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 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITCHFORD FALLS HEALTHCARE & REHABILITATION CENTER	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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/05/25 through 05/08/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #F6HD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/05/25 through 05/08/25. Event ID #F6HD11. The following intakes were investigated NC00230046, NC00229158, NC00228674, NC00228451, NC00228295, NC00227847, NC00227803, NC00227688, NC00225528, NC00225499, NC00223965, NC00223115, NC00222246, NC00220808, and NC00221325. 13 of the 57 allegations resulted in a deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		6/5/25

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

Electronically Signed | 05/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean and maintain in good repair the floors, walls, and the individual heating and air conditioning units (PTAC units) in 5 of 7 resident rooms (Room #304, #305, #306, #308, and #309) on 1 of 3 halls observed for a clean, comfortable and homelike environment (300 Hall). The findings included: Accompanied by the facility's Maintenance Director, a tour of seven (7) residents' rooms on the 300 Hall was conducted on 5/7/25 from 3:00 PM to 3:20 PM. Concerns related to the	F 584	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilitys allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F584 1. Address how the corrective action will be accomplished for those residents	

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F 584	Continued From page 2 cleanliness and condition of five of these rooms included the following: --Room #304: An observation of Room 304 was conducted. Two of the vent louvers on the PTAC unit were observed to be broken. The filter/coils of the unit were observed to be dirty with multiple light tan and dark brown particles lying on top of the surface inside the unit. The unit appeared to be detached from the wall on its right side. The Maintenance Director also noted that one of the two filters for the PTAC unit was missing. He acknowledged one side of the unit was pulling away from the wall and needed to be re-attached. --Room #305: An observation of Room 305 revealed 1 of 4 front vents on the PTAC unit had a brown, dried substance ranging from ¼ to 1 inch in width and running all the way down the front of the unit's cover. The baseboard and flooring near the PTAC unit appeared dirty and covered with a dark gray substance. Also, the plastic plate covering an electrical outlet near the PTAC unit was observed to be broken with the top 2-inches of the outlet cover missing. --Room #306: An observation of Room 306 was conducted with the Maintenance Director. Four (4) floor tiles located at the foot of Bed A were observed to be damaged with several deep scratches/etching of the tiles. The Maintenance Director reported these tiles would have to be replaced. --Room #308: An observation of Room 308 was conducted. A dark gray/black adhesive located between 3 floor tiles appeared to have seeped out from under the tiles and dried. The Maintenance Director reported the adhesive could possibly be cleaned off the tiles. If not, he	F 584	found to have been affected by the deficient practice. The PTAC units for rooms #304, 305 and 308 were replaced by the maintenance director on 5/12/25. The PTAC unit for room 306 and 309 has been cleaned and is working at this time. PTAC replacements for these two rooms have been ordered and will be replaced by the Maintenance director when they arrive at the facility. The area around the PTAC units for room #304, 305, 306, 308 and 309 have been cleaned including the baseboard and flooring near and around the PTAC unit on 5/12/25. The electrical outlet cover near the PTAC unit was replaced by the maintenance director on 5/8/25. Identified floor tiles with deep scratches/etching were replaced in room #306 by the maintenance director on 5/8/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in occupied rooms are at risk of being affected by the deficient practice. All occupied residents' rooms were inspected for clean, intact PTAC units, Intact and undamaged electrical outlet covers and intact floor tiles by the maintenance director and housekeeping on 5/8/25. 3. address what measures will be put into place, and systemic changes made to	

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F 584	Continued From page 3 reported the floor tiles may need to be replaced. --Room #309: An observation of Room 309 revealed the room's PTAC had multiple pieces of debris visible from its top vents lying on the filter/coils inside the unit. The debris included rubber bands and several pieces of brown, unidentified substances. The control panel on the right side of the unit was dusty/dirty with a dark gray and brown substance covering the surface. Upon conclusion of the room tour, the Maintenance Director reported his department worked with the Housekeeping Department to take care of issues such as those observed during the tour. An interview was conducted with the facility's Housekeeping Director on 5/8/25 at 3:25 PM. During the interview, the concerns identified during the tour of the residents' rooms were discussed. The Housekeeping Director reported that his staff was responsible to clean each room daily. The "daily clean" included emptying the trash, checking supplies, wiping down all horizontal and vertical surfaces, sweeping the room (corner to corner) and wet mopping the floors. When specifically informed of the observations of the PTAC units, the Director reported the Housekeeping Department was responsible to clean the outside surfaces of the units while the Maintenance Department took care of the inside. An interview was conducted on 5/8/25 at 4:20 PM with the facility's Administrator in the presence of the Regional Consultant. During the interview, the maintenance and housekeeping concerns identified were discussed. When asked, the Administrator reported she would expect the	F 584	ensure that deficient practice will not occur. All occupied resident rooms will be inspected for clean, intact PTAC units , intact and undamaged electrical outlet covers , and intact floor tiles by the maintenance director weekly , additionally facility staff will be instructed and educated to report identified needs to PTAC , electrical and floor repairs to Maintenance director and housekeeping director , any identified needs will be reviewed on a daily basis during the morning stand up meeting by the administrator , maintenance director and housekeeping director. Education was provided to the maintenance director on 5/11/25 by Administrator. Education was provided to the housekeeping director on 5/11/25 by the Administrator. Education was provided to the facility staff on 5/11/25 by the Administrator. 4. Indicates how the facility plans to monitor its performance to make sure the solutions are sustained. The maintenance director and housekeeping director will review requests for identified needs for housekeeping and repairs daily , and report progress of completed audits of room inspection for PTAC units , electoral outlet covers and floor tiles weekly x 4, than every other week x 2 , than monthly with results	

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F 584	Continued From page 4 residents' rooms to be clean, filters changed on the PTAC units as needed, and equipment kept in working order.	F 584	presented at the monthly QAPI meeting until the IDT concludes the goal has been achieved The Administrator will audit each room daily Monday through Friday for 30 days and then 10% weekly thereafter to ensure all PTAC units are functioning and in good working order. 5. compliance date 6/5/25	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 641		6/5/25

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F 641	Continued From page 5 subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment to reflect the use of an antibiotic (Resident #4) and failed to complete an MDS at discharge (Resident #20). This occurred for 2 of 41 residents whose MDS assessments were reviewed. The findings included: 1. Resident #4 was admitted to the facility on 8/14/11 with re-entry on 7/26/24 from a hospital. His cumulative diagnoses included non-Alzheimer's dementia and a neurogenic bladder (a condition where the urinary bladder lacks control due to nerve or muscle problems). The resident's care plan included the following area of focus, in part, "The resident requires a suprapubic catheter [a urinary catheter that is inserted into the bladder from a small incision in the lower abdomen] related to neurogenic bladder ..." (Date Initiated: 7/27/24). Resident #4's electronic medical record (EMR) indicated a physician's order was received on 3/3/25 for 1 gram (g) of ertapenem (an intravenous antibiotic) to be administered one time a day for 7 days to treat a UTI. A review of the resident's March 2025 Medication Administration Record (MAR) revealed the ertapenem was administered to Resident #4 on 3/4/25 and 3/5/25 (in accordance with the	F 641	F641 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #4 was reassessed and their Minimum Data Set (MDS) was corrected and transmitted to reflect the use of antibiotic in section N on 05/08/2025. Resident #20 was reassessed and their Discharge MDS was completed on 5/8/25 and transmitted to CMS on 5/9/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Regional MDS nurse or designee will complete an audit by 6/5/25 of all active residents most recent MDS assessments to ensure accurate coding of antibiotic in section N. MDS modifications will be completed to correct erroneous coding of antibiotics. There were no discrepancies noted. The Regional MDS nurse or designee will complete an audit by 6/5/25 of discharged residents in the last 30 days to ensure the Discharge MDS was completed and transmitted to CMS. Missed discharges will be completed and transmitted to CMS. There were no discrepancies noted.	

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F 641	Continued From page 6 physician's orders) as part of the prescribed antibiotic treatment regimen. Resident #4's most recent MDS was a quarterly assessment dated 3/5/25. The Bladder and Bowel section of the MDS assessment reported the resident had an indwelling urinary catheter. However, the Medication section of this assessment did not report this antibiotic was administered to Resident #4 during the 7-day look back period from 2/27/25 to 3/5/25. An interview was conducted on 5/8/25 at 1:45 PM with MDS Nurse #1 and the facility's Regional MDS Nurse. During the interview, Resident #4's MDS assessment was discussed. Upon review of his 3/5/25 quarterly MDS, the Regional MDS Nurse confirmed this assessment did not indicate the resident received an antibiotic. However, it was noted that Resident #4's March 2025 Medication Administration Record (MAR) documented he was administered the ertapenem on 2 days (3/4/25 and 3/5/25) during the 7-day look back period. MDS Nurse #1 reported the 3/5/25 MDS assessment would need to be corrected to reflect the use of an antibiotic given during the look back period. An interview was conducted on 5/8/25 at 4:20 PM with the facility's Administrator in the presence of the Regional Consultant. When asked, the Administrator reported she would expect the MDS information to be accurate. 2. Resident #20 admitted to the facility on 11/6/24. A nursing progress note dated 11/17/24 noted Resident #20 discharged home with a family	F 641	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The MDS nurse will review the Medication Administration Records in the look back period and code high-risk medications according to their drug classification. The MDS nurse will run the Point Click Care (PCC) Action Summary Report daily to ensure discharge assessments are opened and completed per the RAI manual. The Regional MDS nurse will provide immediate, focused training to all MDS staff in assessments specific to proper coding of high-risk medication in section N by 6/5/25. The Regional MDS nurse will provide immediate, focused training to all MDS staff in assessments specific to proper and timely scheduling, completing, and transmitting Discharge MDSs by 6/5/25. The Regional MDS nurse or designee will audit five MDS assessments three times a week x 2 weeks, twice a week x 2 weeks, once a week x 1 week, and then once a month x 3 months. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Results of the audit will be reported by MDS nurse to Quality Assurance Committee (QAPI) Meeting x1 month for 3 months for further resolution if needed. 5.Date of Compliance: 06/05/25	

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F 641	Continued From page 7 member. Review of the Minimum Data Set (MDS) assessments for Resident #20 did not include a Discharge MDS assessment. In an interview on 5/08/25 at 4:45 PM, MDS Coordinator #1 stated the Discharge MDS assessment should have been completed when Resident #20 discharged and it was an oversight and was missed. In an interview on 5/08/25 at 5:08 PM, the Administrator stated the MDS was missed and should have been done.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		6/5/25

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F 657	Continued From page 8 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to accurately care plan the interventions related to smoking for 1 of 2 residents reviewed and identified as an independent smoker (Resident #58). The findings included: Resident #58 was admitted to the facility on 6/4/24 with re-entry from a hospital on 6/21/24. His cumulative diagnoses included a history of respiratory failure. Resident #58's most recent MDS was a quarterly assessment dated 3/13/25. The MDS revealed this resident had intact cognition. The MDS assessment indicated Resident #58 required set-up or clean-up assistance only for most of his Activities of Daily Living (including eating, toileting, dressing, personal hygiene, bed mobility sit to stand, and chair/bed to chair transfers). Resident #58's most recent Smoking Safety Screen was dated 4/24/25. The last section of the screening was checked to indicate the resident could smoke independently. However, this screen also indicated Resident #58 required supervision for smoking.	F 657	F657 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #58 was reassessed and their Care Plan was corrected to reflect the correct smoking interventions on 5/8/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Regional Minimum Data Set (MDS) nurse will complete an audit of the Care Plans for residents who smoke to ensure it is resident specific and accurate by 6/5/25. Discrepancies will be corrected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The MDS nurse will review the Smoking UDA and verify the interventions by talking to the resident and staff and ensure the care plan is accurate. The care plan will be revised as changes occur per staff and resident□s reports. The Regional MDS nurse or designee will	

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F 657	Continued From page 9 The resident's current care plan included the following area of focus: The resident prefers to smoke (Date Initiated: 12/24/24; Date Revised 4/24/25). The planned interventions noted the following, in part: --May smoke independently (Date Initiated: 12/24/24); --Smoking assessment as needed (Date Initiated: 12/24/24); --Supervise with smoking (Date Initiated: 4/24/25). Upon entrance to the facility on 5/5/25, the facility provided a current list of residents who smoked. Resident #58 was one of two residents listed who was identified as an "Independent" smoker. An interview was conducted on 5/7/25 at 11:35 AM with the Unit Manager for Resident #58's hallway. During the interview, the Unit Manager stated Resident #58 was an independent and safe smoker. She reported the resident could (and did) frequently go out to smoke every day unsupervised. An interview and observation were conducted on 5/8/25 at 9:40 AM with Resident #58. At that time, the resident reported he was an independent smoker. He stated that being an independent smoker meant he did not need to be supervised and that he could smoke at times of his choosing. An interview was conducted on 5/8/25 at 1:45 PM with MDS Nurse #1 and the facility's Regional MDS Nurse. During the interview, the conflicting smoking interventions on Resident #58's care plan were discussed. When asked, the MDS Nurses reviewed Resident #58's care plan. The	F 657	audit the Care Plans of five residents who are smokers three times a week x 2 weeks, twice a week x 2 weeks, once a week x 1 week, and then once a month x 3 months. The Regional MDS nurse will provide immediate, focused training to all MDS staff proper resident specific care planning related to smoking by 6/5/25. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Results of the audit will be reported by MDS nurse to Quality Assurance Committee (QAPI) Meeting x1 month for 3 months for further resolution if needed. Date of Compliance: 06/05/25	

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F 657	Continued From page 10 MDS nurses agreed the care plan should indicate that either the resident was a safe smoker and could smoke independently or he required supervision for smoking (one or the other). MDS Nurse #1 confirmed Resident #58 was an independent smoker. She also noted that MDS was ultimately responsible to make any revisions and updates on the residents' care plan. The Regional MDS Nurse stated they would need to review this area of focus on Resident #58's care plan further. She added, "We will update that." An interview was conducted on 5/8/25 at 4:20 PM with the facility's Administrator in the presence of the Regional Consultant. During the interview, concern related to the conflicting information on Resident #58's Smoking Safety Screen and care plan were discussed. When asked, the Administrator reported she would expect the residents' care plans to be accurate.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide routine fingernail care for a dependent resident, and shave a resident's facial hair in accordance with his preference to be clean shaven. This occurred for 1 of 7 dependent residents (Resident #4) reviewed for Activities of Daily Living (ADLs).	F 677	F677 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident number 4 Fingernails were cleaned and trimmed 5/8/25. 2. Address how the facility will identify other residents having the potential to be	6/5/25

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	345499	A. BUILDING _____ B. WING _____	C 05/08/2025

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F 677	Continued From page 11 The findings included: Resident #4 was admitted to the facility on 8/14/11 with re-entry on 7/26/24 from a hospital. His cumulative diagnoses included non-Alzheimer's dementia and contractures of both hands. The resident's care plan included the following area of focus, in part, --The resident requires assistance with Activities of Daily Living (ADL) related to chronic health conditions and inability to perform ADL (Date Initiated: 7/27/24). Resident #4's most recent MDS was a quarterly assessment dated 3/5/25. Resident #4 was assessed to have moderately impaired cognition. He did not exhibit any behaviors or rejection of care. The MDS assessment indicated Resident #4 was totally dependent on staff for bathing and personal hygiene. An observation was conducted on 5/5/25 at 12:44 PM of Resident #4 as he was lying in bed. Only the resident's fingernail of his forefinger on the left hand was visible at that time. The fingernail was observed to be 1/2 inch long beyond the nail bed with a dark brown/black substance present underneath the nail. He was observed to have facial hair during the initial observation. A second observation and an interview was conducted on 5/5/25 at 3:41 PM with Resident #4 as he was lying in bed. The resident's facial hair was noted to be approximately 1/2 inch long. All fingernails were visible on both of his hands at that time. Each of his fingernails were at least 1/2 inch long beyond the nail bed and were	F 677	affected by the same deficient practices: All residents were assessed for routine fingernail and facial hair shaving by unit managers, residents with the need for routine fingernails and facial hair care, and preferences for staff to perform nail and facial hair care, had care completed on 5/11/25. Nursing staff were educated on nail and facial hair care on 5/11/25 by the Director of Nursing. 3. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not occur. To ensure that all residents receive routine fingernails and facial hair care, the director of nursing and or designee will review shower schedules with completes fingernail and facial hair care in the morning meeting, Nursing staff were educated on 5/11/25 . All new hires will receive this education in orientation by the DON or designee during training. All employees who have not received this education will not work until it is completed. 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. The director of nursing will audit shower schedule and completed to ensure fingernail and facial hair care completion for residents weekly x4 weeks, biweekly	

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F 677	Continued From page 12 discolored brown with a darker brown substance appearing underneath each nail. When the resident was asked if staff would help him to trim his nails, he did not reply. Upon further inquiry as to whether he preferred to have a mustache and beard (facial hair) or to be clean shaven, Resident #4 stated he wanted to be shaved. Another observation and interview was conducted on 5/6/25 at 11:15 AM of Resident #4. At that time, the resident's fingernails were observed to be clean and neatly trimmed down to be approximately 1/8 inch long. The resident was not shaved. Upon inquiry, the resident reported "the activities lady from BINGO" came and trimmed his fingernails. When asked, the resident reiterated that he did want to be shaved. On 5/7/25 at 4:10 PM, an interview was conducted with Activities Staff Member #1. This staff member was identified as having recently trimmed Resident #4's fingernails. During the interview, the Staff Member reported that a family member had requested that she check Resident #4's fingernails, so she did. When asked to describe what his fingernails looked like when she went to clean and trim them, she stated, "They were horrible." Upon further inquiry, the Activities Staff Member estimated Resident #4's fingernails were approximately 1/2 inch above the nail bed and were very brown with "dirt under them." The Activities staff member reported she used to be an NA. She stated the NAs were supposed to clean/trim fingernails and shave residents in accordance with the resident's preference. On 5/7/25 at 11:17 AM, an interview was conducted with Nurse Aide (NA) #1. NA #1 was	F 677	x2, then monthly with results presented at the monthly QAPI meetings until IDT concludes the goal has been achieved 5. Compliance date 6/5/25.	

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F 677	Continued From page 13	F 677		

identified as the nurse aide who was assigned to care for this resident on the first shift of 5/6/25 and 5/7/25. Upon inquiry, the NA reported Resident #4's bath days were on Tuesdays and Fridays. She stated the resident was given a "really good" bed bath on 5/6/25 (a Tuesday). When asked what his shower days typically involved, the NA stated she would bathe or shower him and clean his teeth with a toothette swab (a small sponge). The NA stated she knew she was not supposed to trim his toenails but wasn't sure if she was allowed to trim his fingernails because she was relatively new to the facility. When asked, the NA confirmed the resident's fingernails had been very long (at least ½ inch long) and brown prior to being trimmed by Activities. Upon further inquiry, the NA stated she was responsible for shaving female residents if needed, but reported the facility's Scheduler shaved the male residents.

An interview was conducted on 5/7/25 at 11:26 AM with the facility's Scheduler. During the interview, the Scheduler reported he shaved the male residents only when he cut their hair. The Scheduler stated that to his knowledge, the NAs typically shaved male residents who wanted to be shaved on the resident's shower days.

An interview was conducted on 5/8/25 at 4:20 PM with the facility's Administrator in the presence of the Regional Consultant. During the interview, the observation of Resident #4's fingernails and facial hair were discussed. The Administrator reported she would expect facility staff to provide care exactly as the resident preferred, including grooming his/her fingernails and shaving facial hair. She stated a resident's fingernails should typically be cleaned/trimmed on his/her bath days

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F 677	Continued From page 14 and as needed.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a medication cart in clean and sanitary conditions for 1 of 2 medication carts reviewed for medication storage (100 West medication cart). The findings included:	F 761	F761- Medication carts 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practices: The medication cart on 100 West Hall	6/5/25

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F 761	Continued From page 15 An observation and interview on 05/08/2025 at 02:25 PM with Nurse#2, Unit Manager, revealed red, clear and white dried substances and pink and white powder on the bottom of the second drawer of the 100 West medication cart. The observation also revealed 6 loose circular, partially dissolved white pills on the bottom of the second drawer of the 100 West medication cart. Nurse #2, Unit Manager, stated that nurses were expected to keep the medication carts clean and dispose of loose pills. Interview with DON on 05/08/2025 at 02:35 PM revealed that she expected the nursing staff to practice according to safety and regulatory standards independently and for the unit managers to monitor and maintain compliance. Medication carts should be maintained daily, each nurse on each shift was responsible for keeping the medication cart clean. An interview with the Administrator on 05/08/2025 at 02:48PM revealed that she expected the DON to ensure that Nursing Staff and Unit Managers were maintaining medication carts and areas according to safety and regulatory standards.	F 761	was inspected and cleaned on May 7th, 2025. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All medication and treatment carts have the potential to be affected by this same deficient practice. All medication and treatment carts were inspected for cleanliness, including fluid and debris by May 8th, 2025. Of the 4 medication carts and 2 treatment carts, No additional carts needed to be cleaned at this time. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing staff were educated on medication cart cleanliness and maintenance on May 8th, 2025 by Director of Nursing. Any nurse that has not completed the in-service will not be allowed to work until education is received. All new hires will receive education during the orientation process by the Director of Nursing or designee. To ensure that medication and treatment carts remain clean and free of debris, the Director of Nursing or designee will inspect medication and treatment carts 5	

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F 761	Continued From page 16	F 761	times a week for 4 weeks, then 3 times a week for 4 weeks and then weekly for 4 weeks. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The results of the medication and treatment cart audits will be presented at the monthly QAPI meeting until the Interdisciplinary Team concludes the goal has been achieved. 5) Compliance Date: June 5, 2025	