

APR 09 2013

PRINTED: 03/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/13/2013
NAME OF PROVIDER OR SUPPLIER  LITCHFORD FALLS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8200 LITCHFORD ROAD RALEIGH, NC 27615	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon record review, observations and staff interviews the facility failed to provide toenail care for one (1) of two (2) dependent residents requiring toenail care. (Resident# 7)</p> <p>The findings include:</p> <p>Resident # 7 was originally admitted to the facility on 11/6/06 and was readmitted on 6/12/11, with diagnoses including Late effect Intracranial Injury, Hemiplegia, Edema, Benign Hypertension, Long term use of anticoagulant, Rehabilitation and Diabetes Mellitus II. Review of the most recent Quarterly Minimum Data Set (MDS) dated 12/10/12 revealed Resident # 7's cognition was intact. She required extensive to total assistance in the majority of areas of activities of daily living. She was independent in feeding herself after set up.</p> <p>Review of Resident # 7's Care Plan in the area of activities of daily living was last updated on 12/10/12. The Care Plan read in part, "Resident requires extensive to total assist with activities of daily living related to generalized weakness and left sided hemiplegia. Resident is not able to reach lower extremities or dress/bathe right side</p>	F 312	<p>"Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction".</p> <p>Resident #7 was seen by Onsite Podiatry on 03/18/2013. Toenails were trimmed and feet were inspected. Follow up in 9 weeks.</p> <p>92 of 92 resident's feet were examined by Unit Managers to ensure nails were appropriate length and feet in satisfactory condition on 03/29/2013. 81 out of 92 resident's were satisfactory. The other 11 residents are scheduled to be seen at podiatry clinic on 04/09/13.</p> <p>Nurses and certified nursing assistants were in-serviced by Unit Manager on identifying and reporting</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Dwyer, CNHA TITLE: Administrator (X6) DATE: 4/5/13

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.

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F 312	Continued From page 1 of her body." The goal in the area of activities of daily living, read, "Resident will maintain or improve current activities of daily living status without evidence of decline with use of interventions through next review." Interventions in the area of activities of daily living included, "Setting up washing apparatus and supplies and have resident attempt to wash her face. Assist as needed. Provide daily care and care as needed. Encourage resident to assist as tolerated. Finger nails and toe nails checked and cleaned."  Review of a Nursing Note dated 8/17/12 at 10:50 PM, read in part, "Resident observed with sore on her right great toe while being cleaned and changed for the night. Resident complained of pain when in contact with anything or touched. Area cleaned with normal saline and medical doctor notified. Order received to start bactroban. No signs or symptoms of infection noted."  A Nursing Note dated 8/22/13 read in part, "Resident started on doxycycline for ingrown toenail and infection."  Review of a doctor's telephone order dated 12/31/12 read, "(Diabetic) Podiatry Consult-Nail Care."  Review of a Quarterly Interdisciplinary Assessment dated 2/10/13, revealed nothing was checked under the area of foot problems and care.  Review of a facility weekly skin check-Resident record sheet dated February 7th through February 28th revealed no mention of the condition of Resident # 7's toenails.	F 312	issues with resident's feet on 04/01/2013. New hires will be educated during orientation process to ensure continuity of care and compliance.  Foot inspection audits will be conducted by Director of Nursing and/or Unit Manager three times a week for ten residents for four weeks then monthly for three months. These audits will include the entire foot.  These results will be brought into monthly QA&A meeting and reviewed.	4/9/13	

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F 312	<p>Continued From page 2</p> <p>On 3/11/13 at 4:00 PM an observation was made of Resident # 7's toenails on her left foot. Resident # 7 had a half shoe on her left foot which exposed her toes. The left great toenail was thick and appeared to have been cut. Other nails on her left foot appeared to be a quarter of an inch long and curled over the nail bed of each toe. The resident had a shoe on her right foot and no observation was made of toe nails on the resident's right foot.</p> <p>On 3/12/13 at 4:45 PM, an observation was made of Resident # 7's left foot and toe nails. The toenails were in the same condition as the previous day, the left great toenail was thick and had been cut and the other four toenails were about a quarter of an inch long and curled over the nail bed of each toe. Resident # 7 had a shoe on her right foot, therefore her right foot was not observed.</p> <p>During an interview on 3/13/13 at 9:05 AM, Nursing Assistant # 4 revealed she had worked with Resident # 7 since December of last year. She stated she assisted Resident # 7 with bathing, dressing, combing her hair and Resident # 7 completed her mouth care. NA# 4 said Resident # 7 could feed herself after her meal tray was set up. She stated she transferred Resident # 7 into her wheelchair with a mechanical lift. NA # 4 revealed Resident # 7 could wash her face. She stated Resident # 7 could turn with assistance in bed, from left to right but not from right to left. In reference to nail care, NA # 4 stated she cleaned Resident # 7's nails and her family member cut her nails. NA # 4 revealed that if Resident # 7's toenails were too</p>	F 312			

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F 312	<p>Continued From page 3</p> <p>long and needed to be cut she would let the nurse know to put her name on the list to see the Podiatrist.</p> <p>During an interview on 3/13/13 at 10:15 AM, the Director of Nursing (DON) explained that a doctor's order written in December for a Podiatry Consult was for Resident # 7 to be added to a list to be seen by a Podiatrist on March 18th.</p> <p>During an interview on 3/13/13 11:15AM, Staff Nurse# 1 revealed Nursing Assistants cleaned Resident # 7 ' s nails. She stated Resident # 7 had not requested her nails be cut or trimmed. Staff Nurse # 1 explained the podiatrist cut or trimmed Resident # 7 ' s toenails.</p> <p>During an and observation of Resident # 7's toenails on 3/13/13 at 2:15 PM, NA # 4 was present during the observation. Resident # 7's toenails on her right foot appeared to be a quarter of an inch long. The great toe and toenail on Resident # 7's right foot curled over to the second toe. The toe nail on the resident's great toe appeared to be longer than the other nails on her toes. The toenails on Resident # 7's left foot remained the same, the great toe nail appeared to be cut and the toe nails on her other toes curled over the nail bed of each toe.</p> <p>During an interview and observation of Resident # 7's toe nails with the DON on 3/13/13 at 2:30 PM, she explained that with the condition of Resident # 7's feet and because she was diabetic, they would have a podiatrist cut her toenails. She stated Resident # 7's toenails were in bad condition and if she had known about it, it might have been possible to have gotten a podiatry</p>	F 312			

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F 312	Continued From page 4 appointment earlier.  During another interview on 3/13/13 at 2:40 PM, the DON revealed Resident # 7 nor her family member never mentioned anything or complained about the resident's toenails. She revealed it was the first time she had heard anything about Resident # 7's toenails being an issue. The DON revealed Resident # 7 went to the podiatrist for an infected toenail in August, 2012. She stated the resident returned for a follow-up visit in September, 2012, and she revealed that by that time the resident's toe had healed by then. The Director of Nursing stated Nursing staff do skin assessments weekly. She stated the condition of Resident # 7's toenails had not been mentioned to her and if she had known it was an issue she could have sent the resident out to a podiatrist. The DON revealed Resident # 7's Nursing Assistant while assisting with her care should have reported the condition of the resident's toenails.	F 312		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that residents were free of significant medication errors for 1 (Resident #22) of 11 residents observed during medication administration by failing to identify the correct type of insulin to be administered to the resident. The findings include:	F 333	"Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction".	

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F 333	Continued From page 5  Resident #22 was admitted to the facility on 03/13/06 and had diagnoses that included Diabetes Mellitus.  A review of the monthly physician's orders dated March 2013 for Resident #22 revealed an order to check a finger stick blood sugar before meals and at bedtime and to administer the following: "Humulog 100 units/ml (milliliter) sliding scale insulin: Blood sugar - (minus) 150, then divide by 20 = (equals) # (number) of units of insulin to inject."  A review of the resident's Medication Administration Record (MAR) for March 2013 revealed an order to do a finger stick blood sugar before meals and at bedtime and to administer the following: " Humulog 100 units/ml (milliliter) sliding scale insulin: Blood sugar - (minus) 150, then divide by 20 = (equals) # (number) of units of insulin to inject. "  On 03/12/13 at 11:58 AM, Nurse #1 was observed to check a fingerstick blood sugar on Resident #22. The Nurse was observed to do the above calculation and stated that the resident would need to receive 3 units of Humulog Insulin. Nurse #1 was observed to look in the medication cart for the Humulog Insulin but was unable to find the insulin for Resident #22. The Nurse stated that she would check to see if the resident had a bottle of Humulog Insulin in the refrigerator and if not would get a bottle from the E-Kit (Emergency Kit). The nurse returned with a bottle that read: " Humulog 75/25 MIX. " The nurse was observed to draw up 3 units of insulin from the bottle, put the bottle in a drawer of the	F 333	Resident #22 received a new bottle of insulin that afternoon. Nurse #1 was educated on different insulin's, usage, side effects and administration by Director of Nursing on 03/29/2013.  Any resident receiving insulin had the potential of being affected by this alleged deficient practice.  Licensed nurses will be educated by Medipack Pharmacist on the different types of insulin, there usage, side effects and administration on 04/02/2013. New hired licensed nurses will be educated on same information during the orientation process by Director of Nursing and/or Staff Development Coordinator.		

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F 333	<p>Continued From page 6</p> <p>medication cart, closed the MAR and turned to enter the resident ' s room with the syringe of insulin. The nurse was stopped and asked to recheck the bottle of insulin. The nurse removed a bottle of Humulog 75/25 Mix Insulin from the medication cart and looked at the bottle. The nurse was asked what the 75/25 Mix was and the Nurse stated: " It is Humulog Insulin. " The nurse then stated that she would go and ask another nurse. Nurse #1 was observed to ask the wound care nurse about the insulin. The Wound Care Nurse stated that the 75/25 mix was a longer acting insulin mixed with a shorter acting insulin.</p> <p>According to the manufacturer, Humulog Insulin is a blood glucose-lowering agent with a rapid onset and a short duration of action and should be given within 15 minutes before or immediately after a meal. Humulog 75/25 MIX is a combination of a short acting insulin combined with an insulin that has a prolonged action that peaks in 30-240 minutes after dosing.</p> <p>On 03/12/13 at 12:21 PM, Nurse #1 stated in an interview that she thought that the Humulog 75/25 mix was the same as Humulog Insulin. The Nurse stated: " The bottle said Humulog. "</p> <p>The Director of Nursing (DON) stated in an interview on 03/13/13 at 2:25 PM that Nurse #1 was a new nurse. The DON stated that she needed to do inservices with the nurses to ensure they understood the differences between the insulins.</p>	F 333	<p>Medication administration audits will be performed by observing insulin administration by Director of Nursing or Unit Manager three times a week for four weeks and then monthly for four months.</p> <p>These results will be brought into monthly QA&amp;A meeting and reviewed.</p>	4/9/13
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	<p>Continued From page 7</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide food prepared in a form to meet the needs of residents receiving puree diets.</p> <p>The undated Facility Food Service Policy reads as follows: " Policy: the facility provides and each resident receives food that is: *prepared by methods that conserve nutritive value, flavor and appearance. *palatable, attractive and at the proper temperature and *prepared in a form designed to meet individual needs. "</p> <p>The Academy of Nutrition and Dietetics defines a Puree diet as, a diet consisting of foods that are easy to swallow. Food should be " pudding like. " Pureed foods prepared in advance are the consistency of pudding or moist mashed potatoes. "</p> <p>During an observation on 3/11/13 at 12:10 PM, residents in the small dining room were observed eating pureed meals. The puree hot dog, hot dog bun, green vegetable and baked beans was observed to be runny with a thin consistency with foods touching on the plate.</p>	F 364	<p>"Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction".</p> <p>At the time of the alleged deficient practice was found, present dietary staff were in-serviced at that time on following puree recipe to ensure correct consistency.</p> <p>31 of 92 residents were found to have potential to be affected by the deficient practice.</p> <p>After the alleged deficient practice was found, dietary staff was in-serviced on proper preparation of puree foods per the recipes. Newly hired dietary staff will be educated on puree recipes upon hire during orientation.</p>		



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F 364	<p>Continued From page 8</p> <p>During a kitchen observation on 3/12/13 at 12:07 PM the cook was observed plating up food. The cook was observed to plate up a puree meal onto a divided plate and hand to staff that covered the plate and placed into the meal cart. The cook then plated up two puree meals onto dinner plates and handed to staff that covered the plate and placed into the meal cart. The puree beef pot pie and yellow squash was observed to be runny with a thin consistency with foods touching on the plate. The puree bread and mash potato was observed to have a smooth, pudding like consistency.</p> <p>During an interview on 3/12/13 at 12:13 PM the cook indicated she had followed the facility recipe for puree food.</p> <p>During an interview on 3/12/13 at 12:14 PM the Dietary Manager stated, " I expect the puree food to look right and staff to follow the recipe. I will do an In-Service right after the meal. "</p>	F 364	<p>The dietary manager will observe the puree food before served to residents for 3 times a week for 4 weeks, then 1 time a week for 3 months to ensure proper consistency.</p> <p>These results will be reviewed in the QA &amp; A meeting monthly.</p>	4/9/13
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CONSTRUCTION SECTION

NAME OF PROVIDER OR SUPPLIER  LITCHFORD FALLS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8200 LITCHFORD ROAD RALEIGH, NC 27615
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K 000	INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (111) construction, one story, with a complete automatic sprinkler system.	K 000		
K 012 SS=D	The deficiencies determined during the survey are as follows: NFFA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012	K 012 The ceiling exhaust fans in the soiled linen And the bio-hazard rooms are protected With fire dampers To meet NFPA 101 standards. As further inspected by Progressive HVAC. UL listed Fire dampers. With Fused links are present.  Noted ceiling exhaust fans will Be photographed with the covers off For easier future inspections.	5-1-13
K 029 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 04/17/2013 there were unprotected ceiling exhaust fans in the soiled linen and the bio-hazard rooms. 42 CFR 483.70 (a) NFFA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K 029 The problem will not re-occur as dampers are permanent fixtures and maintenance Will keep a copy of the pictures in the Maintenance log book.  Photographs of the vents will be included In with the monthly QA meeting for future Reference if needed.  Vent dampers and fans were inspected on April 30 2013 by the HVAC company And photographs were taken with the covers Off May 1 <sup>st</sup> 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Helen Jones* TITLE *Administrator* (X6) DATE *5/6/13*

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.

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NAME OF PROVIDER OR SUPPLIER  LITCHFORD FALLS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8200 LITCHFORD ROAD RALEIGH, NC 27616	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1  This STANDARD is not met as evidenced by: A Based on observation on 04/17/2013 the door to the dry storage room in the kitchen was propped open. B. Across from the residents personal supply room is a gas fired water heater in a room with only a twenty (20) minute door . This room must have at least a 3/4 hour self closing door. C. The Activities Room is greater than 100 sq. feet and storing a large amount of combustables and must have a closer on the door. 42 CFR 483.70 (a)	K 029	K 029 A. The dry storage room door in the Kitchen will no longer be propped open.  All facility doors with self closure Devices will be checked weekly at Random by the maintenance director To ensure none are propped open.  The dietary staff will be in-serviced by the maintenance director to ensure They understand the door can not be Propped open  The safety committee will check door On monthly inspections and document Status of door on the dietary inspection form. This will be reported At the monthly QA meeting for six Months.  The dietary staff will be in-serviced by May 17 <sup>th</sup> 2013.	5-17-13

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  LITCHFORD FALLS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8200 LITCHFORD ROAD RALEIGH, NC 27615	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1  This STANDARD is not met as evidenced by: A Based on observation on 04/17/2013 the door to the dry storage room in the kitchen was propped open. B. Across from the residents personal supply room is a gas fired water heater in a room with only a twenty (20) minute door . This room must have at least a 3/4 hour self closing door. C. The Activities Room is greater than 100 sq. feet and storing a large amount of combustables and must have a closer on the door. 42 CFR 483.70 (a)	K 029	B. Across from the residents personal Supply room, the gas fired water heater Room door was replaced with a ¾ hour Fire rated Self closing door.  Maintenance director will check all other water heater room doors to verify the proper Doors are installed, and correct if necessary.  The maintenance director will be in-serviced By the administrator on NFPA 101 Life Safety Code Standard pertaining to One Hour fire rated Construction ( with ¾ fire rated doors)  All water heater room doors will be Checked Monthly by the maintenance director to Ensure compliance and proper operation.  Adminstrator will in-service the maintenance Director by May 17 <sup>th</sup> 2013.  K 029	5-17-13
			C. The activity room door has been modified to Include a self closing Device.  All spaces greater than 100 square feet will Be Checked for large amounts of combustibles.  A Self closure device will be installed if needed.  The monthly safety committee will include Inspections of any spaces used for storage And if a self closing device is needed, it Will be installed.  The findings of the safety committee will Be Reported at the monthly QA meeting for six Months.  Self closure was installed on the activity Room door April 30 <sup>th</sup> 2013.	4-30-13