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	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [ROOM NUMBER], #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 cleanliness and condition of five of these rooms included the following: --room [ROOM NUMBER]: An observation of room [ROOM NUMBER] 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 [ROOM NUMBER]: An observation of room [ROOM NUMBER] 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 [ROOM NUMBER]: An observation of room [ROOM NUMBER] 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 [ROOM NUMBER]: An observation of room [ROOM NUMBER] 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 reported the floor tiles may need to be replaced. (continued on next page)

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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--room [ROOM NUMBER]: An observation of room [ROOM NUMBER] 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 residents' rooms to be clean, filters changed on the PTAC units as needed, and equipment kept in working order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #20 admitted to the facility on [DATE]. A nursing progress note dated 11/17/24 noted Resident #20 discharged home with a family 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. 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 [DATE] 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 physician's orders) as part of the prescribed antibiotic treatment regimen. Resident #4's most recent MDS was a quarterly assessment dated [DATE]. 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. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE]. 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. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included: Resident #4 was admitted to the facility on [DATE] 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 [DATE]. 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 and as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 [NAME] medication cart). The findings included: 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 [NAME] medication cart. The observation also revealed 6 loose circular, partially dissolved white pills on the bottom of the second drawer of the 100 [NAME] 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.