The REGULTORY OR LSCIDENTIFYING INFORMATION) The CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY DWE F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS <tdid< td=""> <tdid< td=""> <tdid< td=""></tdid<></tdid<></tdid<>								RM APPROVED
AND FLAN OF CORRECTION DEMNTIFICATION NUMBER: A BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE UTCHFORD FALLS HEALTHCARE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE OWNON STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE OWNON STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE OWNON STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE OWNON STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE OWNON STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE F 000 INITIAL COMMENTS F 000 The surveyor entered the facility on 1/11/18 to conduct a complaint survey and exited on 1/16/18. Therefore, the exit date was changed to 1/16/18. Therefore, the exit date was changed to 1/16/18. The facility must ensure that - §483.25(d)(1/2)Each resident remains as fine of accident hazards as is possible, and supervision and assistance devices to prevent accidents. F 689 This plan of correction constitutes a written allegation of compliance. Preparation and submistion or file addition with the resident in it. The resident muse aide was at ink of falling, and the nurse aide inft the resident for falling, and the nurse aide inft the resident is with a histop of falls. The resident muse aide was an in a elevated care position with the resident in it. The	CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>IO. 0938-0391</u>
JA4699 D. WING Control Contrecont Contente Control Control Contente Control Control Contente			, <i>'</i>			COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE OF CODE LITCHFORD FALLS HEALTHCARE IN ENTREET ADDRESS, CITY STATE OF CODE CODE DMUID PREFIX TAG ISLUMMARY STATEMENT OF DEFICIENCIES (CACH SECTIONY MUST BE PRECEDED BY FULL RESULTION OF LSC DENTIFYING INFORMATION) IN PREFIX PROVIDERS PLAN OF CORRECTION (CACH SORDECTIVE ACTION SINGLE BE CACESS-REPRECEDED IN HEALTHCARE 0.0004 (CACH SORDECTIVE ACTION SINGLE BE CACESS-REPRECEDED IN HEALTHCARE 0.0004 (CACESTINE ACTION SINGLE BE CACESS-REPRECEDED IN HEALTHCARE 0.0004 (CACESTINE ACTION SINGLE BE CACESS-REPRECEDED IN HEALTHCARE ACTION SINGLE BE CACESSTATE ACTION ACTION ACTION ACTION ACTION A			345499	B. WING _			0	
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UTCHORD FALLS HEALTHCARE RALEIGH, NC 27615 (%1)0 PREETX TAG EMMARY STREMENT OF DEFICIENCIES (EACH DEPICIENCY OF LISC DEPITY INTER INFORMATION) ID PREETX (EACH DEPICIENCY OF LISC DEPITY INTER INFORMATION) ID PREETX (EACH DEPICIENCY) PROVIDER'S PLANT CORRECTIVE AT 100S INCLORE (EACH OPECIDENT MUST EN RECEIPTION (EACH OPECIDENT MUST EN RECEIPTION DEPICIENCY) OPECIDENCY) F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 The surveyor entered the facility on 1/11/18 to conduct a complaint survey and exited on 1/12/18. Additional information was obtained on 1/16/18. Therefore, the exit date was changed to 1/16/18. Therefore, the exit date was a hare exit and facility must ensure that - \$483.25(d)(1) The resident fata of substaince devices to prevent accidents. This RECOUREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to assure safety measures were taken for one (Resident # 3 of three sampled resident # 3 was admitted to the facility on 72/16. The resident had diagnoses of dementain . The finding included: Record review revealed Resident # 3 was admitted to the facility on 72/2616. The resident had diagnoses of dementain, carechrowascular diseaserewith ap								
might Tx0 itext0 beforency MUSTER PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION PRETX Tx0 CACH CORRECTIVE ACTION SHOULD BE CROSS-HEERENCED TO THE APPROPRIATE DEFICIENCY CACH CACH DEFICIENCY F 000 INITIAL COMMENTS F 000 F 689 F 68	LITCHFOF	LITCHFORD FALLS HEALTHCARE						
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conduct a complaint survey and exited on 1/12/18. Additional information was obtained on 1/12/18. Additional information was obtained on 1/16/18. F 689 F 689<	F 000	INITIAL COMMENTS		FC	00			
§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to assure safety measures were taken for one (Resident # 3) of three sampled residents with a history of falls. The resident's nurse aide was unaware the resident was at risk of falling, and the nurse aide left the resident's bedside while the bed was in an elevated care position with the resident in it. The findings included:This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. ROOT CAUSEReview of the resident's quarterly minimum dataNurse Aide (NA) #1 was hired by the facility on 12/13/2017. During NA #1 new employee orientation process, she was		conduct a complaint s 1/12/18. Additional in 1/16/18. Therefore, t 1/16/18. Free of Accident Haz	survey and exited on formation was obtained on he exit date was changed to ards/Supervision/Devices	F 6	89			1/30/18
by: Based on observation, record review, and staff interviews the facility failed to assure safety measures were taken for one (Resident # 3) of three sampled residents with a history of falls. The resident's nurse aide was unaware the resident was at risk of falling, and the nurse aide left the resident's bedside while the bed was in an elevated care position with the resident in it. The findings included:This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.Record review revealed Resident # 3 was admitted to the facility on 7/28/16. The resident had diagnoses of dementia, cerebrovascular disease with aphasia, diabetes, osteoarthritis, chronic kidney disease, hypertension, atrial fibrillation, glaucoma, and contracture of the right knee.ROOT CAUSENurse Aide (NA) #1 was hired by the facility on 12/13/2017. During NA #1 new employee orientation process, she wasROOT CAUSE	SS=D	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.						
Record review revealed Resident # 3 was admitted to the facility on 7/28/16. The resident had diagnoses of dementia, cerebrovascular disease with aphasia, diabetes, osteoarthritis, chronic kidney disease, hypertension, atrial fibrillation, glaucoma, and contracture of the right knee. Review of the resident's quarterly minimum datastate and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETITLE(X6) DATE		by: Based on observatio interviews the facility measures were taken three sampled reside The resident's nurse resident was at risk o left the resident's bed elevated care position	n, record review, and staff failed to assure safety for one (Resident # 3) of nts with a history of falls. aide was unaware the f falling, and the nurse aide side while the bed was in an n with the resident in it.		written a Preparat correctio admissio the truth correctne on the st of correc	Ilegation of compliance. tion and submission of this on does not constitute an on or agreement by the prov of the facts or alleged or th ess of the conclusions set f tatement of deficiencies. The ction is prepared and submi	plan of vider of forth ne plan itted	
knee. Nurse Aide (NA) #1 was hired by the facility on 12/13/2017. During NA #1 new employee orientation process, she was LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		admitted to the facility had diagnoses of der disease with aphasia chronic kidney diseas	/ on 7/28/16. The resident nentia, cerebrovascular , diabetes, osteoarthritis, se, hypertension, atrial		state and the good improve	d federal law, and to demor I faith attempts by the provi the quality of life of each re	nstrate ider to	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		knee.	-		facility or	n 12/13/2017. During NA #	≠1 new	
		Review of the resider	t's quarterly minimum data		employe	e orientation process, she	was	
	LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	1	TITLE		(X6) DATE
								01/24/2018

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.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345499	B. WING			C 01/16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		01/10/2010
				8200 LITCHFORD ROAD		
LITCHFO	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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	a 1	F 68	20		
1 003	· · · · · · · · · · · · · · · · ·		FOC		e efidentifiine	
		d 10/31/17, revealed the / cognitively impaired and		not educated on the process residents at risk for falling in		
		aff for her activities of daily		Task Care Guide and the pr		
	living.			identifying current fall interv		
				Care Guide Safety Devices		
	Review of the resider	nt's care plan, last reviewed		Appliances.		
		the resident was identified				
	as being at risk for fal	lls. Two of the interventions		IMMEDIATE ACTION		
	on the care plan were	e to maintain the bed in a low				
	position, and to provid	de a mat beside the bed for		On 01/12/2018, the Director	•	
	safety.			and Nurse Aide #1 went to I		
				room and placed bed in low	position and	
		tes revealed an entry on		fall mat at the bedside.		
	-	sident was found on the floor				
	between the bed and			Nurse Aide #1 was educate	-	
	documented the resid	tent was not injured.		Director of Nursing on 01/12		
	On 1/16/19 at 1:55 D	M the DON (director of		process of locating if resider		
	nursing) was interview	M the DON (director of		for falls and their current fall under the Scheduled Task C		
		resident's 11/7/17 fall.		and Care Guide Safety Dev		
		I the fall was unwitnessed.		Appliances in the electronic		
		resident had a history of		Appliances in the electronic	nealth record.	
		nitiating movement when		IDENTIFICATION OF OTHE	-RS	
		and she was also on an air				
		o the DON, the facility's		Starting 01/24/2018-01/26/2	2018. the	
		fall revealed these three		Director of Nursing, Staff De		
		ributed to the resident falling		Coordinator and/or designat	•	
		7/17 although the fall was		nurse will complete 100% a		
	unwitnessed.	C C		current residents to ensure		
				interventions are in place. T	his audit will	
	On 1/12/18 at 9:20 A	M Nurse Aide (NA) # 1 was		be documented on Current	Fall	
		nged Resident # 3's room in		Interventions Audit Tool.		
		sfer. The NA had just				
		nt's morning care and was		Starting 01/24/2018-01/26/2		
	observed to have Res			Director of Nursing, Staff De		
	elevated care position			Coordinator and/or designat		
		e room for transfer, the NA		nurse will complete 100% o		
		dent's bed from the elevated		licensed nurses and certified		
	care position. Reside	ent # 3 was observed during		assistants to identify if staff	are able to	

Facility ID: 920763

If continuation sheet Page 2 of 5

ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED		
345499	B. WING		_	6/2018	
	· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
_		8200 LITCHFORD ROAD			
-		RALEIGH, NC 27615			
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE	
e 2 bed farthest from the preparation, the NA walked of the room in close vicinity to vas no other NA in the room as preparing the room. I observed in an elevated ttended while NA # 1 was on he room. Also during this bor mat was observed not in . It was rolled up and on the ne roommate's bed. M NA # 1 was interviewed ident in the elevated ed she began working at the 2017 and did not know the or that she had fallen in cording to the NA, Resident en at the head of the n she (NA # 1) first saw eginning of her shift. The NA ad not been at Resident # v with the NA revealed she o find information related to history of falls or were sk of falling. DN (Director of Nursing) on evealed there was a for NAs to reference for needs. A review of Resident vith the DON at this time 3 was identified to be at risk o the DON, NA # 1 was a ot have known about the	F 68	9 locate if residents are at risk for their current fall interventions u Scheduled Task Care Guide are Guide Safety Devices and Applithe electronic health record. The will be documented on the Sch Task Care Guide and Care Guide Devices and Appliances Knowl Tool. SYSTEMATIC CHANGES Director of Nursing (DON) and/Development Coordinator (SDC complete 100% education for a nurses and certified nursing aid include full time, part time and needed staff. The education wi staff being able to identify the letthe resident's fall risk and any of interventions under the Schedu Care Guide and Care Guide Sa Devices and Appliances in the health record. The education wi include that current fall interver place when licensed nurse and nursing aides are not at bedsid education will be completed by 01/30/2018 will not be allowed until educated. This educatior be added to new hire orientatio for all new Licensed nurses and nursing assistants effective 01/	nder the d Care iances in his audit eduled de Safety edge Audit or Staff C) will Il licensed les, to d as Il include, bocation of current fall led Task afety electronic ill also htions are in /or certified e. This e or ated by to work n process d certified 30/2018.		
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345499 345499 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 2 bed farthest from the preparation, the NA walked of the room in close vicinity to vas no other NA in the room as preparing the room. I observed in an elevated ttended while NA # 1 was on he room. Also during this for mat was observed not in . It was rolled up and on the he roommate's bed. M NA # 1 was interviewed ident in the elevated ed she began working at the 2017 and did not know the or that she had fallen in cording to the NA, Resident een at the head of the n she (NA # 1) first saw eginning of her shift. The NA ad not been at Resident # v with the NA revealed she o find information related to history of falls or were sk of falling. DN (Director of Nursing) on evealed there was a for NAs to reference for needs. A review of Resident vith the DON at this time 3 was identified to be at risk the DON, NA # 1 was a ot have known about the	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING 345499 B. WING 345499 B. WING ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG e 2 F 68 bed farthest from the preparation, the NA walked of the room in close vicinity to vas no other NA in the room as preparing the room. F 68 I observed in an elevated ttended while NA # 1 was on he room. Also during this oor mat was observed not in . It was rolled up and on the ne roommate's bed. M NA # 1 was interviewed ident in the elevated ed she began working at the 2017 and did not know the or that she had fallen in cording to the NA, Resident seen at the head of the n she (NA # 1) first saw eginning of her shift. The NA ad not been at Resident # v with the NA revealed she o find information related to history of falls or were sk of falling. DN (Director of Nursing) on evealed there was a for NAs to reference for needs. A review of Resident vith the DON at this time 3 was identified to be at risk the DON, NA # 1 was a ot have known about the	MEDICAID SERVICES (x1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION 345499 B. WING 345499 STREET ADDRESS, CITY, STATE, 2IP CODE 200 LITCHFORD ROAD RALEIGH, NC 27615 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREPRX TAG PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTIONS CROSS-REFERENCED TO THE A DEFICIENCY) b 2 F 689 b cate if residents are at risk for their current fall interventions u Scheduled Task Care Guide an Guide Safety Devices and Appliances Knowl Tool. c 2 F 689 b cate if residents are at risk for their current fall interventions u Scheduled Task Care Guide an Guide Safety Devices and Appliances Knowl Tool. It was rolled up and on the the room Also during this cording to the NA, Resident sen at the head of the n she (NA # 1) first saw eginning of her shift. The NA ad not been at Resident # v with the NA revealed she o find information related to history of falls or were is do falling. Director of Nursing (DON) and/ Devices and Appliances in the health record. The education wi staff being able to identify the ld care Guide and Care Guide Safe Devices and Appliances in the health record. The education wi include that current fall interver place when licensed nurse and nursing aides are not at bedsid education will be completed by 01/30/2018 will not be allowed until educated. This education winclude thare was a for NAs to reference for needs. A review of Resident with the DON, NA # 1 was a ot have known about the OI 10 PA <td>UD HUMAN SERVICES OMB NO. MEDICAID SERVICES OMB NO. (x1) PROVIDERSUPPLIENCIA (x2) MULTIPLE CONSTRUCTION (x3) ORT E </td>	UD HUMAN SERVICES OMB NO. MEDICAID SERVICES OMB NO. (x1) PROVIDERSUPPLIENCIA (x2) MULTIPLE CONSTRUCTION (x3) ORT E	

Event ID: 6GH511

Facility ID: 920763

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PRINTED: 02/16/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION		A. BUILDING	A. BUILDING				
345499			B. WING		C		
NAME OF F	ROVIDER OR SUPPLIER	575755		TREET ADDRESS, CITY, STATE, ZIP CODE	01/16/2018		
				200 LITCHFORD ROAD			
LITCHFO	RD FALLS HEALTHCAR	E		ALEIGH, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE		
F 689	Continued From pag	e 3	F 689	DEFICIENCY) able to locate if residents are at falls and their current fall interve under the Scheduled Task Care and Care Guide Safety Devices Appliances in the electronic hea MONITORING PROCESS Effective 01/30/2018, the Direct Nursing and/or Staff Developme Coordinator, will monitor compli the Scheduled Task Care Guide Guide Safety Devices and Appli orientation and education by au 100% new hired licenses nurses certified nursing assistants to er was completed. This audit will b completed on all new hires daily weeks, weekly X 2 weeks, then 3 months or until the pattern of compliance is achieved. Effective 01/30/2018, the Direct Nursing and/or Staff Developme Coordinator, will monitor compli licensed nurses and certified nu assistant knowledge on locating Scheduled Task Care Guide and Guide Safety Devices and Appli This audit will be completed on hires daily for 2 weeks, weekly 2 then monthly X 3 months or unt pattern of compliance is achieved	entions Guide and anth record. or of ent ance of e and Care ances diting s and nsure it re v for 2 monthly X or of ent ance of rrsing the d Care ances. all new X 2 weeks, il the ed.		

Event ID: 6GH511

Facility ID: 920763

If continuation sheet Page 4 of 5

PRINTED: 02/16/2018

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT		(X3) DATE SURVEY COMPLETED			
			A. BUILDI	NG			C
345499						01/16/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 011	
	RD FALLS HEALTHCARE			82	200 LITCHFORD ROAD		
		-		R	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	€ 4	F	689	nursing assistants are away from the bedside on 5 residents for daily 2 weeks 5 residents weekly X 2 weeks, then 5 residents X 3 months or until the patter of compliance is achieved. Effective 01/30/2018, Director of Nursi will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitorir or modification of this plan monthly X3 months, or until the pattern of compliant is maintained. The QAPI committee ca modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 01/30/2018, the center Administrator and the Director of Nursi will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensu- the facility remains in substantial compliance.	rn ng ng nce in in ing	

Facility ID: 920763

If continuation sheet Page 5 of 5

PRINTED: 02/16/2018