

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0558</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LITCHFORD FALLS HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8200 LITCHFORD ROAD</b> <b>RALEIGH, NC 27615</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited as a result of this complaint investigation (Event W02E11).</p>	L 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE
---	-------	-----------