the resident's left foot at worked on 11/28/17 was ewed but was unavailable.	F	686				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345555	B. WING				04/2018
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST RALEIGH AT CRABTE	REE VALLEY			3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	he was not really fam could not remember i not. He stated that if not do the dressing of supposed to do it. He remember if the resid heels before she wen The Medical Director 12/29/17 at 6:45 PM. familiar with this resid the facility and at the was really poor and s He stated that when s there were some wou sacrum. They were of to the resident's cond The resident was place another facility. The m because she was not and was in and out. H did have a wound at the not know about the w until till she went to the wound was bad and w blood cell count was have was from the UTI or the changes were not do cause the wound to g The Director of Nursin 12/29/17 at 6:46 PM. nurse's responsibility changes on the hall. rounded weekly to as changes occurred. If then the nurse should (unless the resident is	iliar with the resident. He f he did the wound care of the wound care nurse does hange then the nurses were stated that he does not ent had any wounds to her t to the hospital. was interviewed on He stated that he was very lent as he cared for her at hospital. Her baseline status he had circulation problem. she arrived to the hospital, ands to her extremities and onsidering surgery but due ition called palliative care. ced on palliative care at esident went to the hospital doing well, was stuporous He stated that the resident he facility. He stated he did ound to the resident's feet ue hospital. The sacrum was infected and her white high and he was not sure it he wounds. If dressing he regularly then it could	F	686	3		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345555	B. WING				C 04/2018
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRES	ST RALEIGH AT CRABTR	REE VALLEY					
(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 686	calls. The Unit Nurse Mana 12/19/17 at 7:14 PM. was a bit lethargic at she was sent to the h to take any chances s He stated he did not H resident had and had changes before. If the they would call the do implement wound car The Administrator was 7:19 PM. She stated he wound care policy to 1b. Resident #1 was a 5/19/17 with the diagr Peripheral Vascular D Resident's #1 Quarter 8/21/17 revealed the cognitively impaired a assistance with bed n personal hygiene. The pressure ulcer that was unstageable pressure entry. The resident ha device for the bed, nu interventions and was care. A physician's telephon revealed to clean the Normal Saline, apply	d be the one to make the ger was interviewed on He stated that Resident #1 the nursing station (the day ospital) and they didn't want so they sent the resident out. (now how many wounds the never done her dressing ere was a new wound then befor and each nurse would e. s interviewed on 12/29/17 at that she did not know how ident had went she left the r expectation was for the be followed. admitted to the facility on noses of dementia, bisease and malnutrition. rly Minimum Data Set dated resident was severely and required extensive nobility, dressing, and e resident had one stage 2 as present on entry and one a ulcer that was present on ad a pressure reducing thition and hydration as receiving pressure ulcer the order dated 10/9/17 open area on sacrum with hydrogel, and cover with a	F	686			
	Normal Saline, apply dry dressing and char						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIPLE CONSTRUCTION LDING		SURVEY PLETED
		345555	B. WING			C 01/04/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
HILLCRE	ST RALEIGH AT CRABTE	REE VALLEY			3830 BLUE RIDGE ROAD RALEIGH, NC 27612		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Review of the pressur 10/19/17 through 11/7 resident's sacral press size and was slowly h sacral pressure ulcer measured 0.8 cm x 0 Review of the resider Record (TAR) for 10/2 areas to sacrum with hydrogel and dry dress The TAR was blank for dressing change for 2 10/14/17, 10/17/17, 1 10/23/17, 10/25/17 th and 10/30/17. It was resident refused wour was no other docume rationale for the blank The nursing notes we through 10/29/17. A n from 2nd shift reveale to the resident's sacru Resident #1 was admit 12/7/17. Hospital records date resident was admitted wounds, altered ment Infection. The wound care nurs on 12/29/17 at 11:21	re ulcer assessments from 16/17 revealed that the sure ulcer had decreased in realing. On 11/16/17, the was a stage 3 and .4 cm. at's Treatment Administration 2017 revealed to clean open normal saline, apply using and to change daily. or the following dates for the 2nd shift: 10/10/17 through 0/18/17, 10/20/17 10/21/17, rough 10/27/17, 10/29/17, only documented that the end care on 10/16/17. There entation on the TAR of the a documentation. are reviewed from 10/10/17 pursing note dated 10/20/17 ad that the dressing change	F	686			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345555	B. WING			C 01/04/2018			
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
HILLCRES	ST RALEIGH AT CRABTR	REE VALLEY		3830 BLUE RIDGE ROAD RALEIGH, NC 27612					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 686	thought that the Reside was checked by the w time and revealed the and right ankle wound initial assessment. Sh had the coccyx wound for personal reasons seen the resident's co completed a dressing the TAR. The rule of r change wasn't signed nursing staff were res treatments after the p position. She stated th that treatments was n resident for the month Nurse #3 (who worke this resident) was inte PM. She stated that s the resident's skin wa resident was not getti she knew of. The nurs responsible for doing She stated she had n changes on this resid Nurse #4 (who worke this resident) was inte AM. She stated that s resident specifically. wound care nurse doo facility and sometimes you when to complete residents. Nurse #5 (who worke 10/12/17, 10/18/17, 1	dent's initial assessment yound care nurse at that e resident had a buttock, left d as was indicated in the ne stated that resident only d when she left the facility in 8/2017. She only had occyx since then. If a nurse then they should sign off on nursing was that if dressing I off then it wasn't done. The ponsible for doing the revious WCN quit her hat she was not informed ot completed for this n of 10/2017. d 2nd shift on 10/20/17 for erviewed on 12/29/17 at 4:11 the could not remember if s intact. She stated that the ng dressing changes that ses would be the ones the treatments to wounds. ever completed dressing ent before. d 2nd shift on 10/10/17 for erviewed on 12/29/17 at 4:19 the could not remember this She added that usually the es the wound care in the s there was a book that tells e the wound care for a d 2nd shift on 10/11/17, 0/23/17, 10/25/17, 10/26/17) nterviewed on 12/29/17 but	F	68	6				

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	-	ID HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMPLETED		
		345555	B. WING			C 01/04/2018		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	01/04/2018	
				:	3830 BLUE RIDGE ROAD			
HILLORES	ST RALEIGH AT CRABTE				RALEIGH, NC 27612			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 686	Continued From page 14		F	686	6			
	Nurse #7 (who worked second shift on 10/17/17 with the resident) was attempted to be interviewed via phone on 12/29/17 at 4:09 PM but was unsuccessful.							
	Nurse #6 (who worked on 10/13/17, 10/14/17, 10/21/17, 10/27/17, and 10/29/17) was interviewed on 1/4/17 at 1:55 PM. He stated that he usually worked as needed. He stated that the resident had a skin tear on her arm. He stated that he only remembers that he had done wound care to her arms. He stated that he was not really familiar with the resident. He could not remember if he did wound care to this resident or not. He stated that if the wound care nurse does not do the dressing change then the nurses were supposed to do it.							
	6:45 PM. He stated the this resident as he can at the hospital. If they done regularly, then it go deep. Usually even the sacrum ulcer was had poor circulation a worse very easily even	was interview on 12/29/17 at nat he was very familiar with red for her at the facility and dressing changes were not t could cause the wound to n if pressure ulcer care to completed, the resident and the wound could get en if it was done the right way te all these things. He was es with this wound.						
	PM. She stated that the responsible for doing stated that she never dressing changes we wound care nurse rou wounds and if any ch	ewed on 12/29/17 at 6:46 he nurses on the hall were the dressing changes. She known of a time that re not completed. The unded weekly to assess the anges occur. The nurses ument the dressing changes						

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	-	ID HUMAN SERVICES				FORM	APPROVED				
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED						
		345555	B. WING			C 01/04/2018					
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE						
HILLCRES	ST RALEIGH AT CRABTE	REE VALLEY		3830 BLUE RIDGE ROAD RALEIGH, NC 27612							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE				
F 686	12/19/17 at 7:14 PM. known of a time that of being done for Reside family had never had he did not know how had and had never do before. He also added come to him if they co change done. The Administrator wa 7:19 PM. She stated aware of a time that of being performed. She	ger was interviewed on He stated that he had never dressing changes were not ent #1 and the resident's any complaints. He stated many wounds the resident one her dressing change d that the nurses could	F	686							

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