	-	ID HUMAN SERVICES			FOF	RM APPROVED	
		MEDICAID SERVICES				<u>O. 0938-0391</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY IPLETED	
		345499	B. WING		0;	C 5/14/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	RD FALLS HEALTHCARE		82	00 LITCHFORD ROAD			
		-	R	ALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments		E 000				
F 000	to conduct a recertific The survey team was 5/13/21. Additional ir offsite 5/13/21 throug exit date was 5/14/21 compliance with the r Emergency Prepared INITIAL COMMENTS The survey team ent to conduct a recertific The survey team was 5/13/21. Additional ir	ered the facility on 5/10/21 ation and complaint survey. onsite 5/10/21 through oformation was obtained h 5/14/21. Therefore, the	F 000				
F 550 SS=D	with a deficiency. Event ID: DWUJ11 Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section. §483.10(a)(1) A facility with respect and dign resident in a manner	(2)(b)(1)(2) Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in ty must treat each resident	F 550			6/11/21	
	her quality of life, reco	ognizing each resident's					
	individuality. The facil	lity must protect and					
		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		(X6) DATE	
Electroni	cally Signed					06/10/2021	

Electronically Signed

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	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345499	B. WING				_ 14/2021
	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 200 LITCHFORD ROAD RALEIGH, NC 27615	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 550	access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The resident can exercise interference, coercion from the facility. §483.10(b)(2) The resident can exercise of interference, c reprisal from the facilit rights and to be support exercise of his or her subpart. This REQUIREMENT by: Based on observatio resident, and staff into provide a dependent care (Resident #3) for for dignity. Resident # changed and his feeli and didn't like it. Finding included:	the resident. clifty must provide equal a regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her i the facility and as a citizen ted States. clifty must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this as not met as evidenced ns, record reviews, family, erview the facility failed to resident with incontinence r 1 of 3 residents reviewed 43 waited for 3 hours to be ngs were hurt, he felt bad	F	550	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pla correction does not constitute an admission or agreement by the provid the truth of the facts or alleged, or the correctness of the conclusions set fort on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the	er of h	
1	Resident #3 was adm	nitted to the facility on			requirement under state and federal la	W	

Facility ID: 920763

If continuation sheet Page 2 of 13

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · ·	ATE SURVEY OMPLETED
		345499	B. WING			С
	ROVIDER OR SUPPLIER	343433		STREET ADDRESS, CITY, STATE, ZIP CODI		05/14/2021
	NOWDER ON SOLT EIER			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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 550	Continued From page	a 2	F 5	50		
		ses that included hemiplegia	1.5	and to demonstrate the good	faith	
		oke, type 2 diabetes mellitus		attempts by the provider to im		
	without complications	• •		quality of life of each resident.		
	Review of Resident #	3's quarterly Minimum Date		IMMEDIATE ACTION		
		24/21 revealed Resident #3		On 5/11/2021, Resident #3 wa	as provided	
	had no memory issue			incontinence care after breakf		
		eds to staff and required		also encouraged to voice any		
		to total dependence with all		has or report any delays in ca		
		iving. Resident #3 was		reported concerns will be inco		
	always incontinent of	bower and bladder.		into community's grievance pr further modification of this pla		
	During an interview w	vith Resident #3 on 05/11/21				
		ed it took staff a long time		By 6/11/2021, Nursing Assista	int #13 was	
		his brief. Resident #3 also		re-educated by the facility Sta		
	indicated sometimes	he had to call his family and		Development Coordinator on	the	
		acility to let them know he		importance of ensuring reside		
		d. Resident #3 indicated he		provided incontinent care time		
		or his brief to get changed		includes physically checking r		
		e staff would not change him		who sometimes do not voice t		
		all. Resident #3 indicated		caregiver that they are soiled		
		to setting around wet for It's not a good feeling at all."		incontinent care. Nursing Ass voiced understanding of this e		
	Incontinence care for	Resident #3 was observed		IDENTIFICATION OF OTHER	S	
		m and the odor of urine was		All residents who need inconti		
		neet on the bed was noted to		have the potential to be affect	ed by this	
		rith a yellow ring that was		alleged deficient practice.		
		ower back. The lift sheet as wet. The incontinence		By 6/11/2021 the Director of N	lursing	
		and the odor of urine was		and/or Staff development Coo	•	
	present during care.			completed an audit of current		
				the facility that need incontine		
	An interview with Nur	sing Assistant (NA) #13 on		other resident was identified r		
		revealed she performed her		delayed incontinent care. Fin		
		ner shift and Resident #3		audit are documented on the		
		also stated Resident #3 did		Audit Tool maintained in the fa	acility's	
	not inform her that he she delivered his brea	e was wet prior to or when		compliance binder.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345499	B. WING				C 14/2021
NAME OF P	ROVIDER OR SUPPLIER			S	•		
				8	200 LITCHFORD ROAD		
	RD FALLS HEALTHCARE			R	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	SE ATE	(X5) COMPLETION DATE	
F 550	During an interview w member (FM) on 05/1 indicated Resident #3 week and most of the Resident #3 would tel bell on for two or mor to be changed. The F bowel movements an stated he had called t asked that someone g and provide the care indicated a complaint times during his stay. knew Resident #3 felt feeling were hurt. During an interview w (DON) on 05/13/21 at she expected staff to to all residents and no 15 minutes for care a	with Resident #3's family (2/21 at 11:30am, the FM a would call them during the time during the weekend. If the FM that he had his call e hours because he needed M indicated it was both d/or urine. The FM also the facility several times and go to Resident #3's room he needed. The FM had been filed several FM also indicated that she t bad about his situation and with the Director of Nursing t 2:15pm, the DON indicated provide dignity and respect to resident should wait over and treatment to be provided. Il residents to be treated	F	550	SYSTEMIC CHANGES Effective 6/11/2021 and moving forwar nursing staff will complete incontinence rounds timely and provide said care at point of identification to ensure resider dignity. Starting 6/11/2021, the Director of Nur and/or the Staff Development Coordina will complete education for all current nursing staff and care givers, to includ full time, part time, and as needed employees on completing incontinence rounds timely and providing said care the point of identification. This includes physically checking residents who sometimes do not voice to their caregi that they are soiled and need incontine care. The education will put an empha on the importance of maintaining residents' dignity by completing incontinence rounds timely and providi said care at the point of identification. This education will be completed by 6/11/2021. This education will also be added on new hires orientation process for all new nursing staff and care giver effective 6/11/2021, the Administrator, Director of Nursing, Staff Developmen Coordinator, Unit Coordinators, Weeke Supervisors and/or Charge nurses will make observations throughout the day include the observance of incontinent rounds and incontinent care and ensur- nursing staff and care givers are maintaining resident dignity by providir	e the the sing ator e e at s ver ent asis ng s s t end to re	

Event ID: DWUJ11

Facility ID: 920763

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	MENT OF HEALTH AN					FOR	D: 07/01/2021 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345499	B. WING				C / 14/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
LITCHFO	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550 F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)- §483.10(f) Self-deterr The resident has the promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The res activities, schedules (waking times), health	(3)(8) mination. right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f) is section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other		550	timely care. Findings from this monito process will be documented on a Dign Audit Tool maintained in the facility compliance binder. This monitoring process will take place daily for 2 weel then 3x/week for two more weeks, then weekly for 4 weeks, and then monthly the pattern of compliance is maintaine Effective 6/11/2021, the Administrator, Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to th facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	ity ks, n until d. he for on or	6/11/21

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345499	B. WING _				C 14/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				82	00 LITCHFORD ROAD		
	RD FALLS HEALTHCARE			R/	ALEIGH, NC 27615		
(X4) ID PREFIX TAG				(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	choices about aspects facility that are signific §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res participate in other activities to facility. This REQUIREMENT by: Based on record revit and staff interviews, to showers for 1 of 24 ref reviewed for choices. Findings included: Resident #60 was add 4-23-21 with multiple stage renal disease, of extremities and diabe There was no Minimu but Resident #60 was and oriented to person needed total assist wit transfers, toileting, an There was no care pla activities of daily living During an interview w	ident has a right to make s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the ident has a right to tivities, including social, nity activities that do not ts of other residents in the if is not met as evidenced ew, observation, resident he facility failed to provide esidents (Resident #60) mitted to the facility on diagnoses that included end cellulitis of bilateral tes. Im Data Set (MDS) available a documented as being alert n, place and time and th 2 people for bed mobility, d personal hygiene. an for assistance with g. ith Resident #60 on 5-11-21	F 5	661	IMMEDIATE ACTION By 6/11/2021, Nursing Assistant #1 and Nursing Assistant #2 were re-educated the facility Staff Development Coordina on the importance of ensuring resident have the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including the choice of when to bath. Nursing Assistants #1 a #2 voiced understanding of this expectation. On 5/13/2021, Resident #60 was asked by her CNA about her time preference getting a shower. Resident prefers ea evening showers on her current assign days. Resident #60 was observed by I Coordinator receiving her shower durin her preferred bathing time. Leg wraps were also replaced post her bathing.	by tor s nd for arly ed Jnit g	
		ith Resident #60 on 5-11-21 ent stated she was not			On 6/09/2021, Resident was successfu	illy	

Event ID: DWUJ11

Facility ID: 920763

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	Сом	E SURVEY PLETED
		345499	B. WING				C 5/14/2021
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	05	/14/2021
					200 LITCHFORD ROAD		
LITCHFO	RD FALLS HEALTHCARE				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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 561	Continued From page		F 56	61			
		vice a week as she was ained she was to receive a			discharged home with her husband.		
		3:00pm to 11:00pm) on			IDENTIFICATION OF OTHERS		
	Monday's and Wedne	esday's.			All residents have the potential to be affected by this alleged deficient practic	ce.	
		r documentation for the					
		ay revealed the resident had			By 6/11/2021 the Director of Nursing		
	received a shower on	1 5-3-21 and 5-5-21.			and/or Staff development Coordinator		
	The Director of Nursi	ng (DON) was interviewed			completed an audit of current residents the facility to determine their time	sin	
		n. The DON stated there			preference for bathing. Findings of this	2	
		for the month of April and no			audit are documented on the Initial	5	
		n that Resident #60 had			Preferred Bathing Times Audit Tool		
	received a shower pa				maintained in the facility's compliance		
					binder and each resident's care card w	/as	
	Nursing Assistant (NA			updated.			
		IA #1 stated she had offered					
		#60 on 5-10-21 but the			SYSTEMIC CHANGES		
		e explained she could not sident #60 until 8:30pm or			In May 2021, the community purchase an extra shower gurney to meet the	a	
		nt would refuse a shower.			current preference demand of the		
		discussed the time issue			community's resident population and to	r	
		assistant but there had not			allow more flexibility to meet the	-	
	been any changes ma				preferences of our resident population.		
	During an interview w	/ith NA #2 on 5-12-21 at			Starting 6/11/2021, the Director of Nurs	sing	
	-	d he was aware Resident			and/or the Staff Development Coordina	ator	
		fered a shower until 8:30pm			will complete education for all current		
		e resident did not want to			nursing staff and caregivers, to include		
	get a shower at that the sident #60 would r	ime. He also stated efuse a shower if she felt			time, part time, and as needed employ on the importance of ensuring resident		
		d not be completed by the			have the right to and the facility must	.5	
	evening nurse. NA #2				promote and facilitate resident		
	discussed the issue v				self-determination through support of		
		stated he had spoken with			resident choice, including their choice	of	
		5-12-21) to confirm a more			when to bath. The education will put a		
		o receive her showers.			emphasis on the importance of		
					maintaining residents' self-determination		
	The Administrator wa	s interviewed on 5-13-21 at			and empower all staff with the ability to)	

Facility ID: 920763

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/01/2021 M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345499	B. WING _			C 05/14/2021		
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
LITCHEOF	RD FALLS HEALTHCARE			82	200 LITCHFORD ROAD			
		-		R	ALEIGH, NC 27615			
(X4) ID PREFIX TAG			ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 561	aware showers were He also stated he exp	istrator stated he was not offered late in the evening. Dected and taught staff the and that the staff needed to	F	561	update the residents' care cards to re resident's current preferences. Educ will also include how to document res bathing and or refusals. This educat will be completed by 6/11/2021. This education will also be added to the n hire orientation process for all new nursing staff and care givers effective 6/11/2021. MONITORING PROCESS Effective 6/11/2021, the Administrato Director of Nursing, Staff Developme Coordinator, Unit Coordinators, Wee Supervisors and/or Charge nurses w make observations throughout the da include the observed preferences of resident bathing times and ensure ba was completed or refusal documente Findings from this monitoring process be documented on a Self-determination/Preferred Bathing Times Audit Tool maintained in the fa compliance binder. This monitoring process will take place daily for 2 we then 3x/week for two more weeks, th weekly for 4 weeks, and then monthil the pattern of compliance is maintain Effective 6/11/2021, the Administrato Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to facility Quality Assurance and Performance Improvement Committe any additional monitoring or modifica of this plan monthly for three months until the pattern of compliance is maintained. The QAPI committee car	ation sident ion sew r, nt kend ill ay to athing d. s will cility eks, en y until ed. r, the e for tion , or		

Event ID: DWUJ11

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				E SURVEY IPLETED
		345499				0	C 5/14/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOR	RD FALLS HEALTHCARE				00 LITCHFORD ROAD		
				R/	ALEIGH, NC 27615		
(X4) ID PREFIX TAG			ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page 8		F	561			
					modify this plan to ensure the facility remains in substantial compliance.		
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ients	F6	641			6/11/21
	 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the special treatments and program section (Section O) on the Minimum Data Set (MDS) assessment for 1 of 4 residents (Resident #68) reviewed for MDS accuracy. Findings included: Resident #68 was readmitted to the facility on 				IMMEDIATE ACTION The quarterly MDS assessment for resident #68 dated 4/7/2021 was modifie on 6/8/2021 to reflect the resident s Pneumococcal Vaccine was offered and up to date. The modified assessment w be transmitted on 6/9/2021 by MDS Nur #4. IDENTIFICATION OF OTHERS	l vill	
		diagnosis that included structive pulmonary disease			All residents have the potential to be affected by this alleged deficient practice On 6/8/2021, the MDS Nurse #4 and Sta		
	Review of Resident #68's Flu and Pneumonia documentation revealed the resident had a consent form signed 9-30-20 to receive the Flu and Pneumonia vaccines. The documentation also revealed Resident #68 had received the Flu and pneumonia vaccine on 10-15-20.				Development Coordinator completed an audit of current residents most recent MDS assessment, specifically Section 00250 and Section 00030 to ensure the MDS accurately reflects the Vaccination Status of the residents. The results of th audit indicate two other resident s	e	
	4-7-21 revealed Resi intact. Section O0030	m Data Set (MDS) dated dent #68 was cognitively) Pneumococcal Vaccine ent's pneumococcal vaccine nd not offered.			Section O0250 or Section OO0030 were coded incorrectly. Findings of this audit are documented on the Initial MDS Accuracy of Vaccination Status Audit To maintained in the facility s compliance binder.		

Facility ID: 920763

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145499 D. WING STREET ADDRESS, CITY, STATE, ZIP CODE INTERFORD FALLS HEALTHCARE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE (M1) D PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) STREET ADDRESS, CITY, STATE, ZIP CODE (M2) D PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EX PRECEDED BY FULL (EACH DEFICIENCY MUST EX PRECEDED BY FULL (EACH DEFICIENCY MUST EX PRECEDED BY FULL (EACH DEFICIENCY) PROVIDERS ON CORRECTION (EACH CORRECT MUST EX PRECEDED BY FULL (EACH DEFICIENCY) F 641 Continued From page 9 5-13-21 at 11:30am. The nurse explained she worked part time in the evenings and weekends. She stated she would look for documentation in the medical record if the vaccines had been offered and/or provided. Nurse #6 explained if she did not see any documentation then she would document "not offered" under O0030. She further explained lue to her schedule there was not anyone available to assist her in verifying the information. Nurse #6 stated she would leave notes for the full time MDS nurse if she felt information. Her #6 stated she would leave notes for the full time MDS nurse if she felt information. Her #6 stated she would leave notes for the full time MDS nurse if there was a need for follow up. The Administrator confirmed Nurse #6 worked part time and that there was not someone available for her to speak with to verify information. Her also stated Nurse #6 would leave notes for the full time MDS nurse if there was a need for follow up. The Administrator said he expected the information in the resident's medical record to be accurate. MONITORING PROCESS Effectince 6/11/2021, prior to submission, MDS Nurse #4 up fid Nurse #6	E SURVEY PLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LITCHFORD FALLS HEALTHCARE STREET ADDRESS, CITY, STATE, ZIP CODE COULD PRETRY TAG SUMMARY STRTEMENT OF DEFICIENCIES (CONDECTIVE ADDRESS, CITY, STATE, ZIP CODE COULD PRETRY TAG SUMMARY STRTEMENT OF DEFICIENCIES (CONDECTIVE ADDRESS, CITY, STATE, ZIP CODE F 641 Continued From page 9 5-13-21 at 11:30am. The nurse explained she worked part time in the evenings and weekends. She stated she would look for documentation in the medical record if the vaccines had been offered and/or provided. Nurse #6 explained if she did not see any documentation hen she would document "not offered" under O0030. She further explained due to her schedule there was not anyone available to assist her in verifying the information. Nurse #6 stated she would leave notes for the full time MDS nurse if she fielt information needed verified but stated she could not remember if she had left a not regarding Resident #86% MDS Information. F 641 MONITORING PROCESS The Administrator was interviewed on 5-13-21 at 12:15pm. The Administrator confirmed Nurse #6 worked part time mDS nurse if were in the resident's medical record to be accurate. MONITORING PROCESS Effective 611/12021, prior to submission, weekends. She stated Nurse #6 would leave notes for the full time MDS nurse #16 there was a need for follow up. The Administrator said he expected the information in the resident's medical record to be accurate. MONITORING PROCESS Effective 6111/2021, prior to submission worked part time and that three was a need for follow up. The Administrator said he expected the inf	C 05/14/2021		
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Vaccination Status Audit Tool maintained			
in the facility⊡s compliance binder.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OM								
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345499	B. WING _				C 14/2021	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LITCHFOF	RD FALLS HEALTHCARE		8200 LITCHFORD ROAD RALEIGH, NC 27615					
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 641	Continued From page 10		F 641 #6 will report findings of this monitorin process to the facility Quality Assurance and Performance Improvement Committee for any additional monitorin or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ens the facility remains in substantial compliance.		e g			
	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced		F6	\$77			6/11/21	
	and staff interview the dependent resident w of 5 residents reviewe (Resident #3) Finding included: Resident #3 was adm 01/19/21 with diagnos following cerebral stro without complications Review of Resident # Set (MDS) dated 04/2 had no memory issue communicate his nee extensive assistance	es that included hemiplegia oke, type 2 diabetes mellitus , and dysphasia. 3's quarterly Minimum Date 4/21 revealed Resident #3			IMMEDIATE ACTION On 5/11/2021, Resident #3 was provide incontinence care after breakfast. He was also encouraged to voice any concerns has or report any delays in care. Any reported concerns will be incorporated into community's grievance process for further modification of this plan. By 6/11/2021, Nursing Assistant #13 was re-educated by the facility Staff Development Coordinator on the importance of ensuring residents are provided incontinent care timely. This includes physically checking residents who sometimes do not voice to their caregiver that they are soiled and need incontinent care. Nursing Assistant #13 voiced understanding of this expectation	vas he as		

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FOR OMB N	D: 07/01/2021 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	Сом	E SURVEY PLETED C
		345499	B. WING				5/14/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOF	RD FALLS HEALTHCARE	I		-	200 LITCHFORD ROAD ALEIGH, NC 27615		
			-	ĸ	, 		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From page	9 11	F	677			
	always incontinent of	bowel and bladder.					
					IDENTIFICATION OF OTHERS		
		ith Resident #3 05/11/21 at			All residents who need incontinent of		
		t took staff a long time his brief. Resident #3 also			have the potential to be affected by alleged deficient practice.	.1115	
		he had to call his family and					
		acility to let them know he			By 6/11/2021 the Director of Nursing	J	
		d. Resident #3 indicated he			and/or Staff development Coordinat		
		r his brief to get changed			completed an audit of current reside		
		e staff would not change him			the facility that need incontinent car		
	during mealtimes at a	П.			other resident was identified receivi	•	
	Incontinence care for	Resident #3 was observed			delayed incontinent care. Findings audit are documented on the Initial		
		m. the odor of urine was			Audit Tool maintained in the facility'		
		eet on the bed was noted to			compliance binder.		
	be wet and stained wi	ith a yellow ring that was					
		ower back. The lift sheet			SYSTEMIC CHANGES		
		as wet. The incontinence			Effective 6/1/2021 and moving forw		
		nd the odor of urine was			nursing staff will complete incontine		
	present during care.				rounds timely and provide said care point of identification to ensure resid		
		sing Assistant (NA) #13 on			dignity.		
		evealed she performed her					
		er shift and Resident #3			By 6/11/2021, the Director of Nursin	-	
		also stated Resident #3 did was wet prior to or when			and/or the Staff Development Coord will complete education for current r		
	she delivered his brea	-			staff and care givers, to include full	•	
					part time, and as needed employee		
	During an interview w	ith Resident #3's family			completing incontinence rounds tim		
	•	2/21 at 11:30am, the FM			and providing said care at the point		
		would call them during the			identification. This includes physica	•	
		time during the weekend.			checking residents who sometimes		
		I the FM that he had his call			voice to their caregiver that they are		
		e hours because he needed			and need incontinent care. The edu		
	-	M indicated it was both d/or urine. The FM also			will put an emphasis on the importa maintaining residents' dignity by		
		he facility several times and			completing incontinence rounds tim	٠lv	
		go to Resident #3's room			and providing said care at the point	-	
	and provide the care				identification. This education will be		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345499		(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		B. WING		05/14/2021		
NAME OF PROVIDER OR SUPPLIER LITCHFORD FALLS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE		•	
			8200 LITCHFORD ROAD RALEIGH, NC 27615			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLETION	
F 677	times during his stay. During an interview w (DON) on 05/13/21 at she expected staff to for all residents in a ti	had been filed several with the Director of Nursing t 2:15pm, the DON indicated provide incontinence care imely manner. The DON inutes of the residents	F 677	completed by 6/11/2021. This educa will also be added on new hires orientation process for all new nursir staff and care givers effective 6/11/2 MONITORING PROCESS Effective 6/11/2021, the Administrate Director of Nursing, Staff Developme Coordinator, Unit Coordinators, Wee Supervisors and/or Charge nurses w make observations throughout the d include the observance of incontiner rounds and incontinent care and ens nursing staff and care givers are maintaining resident dignity by provi timely care. Findings from this moni process will be documented on a Dig Audit Tool maintained in the facility compliance binder. This monitoring process will take place daily for 2 we then 3x/week for two more weeks, th weekly for 4 weeks, and then month the pattern of compliance is maintain Effective 6/11/2021, the Administrate Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to facility Quality Assurance and Performance Improvement Committe any additional monitoring or modifica of this plan monthly for three months until the pattern of compliance is maintained. The QAPI committee ca modify this plan to ensure the facility remains in substantial compliance.	ng 1021. pr, ent ekend vill ay to nt sure ding toring gnity eeks, nen ly until ned. pr, p the ee for ation s, or an	

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