						M APPROVED
						O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		Сом	E SURVEY PLETED
		345499	B. WING			C 2/ <b>17/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOR	RD FALLS HEALTHCARE	& REHABILITATION CENTER		8200 LITCHFORD ROAD RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000	D		
	from 12/10/24 through information was obtain The credible allegation	ned offsite on 12/16/24. n of immediate jeopardy d on 12/17/24. Therefore, nged to 12/17/24. were investigated:				
	NC00224859 and NC					
	3 of the 22 complaint deficiency.	allegations resulted in				
	of J CFR 483.45 at tag F7 of J	was identified at: i80 at a scope and severity i756 at a scope and severity i60 at a scope and severity				
	of J	ited Substandard Quality of				
	Care.					
	and F760) and on 11/ removed on 12/14/24 was conducted.	began on 10/28/24 (for F580 13/24 (for F756) and was . A partial extended survey				
F 580 SS=J	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) )(i)-(iv)(15)	F 580			1/17/25
	consult with the reside	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					01/13/2025

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 (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345499	B. WING _				C 17/2024	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LITCHFOR	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 LITCHFORD ROAD ALEIGH, NC 27615			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 580	representative(s) whee (A) An accident involver results in injury and his physician intervention (B) A significant changer mental, or psychosoccideterioration in healther status in either life-threet clinical complications; (C) A need to alter treet a need to discontinuer treatment due to advect commence a new form (D) A decision to trans- resident from the facilits §483.15(c)(1)(ii). (ii) When making noti- (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must at resident and the resider when there is- (A) A change in room- as specified in §483.10 (B) A change in resider State law or regulation (e)(10) of this section (iv) The facility must re- update the address (re- phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite dis-	en there is- ving the resident which as the potential for requiring y; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial eatening conditions or ); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity 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 lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and	F	580				

Facility ID: 920763

If continuation sheet Page 2 of 53

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/28/202 RM APPROVE IO. 0938-039	
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345499	B. WING		1:	C 2/17/2024	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
			8	3200 LITCHFORD ROAD			
LITCHFOR	D FALLS HEALTHCARE	E & REHABILITATION CENTER		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 580	Continued From page	e 2	F 580				
F 380	its physical configural locations that compris part, and must specifi room changes between under §483.15(c)(9). This REQUIREMENT by: Based on facility staff interviews, and facility reviews, the facility fat with the resident's Met clarification when the resident's coverage of medication (Eliquis). medication used to re- blood clots in people type of irregular heart discontinued 11 days for a one-month Vasc by an outside provide of bilateral lower extra (or DVTs, a condition a deep vein, typically failed to clarify with e or Resident #6's phys Eliquis needed to be Vascular consult on 1 of 1 resident reviewer (Resident #6) with a fi pulmonary embolism blood clot travels to th fibrillation. Resident	tion, including the various se the composite distinct by the policies that apply to en its different locations T is not met as evidenced ff interviews, physicians' y and hospital record ailed to immediately consult edical Doctor (MD) for order re was a lapse in the of an oral anticoagulant Eliquis is a prescription educe the risk of stroke and who have atrial fibrillation (a tbeat). Eliquis was before Resident #6 returned cular follow-up appointment er due to a recent diagnosis emity deep vein thrombosis where a blood clot forms in in the legs). The facility ither the Vascular consultant sician as to whether the continued until the next 11/8/24. This occurred for 1 d for notification of change history of strokes, DVTs, (or PE, a condition where a	F 580	The creation and submission of allegation of compliance does n constitute an admission by this any wrongful did, or of any viola regulation. It is solely created to demonstrate our good faith atter continue to provide a quality of residents. F580 Corrective actions accomplishe residents found to be affected to deficient practice: Resident #6 is no longer in the Identification of other residents the potential to be affected by to deficient practice: 100% audit of all current resided discontinued/stopped medication last 30 days completed on 12/1 the Director of Nursing, Assista of Nursing, and/or Unit Coordin #2) to identify any other medication was discontinued/stopped/ran-o- consultation with an attending p	not provider of ation of o empt to life for our ed for those by the facility. s having he same ents on in the l3/2024, by int Director pator (1 or ation that out without		
	middle cerebral artery	s which included an acute y (MCA) stroke. An MCA blood flow through the middle brain is interrupted		Any resident(s) identified with a discontinued order without atter physician consultation, the Dire nursing will inform the physician	nding ector of		
		d hospitalized as of the date		appropriate measures and or interventions and implement the			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/28/2 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345499	B. WING		12/17/2024
NAME OF PI	ROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP COL	
LITCHFOF	RD FALLS HEALTHCARE	& REHABILITATION CENTER		8200 LITCHFORD ROAD RALEIGH, NC 27615	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIN E APPROPRIATE DATE
F 580	Continued From page	e 3	F 580		
				interventions as ordered.	
		began on 10/28/24 when was discontinued without		Measures/systemic changes	will be put
	consulting with the ph			into place to ensure that the	
	jeopardy was remove	d on 12/14/24 when the		practice does not recur	
		an acceptable credible			
	•	te jeopardy removal. The of compliance at a D (no		Effective 12/13/2024, facility will ensure any changes in m	
		ential for more than minimal		treatment, to include disconti	
	•	ediate jeopardy) to ensure		medication such as Eliquis, w	
		ication and monitoring		reported to the physician prio	
	systems are in place.			discontinuation to ensure app	-
	The findings included			medical intervention/assessn	
	The findings included			implemented to prevent poss consequences that may resu	-
	Resident #6 was adm	nitted to the hospital on		abruptly discontinuing medica	
	2/13/24 after sustaini	•		Eliquis. This systemic modifie	
		e small bone of the lower		accomplished by implementing	ng the
		om a fall. The resident's		following measures:	
	· •	ummary dated 2/20/24 noted		Effective 12/13/2024, license	
		nticoagulation due to atrial ry of DVT and PE.Resident		duty will inform the resident; the resident⊡s physician; and	
		ge Medication List included 5		resident representative when	-
		is to be administered as one		significant change in the resid	
	-	daily. She was discharged		physical, mental, or psychoso	
		admitted to the facility on		need to alter treatment signifi	
	2/20/24.			is, a need to discontinue an e of treatment due to adverse	existing form
	A review of Resident	#6's February 2024 through		consequences, or to commer	nce a new
		sician Orders revealed the		form of treatment). This notifi	
		regimen continued to		documented on each residen	
		administered by mouth two		electronic medical records by	/ the licensed
	times a day from 2/20	)/24 to 9/17/24.		nurse on duty.	
	On 9/17/24, a venous	doppler ultrasound study		Effective 12/13/2024, the fact	ility⊡s clinical
	was conducted of Re	•••		team, which includes Directo	-
	extremity due to the r	esident's complaint of pain		Assistant Director of Nursing	, Medical
		mity and history of frequent		records coordinator, Unit coo	
	DVTs. The Radiology	y Results read in part,		Unit coordinator #2, and/or A	dmission

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
		345499	B. WING		1:	C 2/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		E & REHABILITATION CENTER		8200 LITCHFORD ROAD		
	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 580	Continued From page	e 4	F 58	0		
	<ul> <li>Continued From page 4</li> <li>"Impression: Findings are consistent with deep venous thrombosis [DVT]Clinical Follow-up is recommended."</li> <li>A Health Status Note dated 9/17/24 at 2:54 PM reported Resident #6's MD was informed of the radiology results. A new physician's order was received to discontinue the resident's Eliquis and initiate the administration of 40 mg enoxaparin (an injectable anticoagulant used for the treatment of DVTs) to be administered subcutaneously (under the skin) every 12 hours to prevent blood clotting. The physician also ordered a Vascular consult for Resident #6 at that time.</li> <li>Resident #6 was seen for an outside Vascular consultation on 9/27/24. Upon her return to the facility, paperwork provided from the consultation included a Doctor's Order Consult Request. A notation made on this form indicated the reason for the consultation was due to concerns for blood clots given the resident's positive history and bilateral leg pain. The "Consultation Findings" indicated a bilateral lower extremity (BLE) venous duplex (ultrasound) was conducted with a diagnosis of "Bilateral lower extremity non-occlusive DVTs [a condition where veins are partially blocked, allowing some blood to flow around the clots]." The "Recommendations" read as follows: "Compression stockingsdaily (on in AM, off in PM) and Eliquis 5 mg BID [twice daily] x 30 days and follow-up in 1 month with a repeat BLE venous duplex [ultrasound to be completed at the next visit] to check on the status of the thrombi [clots]. Patient may need to be on low anticoagulation indefinitely with her history of DVT/PE." The Doctor's Order Consult Request form also noted the resident's 1 monthly follow-up</li> </ul>			nurse initiated a process for revie clinical documentation for the last hours and physician orders written last 24 hours (including orders to discontinue medication), or from t clinical meeting to ensure any nee notification of changes to the phys and/or responsible party was don- timely manner. This systemic pro take place Monday through Friday identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any negative findings wi addressed promptly. The nursing administrative team will review the documentation and physician orde written on Friday, Saturday, and/o Sunday at the next clinical meeting following Monday.	24 n in the he last eded sician, e in a cess will /. Any f II be e clinical ers or	
				100% education of all licensed nuinclude full time, part time, and as licensed nurses will be completed Director of Nursing, Assistant Director and/or Unit Coordinators (1, #2). emphasis of this education will be importance of notifying an attendi physician and the party responsib timely manner for any change in or change of treatment/intervention a discontinuation of medication. The education emphasized that an atte physician should be consulted be medication ran out/stopped for pre- intervention. This education will be completed by 12/13/2024, any lice nurses not educated by 12/13/202	needed by the ector of dinator, The the ng le in a condition, and ending fore oper e ensed	

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		MEDICAID SERVICES					<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	<b>I</b> ` /	TE SURVEY MPLETED
		345499	B. WING			1	C 2/17/2024
	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		2/11/2024
					00 LITCHFORD ROAD		
ITCHFOF	RD FALLS HEALTHCARE	& REHABILITATION CENTER			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 580	Continued From page	5	F 58	20			
1 000		eduled for 11/4/24 at 3:00	1.50		not be allowed to work until educated.		
		gned by the Vascular clinic			Director of Nursing, Assistant Director	of	
	Nurse Practitioner #1				Nursing, and/or Unit Coordinators (1, #		
					will monitor and track the completion of		
	Upon Resident #6's r	eturn to the facility on			this education and will complete this		
	9/27/24, a physician's			education for any newly hired licensed			
	transcribed by Nurse				nurses during the new hire orientation		
	electronic medical rec	cord (EMR) to re-start her			effective 12/13/2024		
	Eliquis as 5 mg admir	nistered as one tablet by			100% education of all current clinical		
	-	30 days. The order for			leadership team members to include		
		rt date of 9/28/24 and an			Director of Nursing, Assistant Director		
		A physician's order was			Nursing, Medical records coordinator,		
		nscribed into Resident #6's			coordinator #1, Unit coordinator #2 and	d/or	
	-	rin to be discontinued as of			Admission nurse completed by the	<b>-</b> .	
	9/27/24.				Regional Director of Clinical services.		
	A tolophono intorviow	was conducted on 12/16/24			emphasis of this education includes, b not limited to, the importance of ensuri		
	at 7:56 PM with Nurse				residents discontinued medication ar	-	
		anscribed the order for			other changes of condition is reviewed		
	Resident #6's Eliquis				the daily clinical meeting to ensure the		
		her Vascular consultation.			attending physician was consulted bef		
		se recalled Resident #6 but			the medication ran out/stopped or		
		any specifics related to the			discontinued. This education will be		
		o the resident's EMR on			completed by 12/13/2024, any clinical		
	9/27/24. When asked	d, Nurse #1 reported if she			team member not educated by 12/13/2	24,	
		the resident's paperwork			will not be allowed to work until educat	ed.	
		would have told the Unit			This education is added to a new hire		
	Manager. The nurse				orientation for all clinical team member	ſS	
	understanding that th				effective 12/13/2024.		
		bllow-up deemed necessary					
	regarding the physicia	ans orders.			Monitoring of corrective actions to ens	ure	
	A telephone interview	was conducted on 12/16/24			that the deficient practice is being corrected and will not recur:		
	-	acility's former Unit Manager.					
		the Unit Manager reported			Effective 01/13/2025, DON and/or ADO	ON	
	-	specific details about the			will monitor compliance with notificatio		
		rom Resident #6's Vascular			changes to physician and or responsib		
		ders received on 9/27/24.			party by reviewing the daily clinical		

Event ID: SZH311

Facility ID: 920763

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						0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	E SURVEY PLETED
						С
		345499	B. WING			/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ITCHEO	RD FALLS HEALTHCAR	E & REHABILITATION CENTER		8200 LITCHFORD ROAD		
				RALEIGH, NC 27615		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 580	Continued From page	e 6	F 580			
	not certain the facility to receive and addre- made by outside con- inquiry as to whether Doctor's Order Consul- #6's Vascular consul- Manager stated she A review of the reside Medication Administr revealed Resident #6 Eliquis administered daily on 9/28/24 in ac physician's order. A Health Status Note and authored by the (DON) reported Resi program "notified fac upcoming Vascular a 11/4/24, stating that t like to reschedule du Awaiting time and o [appointment]."	A Health Status Note dated 10/28/24 at 3:25 PM nd authored by the facility's Director of Nursing DON) reported Resident #6's managed care rogram "notified facility about resident's pcoming Vascular appointment scheduled for 1/4/24, stating that the [family member] would ke to reschedule due to a conflicting event .Awaiting time and date for rescheduled appt		<ul> <li>timely notification to physician an responsible party for any item ide meet notification requirements. A issues identified during this moni process will be addressed promp monitoring process will be condu Monday to Friday for two weeks, for two more weeks, then monthl three months or until a pattern of compliance is maintained.</li> <li>Effective 01/13/2025, Director of will report findings of this monitor process to the facility Quality Ass and Performance Improvement Committee for any additional mon or modification of this plan month three months, or until a pattern or compliance is maintained. The Committee can modify this plan to the facility remains in substantial compliance.</li> <li>Compliance date: 01/17/2025.</li> </ul>	entified to iny toring tty. This cted daily weekly y for Nursing ing surance nitoring ily for f QAPI	
	Nursing (DON), who facility's Assistant Dir During the interview, her 10/28/24 notation informed Resident #6 reschedule the Vascu asked if she realized be receiving Eliquis a responded by saying	was currently working as the rector of Nursing (ADON). the ADON was asked about which indicated she was 5's family wished to ular consultation. When Resident #6 would no longer after 10/28/24, the ADON , "Nonot at that moment." she had realized at the time				

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE		
		345499	B. WING _				C 17/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LITCHFO	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 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	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	TIVE ACTION SHOULD BE COMP CED TO THE APPROPRIATE D		
F 580	appointment, she wou clarify the order for the inquiry, the ADON was staff should do if there order for a medication ADON responded by wanted the nursing st physician that the res pertinent drug (Eliquis wanted to do. A review of Resident i November 2024 MAR received her last dose of 10/28/24. No other documented as admir MARs from 10/28/24 represented an 11-da of Eliquis to Resident On 11/8/24 at 2:00 PM her outside Vascular of due to her bilateral DM Consult Request form upon conclusion of the resident's thrombil we Consultation Findings indicated the resident extremity DVTs. The consult form read in p [twice daily] po [by more Referral for hematolog DVTs and PE."	<ul> <li>IId have called the MD to e Eliquis. Upon further is asked what the nursing e was a question on an in such as Eliquis. The saying she would have aff to notify Resident #6's ident would be without this is) and to see what he</li> <li>#6's October 2024 and the resident e of Eliquis on the morning of doses of Eliquis were the histered on the resident's to 11/8/24. This y lapse in the administration #6.</li> <li>M, Resident #6 was seen for consultation and follow-up VTs. The Doctor's Order in provided to the facility is follow-up reported the re unchanged. The for her "Diagnosis" thad chronic bilateral lower "Recommendations" on the part: "Eliquis 5 mg BID buth] x 90 days #2 refills. gy due to history of multiple</li> <li>#6's physician's orders and mber 2024 MARs revealed tribed into the resident's</li> </ul>	F	580				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
						С
		345499	B. WING		1:	2/17/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
LITCHFOF	RD FALLS HEALTHCAR	E & REHABILITATION CENTER		8200 LITCHFORD ROAD RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIO DATE
F 580	Continued From page	e 8	F 5	80		
		e of her discharge to the				
 	Resident #6's EMR included a Skilled Nursing Facility (SNF) to Hospital Transfer form dated 12/3/24 at 6:50 PM. The transfer form reported Resident #6 was sent out to the hospital for evaluation and treatment due to a change in mental status and possible stroke.					
	Note's History and Pl 11:36 PM was condu Resident #6 was tran Emergency Medical S presented with altere speech, and confusio resident had a history deficits. Resident #6 also included, in part anticoagulation and D device that prevents from the legs to the lu	ent's hospital Admission hysical dated 12/3/24 at cted. The note indicated isported to the hospital via Services (EMS) and d mental status, garbled on. The notes reported the y of stroke with left sided 's History of Present Illness , atrial fibrillation not on DVT with IVC filter (a small blood clots from traveling ungs). The Emergency I a computerized tomography				
	(CT) scan of the head subacute ischemic ev stroke was caused by brain) involving the le part of the brain for u learning, and rememi and temporal parietal human brain that is in cognitive and motor f was reported to have she was not currently hospital record also in	d showed an acute to vent (a situation where a y blocked blood flow to the eff posterior temporal lobe (a nderstanding language, bering verbal information) I junction (a region of the nvolved in many higher-order functions). The resident e atrial fibrillation and noted y on anticoagulation. The ndicated Resident #6 was , but it been discontinued				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				PLETED
		345499	B. WING				C 1 <b>7/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOR	RD FALLS HEALTHCARE	& REHABILITATION CENTER			2200 LITCHFORD ROAD RALEIGH, NC 27615		
(X4) ID PREFIX TAG			ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 580	at 12:12 PM with the outside consulting clir saw Resident #6 on 9 employed by the Vaso the MD stated he wou to call his office if ther whether the Eliquis sh until her follow-up app During the interview, 1 Eliquis administration was "definitely not an A telephone interview at 10:13 AM with Res (MD) at the facility. D stated he felt the "cru the 9/27/24 order was He reported that ideal the Eliquis should hav scheduled follow-up a reported if he had bee being discontinued or asked the facility to ca see what he/she reco "I commonly do that k The Administrator was jeopardy at F580 on 1 The facility provided t allegation of immedia	date of the review was conducted on 12/13/24 Vascular MD from the nic. He reported the NP who /27/24 was no longer cular clinic. When asked, ild have wanted the facility re was any question as to nould have been continued pointment on 11/8/24. the MD reported the lapse in (from 10/28/24 to 11/8/24) intentional lapse." was conducted on 12/13/24 ident #6's Medical Doctor ruring the interview, the MD x of the problem" was that s written for a 30-day period. Ily, he would have thought /e been continued until her uppointment. The MD en called about the Eliquis in 10/28/24, he would have all the Vascular consultant to mmended. The MD added, ind of thing."	F	580			
		serious adverse outcome as					

Facility ID: 920763

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8	FORM	MAPPROVED 0. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í	IPLE CONST		(X3) DATE	
		A. BUILDIN	IG			с
	345499	B. WING			12/	17/2024
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LITCHFORD FALLS HEALTHCAR	E & REHABILITATION CENTER			CHFORD ROAD H, NC 27615		
PREFIX (EACH DEFICIEN			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 580 Continued From pag	le 10	F 5	580			
Review of Resident indicates; on 9/27/24 appointment. The correcommendation to 5mg twice daily for 3 transcribed onto the records and implement was ordered to start date of 10/28/24. Re have a follow up app consultation form ind up appointments to indication that the at consulted regarding of Eliquis prior to the Review of facility clin 10/8/24 indicate Res requested for the Var rescheduled due to appointment was res indication that the at consulted regarding of Eliquis prior to the Resident #6 went to appointment on 11/8 physician ordered E twice daily for 30 da Review of Resident from 10/28/2024 to orders for Eliquis we facility's Electronic F the attending physic run out on 10/28/2024	<ul> <li>#6's clinical documentation</li> <li># Resident #6 had a vascular onsultation resulted in resume Apixaban (Eliquis)</li> <li>40 days. The order was facility Electronic Health ented as ordered. Medication on 9/28/2024 with the stop esident #6 was ordered to bointment in 30 days. The dicated that residents' follow of 11/4/2024 at 3pm. No tending physician was what to do about running out escheduled appointment.</li> <li>antical documentation dated sident #6's daughter scular appointment to be conflict of interest. The scheduled for 11/8/2024. No tending physician was what to do about running out escheduled for 11/8/2024. No tending physician was what to do about running out escheduled appointment.</li> <li>bical documentation dated sident #6's daughter scular appointment to be conflict of interest. The scheduled for 11/8/2024. No tending physician was what to do about running out escheduled appointment.</li> <li>the follow up Vascular //2024. The Vascular iquis 5mg to be restarted ys.</li> <li>#6 Electronic Health Records 11/08/2024 indicated that no re transcribed onto the lealth Records. No indication ian was notified when Eliquis 24. Resident #6 was sent to tal on 12/3/2024 due to</li> </ul>					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							): 01/28/2025 MAPPROVED ). 0938-0391	
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		345499	B. WING				C 17/2024	
NAME OF PRO	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LITCHFOR	D FALLS HEALTHCARE	& REHABILITATION CENTER			200 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 PREFIZ TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 580	Continued From page	: 11	F	580				
	(MARs) revealed she anticoagulant from 10 the medication was st run out. No indication records that the Atten consulted before med Resident #6 is no long The Governing body I Operation, the facility Director of Clinical Se Nursing conducted the 12/13/2024, to identify alleged noncompliance failure of the facility en Eliquis and for DVT pro order. The RCA furth also failed to consult t #6 was running out of scheduled appointme 11/8/24. The governing body p for identification for th to suffer a serious adv the alleged noncompli measures below to all serious adverse outco 100% audit of all curred discontinued/stopped	tion Administration Records did not receive this oral //28/24 to 11/08/2024 after copped after 30 days' supply on Resident #6's clinical ding physician was lication ran out on 10/28/24. ger in the facility. ed by the Vice President of Administrator, Regional rvices, and Director of e root cause analysis on y the causative factor for this ce. ysis (RCA) identified the mere resulted from the mployee to administer revention per physician er identified that facility staff the physician when Resident filliquis before the nt that took place on but forth the following plan ose residents who are likely verse outcome as a result of iance and implemented the ter the process to prevent a one from occurring.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345499	B. WING				C 17/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOR	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 LITCHFORD ROAD ALEIGH, NC 27615		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Unit Coordinator (1 or medication that was or without consultation w Any resident(s) identi- order without attendin the Director of nursing for appropriate measu and implement the int Specify the action the process or system fai adverse outcome from when the action will b Effective 12/13/2024, ensure any changes in to include discontinua Eliquis, will be reported the discontinuation to intervention/assessme prevent possible nega- may result from abrup such as Eliquis. This be accomplished by in measures: Effective 12/13/2024, inform the resident; co- physician; and notify, when there is; a signi- resident's physical, m status, a need to alter is, a need to discontir treatment due to adve commence a new form notification will be door	rector of Nursing, and/or r #2) to identify any other discontinued/stopped/ran-out with an attending physician. fied with a discontinued ag physician consultation, g will inform the physician ures and or interventions terventions as ordered. • entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete: facility employees will in medication or treatment, ation of medication such as ed to the physician prior to ensure appropriate medical ent is implemented to ative consequences that obly discontinuing medication systemic modification will mplementing the following licensed nurse on duty will onsult with the resident's the resident representative ficant change in the tental, or psychosocial r treatment significantly (that hue an existing form of erse consequences, or to	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345499	B. WING				C 17/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				8	200 LITCHFORD ROAD		
LITCHFO	RD FALLS HEALTHCARE	& REHABILITATION CENTER		R	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	Continued From page	e 13	F	580			
	which includes Direct Director of Nursing, M Unit coordinator #1 U Admission nurse initia clinical documentation physician orders writt (including orders to di from the last clinical m needed notification of and/or responsible par manner. This system Monday through Frida be addressed prompt incorporated into the negative findings will The nursing administ clinical documentation written on Friday, Sat next clinical meeting of 100% education of all full time, part time, an nurses will be comple Nursing, Assistant Din Development Coordin Coordinators (1, #2). education will be the attending physician a timely manner for any change of treatment/i discontinuation of me emphasized that an a be consulted before m for proper intervention completed by 12/13/2	<ul> <li>I changes to the physician, arty was done in a timely hic process will take place ay. Any identified issues will dy. This process will be daily clinical meeting. Any be addressed promptly. This process will review the n and physician orders durady, and/or Sunday at the on the following Monday.</li> <li>I licensed nurses to include das needed licensed eted by the Director of rector of Nursing, Staff hator, and/or Unit The emphasis of this importance of notifying an nd the party responsible in a v change in condition, ntervention and dication. The education tittending physician should medication ran out/stopped n. This education will be 2024, any licensed nurses 3/2024 will not be allowed to</li> </ul>					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	1G			
		345499	B. WING				-
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b> T	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	11/2024
	RD FALLS HEALTHCARE	& REHABILITATION CENTER		82	200 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	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	F 580Continued From page 14F 580Assistant Director of Nursing, and/or Unit Coordinators (1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses during the new hire orientation effective 12/13/2024F 580						
	completion of this edu this education for any during the new hire of	ucation and will complete newly hired licensed nurses				D BE COMPLETIO	
	team members to incl Assistant Director of I coordinator, Unit coor #2 and/or Admission Regional Director of C emphasis of this educ limited to, the importa discontinued medicat condition is reviewed to ensure the attendir before the medication discontinued. This ed by 12/13/2024, any cl educated by 12/13/24 until educated. This ed	cation includes, but is not ince of ensuring residents' ion and other changes of in the daily clinical meeting ng physician was consulted					
	12/17/24. A review or current residents with medication within the were completed as pl assigned to a hall with interviewed regarding received. Additionally documented the educ	oval plan was conducted on f the audits conducted for discontinued/stopped last 30 days revealed they anned. All licensed nurses hin the facility were the in-service education					

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED	
		345499	B. WING			C 12/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/11/2024	
				8200 LITCHFORD ROAD			
LITCHFOF	RD FALLS HEALTHCARE	& REHABILITATION CENTER		RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COR TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETIO DATE	
F 580	Continued From page	e 15 e to describe the education	F 58	0			
F 684 SS=D	provided on the facilit notification of the resi or Responsible Party consistently verbalize need to consult with t resident/RP when the in the resident's medi discontinuation) and/o The IJ removal date of Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas	y's procedures regarding the dent's provider and resident (RP). The nurses ed an understanding of the he MD and notify the ere was a significant change cation (including medication or in the resident's condition.	F 68	4		1/16/25	
	that residents receive accordance with profe practice, the compret care plan, and the res This REQUIREMENT by: Based on facility staf interviews, and facility reviews, the facility fac compression stocking reviewed (Resident # thrombosis or DVTs ( clot forms in a deep v	e treatment and care in essional standards of hensive person-centered sidents' choices. T is not met as evidenced if interviews, physicians' y and hospital record liled to initiate the use of gs for 1 of 1 resident 6) with a history of deep vein a condition where a blood rein such as the legs), or PE (a condition where a he lungs) and atrial regular heartbeat).		F684 Corrective actions accomplished residents found to be affected by deficient practice: Resident #6 is no longer in the fa Identification of other residents ha potential to be affected by the sai deficient practice: 100% audit of current residents w had medical appointments in the days was completed by the Director Nursing and/or Assistant Director	the cility. aving the me /ho have last 30 tor of		

Event ID: SZH311

Facility ID: 920763

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		MEDICAID SERVICES				<u>NO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY
	CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING	i		
		245400	B WINC			С
		345499	B. WING			2/17/2024
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
ITCHFOF	RD FALLS HEALTHCARI	E & REHABILITATION CENTER		8200 LITCHFORD ROAD		
				RALEIGH, NC 27615		
(X4) ID			ID			(X5) COMPLETIC
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE
F 684	Continued From page	e 16	F 68	4		
	Resident #6 was adn	nitted to the hospital on		Nursing on 12/13/2024 to va	llidate any	
	2/13/24 after sustaini	ng a left distal fibular		orders/recommendation from		
		ne small bone of the lower		consulting physician were tra		
	leg near the ankle) fr			the facility electronic health		
	•	hospital and admitted to the		implemented as ordered. No		
		er diagnoses included a		resident identified with any c	•	
	personal history of D	VTs, PE and atrial fibrillation.		Findings of this audit are do		
	On 0/17/24 a vanau	s doppler ultrasound study		a appointment consultation a located in the facility complia		
	was conducted of Re			100% audit of current reside		
		resident's complaint of pain		completed by the Director of		
		mity and history of frequent		and/or Assistant Director of		
		y Results read in part,		12/13/2024 to validate any r	•	
		s are consistent with deep		an order for compression sto		
	venous thrombosis [[	DVT]Clinical Follow-up is		implemented based on the p	ohysician	
	recommended."			orders. Findings of this audi		
				documented on a compress	•	
		dated 9/17/24 at 2:54 PM		audit tool located in the facil	ity compliance	
		's Medical Doctor was		binder.		
		logy results. The physician				
		onsult for Resident #6 at that		Measures/systemic changes	•	
	time.			into place to ensure that the	deficient	
	Resident #6 was see	n for an outside Vascular		practice does not recur		
		24. Upon her return to the		Effective 12/13/24, a license	d nurse on	
		ovided from the consultation		duty will review a consultation		
		Order Consult Request. The		any resident who returned fr	•	
		s" indicated a bilateral lower		appointment while on duty a		
		us duplex (ultrasound) was		any orders in facility electror		
		gnosis of "Bilateral lower		records, to include orders fo	r compression	
		ive DVTs [a condition where		stockings, if any.		
		ocked, allowing some blood		Effective 12/13/24 nursing e		
	to flow around the clo			apply compression stocking		
		read in part: "Compression		physician orders and docum		
	stockingsdaily (on	IN AW, OΠ IN PW)"		application and removal in e	ach	
	Linon Resident #6's r	eturn to the facility on		resident s clinical record.	silitv⊐e clinical	
	9/27/24, the recomm	eturn to the facility on		Effective 12/13/2024, the factor team, which includes Director	•	
		gs was not transcribed into		Assistant Director of Nursing		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/28/2023 RM APPROVEI IO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345499	B. WING			1	C 2/17/2024
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				82	00 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		R/	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	<u>a</u> 17	F 6	84			
	the resident's electron	nic medical record (EMR). was conducted on 12/16/24			records coordinator, Unit coordinator Unit coordinator #2, and/or Admissio nurse initiated a process for reviewin clinical documentation to include the	n	
	of Resident #6's retui	asked, the nurse recalled			review of medical appointments order and/or scheduled in the last 24 hours from the last held clinical meeting to ensure the appointment is scheduled	or	
	specifics related to th EMR on 9/27/24. Nu the resident had a ch	e orders transcribed into her rse #1 stated she did recall ange in her medications nsult, but did not recall			take place as ordered. The review wi also validate the consultation form fro completed medical appointment is reviewed for any orders/recommendation	ll om a	
	seeing an order for co initiated for Resident	ompression stockings to be #6.			and ensure such orders are transcrib onto the facility s electronic health records. This systemic process will ta	ed ake	
	2024 Medication Adm and September 2024 Record (TAR) reveale	ian's orders, September ninistration Record (MAR), Treatment Administration ed there were no orders for			place daily (Monday through Friday). identified issues will be addressed promptly, and appropriate actions will implemented by the DON, ADON, an	l be d/or	
	#6.	gs to be applied for Resident			Unit coordinator #1/#2 Findings of th systemic change will be documented the daily clinical report form and	on	
	(MDS) was a quarter 10/18/24. The MDS	ndicated Resident #6 had			maintained in the daily clinical meetin binder. 100% education of all current clinical	-	
	on staff for all her Act except for requiring o	gnition. She was dependent ivities of Daily Living (ADL), nly set-up or clean up			leadership team members to include Director of Nursing, Assistant Director Nursing, Medical records coordinator	, Unit	
	assistance for persor	s and partial to moderate al hygiene. The diagnoses ssessment included atrial			coordinator #1, Unit coordinator #2 a Admission nurse completed by the Regional Clinical Director. The emph		
	fibrillation as an activ the MDS related to m Resident #6 received				of this education includes, but is not limited to, the importance of ensuring residents medical appointments is		
	medication.	-			reviewed in the daily clinical meeting ensure ordered appointments are	to	
	Resident #6's most re following area of focu -Anticoagulant: The				scheduled, completed, and the consultation forms from the complete appointments are reviewed for any n		

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/28/202 MAPPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
		345499	B. WING		12	C 2/17/2024
IAME OF PF	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COL		
				8200 LITCHFORD ROAD		
ITCHFOR	D FALLS HEALTHCARE	E & REHABILITATION CENTER		RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	- 1 <b>9</b>	F 68			
1 004			F 00		-	
		e, excessive bruising, and		orders and recommendations		
		l to anticoagulant use prillation, DVT (Date Initiated		education also covered the ir applying and removing comp		
		0/24/24). The interventions		stockings as ordered by the p		
		tration of medications as		This education will be comple		
		d 9/5/24). The interventions		12/13/2024, any clinical team	-	
	did not include comp	,		educated by 12/13/24, will no		
		5		to work until educated. This e		
	Resident #6's physici	an's orders and October /		added to a new hire orientation	on for all	
	November 2024 MAF	Rs revealed there were no		clinical team members effecti	ive	
	orders for compression	on stockings to be applied		12/13/2024.		
	for this resident.			The Assistant Director of Nur	-	
				provide 100% education of a		
		M, Resident #6 was seen for		nurses and Medication aids,		
		consultation and follow-up		time, part time, and as neede	-	
		. The Doctor's Order		employees. The emphasis of		
		n provided to the facility		education includes but is not		
	resident's thrombi we	his follow-up reported the		the importance of ensuring th consultation forms for resider		
		ndicated she had chronic		returned from the medical ap		
	bilateral lower extrem			while on duty are reviewed for	•	
		on Resident #6's consult		orders/recommendation and	-	
		:: "Compression stockings		such orders/recommendation		
	daily (on in morning			resident⊡s electronic medica		
				implement such physician or	der, to	
	Resident #6's physici	an's orders and her		include orders for compression		
	November / December	er 2024 MARs revealed no		This education will be comple	•	
		ed into the resident's EMR		12/13/24. Any licensed nurse		
	-	stockings. A review of the		medication aid not educated	•	
	resident's most recer	. ,		will not be allowed to work ur		
		clude a note to indicate		Director of Nursing, Assistant		
	-	posed to use compression		Nursing, and/or Unit Coordina		
	•	ex is an electronic resource		will monitor and track the con	•	
	summary of the resid	ssistants (NAs) to provide a		this education and will compl education for any newly hired		
	Summary of the resid	Unto Care riceus.		nurses and/or medication aid		
	A telephone interview	/ was conducted on 12/16/24		new hire orientation effective	-	
	-	e #2. Nurse #2 was the				
			1	1		

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		ND HUMAN SERVICES			FORM A OMB NO. (	\PPROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
		345499	B. WING		C 12/17	/2024
NAME OF PI	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE		-
				8200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 684	Continued From page	<b>-</b> 10	F 684			
1 001			1 00-		ling	
		e time she returned from her sultation. Upon inquiry, the		that the deficient practice is be corrected and will not recur:		
		ually given to the hall nurse.		Effective 01/13/2025, DON and		
		eiterated she was not given		will monitor compliance with or		
		Vascular consultation on this		transcription to include compre		
	occasion.			stockings by reviewing the dail		
				meeting reports to ensure com	•	
	A telephone interview	/ was conducted on 12/16/24		validate that the clinical team of	cross	
	at 1:56 PM with the fa	acility's former Unit Manager.		referenced consultation forms	from	
		the Unit Manager was asked		previous appointment with ord		
		cess was for addressing any		into the facility EHR for accura	-	
		ade by outside consultations.		be done daily Monday through	•	
		ported that she herself would		two weeks, weekly for two wee		
	sometimes have to p			monthly for three months or ur	ntil a pattern	
		hall nurse did not. When		of compliance is maintained.		
	asked if she was give			Effective 01/13/2025, the Direct		
		n upon Resident #6's return		Nursing, Assistant Director of I	0.	
	Manager stated she	nsult on 11/8/24, the Unit		and/or Unit Coordinators (1, #2 complete the compression stic		
	wanayer stated she t	did Hot recall.		monitoring process. This monit	•	
	A telenhone interview	/ was conducted on 12/16/24		process will be accomplished b	-	
	· ·	facility's Administrator.		completing observation for three	-	
		the Administrator was asked		selected residents with orders	-	
	-	n responsible to review and		compression stockings to ensu		
	transcribe the Vascul	-		applied and removed based or	-	
		ID orders into the Resident		physician orders. This monitor		
	#6's EMR after her co	onsultations. The		will be completed daily (Monda		
	Administrator reporte	d the hall nurse would have		Friday) for two weeks, weekly	for two	
	had the initial respon			more weeks, then monthly for		
	However, he added t	0		months, or until the pattern of		
		ond check to ensure this		is established. Any negative fir	-	
	task had been compl	eted.		be addressed by the Director of		
				promptly. This monitoring proc		
		ducted on 12/12/24 at 1:50		documented on a compression	-	
	-	istant (NA) #1. During the		observation monitoring tool loc	cated in the	
		ted she has worked full time		facility compliance binder.	- Chiumaina	
		ral months and was typically		Effective 01/13/2025, Director		
	assigned to care for l	Resident #6. When asked,		will report findings of this moni	toring	

Facility ID: 920763

If continuation sheet Page 20 of 53

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 01/28/2025 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		345499	B. WING			C 12/17/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				8200 LITCHFORD ROAD		
		E & REHABILITATION CENTER		RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	NA #1 reported Resid compression stocking NA stated a resident' he/she was supposed stockings. An interview was com- with Nurse #3. Nurse frequently cared for F Nurse #3 stated she stockings being used further inquiry, the nu an order to use comp thought the order wor on the resident's MAI An interview was com AM with the facility's (ADON). During the asked to describe wh to be done to implem recommendation for compression stocking once the resident car Vascular consult, the the new orders, calle the order, and then tr Resident #6's EMR. order was put into the show up on the residen for Resident #6 would to assist the resident stockings.	dent #6 did not wear gs. Upon further inquiry, the s Kardex would note if d to wear compression ducted 12/12/24 at 1:30 PM e #3 was identified as having Resident #6. When asked, did not recall compression for Resident #6. Upon urse stated if a resident had oression stockings, she uld typically be documented R. ducted on 12/13/24 at 8:45 Assistant Director of Nursing interview, the ADON was hat she would have expected ent the Vascular consult's Resident #6 to use gs. The ADON reported that me back from her outside nurse should have reviewed d the provider for approval of anscribed the order into She stated that once the e EMR, it would typically	F 68	<ul> <li>process to the facility Quality and Performance Improveme Committee for any additional or modification of this plan m three months, or until a patter compliance is maintained. T committee can modify this pl the facility remains in substa compliance.</li> <li>Compliance date: 01/16/202</li> </ul>	ent I monitoring nonthly for ern of The QAPI lan to ensure intial	
F 684	(EACH DEFICIENC REGULATORY OR Continued From page NA #1 reported Resid compression stocking NA stated a resident' he/she was supposed stockings. An interview was com- with Nurse #3. Nurse frequently cared for F Nurse #3 stated she stockings being used further inquiry, the nu an order to use comp thought the order wor on the resident's MAI An interview was com AM with the facility's. (ADON). During the asked to describe wh to be done to implem recommendation for compression stocking once the resident car Vascular consult, the the new orders, calle the order, and then tr Resident #6's EMR. order was put into the show up on the resident for Resident #6 would to assist the resident stockings. A telephone interview	AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F 68	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY and Performance Improveme Committee for any additional or modification of this plan m three months, or until a patter compliance is maintained. T committee can modify this pl the facility remains in substa compliance.	Assurance ent I monitoring nonthly for ern of The QAPI lan to ensure intial	

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/28/202 RM APPROVEI IO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345499	B. WING		1:	C 2/17/2024
NAME OF PF	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO		
			8200	) LITCHFORD ROAD		
LITCHFOR	TALLS REALINCARE	E & REHABILITATION CENTER	RAL	_EIGH, 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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	<b>2</b> 21	F 684			
1 004			F 004			
	interview, the MD was	de to utilize compression				
	stockings for Resider					
	U	n stockings were primarily				
		nic edema, they also served				
	another purpose. Th	•				
	compressing the vein	is in the leg would lower the				
		(a condition where blood				
		owed or stagnant) and DVT.				
F 756 SS=J		w, Report Irregular, Act On (2)(4)(5)	F 756			1/16/25
		imen Review. ug regimen of each resident least once a month by a				
	§483.45(c)(2) This re of the resident's med	view must include a review ical chart.				
	irregularities to the at facility's medical direct and these reports mu	•				
	drug that meets the c (d) of this section for	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug.				
	()	noted by the pharmacist				
	separate, written repo	ist be documented on a				
		nd the facility's medical				
		of nursing and lists, at a				
		nt's name, the relevant drug,				
	and the irregularity th	e pharmacist identified.				
		sician must document in the				
		cord that the identified				
	irregularity has been action has been take	reviewed and what, if any,				
1						

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		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 01/28/202 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMF	SURVEY PLETED
		345499	B. WING		C 12/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER	1	· 1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	-
				8200 LITCHFORD ROAD		
LITCHFOF	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 756	Continued From page	e 22	F 756	5		
		nedication, the attending ument his or her rationale in Il record.				
	maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action	cility must develop and procedures for the monthly that include, but are not s for the different steps in s the pharmacist must take ifies an irregularity that n to protect the resident.				
	by: Based on staff interv and physician intervie record reviews, the c	☐ is not met as evidenced riews, consultant pharmacist ews, and facility and hospital onsultant pharmacist failed irregularity related to the an oral anticoagulant		F756 Corrective actions accomplishe residents found to be affected b deficient practice: Resident #6 is no longer in the	by the	
	significant medication history of strokes, de DVTs, a condition wh deep vein, typically ir embolism (or PE, a c travels to the lungs), of irregular heartbeat	resident reviewed for a n error (Resident #6) with a ep vein thrombosis (or ere a blood clot forms in a n the legs), pulmonary ondition where a blood clot and atrial fibrillation (a type ). Eliquis is a prescription educe the risk of stroke and		Identification of other residents potential to be affected by the s deficient practice: 100% audit of current residents had medical appointments in th days was completed by the Dir Nursing and/or Assistant Direct Nursing on 12/5/2024 to validat	same who have he last 30 ector of or of	
	Resident #6 was initia consultation on 9/27/2 consultation conducte consultations recomm treated with Eliquis.	ed on 11/8/24. Both nended the resident be The consultant pharmacist Medication Regimen		orders/recommendation from the consulting physician were transi- the facility electronic health rec- implemented as ordered. No of resident identified with any defi Findings of this audit are docur a appointment consultation audit located in the facility compliance	scribed to ords and her ciency. nented on lit tool æ binder.	
	coverage for Resider facility of this lapse u	there was a lapse in Eliquis at #6, she failed to notify the ntil 11/20/24. A Physician as not completed related to		100% of all consulting pharmac recommendations and MD recommendations for current re given in the last 30 days were a	esidents	

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/28/202 MAPPROVE D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		PLETED
		345499	B. WING			C / <b>17/2024</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				8200 LITCHFORD ROAD		
LITCHFOF	D FALLS HEALTHCAR	E & REHABILITATION CENTER		RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From nor	- <u>-</u>				
F 730	Continued From page		F 7			
	•	is for this resident. On		12/13/2024 by the Director		
		was admitted to the hospital		Assistant Director of Nursing	-	
		nental status with diagnoses		Admission nurse to identify	•	
		ute middle cerebral artery CA stroke occurs when blood		recommendations that were transcribed/implemented/ac		
		dle cerebral artery in the		correctly in the facility. The		
		Resident #6 remained		focusses on ensuring any m		
	hospitalized as of the			irregularities were reported		
	(12/17/24).			attending physician and act		
	(			timely. Findings of this audit		
	Immediate ieopardv l	began on 11/13/24 when the		documented on the pharma		
		harmacist completed a		recommendation tool order	•	
		fied the omission of Eliquis		located in the facility compli	ance binder.	
		nedication regimen, but failed				
	to urgently address th	his issue with either the		Address what measures wil	l be put into	
	physician or the facili	ity. Immediate jeopardy was		place or systemic changes	made to	
	removed on 12/14/24	1 when the facility		ensure that the deficient pra	actice will not	
		ble allegation of immediate		recur:		
		he facility will remain out of		Effective 12/13/2024, the lic		
		o actual harm with potential		pharmacist will review each	-	
		al harm that is not immediate		regimen monthly and report		
	• • • • •	he completion of education		irregularities to the attending	- · ·	
	and monitoring syste	ms are in place.		and the Director of Nursing		
	The findings includes	4.		upon in a timely manner. Th		
	The findings included	1.		pharmacist will accomplish		
	$\Omega_{n} 0/17/24$ a versus	s doppler ultrasound study		change by addressing any r irregularities on a physician		
	was conducted of Re			recommendation form that v		
		resident's complaint of pain		provided to the attending ph		
	•	mity and history of frequent		review. Findings of this syst	•	
		y Results read in part,		will be documented on the		
		are consistent with deep		pharmacy consultation revie	•	
		DVT] of the left common		maintained in the Pharmacy		
		al and proximal superficial		Effective 12/13/2024, the fa		
	•	terminate age. Clinical		team, which includes Direct	-	
	Follow-up is recomm			Assistant Director of Nursin	-	
	·			records coordinator, Unit co	-	
	A Health Status Note	e dated 9/17/24 at 2:54 PM		Unit coordinator #2, and/or		
	reported Resident #6	s's Medical Doctor (MD) was		nurse initiated a process for	reviewing	

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		ID HUMAN SERVICES			FORM	): 01/28/20 1 APPROVE
TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE	0. 0938-03 SURVEY LETED
		345499	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		17/2024
	CONDERVOICOUT ELER			8200 LITCHFORD ROAD	-	
LITCHFOF	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 756	Continued From page	a 24	F 75	e		
1750			F / 5	-		
	informed of the radio			pharmacy recommendations of	•	
		s received to discontinue the		by the licensed pharmacist to		
		l initiate the administration of		recommendations to include a		
	used for the treatmer	n injectable anticoagulant		irregularities on drug regimen to the attending physician and	•	
		aneously (under the skin)		in a timely manner. This syste		
		event blood clotting. The		will take place within three day		
		ed a Vascular consult for		of pharmacy consultation repo	•	
	Resident #6 at that til			identified issues will be addres		
				promptly, and appropriate acti		
	Resident #6 was see	n for an outside Vascular		implemented by the DON, AD		
		24. Upon her return to the		Unit coordinator #1/#2 Finding		
		ovided from the consultation		systemic change will be docur		
		Order Consult Request. A		the Monthly pharmacy consult		
	notation made on this	s form indicated the reason		form and maintained in the Ph	armacy	
	for the consultation w	as due to concerns for blood		binder.		
	clots given the reside	nt's positive history and		100% education of all current	clinical	
		e "Consultation Findings"		leadership team members to i	nclude	
		ower extremity (BLE) venous		Director of Nursing, Assistant		
	duplex (ultrasound) w			Nursing, Medical records coor		
	diagnosis of "Bilatera	•		coordinator #1, Unit coordinate		
	-	a condition where veins are		Admission nurse completed by		
		wing some blood to flow		administrator. The emphasis of		
		he "Recommendations" read		education includes, but is not		
		ig BID [twice daily] x 30 days		the importance of reviewing al		
		onth with a repeat BLE sound to be completed at the		recommendations and implem recommendation in a timely m	•	
	· · ·	the status of the thrombi		education will be completed b		
	[clots]. Patient may r			12/13/2024, any clinical team		
		initely with her history of		educated by 12/13/24, will not		
	-	or's Order Consult Request		to work until educated. This ed		
	form also noted the re	•		added to a new hire orientatio		
		nt was scheduled for 11/4/24		clinical team members effectiv		
		n was signed by the Vascular		12/13/2024. Facility Administra		
	clinic Nurse Practitior			monitor and track the complet		
				education and will complete th		
	Upon Resident #6's r	eturn to the facility on		for any newly hired Clinical lea		
		s order was received and		the new hire orientation effect	-	
		#1 into the resident's		12/13/2024.		

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					ED: 01/28/202
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345499	B. WING				C 12/17/2024
NAME OF PF	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	-
				820	0 LITCHFORD ROAD		
LITCHFOR	D FALLS HEALTHCARE	E & REHABILITATION CENTER		RA	LEIGH, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 756	Continued From page	25		FG			
1750	Continued From page		F 75				
		cord (EMR) to re-start her nistered as one tablet by			The facility Administrator conducted		
		30 days. The order for			phone in-service education to the fa medical director, attending physicia	•	
		irt date of 9/28/24 and an			the licensed pharmacist who provid		
		The resident's order for			services to the facility on 12/13/202		
	enoxaparin was disco	ontinued as of 9/27/24. A			emphasis of this education includes		
	physician's order was	s received and transcribed			not limited to, the importance of ens	suring	
		ident #6's enoxaparin to be			any medication irregularity is		
	discontinued as of 9/27/24.				communicated to the attending phy	sician	
					timely for proper follow through.		
		ent's September 2024			Indicate how the facility plane to me	nitor	
	Medication Administration	began to receive 5 mg			Indicate how the facility plans to mo its performance to make sure that		
		as one tablet by mouth twice			solutions are sustained:		
	daily on 9/28/24 in ac	-			Effective 01/13/2025, the facility		
	physician's order.				Administrator completes the monito	ring	
					process for follow ups on pharmacy	-	
		ent's most recent Minimum			consultant reports. This monitoring		
	, ,	a quarterly assessment			process will be accomplished by rev	/iewing	
		MDS indicated Resident #6			the completion of follow ups for all		
	• •	d cognition. The diagnoses			pharmacy consultant reports to ens		
		ssessment included atrial			follow ups were completed timely for		
	the MDS related to m	e diagnosis. The section of redications indicated			pharmacy consultants reported for t previous month. This monitoring pro-		
	Resident #6 received				will be completed monthly for three		
	medication.	5			months, then quarterly, or until the	oattern	
					of compliance is established. Any		
	A review of Resident	#6's October 2024 and			negative findings will be addressed		
		Rs revealed the resident			Administrator and/or Director of nur		
		e of Eliquis on the morning			promptly. This monitoring process v		
		r doses of Eliquis were			documented on a pharmacy consul		
		nistered on the resident's			review monitoring tool located in the	;	
	MARs from 10/28/24	10 11/0/24.			facility compliance binder. Effective 01/13/2025, the Director o	f	
	On 11/8/24 at 2.00 P	M, Resident #6 was seen at			Nursing and/or Assistant Director of		
		consultation and follow-up			Nursing will report the findings of th		
	for her bilateral DVTs				monitoring process to the facility Qu		
		n provided to the facility			Assurance and Performance	,	
		is follow-up reported the			Improvement Committee (QAPI), fo	r	

Facility ID: 920763

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/28/2025 MAPPROVED D. 0938-0391	
STATEMENT (	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345499	B. WING _					17/2024	
	ROVIDER OR SUPPLIER	& REHABILITATION CENTER		82	REET ADDRESS, CITY, STATE, ZIP CO 00 LITCHFORD ROAD ALEIGH, NC 27615	DE			
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B		(X5) COMPLETION DATE	
F 756	resident's thrombi we resident's diagnosis in bilateral lower extrem medications/treatmen Eliquis to be administ for 90 days with 2 refi "Recommendations" included, in part: "Eli po [by mouth] x 90 da hematology due to his PE." A follow-up Vas recommended in 6 m A review of Resident her November 2024 N recommendations fro consultation were not resident's EMR. No of documented as admin 11/8/24 to 11/13/24. Resident #6's EMR in pharmacist Medicatio dated 11/13/24 at 1:2 the following, in part: reviewed Notes / F [Director of Nursing] > note did not address anticoagulant for this Resident #6 had been medication (such as F A telephone interview at 2:08 PM with the fa pharmacist. At the tir pharmacist said she of the facility's EMRs so Resident #6's Novem	re unchanged. The ndicated she had chronic hity DVTs and her hts were noted as 5 mg tered by mouth twice a day ills. The on the consult form quis 5 mg BID [twice daily] ays #2 refills. Referral for story of multiple DVTs and cular appointment was onths. #6's physician's orders and MAR revealed the m the 11/8/24 Vascular transcribed into the doses of Eliquis were nistered to the resident from necluded a monthly consultant in Regimen Review (MRR) 7 PM. The MRR included "New Meds / Changes: Recommendations: DON x 2." The MRR progress the omission of an resident. As of 11/13/24, in without an anticoagulant Eliquis) for 16 days.	F7	56	recommendations and/or mo monthly for three months, or pattern of compliance is arch Compliance Date: 01/16/202	until the nived.	,		

Facility ID: 920763

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	-					FOR	M APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION		D. 0938-0391 SURVEY	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í			COMPLETED		
							С	
		345499	B. WING			12	/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER							
LITCHFOF	RD FALLS HEALTHCARE	E & REHABILITATION CENTER						
(X4) ID PREFIX			ID PREF	IX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE	
F 756	Continued From page	<u>-</u> 27	F	756				
1 100	the resident's Eliquis as of 10/28/24, the pharmacist stated she noticed the resident had a Vascular consultation on 11/8/24. She was also aware of the discontinuation of Resident #6's Eliquis. The pharmacist then reported she,		· ·	150				
		CTION IDENTIFICATION NUMBER: 345499 R OR SUPPLIER LS HEALTHCARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) nued From page 27 esident's Eliquis as of 10/28/24, the nacist stated she noticed the resident had a ular consultation on 11/8/24. She was also e of the discontinuation of Resident #6's						
	· ·							
		0						
	<b>u</b>							
	- ·							
				FIX (EACH CORRECTIVE ACTI G CROSS-REFERENCED TO T				
		-						
		-						
	on this page was a no	otation (dated 11/13/24) that						
		,						
	mg BID x 9 months.							
	restarted?"							
	A review of Posidont	#6's physician orders and						
	A review of Resident	#6's physician orders and						

DEPARTMENT OF HEALT CENTERS FOR MEDICAR						FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345499	B. WING			12	C 2/17/2024
NAME OF PROVIDER OR SUPPLIE	R			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				8	200 LITCHFORD ROAD		
LITCHFORD FALLS HEALTH	CARE	& REHABILITATION CENTER		F	RALEIGH, NC 27615		
PREFIX (EACH DEF	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
the Eliquis was No doses of Elia Resident #6 up discharge to the days had elapse without Residen (such as Eliquis Resident #6's E Facility (SNF) to 12/3/24 at 6:50 Resident #6 was evaluation and t mental status ar Resident #6's E Facility (SNF) to 12/3/24 at 6:50 Resident #6 was evaluation and t mental status ar A review of the n Note's History a 11:36 PM was of Resident #6 was Emergency Med presented with a speech, and cor resident had a h deficits. Reside also included, in anticoagulation device that prev from the legs to Room notes rep (CT) scan of the	December Dec	hber 2024 MARs revealed -initiated for this resident. ere administered to date of the resident's ital on 12/3/24. A total of 36 m 10/28/24 to 12/3/24 ecciving an anticoagulant cluded a Skilled Nursing bital Transfer form dated The transfer form reported to ut to the hospital for tent due to a change in ssible stroke. cluded a Skilled Nursing bital Transfer form dated The transfer form dated The transfer form dated the transfer form reported cout to the hospital for tent due to a change in the transfer form reported cout to the hospital for the transfer form reported cout to the hospital for tent due to a change in	F	756			

Facility ID: 920763

If continuation sheet Page 29 of 53

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/28/2025 ORM APPROVED 3 NO. 0938-0391	
STATEMENT AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345499	B. WING			C 12/17/2024		
NAME OF P	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE			
				820	00 LITCHFORD ROAD			
LITCHFO	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		RA	ALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 756	stroke was caused by brain) involving the lep art of the brain for u learning, and rememil and temporal parietal human brain that is in cognitive and motor f was reported to have she was not currently hospital record also in previously on Eliquis, without her family beil the discontinuation of hospitalized as of the (12/17/24). An interview was con AM with the facility's a started her position of former DON (who was facility's ADON). The Operations joined the began. During the in Administrator confirm consultant pharmacis 11/20/24. However, f wasn't as timely as the in the "snapshot," the mentioned. The ADC look at the snapshot is be addressed first. S Recommendations and Recommendations w given to either the MI staff to take care of. she did not see the p recommendation for l amongst the recomm	y blocked blood flow to the ff posterior temporal lobe (a inderstanding language, bering verbal information) i junction (a region of the hvolved in many higher-order unctions). The resident atrial fibrillation and noted on anticoagulation. The indicated Resident #6 was but it been discontinued ing aware of the reason for fit. Resident #6 remained date of the review ducted on 12/13/24 at 8:19 Administrator, DON (who n 11/20/24), and the facility's s currently working as the e Regional Director of Clinical e interview shortly after it terview, the ADON and led they both received the st's report sent via email on they both agreed the report tey would have expected and or were no urgent needs ON stated she would always first so these issues would the reported the Physician and Nursing ere typically separated and O or the appropriate nursing However, the ADON noted harmacist's Resident #6's Eliquis in	F	756				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/28/2025 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345499	B. WING			( 12/ <sup>-</sup>	; 17/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
LITCHFO	RD FALLS HEALTHCARE	& REHABILITATION CENTER		8200 LITCHFORD ROAD RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	When the Administrat asked if the omission would have been con needed to be address The Administrator add have been addressed stated, "Urgent mean A telephone interview at 12:12 PM with the NP #1. He reported t on 9/27/24 was no lor Vascular clinic. Wher lapse in Eliquis admir an intentional lapse." consultation notes, th the provider wanted to longer duration on 11. coverage for 6 more r review of the consultar reported a referral to this resident. Overall Vascular consult reco would have reasonab A telephone interview at 10:13 AM with Res During the interview, "crux of the problem" was written for a 30-d ideally, he would have have been continued follow-up appointmen added that he didn't k for Eliquis was missed few medications whic to continue, and these medications and bloo	tor, DON, and ADON were of Resident #6's Eliquis sidered an urgent issue that sed, they each said, "Yes." ded, any urgent issue should a by any means. He further s right now." was conducted on 12/13/24 Vascular MD who oversaw he NP who saw Resident #6 nger employed by the n asked, the MD stated the nistration was "definitely not Upon review of the 11/8/24 e MD reported it appeared o write a prescription with a /8/24 so Resident #6 had months. Upon further ation notes, the MD also hematology was made for , the MD stated the 11/8/24 ummendations were what he aly expected. was conducted on 12/13/24 ident #6's MD at the facility. the MD stated he felt the was that the 9/27/24 order lay period. He reported that e thought the Eliquis should	F 75	56			

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/28/2025 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345499	B. WING					C 17/2024
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STAT	FE, ZIP CODE		
		& REHABILITATION CENTER		8	200 LITCHFORD ROAD			
LITCHFOR	TALLS HEALTHOAKE	& REHABILITATION CENTER		R	ALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	ALAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 756	identified that Resider discontinued. He rep have called someone them to the discontinu- noticed it. The Administrator was jeopardy on 12/12/24 The facility provided t allegation of Immedia Identify those recipier are likely to suffer, a s a result of the noncon Review of Resident # indicates; on 9/27/24 appointment. The con recommendation to re 5mg twice daily for 30 transcribed onto the far records and implement was ordered to start of date of 10/28/24. Res have a follow up appor consultation form indii up appointments to be Review of facility clini 10/8/24 indicate Resider requested for the Vas rescheduled due to co	t pharmacist to do when she ht #6's Eliquis had been orted the pharmacist should at the facility and alerted uation of Eliquis when she is notified of immediate at 5:30 PM. the following credible te Jeopardy removal: hts who have suffered, or serious adverse outcome as hpliance: 6's clinical documentation Resident #6 had a vascular nsultation resulted in esume Apixaban (Eliquis) 0 days. The order was acility Electronic Health hted as ordered. Medication on 9/28/2024 with the stop sident #6 was ordered to bintment in 30 days. The cated that resident's follow a 11/4/2024 at 3pm. cal documentation dated dent #6's daughter cular appointment to be onflict of interest. The cheduled for 11/8/2024.	F	756	DE	FICIENCY)		
	appointment on 11/8/2	-						

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	-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391	
	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA         (X2) MULTIPLE CONSTRUCTION							
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			PLETED	
		345499	B. WING				C / <b>17/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
LITCHFO	RD FALLS HEALTHCARE	E & REHABILITATION CENTER			3200 LITCHFORD ROAD			
	1			R	RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 756	twice daily for 30 days Review of Resident # from 11/8/2024 to 12/ orders for Eliquis were facility's Electronic He was sent to the acute due to altered mental Review of Resident # Resident #6's Medica (MARs) revealed she anticoagulant from 10 discharge to the hosp Review of the license summary report dated during monthly reside indicated a notation th consultation with Vass the recommendation of Eliquis should be rest The facility received th recommendation on 1 that the pharmacy red the physician for revie facility. Resident #6 is no long The Governing body I Operation, the facility Director of Clinical Se Nursing conducted th 12/12/2024, to identify alleged noncompliand the medication irregul physician and implem licensed pharmacist g	s. 66 Electronic Health Records (3/2024 indicated that no e transcribed onto the ealth Records. Resident #6 care hospital on 12/3/2024 status. 76 Documentation on ation Administration Records did not receive this oral 0/28/24 up to the date of her bital on 12/3/24. 76 pharmacist-nursing d 11/13/2024, completed ent's drug regimen reviews hat Resident #6 had a cular solutions on 11/8/24, questioned whether the tarted per recommendation. he pharmacy 11/20/2024. No indication commendation was sent to ew and/or followed up by the	F	756				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345499	B. WING				C 17/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 LITCHFORD ROAD		
				R	RALEIGH, 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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756	Continued From page and prevent the reoco		F	756			
	for identification for the to suffer a serious add the alleged noncomple measures below to all serious adverse outco 100% audit of current medical appointments completed by the Dire Assistant Director of I validate any orders/re consulting physician of facility electronic heal as ordered. No other deficiency. Findings on a "appointment co in the facility complian 100% of all consulting recommendations and current residents give audited on 12/13/202 Assistant Director of I nurse to identify any of were not transcribed// correctly in the facility on ensuring any medi reported to the attend upon timely. Findings documented on the p tool order audit tool lo compliance binder.	residents who have had is in the last 30 days was betor of Nursing and/or Nursing on 12/5/2024 to ecommendation from the were transcribed to the th records and implemented resident identified with any of this audit are documented nsultation audit tool" located nee binder. g pharmacist nursing d MD recommendations for in in the last 30 days were 4 by the Director of Nursing, Nursing, and/or Admission other recommendations that implemented/acted upon . The audit also focusses ication irregularities were ling physician and acted is of this audit are harmacy recommendation boated in the facility					
	process or system fai	e entity will take to alter the lure to prevent a serious n occurring or recurring, and					

If continuation sheet Page 34 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345499	B. WING				-
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LITCHFOF	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 LITCHFORD ROAD RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 756	review each resident report any irregularitie and the Director of Na timely manner. The of accomplish this syste any medication irregu- recommendation form attending physician for systemic change will Monthly pharmacy co- maintained in the Pha Effective 12/13/2024, which includes Direct Director of Nursing, M Unit coordinator #1 U Admission nurse initia pharmacy recommen licensed pharmacist to drug regimen are repo- physician and acted u This systemic process days or receipt of pha Any identified issues and appropriate actio the DON, ADON, and Findings of this system documented on the M consultation review for Pharmacy binder.	the licensed pharmacist will drug regimen monthly and es to the attending physician ursing to be acted upon in a consultant pharmacist will mic change by addressing ilarities on a physician in that will be provided to the or review. Findings of this be documented on the insultation review form and armacy binder. the facility's clinical team, or of Nursing, Assistant Medical records coordinator, nit coordinator #2, and/or ated a process for reviewing dations completed by the o ensure the include any irregularities on orted to the attending upon in a timely manner. s will take place within three armacy consultation reports. will be implemented by l/or Unit coordinator #1/#2 mic change will be fonthly pharmacy orm and maintained in the	F	756			
		Nursing, Medical records rdinator #1, Unit coordinator				D BE COMPLETION	

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/28/2025 MAPPROVED ). 0938-0391
STATEMENT ( AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345499	B. WING _			C 12/17/2024		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE,			DE		
LITCHFO	RD FALLS HEALTHCARE	& REHABILITATION CENTER			LITCHFORD ROAD EIGH, 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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 756	<ul> <li>#2 and/or Admission facility administrator. education includes, b importance of review recommendations an recommendation in a education will be corr clinical team member will not be allowed to education is added to clinical team member Facility Administrator completion of this edu this education for any during the new hire o 12/13/2024.</li> <li>The facility Administra Inservice education to attending physician, a who provide services The emphasis of this not limited to, the imp medication irregularit attending physician ti through.</li> <li>Alleged immediate je 12/14/24</li> <li>A validation of the IJ to on 12/17/24. The fact of the audits conductor had medical appoint the validation check of by the recommendati completed as planned</li> </ul>	nurse completed by the The emphasis of this ut is not limited to, the ing all pharmacy d implementing the timely manner. This pleted by 12/13/2024, any not educated by 12/13/24, work until educated. This a new hire orientation for all rs effective 12/13/2024. will monitor and track the ucation and will complete newly hired Clinical leader rientation effective ator conducted a phone of the facility medical director, and the licensed pharmacist to the facility on 12/13/2024. education includes, but is portance of ensuring any y is communicated to the mely for proper follow opardy removal date: removal plan was conducted contant in the last 30 days and of any new orders prompted ons. These audits were d. Documentation was also ation provided to the clinical	F7	/56				

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	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345499	B. WING		C 12/17/2024		
	ROVIDER OR SUPPLIER	E & REHABILITATION CENTER	8	BTREET ADDRESS, CITY, STATE, ZIP CODE 2000 LITCHFORD ROAD RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 756	pharmacy recommenconsultant pharmacis Also, the facility's Add (via telephone) with t and consulting pharm encourage the coordination addressing any medi- by the pharmacist. The IJ removal date of Residents are Free of CFR(s): 483.45(f)(2) The facility must ensu- §483.45(f)(2) Resident medication errors. This REQUIREMENT by: Based on facility stati- interviews, and facility reviews, the facility fa- uninterrupted course anticoagulant or bloo- risk of stroke and blo- atrial fibrillation) when discontinued 11 days for a one-month follor Vascular consultation the follow-up Vasculat that time, the facility fa- that fa	y review to ensure the dations made by the st are promptly addressed. ministrator held in-service he facility's Medical Doctors nacist on 12/13/24 to ination of reporting and cation irregularities identified of 12/14/24 was validated. f Significant Med Errors ure that its- nts are free of any significant T is not met as evidenced ff interviews, physicians' y and hospital record ailed to provide an of Eliquis (an oral d thinner used to reduce the od clots in people who have n the medication was before Resident #6 returned w-up from an outside h. The resident was seen for ir consultation on 11/8/24. At failed to transcribe an order r electronic medical record d in the resident missing this of 36 days until she was spital on 12/3/24. This sident reviewed (Resident	F 756		e ty. ng the have st 30 of ny ed to		

Event ID: SZH311

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/28/2025 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345499	B. WING				C 17/2024
NAME OF F	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFO	RD FALLS HEALTHCARE	& REHABILITATION CENTER		-	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 760	pulmonary embolism blood clot travels to th fibrillation (a type of ir Resident #6 was adm 12/3/24 due to a char diagnoses which inclu cerebral artery (MCA) occurs when blood flo cerebral artery in the Resident #6 remained of the review (12/17/2) Immediate jeopardy to Resident #6's Eliquis Resident #6's Eliquis Resident #6's medica jeopardy was remove facility implemented a allegation of immedia facility will remain out actual harm with pote harm that is not immedia the completion of edu systems are in place. The findings included Resident #6 was adm 2/13/24 after sustaining fracture (a break in th leg near the ankle) fro discharge medical his chronic anticoagulatic and a history of DVT discharge medication (mg) Eliquis to be adm mouth twice daily. St	ein, typically in the legs), (or PE, a condition where a ne lungs), and atrial regular heartbeat). hitted to the hospital on nge in mental status with uded an acute middle of stroke. An MCA stroke ow through the middle brain is interrupted. d hospitalized as of the date eta). began on 10/28/24 when was discontinued from tion orders. Immediate d on 12/14/24 when the an acceptable credible te jeopardy removal. The of compliance at a D (no ntial for more than minimal ediate jeopardy) to ensure incation and monitoring	F	760	<ul> <li>Findings of this audit are documented a appointment consultation audit tool located in the facility compliance binder 100% audit of current residents□ medication discontinues in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/13/2024 to validate any discontinued medication that was done based on the physician orders to ensure such actions are done based on the medical guidance to prevent significan medication error. Findings of this audit documented on a discontinued medica audit tool located in the facility complia binder.</li> <li>Measures/systemic changes will be purinto place to ensure that the deficient practice does not recur</li> <li>Effective 12/13/24, a licensed nurse of duty will review a consultation report for any resident who returned from medica appointment while on duty and transcr any orders in facility electronic health records.</li> <li>Effective 12/13/24 employees will administer medication based on physio orders, to include Eliquis, to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record.</li> <li>Effective 12/13/2024, the facility□s clinical records.</li> </ul>	er. f e irre it are ation ance ut n or al ribe cian	

Facility ID: 920763

JENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			· /	E SURVEY
							С
		345499	B. WING			1	2/17/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
ITCHEOR	D FALLS HEALTHCARE	E & REHABILITATION CENTER		8200 LIT	ICHFORD ROAD		
				RALEI	GH, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 760	Continued From page	e 38	F 76	0			
		#6's February 2024 through	170	-	as initiated a process for reviewin	a	
		an Orders revealed the			se initiated a process for reviewir ical documentation to include the		
		regimen continued to			iew of medical appointments orde		
		administered by mouth two			/or scheduled in the last 24 hours		
		201111131212000000000000000000000000000			n the last held clinical meeting to	5.01	
	diagnosis of atrial fibr				sure the appointment is scheduled	land	
		indion.			e place as ordered. The review w		
	On 9/17/24, a venous	s doppler ultrasound study			o validate the consultation form fr		
	was conducted of Re	• • •			npleted medical appointment is		
	extremity due to the r	resident's complaint of pain			iewed for any orders/recommend	ation	
	-	mity and history of frequent			l ensure such orders are transcrit		
		y Results read in part,		ont	o the facility⊡s electronic health		
		s are consistent with deep			ords. This systemic process will ta	ake	
		DVT]Clinical Follow-up is			ce daily (Monday through Friday)		
	recommended."			ide	ntified issues will be addressed	-	
				pro	mptly, and appropriate actions wi	ll be	
	A Health Status Note	dated 9/17/24 at 2:54 PM		imp	elemented by the DON, ADON, ar	nd/or	
	reported Resident #6	's Medical Doctor (MD) was		Uni	t coordinator #1/#2 Findings of th	is	
	informed of the radiol	logy results. A new		sys	temic change will be documented	lon	
	physician's order was	s received to discontinue the		the	daily clinical report form and		
	resident's Eliquis and	l initiate the administration of		mai	intained in the daily clinical meeti	ng	
		n injectable anticoagulant			der.		
	used for the treatmer				0% education of all current clinica		
		aneously (under the skin)			dership team members to include		
	•	event blood clotting. The			ector of Nursing, Assistant Directo		
	· ·	ed a Vascular consult for			rsing, Medical records coordinato		
	Resident #6 at that til	me.			ordinator #1, Unit coordinator #2 a	ind/or	
	Desides 1 // 0				mission nurse completed by the		
		n for an outside Vascular			gional Clinical Director. The emph	asis	
		24. Upon her return to the			his education includes, but is not		
		ovided from the consultation Order Consult Request. A			ted to, the importance of ensuring	J	
		s form indicated the reason			idents⊡ medical appointments is iowed in the daily clinical meeting	to	
		a form indicated the reason as due to concerns for blood			iewed in the daily clinical meeting	10	
					sure ordered appointments are		
		nt's positive history and e "Consultation Findings"			eduled, completed, and the sultation forms from the complete	bd	
		ower extremity (BLE) venous			pointments are reviewed for any n		
	duplex (ultrasound) w	,			ers and recommendations. The	CW	
			1				1

Facility ID: 920763

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TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		345499	B. WING _		C 12/17/2024		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
				8200 LITCHFORD ROAD			
LITCHFOF	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From page	e 39	F 7	60			
F 760	Continued From page 39 non-occlusive DVTs [a condition where veins are partially blocked, allowing some blood to flow around the clots]." The "Recommendations" read as follows: "Compression stockingsdaily (on in AM, off in PM) and Eliquis 5 mg BID [twice daily] x 30 days and follow-up in 1 month with a repeat BLE venous duplex [ultrasound to be completed at the next visit] to check on the status of the thrombi [clots]. Patient may need to be on low anticoagulation indefinitely with her history of DVT/PE." The Doctor's Order Consult Request form also noted the resident's 1 monthly follow-up appointment was scheduled for 11/4/24 at 3:00 PM. The form was signed by Nurse Practitioner #1 (NP #1) with an additional notation which read, "Reviewed by Attending Physician." Upon Resident #6's return to the facility on 9/27/24, a physician's order was received and transcribed by Nurse #1 into the resident's EMR to re-start her Eliquis as 5 mg administered as one tablet by mouth twice daily for 30 days. The order for Eliquis included a start date of 9/28/24 and an end date of 10/28/24. A physician's order was received and transcribed appropriately for		F7	<ul> <li>Feviewing all medication diathe last 24 hours or from the clinical meeting to validate discontinued medication with on the physician orders to significant medication error education will be complete 12/13/2024, any clinical teated by 12/13/24, will to work until educated. This added to a new hire orienta clinical team members effer 12/13/2024.</li> <li>Assistant Director of Nursing provide 100% education of nurses and Medication aid full time, part time, and as employees will be complete Director of Nursing, and/or Unit Coord The emphasis of this education to include Eliquid medications per physician 2. The importance of cord attending physician before</li> </ul>	e last held any as done based prevent rs. This d by am member not not be allowed s education is ation for all active ng provide will f all licensed es, to include needed nursing ed by the ant Director of linators (1, #2). ation includes ministering tis, and other order. asulting the		
	at 7:56 PM with Nurs identified as having to Resident #6's Eliquis from the Vascular con nurse recalled Reside remember any specifi	ranscribed the order for on 9/27/24 upon her return nsultation. When asked, the ent #6 but could not fics related to the orders		<ul> <li>stopped/discontinued, such avoid the possible serious that can happen when abru the medication.</li> <li>3. The importance of ensiresident is assigned to a lic oversee his/her care include for assessing, monitoring, and a such a such a such as a such a such a such as a such as</li></ul>	n as Eliquis, to consequences uptly stopping suring each censed nurse to ling provision		
	stated she did recall	MR on 9/27/24. Nurse #1 the resident was put back on quis after the injectable ontinued. The nurse		<ul> <li>a change in condition.</li> <li>4. The importance of ensitive consultation forms for residured from the medical and t</li></ul>	lents who		

Facility ID: 920763

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/28/202 M APPROVE D. 0938-039	
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED	
		345499	B. WING		C 12/17/2024		
NAME OF PF	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP CO		-	
				8200 LITCHFORD ROAD			
LITCHFOR	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From page	≥ <i>1</i> 0	F 76				
1 700							
	reported if she had a			while on duty are reviewed f	•		
		orders put on the resident's onsult, she would have told		orders/recommendation and such orders/recommendatio			
		urse #1 reported the Unit		resident s electronic medica			
		sible for any follow-up		implement such per physicia			
		or the physician's orders.		This education will be compl			
		se stated that usually when a		12/13/24. Any licensed nurse			
		n an outside appointment,		medication aide not educate			
		uld review the consultation		will not be allowed to work u	•		
		would often be the staff		Director of Nursing, Assistar			
		new or changed physician's		Nursing, and/or Unit Coordir			
	orders into the reside			will monitor and track the co			
				this education and will comp			
	A review of the reside	ent's September 2024		education for any newly hire	d licensed		
	Medication Administr	ation Record (MAR)		nurses and/or medication aid	des during the		
		began to receive 5 mg		new hire orientation effective	e 12/13/2024.		
	-	as one tablet by mouth twice		Manitaring of corrective activ	and to oncure		
	daily on 9/28/24 in ac	cordance with the		Monitoring of corrective action that the deficient practice is			
	physician's order.			corrected and will not recur:	beilig		
		ent's most recent Minimum					
		a quarterly assessment		Effective 01/13/2025, DON a			
		MDS indicated Resident #6		will monitor compliance with			
		d cognition. The diagnoses		transcription to include Eliqu	•		
		ssessment included atrial		reviewing the daily clinical m			
		e diagnosis. The section of		to ensure completion and va			
	the MDS related to m			clinical team cross reference			
	Resident #6 received	i an anticoaguiant		consultation forms from prev			
	medication.			appointment with orders enter facility EHR for accuracy. The			
	Resident #6's most r	ecent care plan included the		done daily Monday through			
	following area of focu	•		weeks, weekly for two weeks			
	Anticoagulant: The			monthly for three months or			
		e, excessive bruising, and		of compliance is maintained.			
	complications related	-		Effective 01/13/2025, the Di			
		orillation, DVT (Date Initiated		Nursing, Assistant Director of			
	-	0/24/24). The interventions		and/or Unit Coordinators (1,	-		
		tration of medications as		complete discontinued medi	•		
	ordered (Date Initiate			monitoring process. This mo		1	

Facility ID: 920763

If continuation sheet Page 41 of 53

D PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		PLE	CONSTRUCTION	(X3) DATE	
		DENTIFICATION NUMBER:	. ,			COMF	PLETED
							С
		345499	B. WING			12	17/2024
AME OF PF	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
ITCHFOR	D FALLS HEALTHCARE	& REHABILITATION CENTER		82	200 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 760	Continued From page	e 41	F 76	60			
					process will be accomplished by review	wing	
		#6's October 2024 and			three randomly selected residents		
		s revealed the resident			medication orders to validate any	_	
		e of Eliquis on the morning r doses of Eliquis were			discontinued medication that was done based on the physician orders and bas		
		nistered on the resident's			on the medical guidance to prevent	seu	
	MARs from 10/28/24				significant medication errors. This will	be	
					done daily Monday through Friday for		
	A Health Status Note	dated 10/28/24 at 3:25 PM			weeks, weekly for two weeks, then		
		acility's Director of Nursing			monthly for three months or until a pat	tern	
		lent #6's managed care			of compliance is maintained.		
	program "notified faci	-			Effective 01/13/2025, the Director of		
		opointment scheduled for ne [family member] would			Nursing and/or Assistant Director of Nursing will report the findings of this		
		e to a conflicting event			monitoring process to the facility Quali	tv	
		te for rescheduled appt			Assurance and Performance	cy	
	[appointment]."				Improvement Committee (QAPI), for		
					recommendations and/or modifications	S,	
		was conducted on 12/16/24			monthly for three months, or until the		
		acility's former Director of			pattern of compliance is archived.		
		was currently working as the			O		
		ector of Nursing (ADON). the ADON was asked about			Compliance Date: 01/16/2025		
	-	which indicated she was					
		nt #6's family wished to					
		lar consultation. When					
		that Resident #6 would no					
		liquis after 10/28/24, the					
		saying, "Nonot at that					
	moment."						
	On 11/8/24 at 2.00 PM	/l, Resident #6 was seen for					
		consultation and follow-up					
	for her bilateral DVTs						
	Consult Request form	n provided to the facility					
		is follow-up reported the					
	resident's thrombi we	-					
		ndicated she had chronic ity DVTs. Resident #6's					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345499	B. WING				C 17/2024
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LITCHFO	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 LITCHFORD ROAD RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	medications/treatment Eliquis to be administ for 90 days with 2 refi "Recommendations" of follows: "Compression morning off in evening daily] po [by mouth] x for hematology due to and PE." A follow-up recommended in 6 m A review of Resident her November / Dece no orders were transo EMR for Eliquis. No of documented as admin 11/8/24 up to the date hospital on 12/3/24. A telephone interview at 1:42 PM with Nurse nurse identified to hav Resident #6 at the tim 11/8/24 Vascular cons telephone interview, N recalled Resident #6 11/8/24 but she didn't resident until she wer pass medications aro stated, "Nobody gave further inquiry, the nu outside consultations nurse. However, Nur given any papers from on this occasion. A telephone interview at 1:56 PM with the fa	tts were noted as 5 mg ered by mouth twice a day ills. The on the consult form read as on stockingsdaily (on in g), Eliquis 5 mg BID [twice 90 days #2 refills. Referral o history of multiple DVTs Vascular appointment was onths. #6's physician's orders and ember 2024 MARs revealed cribed into the resident's doses of Eliquis were nistered to the resident from a of her discharge to the e was conducted on 12/16/24 e #2. Nurse #2 was the we been assigned to care for ne she returned from her	F	760			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345499	B. WING	_			C
NAME OF P	ROVIDER OR SUPPLIER	0+0+00			TREET ADDRESS, CITY, STATE, ZIP CODE	12/	17/2024
				8	200 LITCHFORD ROAD		
LITCHFO	CO FALLS REALTINGARE	& REHABILITATION CENTER		F	RALEIGH, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 760	what the facility's proc recommendations ma The Unit Manager rep sometimes have to pur resident's EMR if the further inquiry, the Unit sometimes a resident the Doctor's Order Co with them to the const case, the facility would consulting provider to the information shared was given the Doctor' form upon Resident # consult on 11/8/24, the did not recall. A telephone interview at 10:49 AM with the find During the interview, find who would have been transcribe the Vascular recommendations / M #6's EMR after her Va 11/8/24. The Administ nurse would have had this task. However, h was responsible as a task had been complet Resident #6's EMR in Facility (SNF) to Hosp 12/3/24 at 6:50 PM. Resident #6 was sent evaluation and treatm mental status and post A review of the reside	cess was for addressing any ide by outside consultations. ported that she herself would at the orders into the hall nurse did not. Upon it Manager stated that would not come back with onsult Request form sent ultation. If that was the d then have to call the try to obtain the form and d on it. When asked if she s Order Consult Request 6's return from her Vascular e Unit Manager stated she was conducted on 12/16/24 facility's Administrator. the Administrator was asked a responsible to review and ar consultation ID orders into the Resident ascular consultation on strator reported the hall d the initial responsibility for e added the Unit Manager second check to ensure this eted. cluded a Skilled Nursing bital Transfer form dated The transfer form reported c out to the hospital for uent due to a change in	F	760			

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 01/28/2025 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) I	DATE SURVEY
		345499	B. WING				C 12/17/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				82	00 LITCHFORD ROAD		
LITCHFO	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		R/	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 760	11:36 PM was condu Resident #6 was tran Emergency Medical S presented with altere speech, and confusion resident had a history deficits. Resident #6 also included, in part, anticoagulation and D device that prevents of from the legs to the lu Room notes reported (CT) scan of the head subacute ischemic events stroke was caused by brain) involving the leg part of the brain for u learning, and remember and temporal parietal human brain that is in cognitive and motor f was reported to have she was not currently hospital record also in previously on Eliquis, without her family be the discontinuation of hospitalized as of the (12/17/24). A telephone interview at 12:12 PM with the NP #1. He reported to on 9/27/24 was no loo Vascular clinic. Whe lapse in Eliquis admin an intentional lapse." him to be a "logistical	cted. The note indicated sported to the hospital via Services (EMS) and d mental status, garbled on. The notes reported the y of stroke with left sided 's History of Present Illness , atrial fibrillation not on DVT with IVC filter (a small blood clots from traveling ungs). The Emergency a computerized tomography d showed an acute to yent (a situation where a y blocked blood flow to the off posterior temporal lobe (a nderstanding language, bering verbal information) junction (a region of the nvolved in many higher-order unctions). The resident atrial fibrillation and noted y on anticoagulation. The ndicated Resident #6 was but it been discontinued ing aware of the reason for f it. Resident #6 remained	F	760			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/28/2025 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345499	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	17/2024
					200 LITCHFORD ROAD		
LITCHFOR	RD FALLS HEALTHCARE	E & REHABILITATION CENTER		R	ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	review of the 11/8/24 reported it appeared it a prescription with a l she had coverage for review of the consulta noted a referral to her resident. Overall, the Vascular consult reco would reasonably exp A telephone interview at 10:13 AM with Res During the interview, "crux of the problem" was written for a 30-d ideally, he would have have been continued follow-up appointmen added that he didn't k for Eliquis was missed few medications whice to continue, and these medications and bloo The Administrator wa jeopardy on 12/12/24 The facility provided t allegation of Immedia Identify those recipier are likely to suffer, a s a result of the noncor Review of Resident # indicates; on 9/27/24 appointment. The co recommendation to re	consultation notes, the MD the provider wanted to write onger duration on 11/8/24 so 6 more months. Upon ation notes, the MD also matology was made for this e MD stated the 11/8/24 ommendations were what he bect. was conducted on 12/13/24 sident #6's MD at the facility. the MD stated he felt the was that the 9/27/24 order lay period. He reported that e thought the Eliquis should until her scheduled at. When asked, the MD show why the 11/8/24 order d. He stated that there are a sh are particularly important e would include antiseizure d thinners (anticoagulants). s notified of immediate at 5:30 PM. the following credible ate Jeopardy removal: this who have suffered, or serious adverse outcome as inpliance: 6's clinical documentation Resident #6 had a vascular	F	760			

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		D HUMAN SERVICES				FORM	/ APPROVED
	<u>S FOR MEDICARE &amp; I</u> DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F	CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· /			<b>I Y</b>	LETED
							C
		345499	B. WING			12/	17/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 200 LITCHFORD ROAD		
LITCHFOF	RD FALLS HEALTHCARE	& REHABILITATION CENTER			RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 760	of 10/28/24. Residen follow up appointment consultation form indi up appointments to be indication that the atte consulted regarding w of Eliquis prior to the Review of facility clini 10/8/24 indicate Resid requested for the Vas rescheduled due to co appointment was resc indication that the atte consulted regarding w of Eliquis prior to the Resident #6 went to t appointment on 11/8/2 physician ordered Elic twice daily for 30 days Review of Resident # from 11/8/2024 to 12/ orders for Eliquis was facility's Electronic He was sent to the acute due to altered mental Review of Resident # Resident #6's Medicaa (MARs) revealed she anticoagulant from 10 discharge to the hosp Review of the license	Health records and red. Medication was 28/2024 with the stop date t #6 was ordered to have a t in 30 days. The cated that residents' follow e 11/4/2024 at 3pm. No ending physician was what to do about running out scheduled appointment. cal documentation dated dent #6's daughter cular appointment to be onflict of interest. The cheduled for 11/8/2024. No ending physician was what to do about running out scheduled appointment. to be about running out scheduled appointment. the follow up Vascular 2024. The Vascular quis 5mg to be restarted s. 6 Electronic Health Records 3/2024 indicated that no transcribed onto the ealth Records. Resident #6 care hospital on 12/3/2024 status. 6 Documentation on tion Administration Records did not receive this oral //28/24 up to the date of her ital on 12/3/24. d pharmacist-nursing	F7	760			
	Resident #6's Medica (MARs) revealed she anticoagulant from 10 discharge to the hosp Review of the license	tion Administration Records did not receive this oral //28/24 up to the date of her ital on 12/3/24.					

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	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI I	E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							C
		345499	B. WING	_		12/	17/2024
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOF	RD FALLS HEALTHCARE	E & REHABILITATION CENTER			8200 LITCHFORD ROAD RALEIGH, NC 27615		
							0(5)
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 760	Continued From page	e 47	F	760			
		ent's drug regimen reviews		100			
		hat Resident #6 had a					
		cular solutions on 11/8/24,					
		questioned whether the tarted per recommendation.					
	-	pharmacy recommendation					
	was followed up by th						
	Resident #6 is no long	ger in the facility.					
	The Governing body	led by the Vice President of					
		Administrator, Regional					
		ervices, and Director of					
		e root cause analysis (RCA)					
		ntify the causative factor for liance and implemented					
		s to correct and prevent the					
	reoccurrences.						
	The Deet Course Area	(DCA) identified the					
	alleged noncompliance	lysis (RCA) identified the					
		mployee to administer					
	Eliquis and apply con	npression stockings for DVT					
		ian order. The RCA further					
	-	staff also failed to consult Resident #6 was running out					
		scheduled appointment that					
	took place on 11/8/24						
		tified that the significant Ited from the failure of the					
		es to follow the professional					
		on transcribing physician					
		ordered by the outside					
		on 11/8/2024. The RCA					
		t the failure to transcribe the y the outside vascular					
	consultant resulted fro	-					
		ig outside appointments to					

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If continuation sheet Page 48 of 53

		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345499	B. WING	B. WING			C / <b>17/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFOF	RD FALLS HEALTHCARE	& REHABILITATION CENTER			200 LITCHFORD ROAD RALEIGH, NC 27615		
							1
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR L Continued From page validate all recommer effectively and timely. The governing body p for identification for th to suffer a serious add the alleged noncompl measures below to al serious adverse outco 100% audit of current medical appointments completed by the Dire Assistant Director of N validate any orders/re consulting physician of facility electronic heal as ordered. No other deficiency. Findings on a "appointment co in the facility compliar 100% audit of current discontinues in the las by the Director of Nursing or discontinued medicati the physician orders t done based on the m significant medication	A 48 adations are carried out but forth the following plan ose residents who are likely verse outcome as a result of iance and implemented the ter the process to prevent a ome from occurring. The residents who have had is in the last 30 days was ector of Nursing and/or Nursing on 12/13/2024 to ecommendation from the were transcribed to the th records and implemented resident identified with any of this audit are documented neultation audit tool" located nee binder. The residents' medication is 30 days was completed sing and/or Assistant in 12/13/2024 to validate any ion that was done based on o ensure such actions are edical guidance to prevent error. Findings of this audit "discontinued medication	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
	Specify the action the process or system fai	e entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete:					

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	01/28/2025 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE		
	345499	B. WING		C 12/1	7/2024	
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
			8200 LITCHFORD ROAD			
LITCHFORD FALLS HEALTHC	ARE & REHABILITATION CENTER		RALEIGH, NC 27615			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
review a consultar returned from mer and transcribe and health records. Effective 12/13/24 medication based Eliquis, to treat a and document the medication in eac Effective 12/13/20 which includes Di Director of Nursin Unit coordinator # Admission nurse i clinical documents medical appointm in the last 24 hour meeting to ensure and take place as validate the consu medical appointm orders/recommen are transcribed or records. This sys daily (Monday thr issues will be add appropriate actior DON, ADON, and Findings of this sy documented on th maintained in the 100% education of team members to Assistant Director coordinator, Unit of	age 49 , a licensed nurse on duty will ion report for any resident who dical appointment while on duty y orders in facility electronic employees will administer on physician orders, to include specific condition as diagnosed, administration of such in resident's clinical record. 24, the facility's clinical team, rector of Nursing, Assistant g, Medical records coordinator, 1 Unit coordinator #2, and/or nitiated a process for reviewing ation to include the review of ents ordered and/or scheduled s or from the last held clinical the appointment is scheduled ordered. The review will also ultation form from a completed ent is reviewed for any dation and ensure such orders to the facility's electronic health temic process will take place bugh Friday). Any identified ressed promptly, and s will be implemented by the /or Unit coordinator #1/#2 stemic change will be e daily clinical report form and daily clinical meeting binder. f all current clinical leadership include Director of Nursing, of Nursing, Medical records coordinator #1, Unit coordinator on nurse completed by the	F 76				

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	-	ID HUMAN SERVICES				-	RINTED: 01/28/202 FORM APPROVE MB NO. 0938-039
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		X3) DATE SURVEY COMPLETED
		345499	B. WING				C 12/17/2024
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	ST	REET ADDRESS, CITY, STATE, ZIP COD	E	-
		E & REHABILITATION CENTER		820	00 LITCHFORD ROAD		
LITCHFOR	D FALLS HEALTHCARE	& REHABILITATION CENTER		RA	LEIGH, NC 27615		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page		F	760			
	education includes, b importance of ensurin appointments is revie meeting to ensure or scheduled, completed from the completed a for any new orders an education also covera reviewing all medicat 24 hours or from the validate any discontin based on the physicia significant medication be completed by 12/1 member not educated allowed to work until added to a new hire of team members effect	weed in the daily clinical dered appointments are d, and the consultation forms ppointments are reviewed nd recommendations. The ed the importance of ion discontinues in the last last held clinical meeting to nued medication was done an orders to prevent n errors. This education will 13/2024, any clinical team d by 12/13/24, will not be educated. This education is prientation for all clinical ive 12/13/2024.					
	100% education of al Medication aides, to i and as needed nursir completed by the Dire Director of Nursing, a #2). The emphasis of is not limited to: 1. The importance of include Eliquis, and o physician order.	ector of Nursing, Assistant Ind/or Unit Coordinators (1, f this education includes but administering medication to other medications per					
	physician before med stopped/discontinued the possible serious of happen when abruptl 3. The importance of	l, such as Eliquis, to avoid consequences that can y stopping the medication. ensuring each resident is d nurse to oversee his/her					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	APPROVED
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345499	B. WING			C 12/17/2024	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				8	200 LITCHFORD ROAD		
	ND FALLS HEALTHCARE	& REHABILITATION CENTER		F	RALEIGH, NC 27615		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 760	monitoring, and addre 4. The importance of a forms for residents wh medical appointment for any new orders/re- transcribe such orders resident's electronic m implement such per p This education will be Any licensed nurses a educated by 12/13/24 until educated. Direct Director of Nursing, a 2) will monitor and tra education and will cor newly hired licensed r aides during the new 12/13/2024. Alleged immediate ject 12/14/24 A validation of IJ remo 12/17/24. A review of current residents who in the last 30 days and medication discontinue revealed they were con nurses and one Medica a hall within the facility to the in-service education provided and the nursy When asked, the nu	essing a change in condition. ensuring the consultation to returned from the while on duty are reviewed commendation and s/recommendation onto nedical records and hysician order. completed by 12/13/24. and/or medication aide not will not be allowed to work for of Nursing, Assistant ind/or Unit Coordinators (1, ck the completion of this implete this education for any nurses and/or medication hire orientation effective opardy removal date: by al plan was conducted on if the audits conducted for had medical appointments d for current residents' ation in the last 30 days ompleted as planned. All cation Aide (MA) assigned to y were interviewed in regard ation received. Additionally, ented the education ing staff who received it.	F	760			

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DEPARTMENT OF HEALTH				FORM APPROV
CENTERS FOR MEDICARE				OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345499			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING _		C 12/17/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
LITCHEORD FALLS HEALTHCA	RE & REHABILITATION CENTER		8200 LITCHFORD ROAD	
			RALEIGH, NC 27615	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETIC THE APPROPRIATE DATE
resident's physician recommendations new orders into the They were also abl need for communic departments, inclu- the transportation of appointments), and	of the need to notify the n and RP of any new made and to transcribe the e electronic medical record. e to consistently describe the cation with several other ding the resident's physician, department (for follow-up	F7	760	

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