## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
345499 <sub>Y1</sub>	B. Wing	Y2	3/13/2025	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LITCHFORD FALLS HEALTHCARE	E & REHABILITATION CENTER	8200 LITCHFORD ROAD		
		RALEIGH, NC 27615		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	Μ	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0578 483.10(c)(6)(8)(g)(1 (v)	2)(i)- Completed 03/06/2025	ID Prefix Reg. # LSC	F0580 483.10(g)(14)(i)-(iv)(15)	Correction Completed 03/06/2025	ID Prefix Reg. # LSC	F0684 483.25	Correction Completed 03/06/2025
ID Prefix Reg. # LSC	F0686 483.25(b)(1)(i)(ii)	Correction Completed 03/06/2025	ID Prefix Reg. # LSC	F0842 483.20(f)(5), 483.70(h) (1)-(5)	Correction Completed 03/06/2025	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
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