STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiences were cite as a result of this complaint investigation conducted 7/13/17. Event ID Q6YI11	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately transcribe a medication order for one of three residents reviewed for medication management (Resident #52). Findings included: Resident #52 was admitted 01/27/17. Diagnoses included dementia without behavioral disturbance, and depression. The most recent quarterly Minimum Data Set dated 05/05/17 indicated severe cognitive impairment with "resident is rarely/never understood" being checked. She was admitted to hospice care upon entering the facility. The most recent care plan for Resident #52 (07/12/17) addressed end-of-life issues, psychotropic medication use, and skin integrity issues. A physician ' s order dated 06/23/17 started	F 281	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F281 IMMEDIATE ACTION TAKEN Staff Development Coordinator (SDC) obtained a clarification order from physician on 7/12/17 for resident #52. Ativan 0.5mg twice a day was clarified to Ativan 0.25mg in the morning and Ativan	8/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 Ativan 0.25 milligrams (mg) by mouth (po) every morning and 0.5 mg po at hour of sleep. The order also discontinued the previous order for Ativan 0.5 mg po twice a day (bid) for anxiety. This was a response to a recommendation from the Pharmacy to attempt a gradual dose reduction for Ativan. The order was given by telephone and initialed by the nurse at 1:00 p.m. The box on the order form was unchecked for "verbal orders read back." The order was transcribed on the Medication Administration Record (MAR) as two entries on 06/23/17: "Ativan 0.5 mg po q a.m." at 9:00 a.m. and "Ativan 0.5 mg po q HS po" at 9:00 p.m. The MAR for the months of June (06/23 - 06/30) and July (07/01 - 07/11) reflected that Ativan 0.5 mg po was administered each morning in contrast with the order written on 06/23/17 to give Ativan 0.25 mg each morning. Resident #52 continued to receive her previous daily dosage of Ativan during this period. In an interview on 07/12/17 at 12:44 p.m., the Director of Nursing (DON) acknowledged the error in transcription and indicated he would correct the error and inform the attending physician. In an interview on 07/12/17 at 6:40 p.m., the attending physician shared his expectation that physician orders be followed as written. The nurse who transcribed the order and the night nurse who reviewed the transcription for errors were unavailable for interviews. In an interview on 07/13/17 at 1:45 p.m., the DON	F 281	0.5mg in the evening. SDC transcribed the clarified order appropriately on residents Medication administration record. Effective 07/12/2017 resident has been receiving Ativan 0.25mg in the morning and Ativan 0.5mg in the evening as ordered by the attending physician. IDENTIFICATION OF OTHERS All residents with medication or treatment orders have the potential to be affected. 100% audit of current medications for all current residents completed on 07/28/2017, 7/31/2017, 8/1/2017, 8/2/2017 and 8/3/2017 by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator to identify any other residents with medication or treatment orders not transcribed appropriately in medication and treatment administration records per Physician orders. One other order was identified as not transcribed per physician order. Resident physician notified of the other identified orders, clarification orders obtained by Director of Nursing on 08/01/2017 and transcribed per order on Resident administration record. Findings of this audit is documented on “Medication transcription audit tool” located in the facility Survey compliance binder. SYSTEMIC CHANGES Effective 8/07/2017, the new 24-hour chart check form revised by Corporate Clinical Consultant will be implemented. This form will enhance the process of checking accuracy of each transcribed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 described the process for order transcription by the nurse receiving the order. The transcription of daily orders was reviewed by the night nurse who initialed that the 24-hour chart review was completed. He stated that the night nurse had signed off the orders for Resident #52 on 06/23/17, however the error was not corrected. He shared his expectation that physician orders were transcribed accurately and that any errors in transcription that might occur were corrected during the 24-hour chart check by the night nurse. In an interview on 07/13/17 at 6:14 p.m., Nurse #2 described the process of receiving a telephone order. She stated that she read back the order, checked for allergies if it was a medication order, faxed a copy to the pharmacy, wrote it in the MAR, and notified the family if an antibiotic was ordered. She indicated that the night nurse did a daily chart check to review for accurate transcription of orders.	F 281	order in a daily basis. Licensed nurse on duty during night shift will be responsible to complete 24-hour chart check while on duty. 24-Hour chart check is the process of checking all orders received in the most recent 24 hours to ensure accurate and proper transcriptions. If any medication or treatment order is not transcribed as ordered, night shift nurse will ensure it is transcribed correctly on the Medication Administration Record or Treatment Administration Records. 24- Hour chart check form will be located in a binder titled 24 Hour report at each nurse's station. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new 24-hour chart check form. This education will be completed by 08/07/2017. Any licensed nurse not educated by 08/07/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses effective 8/7/2017. On 08/04/2017, Regional Clinical Director conducted an education with the center DON, ADON and SDC about the process of reviewing new physician orders or changes of orders daily (Monday through Friday). This education emphasized on how to identify a root cause when an order is not transcribed appropriately and actions to be taken to address any discrepancies in a timely manner.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3	F 281	Effective 8/07/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing all new physician orders or change of orders daily (Monday through Friday) and will address any discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented as appropriate by the DON, ADON, SDC and/or Registered Nurse supervisor. Effective 8/07/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review, all new orders or change of orders every Saturday & Sunday and will address any discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented as appropriate by the Registered Nurse supervisor, and reported to the center's DON timely. MONITORING PROCESS. Effective 08/07/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor proper transcription of physician orders by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4	F 281	conducting clinical meeting daily (M-F), this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure physician orders are transcribed correctly to the MARs/TARs. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical report daily (M-F) X4 weeks, weekly x 4 weeks, then monthly x 3 months. Effective 8/7/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 329		8/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 5 unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, physician and staff interviews the facility failed to	F 329	IMMEDIATE ACTION TAKEN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 administer the correct dose of an anti-anxiety medication for 1 of 5 residents (Resident #52) and failed to monitor blood glucose levels and administer insulin according to physicians orders for 3 of 5 residents (Resident #52, Resident #76 and Resident #40) that were reviewed for unnecessary medications. Findings Included. 1. a) Resident #52 was admitted 01/27/17. Diagnoses included dementia without behavioral disturbance and depression. The most recent quarterly Minimum Data Set dated 05/05/17 indicated severe cognitive impairment with "resident is rarely/never understood" being checked. She was admitted to hospice care upon entering the facility. The most recent care plan last updated on 07/12/17 for Resident #52 addressed end-of-life issues, psychotropic medication use, and skin integrity issues. A physician ' s order dated 06/23/17 started Ativan 0.25 milligrams (mg) by mouth (po) every morning and 0.5 mg po at hour of sleep. The order also discontinued the previous order for Ativan 0.5 mg po twice a day for anxiety. This was a response to a recommendation from the Pharmacy to attempt a gradual dose reduction for Ativan. The order was given by telephone and initialed by the nurse at 1:00 p.m. The box on the order form was unchecked for "verbal orders read back." The order was present on the Medication Administration Record (MAR) as two entries on	F 329	1.a) Staff Development Coordinator (SDC) obtained a clarification order from physician on 7/12/17 for resident #52. Ativan 0.5mg twice a day was clarified to Ativan 0.25mg in the morning and Ativan 0.5mg in the evening. SDC transcribed the clarified order appropriately on residents Medication administration record. Effective 07/12/2017 resident had been receiving Ativan 0.25mg in the morning and Ativan 0.5mg in the evening as ordered by the attending physician. b) Licensed nurse #1, obtained resident #52 blood sugar on 8/3/2017 at 6:30am resident #52 blood sugar was noted to be 208. Resident #52 attending physician was notified on 8/3/17 on omission noted on resident's medical records related to documentation of blood glucose on the following days and times: 11:30 a.m. - 07/03, 07/05, 07/06, 07/08, 07/09, 07/11/ and 7/12; 4:30 p.m. - 07/04, 07/07, 07/08, and 07/09; 9:00 p.m. - 07/05, 07/06, and 07/09. Resident shown no signs and symptoms of destress. Center's Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator identified licensed nurses who failed to document blood glucose for resident #52 on 8/4/2017. Involved licensed nurses counseled per facility protocol and re-educated on the importance of documenting blood glucose in a timely manner on 8/4/2017 by Staff Development Coordinator. 2. a) Licensed Nurse #2 obtained resident #76 blood sugar on 8/3/2017 at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 06/23/17: "Ativan 0.5 mg po q a.m." at 9:00 a.m. and "Ativan 0.5 mg po q HS po" at 9:00 p.m. The MAR for the months of June (06/23 - 06/30) and July (07/01 - 07/11) reflected that Ativan 0.5 mg po was administered each morning in contrast with the order written on 06/23/17 to give Ativan 0.25 mg each morning. Resident #52 continued to receive her previous daily dosage of Ativan during this period. In an interview on 07/12/17 at 12:44 p.m., the Director of Nursing (DON) acknowledged the error and indicated he would correct the error and inform the attending physician. In an interview on 07/12/17 at 6:40 p.m., the attending physician shared his expectation that physician orders be followed as written. The nurse who processed the order and the night nurse who reviewed it for errors were unavailable for interviews. In an interview on 07/13/17 at 1:45 p.m., the DON acknowledged that the Resident #52 resident had received more medication than intended by the most recent physician order for a gradual dose reduction due to the error. 1. b) Resident #52 was admitted 01/27/17. Diagnoses included dementia without behavioral disturbance, and depression. The most recent quarterly Minimum Data Set dated 05/05/17 indicated severe cognitive impairment with "resident is rarely/never understood" being checked. She was admitted to hospice care upon entering the facility. The most recent care plan last updated on	F 329	6:30am resident #76 blood sugar was noted to be 118. Resident #76 attending physician was notified on 8/4/2017 on inaccurate or omission of documentation related to units of insulin administered on the following days and times: 6/1/17 at 4:30 pm, 2 units of insulin documented instead of 4 units per physician order, 6/2/17 at 4:40pm, 6/3/17 at 11:30 am,6/4/17 at 6:30, 6/4/17 at 8:30 pm 6/5/17 at 6:30 am 6/18/17 at 6:30 am,6/19/17 at 4:30 pm,6/20/17 at 4:30 pm, 6/21/17 at 4:30pm,6/30/17 at 4:30pm, resident #76 blood glucose was recorded to be at a level that requires insulin administration, no insulin was documented per physician order. Resident shown no signs and symptoms of destress. On 8/4/2017 Resident attending physician discontinued order for sliding scale coverage. Resident #76 attending physician was notified on 8/4/2017 on omission of documentation related to documentation of blood glucose on the following days and times: 6/3/17 at 8:30 pm, 6/8/17 at 8:30 pm, 6/14/17 at 11:30 am, 6/19/17 at 11:30 am 6/20/17 at 11:30 am, and 6/30/17 at 8:30 pm. Resident shown no signs and symptoms of destress. On 8/03/2017 resident attending physician ordered resident blood sugar to be checked before meals and at bed time with no sliding scale coverage. 3)Resident #40 blood glucose order was changed by attending physician on 7/14/2017. New order for blood sugar	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 8 07/12/17 for Resident #52 addressed end-of-life issues, psychotropic medication use, and skin integrity issues. Accuchecks for blood glucose levels were ordered 02/28/17 to be performed before meals and at bedtime. The times for the checks were recorded in the Medication Administration Record (MAR) as 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. A physician order for Novolog insulin to be provided on a sliding scale based upon blood sugar levels with a start date of 05/08/17 was the only anti-hyperglycemic agent ordered for Resident #52. A review of the MAR and Daily Blood Sugar worksheet for the month of July revealed that no blood glucose level was obtained for Resident #52 on the following days and times: 11:30 a.m. - 07/03, 07/05, 07/06, 07/08, 07/09, 07/11/ and 7/12; 4:30 p.m. - 07/04, 07/07, 07/08, and 07/09; 9:00 p.m. - 07/05, 07/06, and 07/09. The records reviewed were for the partial month of July (07/01 through 07/12). There were no notations of refusals for these times on the front or back of MAR sheet or the corresponding worksheet. In an interview on 07/13/17 at 11:35 a.m., Nurse #1 was unable to provide information on the lack of documentation for Accuchecks at 11:30 on six of the seven missing dates that he worked. He indicated that sometimes the resident refused and he didn ' t always record the refusals because he went back to the resident and tried again. He acknowledged that the resident got sliding scale insulin based on the value and that is the only coverage she received.	F 329	monitoring before meals and at bed time implemented starting 7/14/2017 with sliding scale coverage. Licensed nurse #3 obtained blood sugar on 7/30/2017 at 6:30am resident blood sugar noted to be 243 no insulin administered per physician order of sliding scale. IDENTIFICATION OF OTHERS All residents with medication or treatment orders have the potential to be affected. 100% audit of current medications for all current residents completed on 07/28/2017, 7/31/2017, 8/1/2017, 8/2/2017 and 8/3/2017 by the Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator to identify any other residents with medication or treatment orders not transcribed appropriately in medication and treatment administration records per Physician orders. One other order was identified as not transcribed per physician order. Resident physician notified of the other identified orders, clarification orders obtained by Director of Nursing on 08/01/2017 and transcribed per order on Resident administration record. Findings of this audit is documented on “Medication transcription audit tool” located in the facility Survey compliance binder. 100% audit of all current residents with orders for blood sugar monitoring completed on 07/28/2017, 07/31/2017, 08/01/2017, 08/2/2017 and 8/3/2017 by the Director of Nursing, Assistant Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9 2. Resident #76 was admitted to the facility on 5/8/17 and her diagnoses included diabetes. A review of the care plan dated 5/11/17 for Resident #76 revealed she was a diabetic and received insulin coverage. A review of the admission Minimum Data Set dated 5/22/17 for Resident #76 revealed she was alert and oriented and received insulin injections daily. A review of the June 2017 physician orders for Resident #76 identified an order to preform Accuchecks for blood glucose levels before meals (6:30 am, 11:30 am, 4:30 pm), at bedtime (8:30 pm) and administer Novolog insulin per sliding scale coverage as follows: blood glucose of 201 to 250 give 4 units, 251 to 300 give 6 units, 301 to 350 give 8 units, 351 to 400 give 10 units and greater than 401 notify physician. A review of the medical record for Resident #76 revealed that her blood glucose levels were being recorded on the MAR and on a form identified as "Daily Blood Sugars". A review of the June 2017 MAR and the June 2017 "Daily Blood Sugar" form revealed the following: 6/1/17 at 4:30 pm blood glucose was 208 and received 2 units of insulin, 6/2/17 at 4:40 pm blood glucose was 254 and no insulin documented as given, 6/3/17 at 11:30 am blood glucose was 340 and no insulin documented as given, 6/3/17 at 8:30 pm blood glucose was not recorded, 6/4/17 at 6:30 am blood glucose was 217 and no insulin documented as given, 6/4/17 at 8:30 pm blood glucose not recorded, 6/5/17 at 6:30 am blood glucose 263 and no insulin documented as given,	F 329	of Nursing, and/or Staff Development Coordinator to identify any other residents with blood sugar orders that were not adequately monitored, or insulin coverage not administered following the ordered sliding scale. 9 other residents with blood sugar monitoring were identified with blood sugars not being adequately monitored and/or insulin not administered per physician order. Findings of this audit is documented on the “Blood glucose audit tool” located in the facility survey compliance binder. SYSTEMIC CHANGES Effective 8/07/2017, the new 24-hour chart check form revised by Corporate Clinical Consultant will be implemented. This form will enhance the process of checking accuracy of each transcribed order in a daily basis. Licensed nurse on duty during night shift will be responsible to complete 24-hour chart check while on duty. 24-Hour chart check is the process of checking all orders received in the most recent 24 hours to ensure accurate and proper transcriptions. If any medication or treatment order is not transcribed as ordered, night shift nurse will ensure it is transcribed correctly on the Medication Administration Record or Treatment Administration Records. 24- Hour chart check form will be located in a binder titled 24 Hour report at each nurse’s station. Effective 8/7/2017, all Licensed nurses will obtain, document and sign on the MARs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 6/8/17 at 8:30 pm blood glucose not recorded, 6/14/17 at 11:30 am blood glucose not recorded, 6/18/17 at 6:30 am blood glucose 254 and no insulin documented as given, 6/19/17 at 11:30 am blood glucose not recorded, 6/19/17 at 4:30 pm blood glucose 274 and no insulin documented as given, 6/20/17 at 11:30 am blood glucose not recorded, 6/20/17 at 4:30 pm blood glucose 258 and no insulin documented as given, 6/21/17 at 4:30 pm blood glucose 384 and no insulin documented as given, 6/30/17 at 4:30 pm blood glucose 248 and no insulin documented as given and 6/30/17 at 8:30 pm blood glucose not recorded. An interview on 7/12/17 at 2:40 pm with Resident #76 revealed that the nurses checked her blood sugar but she was not sure how often. She stated that she had never refused to have her blood sugar checked and that she had been concerned that her blood sugar levels were running high; in the 300 to 400 ' s. She stated that in the past she had taken insulin in the morning and at night, but she didn ' t know what type of insulin it was An interview on 7/12/2017 at 2:49 pm with Nurse #3 revealed he had been the nurse for Resident #76. He stated that she had an order to check her blood glucose four times a day and received sliding scale insulin based on her blood sugar result. He stated he wasn ' t sure why some of her blood sugar results were missing, but they should have been done. He stated that Resident #76 had never refused to have her blood sugar checked. An interview on 7/12/2017 at 3:22 pm with Nurse #4 revealed that she had been the nurse for	F 329	to indicate that blood sugar is obtained and based on blood glucose results licensed nurse on duty will administer the correct dose of insulin and document such action on individual resident's Medication Administration records. Effective 8/7/2017, the center will no longer utilize "Daily blood sugar" form to document blood sugar results and insulin administered. Moving forward, effective 8/7/2017 licensed nurses will document blood sugar results, and amount of insulin administered on each resident's MAR based on physician orders. On 08/04/2017, Regional Clinical Director conducted an education with the center DON, ADON and SDC about the process of reviewing new physician orders or changes of orders daily (Monday through Friday). This education emphasized on how to identify a root cause when an order is not transcribed appropriately and actions to be taken to address any discrepancies in a timely manner. The education also emphasized on the importance of consolidating blood sugar documentation process by removing or discontinuing the use of "Daily blood sugar" form. Effective 8/07/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing all new physician orders or change of orders daily (Monday through Friday) and will address any discrepancy in a timely manner. The assigned nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 Resident #76. She stated that the resident is a diabetic and received sliding scale insulin coverage. She stated her blood sugar was checked four times daily. She stated that she wasn ' t sure why there were errors and omissions in Resident #76 ' s blood sugars and insulin. She thought she had completed them correctly, but she guessed she hadn ' t because the MAR was a "mess". An interview on 7/12/17 at 3:31 pm with the DON revealed that the facility had initially used the "Daily Blood Sugar" form because the nurses had complained that there wasn ' t enough room on the MAR to document the blood glucose result and the amount of insulin given in the little blocks. He stated that he had made some adjustments to the MAR to make it easier for them to document, but some nurses continued to use the other form. He stated that it was his expectation that the nurses completed blood sugar checks at the correct times and administer the sliding scale insulin coverage based on the blood sugar results. An interview on 7/13/17 at 2:30 pm with the physician for Resident #76 revealed he was very familiar with the resident. He stated that he expected blood sugars to be checked and the correct amount of sliding scale insulin to be administered according to his orders. 3. Resident #40 was admitted 05/20/15. Diagnoses included hemiplegia following a cardiovascular accident affecting the right dominant side, diabetes mellitus Type 1, chronic kidney disease, and psychotic disorder with hallucinations.	F 329	administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented as appropriate by the DON, ADON, SDC and/or Registered Nurse supervisor. Effective 8/07/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review, all new orders or change of orders every Saturday & Sunday and will address any discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented as appropriate by the Registered Nurse supervisor, and reported to the center’s DON timely. Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on medication and treatment administrations. This education will emphasize on the importance of documenting all care rendered to each resident to include documentation on the medication administration records for blood sugar monitoring per physician order, insulin administration based on ordered sliding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 The most recent MDS (annual) dated 04/21/17 indicated intact cognition with behavioral symptoms not directed toward others for one to three days of the look-back period. She required extensive assistance or was totally dependent for most activities of daily living except for independent eating. The MDS documented that Resident #40 was incontinent of bowel and bladder. The current care plan present in the medical record addressed the risk of elopement and behavioral issues interfering with care such as verbal and physical aggression towards staff and inconsistency in her preference for staff providing care. Accuchecks for blood glucose levels were ordered 01/19/17 to be performed before meals, two hours after meals, daily before supper, and at bedtime. The times for the checks were recorded in the Medication Administration Record (MAR) as 6:30 a.m., 11:30 a.m., 2:00 p.m., 4:30 p.m., and 8:30 p.m. Resident #40 received Humulin N insulin 74 units every morning (ordered 02/15/17) and Humalog Kwikpen 10 units with meals (ordered 03/03/17). A review of the May, June, and July 2017 MAR revealed that Accuchecks for 2:00 p.m. were conducted five days in May (05/01 - 05/03, 05/25, and 05/26) and no days in either June or July. There were no notations of refusals for that time on the missing days. In an interview on 07/13/17 at 6:14 p.m., Nurse #2 indicated that she did not work on the unit in May and did not work the first shift on the days for which documentation of the 2:00 p.m. Accucheck	F 329	scale and documenting the completion of the treatment on the Treatment Administration Record as ordered. Licensed nurses were also educated about their responsibility to cross check their MARs/TARs during shift change and signed off on the Daily MAR/TAR audit tool as monitoring process to ensure compliance by validating that their documentation is complete before handing over residents responsibilities to incoming licensed nurse. This education will be completed on 8/7/2017. Any licensed nurse not educated by 08/07/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses effective 8/7/2017. MONITORING PROCESS Moving forward, effective 08/07/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor proper transcription of physician orders by conducting clinical meeting daily (M-F), this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure physician orders are transcribed correctly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 was missing. She stated that when Resident #40 refused testing of her blood glucose, she documented it on the MAR, wrote a progress note, and notified the physician. She indicated that if the resident had multiple refusals she would contact her supervisor or physician to see if the order needed to be changed. `	F 329	to the MARs/TARs. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical report daily (Monday - Friday) for 4 weeks, weekly x 4 weeks, then monthly x 3 months. Moving forward, effective 08/07/2017, each licensed nurse will be responsible to sign off on the Daily MAR/TAR audit tool. This audit tool should be signed off by each shift indicating that they have documented on their MARs/TARs for each resident. By signing, the licensed nurse acknowledges that their documentation is complete, any omission or discrepancies especially for ordered blood glucose or insulin orders will be addressed promptly. This monitoring process will take place daily (Monday - Friday) for 30 days, weekly x 30 days then monthly for three months or until the pattern of compliance is maintained. Effective 8/7/2017, During the daily clinical meeting (Monday - Friday), the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will be responsible for checking the Daily MAR/TAR Audit tool to ensure each shift from the previous day completed and sign off their MARs/TARs. Any discrepancies noted will be addressed and involved nurse will be counseled following the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14	F 329	center protocol. Once they have verified the audit tool is completed, they will sign off indicating the completion of the MARs/TARs. This monitoring process will take place daily (Monday - Friday) for 30 days, weekly for 30 days then monthly for three months or until the pattern of compliance is maintained. Effective 8/7/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		8/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 15 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to allow dishware to air dry, failed to maintain insulated plate chargers in good condition and failed to maintain clean kitchen equipment. Findings Included: 1. An observation of the kitchen on 7/9/17 at 5:20 pm with the Dietary Manager (DM) revealed: a) 25 meal trays were stacked together wet on a cart ready to be used for service of the supper meal b) 27 insulated plate chargers were stacked together wet on the steam table ready to be used for service of the supper meal c) 12 divided plastic plates were stacked together wet on the steam table ready to be used for service of the supper meal An interview on 7/9/17 at 5:35 pm with Dietary Aide #1 revealed that the dishes should be dried with a towel before being put away. An interview on 7/9/17 at 5:37 pm with the DM revealed that the dishes should be allowed to air dry prior to being put away. She stated that the dishes should not be towel dried.	F 371	IMMEDIATE ACTION TAKEN 1. A. On 07/09/2017, Certified Dietary Manager removed 25 meal trays that were stacked together wet on the cart so they could not be used for the service of the supper meal. Meal trays re-washed and were allowed to air dry. B. On 07/09/2017, Certified Dietary Manager removed 27 insulated plate chargers that were stacked together wet on the steam table so they could not be used for the service of the supper meal. Plate chargers re-washed and were allowed to air dry. 2. On 07/09/2017, Certified Dietary Manager removed 14 insulated plate chargers that were heavily scratched so they could not be used for service of meals. Certified Dietary Manager Discarded 14 insulated plate chargers on 07/09/2017 and were replaced. 3. A. On 07/09/2017, Certified Dietary Manager cleaned the shelving unit used for the juice machine to remove the sticky build-up of substances.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 16 2. An observation of the kitchen on 7/9/17 at 5:40 pm with the DM revealed: 14 insulated plate chargers were heavily scratched with portions of plastic peeling off were on the steam table ready to be used for service of the supper meal. An interview on 7/9/17 at 5:40 pm with the DM revealed that the damaged plate bases should be replaced. 3. An observation of the kitchen on 7/9/17 at 5:45 pm with the DM revealed: a) A shelving unit used for the juice dispensing equipment had a heavy build-up of sticky substances b) The filters in the hood system had a build-up of grease and dust An interview on 7/9/17 at 5:45 pm with the DM revealed that the shelving unit that held the juice machine needed to be cleaned and she would add this to the cleaning schedule. The DM stated that the hood filters had been cleaned about 3 weeks ago and that they needed to be cleaned again. An interview on 7/13/17 at 5:11 pm with the Administrator revealed she expected all dishes to be air dried and that any damaged dishes should be discarded and replaced. She additionally stated that she expected all kitchen equipment to be clean.	F 371	B. On 07/09/2017, Certified Dietary Manager cleaned the filters in the hood system to remove build-up of grease and dust. IDENTIFICATION OF OTHERS All residents have potential to be affected. On 07/09/2017, Certified Dietary Manager audited 100% of all meal trays to ensure no other dishes were stacked together wet prior to the service of the supper meal. Results of this audit revealed no other meal trays were stacked together wet. This audit is documented on “Dishes Sanitation and quality audit” tool located in the facility compliance binder. On 07/09/2017, Certified Dietary Manager completed 100% audit of all insulated plate chargers used to serve residents meal, to ensure no other insulated plate chargers were stacked together wet prior to the service of the supper meal, no other insulated plate chargers were noted stacked together wet. Results of this audit is documented on “Dishes Sanitation and quality audit” tool located in the facility compliance binder. On 07/09/2017, Certified Dietary Manager completed 100% audit of all insulated plate chargers used to serve residents meal to identify if any other insulated plate chargers is in poor condition evident by heavy scratches. Three other insulated plate charger identified as being heavily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 17	F 371	scratched. Identified insulated plate charger was removed and discarded. Results of this audit is documented on Dishes Sanitation and quality audit" tool located in the facility compliance binder. On 07/09/2017, Certified Dietary Manager audited other surface areas used to store resident used items to ensure no other areas are noted with sticky buildup substance or not in a clean and sanitary form. Results of this audit revealed no other surface areas had a sticky buildup substances. On 07/09/2017, Certified Dietary Manager audited hood to ensure it was clean and free of build-up grease and dust. Results of this audit revealed the hood to be free of build-up grease and dust. On 7/31/2017 Licensed Dietician, contracted to provide services for the facility, completed a detailed sanitation inspection to ensure the center store, prepare, distribute and serve food in accordance with professional standards for food service safety. No other issues identified on the station inspection. This sanitation inspection is documented on Sanitation inspection form located in the facility compliance binder. SYSTEMIC CHANGES Moving forward, Effective 8/7/2017 quality check process will be initiated to ensure only dishware that are dry, in good repair and free of heavy scratches are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18	F 371	used to serve food to our residents. The first quality check point will be done by a dietary staff who remove clean dishes from a dishwashing machine. That dietary staff will ensure no dishware with heavy scratches or not in a good repair is placed in a dish rack. The second quality check point will take place at the beginning of the tray line. Dietary aide at the beginning of the line will remove any dishware with heavy scratches or not in a good repair. Any dishes not in a good repair will be removed out of circulation immediately. Dietary manager will re-inspect the dishes removed out of service and determine the proper action not limited to replacing the dishes. Certified Dietary manager revised the kitchen cleaning schedule on 7/9/2017 to include a shelving unit used for juice dispensing equipment and filters in the hood system. This new revised schedule will be used effective 8/7/2017. Moving forward, effective 08/07/2017, the dietary staff will wipe down the shelving unit for the juice dispensing equipment thoroughly each shift per the daily revised cleaning schedule. Moving forward, effective 08/07/2017, the filters in the hood system will be cleaned bi-weekly per the revised cleaning schedule. Moving forward, effective 08/07/2017, the dietary staff will leave the meal trays on the dish racks until air dry after putting them through the dish machine for cleaning. Once dry, the trays will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 19	F 371	stored for usage at the needed time. Moving forward, effective 08/07/2017, the dietary staff will use the drying rack to place the insulated plate chargers on to air dry after putting them through the dish machine for cleaning. Once dry, the insulated plate chargers will be stored for usage at the needed time. Moving forward, effective 08/07/2017, the Registered Dietician will complete sanitation inspection monthly to include inspecting the quality of dishware's used for residents (i.e. insulated plate chargers). The Registered Dietician will also inspect the filters in the hood system for grease and dust during the monthly Kitchen Sanitation Audit. Any negative findings of dishes not in good repair, cleanliness of hood filters will be reported to the Certified Dietary Manager and/or Administrator promptly. This inspection will be documented on the "Kitchen Sanitation audit" tool and will be kept with the facility Quality Assurance and Performance Improvement information. Licensed dietician and/or Administrator completed an in-service education on 7/31/2017 with the Certified Dietary Manager to stress the importance of allowing dishes to air dry and the quality check process that will assure dishes not in good repair are removed from circulation promptly and to ensure the center continue to store, prepare, distribute and serve food in accordance with professional standards for food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 20	F 371	service safety. On 07/09/2017, Certified Dietary Manager conducted individualized education with involved employees regarding not stacking dishes wet before they are completely dry. Certified Dietary Manager completed 100% education with dietary staff to include full time, part time and as needed staff. This education included when washing dishes, they must be stacked to air dry and cannot be stacked when wet. Also, when notice the insulated plate chargers are found heavily scratched, they should be removed from circulation. The shelving unit for the juice dispensing equipment should be wiped down after each shift per revised cleaning schedule and the filters in the hood system should be monitored for grease and dust, and then cleaned per cleaning schedule and as needed. This education will be completed by 08/07/2017, any dietary staff not educated by 08/07/2017 will not be allowed to work until educated. This education will be added on new hire orientation process for all dietary staff effective 08/07/2017 MONITORING PROCESS The Certified Dietary Manager and/or designated staff will audit the meal trays and insulated plate chargers to ensure they are not stacked wet daily x4 weeks, weekly x4 weeks, then monthly until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 21	F 371	substantial compliance is maintained for three consecutive months. The Certified Dietary Manager and/or designated staff will audit the insulated plate chargers to ensure they are not heavily scratched with portions of plastic peeling off prior to usage daily x4 weeks, weekly x4 weeks, then monthly until substantial compliance is maintained for three consecutive months. The Certified Dietary Manager and/or designated staff will audit the shelving unit for the dish machine has been cleaned daily x4 weeks, weekly x4 weeks, and then monthly until substantial compliance is maintained for three consecutive months. The Certified Dietary Manager and/or designated staff will audit the filters in the hood system to ensure they have been cleaned weekly x4 weeks, and then monthly until substantial compliance is maintained for three consecutive months. The Certified dietary Manager and/or Administrator will monitor compliance with quality check process and staff adherence of revised cleaning schedule daily (Monday - Friday) for 4 weeks, weekly for 4 weeks, then monthly until substantial compliance is maintained for three consecutive months. The Dietary Manager will report the summary findings of these audits to Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22	F 371	Improvement Committee monthly for six months or until a pattern of compliance is achieved.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 514		8/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 23 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate treatment documentation for 2 of 3 residents (Resident #104 and Resident #52) that were reviewed for pressure ulcers. Finding Included: 1. Resident #104 was admitted to the facility on 3/27/15 and his diagnoses included malnutrition, contractures and Alzheimer ' s disease. A significant change minimum data set (MDS) dated 6/24/17 for Resident #104 revealed he had an unstageable pressure ulcer, was totally dependent on staff for activities of daily living (ADL ' s) and had severely impaired cognition. A care plan dated 7/11/17 for Resident #104 revealed he had a pressure skin issue to his right hip / greater trochanter area with interventions that included skin care and treatments per physicians order. A review of the June 2017 physician orders for Resident #104 revealed an order on 6/19/17 to cleanse right hip / greater trochanter area wound with normal saline, pat dry, apply santyl ointment and cover with mepilex. Change daily and as needed. A review of the June 2017 treatment administration record (TAR) for Resident #104 revealed a treatment order dated 6/19/17 to cleanse right hip / greater trochanter area wound with normal saline, pat dry, apply santyl ointment	F 514	IMMEDIATE ACTION TAKEN 1.On 07/15/2017, the Assistant Director of Nursing audited clinical record to ensure the facility had the correct treatment orders in place for Resident #104. Results from this audit revealed the facility had the correct orders in place for Resident #104. On 07/15/2017, the Assistant Director of Nursing completed the treatment and documented on the treatment record for resident #104. Resident #104 shown no deterioration of wound noted, resident shown no signs or symptoms of any distress. 2.On 07/15/2017, a Registered Nurse #1, audited clinical record to ensure the facility had the correct treatment orders in place for Resident #50. Results from this audit revealed the facility had the correct orders in place for Resident #50. On 07/15/2017, Registered nurse #1 completed the treatment and documented on the treatment record for resident #50. Resident #50 shown no deterioration of wound noted, resident shown no signs or symptoms of any distress. IDENTIFICATION OF OTHERS 100% audit of current treatment administration records for all current residents completed on 07/28/2017, 07/31/2017, 08/01/2017, 08/2/2017 and 8/3/2017 by the Director of Nursing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 24 and cover with mepilex. Change daily and as needed. There was no documentation (nurses initials) that the treatment had been completed on 6/21, 6/22, 6/23, 6/29 and 6/30. An interview on 7/12/17 at 11:27 am with Nurse #5 revealed that she had been Resident #104 ' s nurse and responsible for completing the treatment for his pressure ulcer on 6/21, 6/22 and 6/30. She stated she felt like she had done the treatment and could have forgotten to sign the TAR. An interview on 7/12/17 at 11:39 am with Nurse #6 revealed that on 6/30/17 the med tech that was assigned to Resident #104 asked her to complete the treatment for his pressure ulcer. She stated that the wound was on his hip and she felt that she had completed the treatment, but had not signed the TAR. The nurse that was assigned to complete the wound treatment for Resident #104 on 6/23 was unavailable for an interview. An interview on 7/12/17 at 3:51 pm with the Director of Nursing (DON) revealed he expected wound treatments to be completed as ordered by the physician and documented as being completed on the TAR. An interview on 7/12/17 at 6:36 pm with the physician for Resident #104 revealed it was his expectation that wound treatments were completed as ordered. He stated that the facility had some turnover in the wound care nurse position and that may have contributed to the treatments not being done.	F 514	Assistant Director of Nursing, and Staff Development Coordinator to identify any other residents with inaccurate or incomplete treatment documentation. 63 other residents noted with incomplete treatment documentation. No deterioration of wounds noted related to this omission. Findings of this audit is documented on the Treatment Record audit tool located in the facility survey compliance binder. SYSTEMIC CHANGES Effective 8/7/2017, all licensed nurses will obtain, document and sign on the Treatment Administration Records to indicate that resident treatment is completed based on physician orders. Effective 8/07/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing all new physician orders or change of orders daily (Monday through Friday) and will address any discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Treatment Administration Record (TAR). Any identified issues will be addressed promptly and actions will be implemented as appropriate by the DON, ADON, SDC and/or Registered Nurse supervisor. Effective 8/07/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review, all new orders or change of orders every Saturday & Sunday and will address any discrepancy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 25 2. Resident # 50 was admitted to the facility on 2/2/17 with diagnoses included insomnia, muscle weakness and dysphagia. A review of Minimum Date Set (MDS) dated 4/30/17 revealed Resident #50 had an unstageable pressure ulcer, was totally dependent on staff for activities of daily living (ADL's). However she only needed set up for eating. A care plan dated 6/11/17 for Resident #50 revealed she had an unstageable pressure ulcer to the right bottom of heal (unstageable due to slough/eschar). Intervention that included skin care and treatment per physicians order. A review of May 2017 physician orders for Resident #50 indicated that right bottom of heel need to be clean with silvasorb gel daily to assist with odor debridement. Change daily and as needed. A review of the May 2017 treatment administration record (TAR) for Resident # 50 revealed that unstageable pressure ulcer to right heel needed to be change daily and as needed. There was no documentation (nurses initials) that the treatment had been completed on 5/23, 5/25, 5/26, 5/27 and 5/28. A review of June 2017 treatment administration record (TAR) for Resident #50 revealed that the unstageable pressure ulcer to the right heel needed to be change daily and as needed. There was no documentation (nurses initials) that the treatment had been completed on 6/9, 6/16, 6/19 and 6/20.	F 514	in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Treatment Administration Record (TAR). Any identified issues will be addressed promptly and actions will be implemented as appropriate by the Registered Nurse supervisor, and reported to the center's DON timely. Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on medication and treatment administrations. This education will emphasize on the importance of documenting all care rendered to each resident to include documentation on the Treatment administration records for any wound care rendered per physician order. Licensed nurses will also be educated about their responsibility to cross check their MARs/TARs during shift change and signed off on the Daily MAR/TAR audit tool as monitoring process to ensure compliance by validating that their documentation is complete, legible and accurate before handing over residents responsibilities to incoming licensed nurse. This education will be completed by 08/07/2017. Any licensed nurse not educated by 08/07/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses effective 8/7/2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 26 An interview with Nurse # 5 on 7/12/17 at 11:40 AM revealed that she had been Resident #50 nurse and responsible for completing the treatment for her pressure ulcer on 5/23, 5/25, 5/26 and 6/9, and 6/16. She stated that she had done the treatment and just forgotten to sign the TAR. An interview with Nurse #1 on 7/12/17 at 11:53 AM he revealed that he had completed the care and treatment Resident #50 on 5/27, 5/28, 6/19 and 6/20 pressure ulcer and just forgotten to sign the TAR. An interview on 7/12/17 at 3:51 PM with the Director of Nursing (DON) revealed he expected wound treatment to be completed as ordered by the physician and documented as being completed on the TAR. An interview on 7/12/17 at 6:36 PM with the physician for Resident #50 revealed it was his expectation that wound treatment were completed as ordered. He stated that the facility had some turnover in the wound care nurse position and that may have contributed to the treatment not being done.	F 514	MONITORING PROCESS. Moving forward, effective 08/07/2017, each licensed nurse will be responsible to sign off on the Daily MAR/TAR audit tool. This audit tool should be signed off by each shift indicating that they have documented on their MARs/TARs for each resident. By signing, the licensed nurse acknowledges that their documentation is complete, any omission or discrepancies especially for ordered blood glucose or insulin orders will be addressed promptly. This monitoring process will take place daily (Monday - Friday) for 30 days, weekly x 30 days then monthly for three months or until the pattern of compliance is maintained. Effective 8/7/2017, During the daily clinical meeting (Monday - Friday), the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will be responsible for checking the Daily MAR/TAR Audit tool to ensure each shift from the previous day completed and sign off their MARs/TARs. Any discrepancies noted will be addressed and involved nurse will be counseled following the center protocol. Once they have verified the audit tool is completed, they will sign off indicating the completion of the MARs/TARs. This monitoring process will take place daily (Monday - Friday) for 30 days, weekly for 30 days then monthly for three months or until the pattern of compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 27	F 514	Moving forward, effective 08/07/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor proper transcription of physician orders by conducting clinical meeting daily (M-F), this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure physician orders are transcribed correctly to the MARs/TARs. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical report daily (Monday - Friday) for 4 weeks, weekly x 4 weeks, then monthly x 3 months. Effective 8/7/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITCHFORD FALLS HEALTHCARE	**8200 LITCHFORD ROAD RALEIGH, NC 27615**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE