STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 05/23/2025

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/19/25 through 5/23/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RRI211.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 5/19/25 through 5/23/25. Event ID #RRI211. The following intakes were investigated: NC00219605, NC00220707, NC00220869, NC00220981, NC00222546, NC00222580, NC00222618, Nc00223121, NC00223130, NC00223322, NC00224025, NC00224152, NC00224157, NC00224290, NC00224364, NC00225812, NC00226020, NC00226162, NC00227704, NC00228488, NC00228845, NC00229487, NC00229727, NC00229772, NNC00230026 and NC00230429. 27 of the 94 complaint allegations resulted in deficiencies.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to place a resident's	F 558	The facility sets forth the following plan of correction to remain in compliance with all	6/20/25

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

Electronically Signed | 06/20/2025

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F 558	Continued From page 1 adaptive flat call light device within reach to allow for the resident to request assistance if needed for 1 of 4 residents reviewed for accommodation of needs (Resident #81). Findings included: Resident #81 was admitted to the facility on 9/14/2022 with diagnoses including legal blindness. The quarterly Minimum Data Set (MDS) dated 4/26/2025 indicated Resident #81 was moderately cognitively impaired, had no impairments with range of motion to both upper body extremities and was dependent on staff assistance for all mobility in and out of the bed. Resident #81's revised care plan dated 4/27/2025 indicated Resident #81 was legally blind. There was no intervention for keeping the call bell in the reach of Resident #81. On 5/19/2025 at 11:01 am, Resident #81 was observed lying in the bed with her head of the bed elevated and an adaptive flat call bell was observed attached to the upper right corner of the mattress cover with the call bell hanging toward the back side of the mattress. When Resident #81 was asked where the call ball was located, Resident #81 was observed moving her hands against the bed on each side of her body to search for the adaptive flat call bell. Resident #81 explained she was blind and stated she did not know where the call bell was located at that moment. When Resident #81 was informed where the adaptive call bell was located (hanging on the right corner of the mattress), Resident #81 stated she was unable to reach the adaptive flat	F 558	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 facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F558 Reasonable accommodations What corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1. The adaptive call bell was immediately secured within reach of Resident #81 by the assigned Certified Nursing Assistant on 5/20/25. How will the facility identify other residents having the potential to be affected and what corrective action will be taken? 2. All residents with an adaptive call bell have the potential to be affected by the deficient practice. On 5/21/25 all residents with adaptive call bells were checked immediately to ensure they were in reach and accessible to the residents by the Director of Nurses (DON). No other residents were identified as being affected by the deficient practice. What measures will be put into place or what systemic changes will be made? 3. All staff will be educated on call bell placement by the Staff development coordinator. This education will be completed by 6/19/25. All staff hired after 6/19/25 will receive this training during orientation. Staff that have not received this training will not be allowed to work	

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F 558	Continued From page 2 call bell. Resident #81 needed assistance with incontinence care, and Nurse #2 was informed of the Resident #81 needs. On 5/20/2025 at 4:51 pm, Resident #81 was observed lying in the bed and the adaptive flat call bell was observed lying in a chair positioned four feet from the right side of the bed. Resident #81 was observed attempting to locate the call bell on the bed and stated she was unable to locate the adaptive flat call bell. Resident #81 stated "they (nursing staff) put the call bell where they want to". On 5/20/2025 at 4:56 pm in an observation and interview with Nurse Aide (NA) #2 who was assigned Resident #81, she stated Resident #81 communicated her needs to staff when they were making rounds. NA #2 stated Resident #81 was checked every hour and when she was last in Resident #81's room thirty minutes ago, Resident #81's call bell was on the bed. NA #2 stated she had no idea Resident #81's call bell was in the chair and the call bell should be clipped to the bed in Resident #81's reach. NA #2 was observed moving the adaptive flat call bell to Resident #81's right side of the bed and informing Resident #81 where the adaptive flat call bell was located. NA #2 stated Resident #81 was unable to get out of bed independently to move the call bell into the chair beside the bed. On 5/21/2025 at 3:50 pm, Resident #81 was observed resting in the bed with a push button call bell positioned on the right side of the bed beside Resident #81. On 5/22/2025 at 8:38 am in an interview with Nurse #2, she stated Resident #81 was able to	F 558	until it is received. All staff will ensure call bells are in reach of residents upon exiting a room. The assigned nurse on duty to each unit will monitor call bell placement throughout their shift to ensure compliance with corrective action occurring immediately as needed. The DON and/or unit manager will monitor call bell placement 5 days a week for 4 weeks, then 3 days per week for 4 weeks and weekly for 4 weeks. All new hires after 6/18/25 will receive this education during orientation. Staff will not be allowed to work until this education is received. How the corrective actions will be monitored to make sure solutions are sustained? The DON will report all the findings of the call bell monitoring audits to QAPI monthly for 3 months. The process will be adjusted as needed with any identified concerns to ensure compliance until there is substantial compliance. Date of Compliance: 6/20/25	

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F 558	Continued From page 3 use the adaptive flat call bell to call for assistance as needed and had always known Resident #81 to use the adaptive flat call bell. She stated Resident #81's call bell was to be within reach for use and when the call bell was observed hanging from the right corner of the mattress (5/19/2025) and in the chair (5/20/2025), the call bell was not in the reach of Resident #81. On 5/22/2025 at 8:40 am in an interview with the Director of Nursing, she stated Resident #81 could use the adaptive flat call bell to call for assistance and Resident #81's adaptive flat call bell should be in the reach of Resident #8. The DON stated Resident #81's adaptive flat call bell should not have been changed to a push button call bell due to Resident #81's blindness and the possibility of Resident #81 missing the button to call for help. On 5/21/2025 at 8:49 am in an interview with Nurse #8, she stated Resident #81 required an adaptive flat call bell and the reason Resident #81 was observed with a push button call bell (5/22/2025) was because the adaptive flat call bell for Resident #81 and the push button call bell for Resident #81's roommate had been switched. On 5/23/2025 at 11:30 am in an interview with the Administrator, she stated Resident #81 adaptive flat call bell should be positioned within the reach of the resident	F 558		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		6/20/25

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F 600	Continued From page 4	F 600		

neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review, and Physician and staff interviews, the facility failed to protect a resident's right to be free from abuse when a cognitively intact resident (Resident #326) hit a moderately cognitively impaired resident (Resident #325) on his arms with an ashtray holder. Resident #325 sustained 3 small skin tears on his left forearm, left elbow, left posterior arm, and right ring finger. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #325).

The findings included:

Resident #326 was admitted to the facility on 7/2/24 and was discharged on 11/7/24. His diagnoses included osteomyelitis, anxiety disorder, depression, and hallucinations.

Resident #326's admission Minimum Data Set (MDS) assessment dated 9/16/24 revealed he was cognitively intact. He was independent with upper body dressing, rolling left and right, sitting to lying, lying to sitting on side of bed, picking up an object, wheeling 50 feet with 2 turns, and wheeling 150 feet. He required partial/moderate

F600

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Resident #326 and Resident #325 were separated immediately.
Resident #326 was placed on 1 :1 supervision after the altercation with resident #325.
The local police department was notified and came on site to interview the residents. Both residents stated they had a misunderstanding and no charges were filed. Adult Protective Services was also notified on 9/30/2024.
Resident #325 received treatment to the skin tears to his left upper arm in house by the treatment nurse on 9/30/2024. The skin tears healed on 10/15/2024.
Resident #326 was also seen on 10/4/2024 by the Psychiatry provider who recommended he continue on psychotherapy sessions and maintain

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F 600	Continued From page 5 assistance with toileting hygiene, showering/bathing himself, lower body dressing, putting on/taking off footwear, and personal hygiene. He needed supervision/touch assistance to sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident #326's revised care plan dated 10/7/24 revealed he exhibited behaviors that included throwing items at staff, cursing at staff, cursing at other residents, destroying others personal property, manipulative behaviors/ fabrication of stories, hitting staff and other residents. Interventions included 1:1 supervision, administering medications as ordered, diverting Resident #326 by giving him an alternative object or activity, listening and calming him. Resident #325 was admitted to the facility on 6/1/24 and was discharged on 1/3/25. His diagnoses included epidural hemorrhage with loss of consciousness, dementia, muscle weakness, abnormalities of gait and mobility, major depressive disorder, seizures, schizophrenia, and chronic pain syndrome. Resident #325's Minimum Data Set (MDS) dated 9/10/24 revealed he was moderately cognitively impaired. He was independent in the areas of eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, sitting to lying, lying to sitting on side of bed, toilet transfer, wheeling 50 feet with 2 turns, and wheeling 150 feet. He required set up/clean up assistance for tub/shower transfer. He needed supervision/touch assistance with shower/bathing himself, sitting to standing, chair/bed to chair transfer, walking 10 feet, and walking 50 feet with	F 600	current medication regimen. Resident #326 discharged on 11/7/2024. Resident #325 discharged on 1/3/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents are at risk for deficient practice. On 9/30/24 the last 14 days of progress notes were reviewed by the Regional Director of Clinical Services for instances of aggressive behavior and intervention and any instance that could be construed as abuse. There were no further instances noted in the progress notes that had not been previously reported. The measures that wil[be put into place or systemic changes made to ensure that the deficient practice will not occur: The Director of Nursing provided training to all nursing staff using the Relias education Managing Aggressive Behaviors and Preventing, Recognizing and Reporting Abuse beginning on 9/30/2024 and ending on 10/7/2024. During the morning meeting the DON will refer any resident in need of psych services to the social worker who will make the referral to psych services on that day. All nursing staff were educated that when a resident is aggressive nursing staff will immediately ensure safety is maintained for all residents by separating the aggressive resident from all other residents and placing the aggressor on 1 on 1. The employee will notify the Director	

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F 600	Continued From page 6 2 turns. He required partial/moderate assistance to walk 150 feet. Resident #325's revised care plan dated 9/4/24 included the focus area of behaviors such as spitting on the floor and throwing briefs on the floor. Review of Resident #326's nursing progress note dated 9/30/24 at 10:40 AM entered by the Director of Nursing (DON) revealed Resident #326 was agitated and challenging with redirection. Resident #326 was medicated for pain and monitored closely for aggression. An emergency mental health tele-visit for Resident #326 was requested. Review of a Physician medical progress note dated 9/30/24 at 11:37 AM indicated during this visit Resident #326 was upset about his pain medication, used profanity and attempted to hit and throw things at the Physician. The Physician's progress note stated Resident #326 was asking for more anxiety medications. The Physician indicated psychiatry was seeing him and reportedly did not change his anxiety medications. The physician further indicated Resident #326 was upset his Physician would not increase his pain medication and started hitting, throwing things, and cursing at the Physician. An interview was conducted with Physician #1 on 5/22/25 at 11:31 AM. He stated Resident #326 always requested to have his pain medication increased. Physician #1 stated as he exited the room Resident #326 told him not to shut the door and then came after him in the hallway. Physician #1 stated Resident #326 attempted to hit him but instead punched his laptop twice. Physician #1	F 600	of Nursing, and the Physician. The Director of Nursing and the physician will determine if the resident needs immediate intervention to include emergency psych evaluation or transfer to the hospital for evaluation and further course of action. This education was completed by 6/19/25. All nursing staff hired after 6/19/25 will receive this training during orientation. Nursing staff that have not received this training will not be allowed to work until it is received. The Director of Nursing and assistant director of nursing, will audit progress notes weekly to ensure that nursing staff are following the proper protocol for residents with aggressive behaviors 5x a week for 4 weeks, 3 times a week for 4 weeks and then weekly for 4 weeks. Monday audits will include the prior Friday, Saturday and Sunday. How the facility plans to monitor its performance to make sure that solutions are sustained: The results of the audits will be reported to the Quality Assurance Performance Committee monthly x 3 by the Director of Nursing for an analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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stated Resident #326 continued to follow him, and Physician #1 went into another resident room. Resident #326 came into the room and took one of the drawers out of a dresser and tried to hit Physician #1 with it. Physician #1 stated a physical therapist was near the room and attempted to intervene. Physician #1 indicated he was told later Resident #326 had an altercation in the courtyard. Regarding emergency mental health tele-visits, Physician #1 stated if a resident was experiencing a serious mental health emergency, that resident would be sent directly to the emergency room (ER). Otherwise, he stated, it was his expectation that a practitioner would see a resident within 24 hours.

An interview with the Rehabilitation Director was conducted on 5/22/25 at 1:51 PM. He stated he and his Physical Therapy Assistant (PTA) saw Resident #326 yelling and belligerent. The Rehabilitation Director stated Resident #326 had cornered the provider in a resident room and was verbally abusive. He stated he removed Resident #326 from the room by pulling on the handles of his wheelchair.

On 5/22/25 at 2:00 PM an interview was conducted with the Physical Therapy Assistant (PTA). He stated he heard a commotion, saw a provider (Physician #1) backing out of a room, and Resident #326 followed him and was verbally abusive and pushing the provider. The PTA stated he and the Rehabilitation Director walked to meet them. The provider backed into another resident's room and Resident #326 followed him and attempted to hit the provider. The PTA stated there was a resident in that room near the window. He stated the provider was positioned in the middle of the room in front of the resident in

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the bed by the window. He further stated it appeared that Resident #326 pulled on dresser drawers, while he was being backed out of the room. The PTA stated the Rehabilitation Director grabbed the back of Resident #326's wheelchair and backed him out of the room. The PTA stated it all happened very fast, in less than a minute. He added the provider was able to get out of the room and go down the hall. The PTA recalled that the Rehabilitation Director released the wheelchair and Resident #326 began pursuing the provider again. The PTA tried to talk to Resident #326 and distract him, however Resident #326 punched the PTA in the stomach and chest to continue to pursue the provider. The PTA talked to Resident #326 to calm him down. Both Resident #326 and the PTA went out to the courtyard and talked while Resident #326 smoked. The PTA stated the Social Worker came out to talk to Resident #326 and the police showed up.

A review of the facility's Initial Allegation Report dated 9/30/24 revealed on 9/30/24 at 12:00 PM there was a resident-to-resident altercation. Resident #326 hit Resident #325 with a small table stand during an argument in the courtyard. The residents were separated immediately, and Resident #326 was placed on one-to-one supervision. Law enforcement was notified.

Review of the witness statement from Medication Aide #1 dated 9/30/24 indicated she was outside with Resident #326 while he was smoking. Resident #326 and Resident #325 started to argue. Resident #326 picked up the ashtray stand and started hitting Resident #325. Medication Aide #1 attempted to grab the ashtray stand but a male housekeeper grabbed it. Medication Aide #1

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brought Resident #326 inside and informed the nurse that Resident # 325 needed help.

An interview was conducted on 5/22/25 at 9:15 AM with Medication Aide #1 who completed one to one observation of Resident #326 on 9/30/24. She stated she did not recall the incident between Resident #326 and Resident #325.

A follow up interview was conducted with Medication Aide #1 on 5/23/25 at 10:34 AM. She stated she performed 15-minute checks on Resident #326 the morning of 9/30/24 after he had requested medications. She stated she was unsure what time he was placed on one-to-one observation.

An interview with Housekeeping Staff #1 who witnessed the incident 9/30/24 was conducted on 5/21/25 at 7:03 PM. Housekeeping Staff #1 stated he was on the 500-hall taking out the garbage and was looking out the window toward the courtyard and saw a resident hit another resident with an ashtray holder. Housekeeping staff #1 stated he ran out and grabbed the ashtray holder out of the resident's hand, separated the residents, and went inside to report it to a staff member immediately. He was unsure which staff member he reported it to and did not recall seeing anyone else outside.

An interview was conducted on 5/23/25 at 12:05 PM with Nurse #9 who was assigned to both Resident #326 and Resident #325 on 9/30/24. Nurse #9 stated she recalled there was an altercation because a housekeeper had reported the incident to her on 9/30/24. Nurse #9 was unsure if Resident #326 was on one-on-one observation prior to the incident, but stated he

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was supervised after the incident. Nurse #9 indicated when she was informed of the incident she assessed both residents for injuries. Resident #325 had skin tears on one arm.

An interview was conducted with the Director of Nursing (DON) on 5/22/25 at 6:45 AM. She stated on 9/30/24 Resident #326 was checked on continuously and was kept at the nurse's station after he became agitated that morning. The DON indicated she was unsure how he could have left the nurse's station. Additional interventions included administering pain and antianxiety medications and 15-minute checks. The DON stated Resident #326's mental health practitioner saw him in person the next day on 10/1/24. She further stated that monitoring a resident closely entailed the resident was monitored every 15 minutes, and those logs were kept in a binder. She stated a safety attendant for one-to-one observations for Resident #326 were in effect until 11/7/24 for the duration of his stay.

A review of Resident #326's one-to-one 15-minute monitoring logs 9/30/24 through 11/7/24. Resident #326's monitoring logs revealed he had 15-minute checks signed by staff.

An interview was conducted with the Social Worker (SW) on 5/22/25 at 2:10 PM. He stated he saw Resident #326 after the incident with the provider (Physician #1) as well as after the incident with another resident. He stated they discussed his aggressive behavior in both instances. He stated he recalled Resident #326 was on one-to-one observation, however, was unsure of how long. The SW stated he could not recall anything further about the incidents that

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F 600	Continued From page 11 occurred on 9/30/24. Review of a psychiatry progress note dated 10/4/24 revealed Resident #326 was able to express insight into the altercation with Resident #325 and demonstrated emotional awareness and control. There were no changes made to Resident #326's medications. Recommendations included continued practice of calming techniques, redirection techniques, support, and redirection as needed. A review of the facility's investigation report dated 10/4/24 revealed in summary, Resident #325 sustained small skin tears on his left forearm, left elbow, left posterior arm, and right ring finger. Resident #325 declined to press charges. Resident #325 denied any lasting trauma because of the incident, stated he felt safe at the facility, and was not afraid of Resident #326. Resident #326 also denied a traumatic response to the incident, was placed on one-to-one observation, and received a mental health evaluation. This was completed by the Administrator. An interview was conducted with the Administrator on 5/22/25 at 3:47 PM. She stated interventions were put in place (15-minute observations and placing Resident #326 at the nurse's station) and was unsure why they did not prevent the incident.	F 600		
F 628 SS=B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a	F 628		6/20/25

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resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in

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paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 628	Continued From page 15 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F 628		

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F 628	Continued From page 16 radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the resident representative in writing of the reason for the transfer/discharge to the hospital and had not mailed a copy of the bed hold policy for 2 of 2 residents (Resident #73 and #45) reviewed for hospitalization. 1) Resident #73 was admitted into the facility on 9/16/21. A review of Resident #73's quarterly Minimum Data Set dated 3/11/25 indicated that she was moderately cognitively impaired. A review of Resident #73's nursing progress notes revealed that she was discharged to the hospital on 3/12/25 and returned on 3/29/25. A review of Resident #73's medical record indicated that on 3/12/25 at both 2:03 PM and 5:20 PM Nurse #1 attempted to contact Resident #73's responsible party by telephone to inform them Resident #73 was transferred to the hospital but were unable to reach them. There was no documentation that a written notice of transfer or discharge was provided or notice of the bed-hold	F 628	F628 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The notification of transfer/discharge to the hospital stating the reason for the transfer and bed hold policy was mailed to the responsible party for Resident #73 and Resident #45 by the social worker on 5/20/25. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents that are discharged from the facility are at risk for this deficient practice. On 5/23/25 all discharges from the facility from the last two weeks were audited by the social worker, and any missed notifications of transfer/discharge and the bed hold policy were mailed to the responsible party. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur;	

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F 628	Continued From page 17 policy. An interview with the Admissions Staff #1 on 5/20/25 at 2:42 PM revealed that they called or attempted to call the families/resident representative on the day of transfer or the next business day if a resident was transferred after hours or on the weekend. They had not mailed any notices regarding the bed hold policy or written notification of transfer or discharge including the reason for the transfer to the families/resident representative. She stated that she was unaware that it was a requirement for these to be mailed. An interview with the Administrator on 05/20/25 02:55 PM indicated that the bed hold information and written notice of transfer or discharge including the reason for transfer should be mailed to the family/resident representative and given to the resident when sent to the Emergency Room or hospital. 2) Resident #45 was admitted into the facility on 3/8/24. A review of Resident #45's significant change Minimum Data Set dated 5/7/25 indicated that she was severely cognitively impaired. A review of Resident #45's nursing progress notes revealed that she was discharged to the hospital on 5/17/25 and returned to the facility on 5/22/25. A review of Resident #45's medical record indicated Nurse #2 notified the resident representative was by telephone of the transfer to the hospital. There was no documentation that a	F 628	All social work department employees will be educated by the administrator that the transfer/discharge notification and the bed hold policy must be mailed to the responsible party to provide written notice of the reason for the transfer and bed hold procedures. This education will be completed by 6/17/25. All new social work employees after 6/17/25 will receive this education during orientation. Social work staff will not be allowed to work until this education is received. The social worker will complete an audit weekly of all discharged residents to ensure that the notification of transfer/discharge and bed hold policy was mailed for all discharges in the previous week. This audit will be completed weekly for 8 weeks by the social worker. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 06/20/25	

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F 628	Continued From page 18 written notice of transfer or discharge was provided or notice of the bed-hold policy. An interview with the Admissions Staff #1 on 5/20/25 at 2:42 PM revealed that they called or attempted to call the families/resident representative on the day of transfer or the next business day if a resident was transferred after hours or on the weekend. They had not mailed any notices regarding the bed hold policy or written notification of transfer or discharge including the reason for the transfer to the families/resident representative. She stated that she was unaware that it was a requirement for these to be mailed. An interview with the Administrator on 05/20/25 02:55 PM indicated that the bed hold information and written notice of transfer or discharge including the reason for transfer should be mailed to the family/resident representative and given to the resident when sent to the Emergency Room or hospital.	F 628		
F 641 SS=B	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	F 641		6/20/25

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F 641	Continued From page 19 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 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 record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of level 2 Pre-Admission Screening and Resident Review (PASRR) (Resident #3) and admission assessment (Resident #98) for 2 out of 30 residents reviewed for accuracy in MDS assessments. The findings included: 1) Resident #3 was admitted into the facility on 7/15/24 with diagnoses of paranoid schizophrenia, anxiety disorder. A review of Resident #3's medical records included a PASSR Level 2 Determination Notification letter a document indicating a resident may need to utilize specialized services due to the presence of a serious mental illness and/or intellectual disability or related condition dated 4/17/25.	F 641	F641 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Minimum Data (MDS) assessment for resident #3 was modified by MDS nurse on 5/23/25 with the correct Preadmission Screening and Resident Review (PASRR) information. The Minimum Data (MDS) assessment for resident #98 was modified by MDS nurse on 5/23/25 with the correct information that this is the first assessment since the most recent admission/entry or reentry. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; 100% audit of all current residents' most current comprehensive assessment was	

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F 641	Continued From page 20 A review of Resident #3's significant change MDS dated 4/29/25 indicated the resident was not currently considered by the state a level 2 PASRR and determined to have a serious mental illness and/or intellectual disability or related condition. An interview with the MDS Coordinator on 5/21/25 at 9:30 AM indicated she reviewed the PASRR information that was on the resident profile. She stated that at the time of the completion of the significant change MDS (dated 4/29/25) for Resident #3 this information had not been updated which resulted in the inaccuracy of the coding of the significant change MDS. An interview with Social Service on 5/21/25 at 10:30 AM revealed that the responsibility of changing the PASSR level in the resident profile was the Social Service Departments. He reviewed the resident profile of Resident #3 in the electronic medical record and noted the PASSR information had not been updated to reflect the change from a level 1 to a level 2 PASSR. An interview with the Administrator on 5/21/25 at 9:45 AM indicated Resident #3's MDS should have reflected Resident #3 was considered by the state a level 2 PASRR and it was social services responsibility to ensure resident profiles were updated with PASRR information when they received it. 2. Resident #98 was admitted to the facility on 6/10/2024 with diagnoses including non-Alzheimer's dementia and Parkinson's disease (a movement disorder of the nervous	F 641	initiated on 6/16/25 by the administrator to ensure all Level II PASRR were coded accurately. Any identified areas of concern were corrected to include modifications by the MDS Nurse during the audit. The audit was completed on 6/19/25. 100% audit of all current residents' most current comprehensive assessment was initiated on 6/16/25 by the administrator to ensure all MDS question A0310E were coded accurately for first assessment since admission/entry or reentry. Any identified areas of concern were corrected to include modifications by the MDS Nurse during the audit. The audit was completed on 6/17/25. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; Completed Comprehensive MDS Assessments will be reviewed by the director of nursing, administrator, or mds consultant to ensure all PASRR level information and A0310E is coded accurately weekly for 8 weeks and monthly for 1 month. Modifications will be completed as indicated. On 06/16/25 an in-service was completed by the administrator with the MDS nurses in regard to accurately coding PASRR Level II and question A0310E. All new MDS nurses hired after 6/16/25 will receive training during orientation. MDS nurses will not be allowed to work until this education is received. 4.How the facility plans to monitor its performance to make sure that solutions are sustained?	

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F 641	Continued From page 21 system that worsens over time. A discharge Minimum Data Set (MDS) assessment date 9/3/2024 indicated Resident #98 had an unplanned discharge to the hospital with return to the facility anticipated. An entry MDS assessment dated 9/7/2024 indicated Resident #98 was re-admitted to the facility. A discharge Minimum Data Set (MDS) assessment dated 3/24/2025 indicated Resident #98 had experienced a fall since admission or the prior assessment (last quarter MDS assessment was dated 2/9/2025) and was coded for one fall as a major injury. Nursing documentation dated 3/27/2025 recorded Resident #98 was re-admitted to the facility from the hospital post-surgical repairment of right hip fracture. The significant change MDS assessment dated 3/31/2025 for Resident #98 was coded as the first assessment since the most recent re-admission (9/7/2024). In an interview with MDS Nurse #1 on 5/23/2025 at 1:25 pm, she stated the admission assessment on the significant change MDS assessment dated 3/31/2025 was coded inaccurately. She stated the significant change MDS assessment should have been coded as the first assessment after a re-entry. In an interview with the Regional Director of Clinical Services, on 5/23/2025 at 1:30 pm, she stated it was the expectation of the facility that all	F 641	All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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F 641	Continued From page 22 MDS assessment should be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		6/20/25

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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F 656	Continued From page 23 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to implement care planned interventions by not placing fall mats at the bedside of a resident with a history of falls with major injuries. This occurred for 1 of 5 residents reviewed with care plan interventions for accidents (Resident #98). Findings included: Resident #98 was admitted to the facility on 6/10/2024 with diagnoses of non-Alzheimer's dementia and Parkinson's disease (a movement disorder of the nervous system that worsens over time). A post fall report dated 3/24/2025 at 3:53 pm indicated Resident #98 had an unwitnessed fall and was found sitting on the floor next to the bed complaining of right hip pain on 9/23/2025 at 9:34 am. X-rays were obtained, and Resident #98 was transferred to the hospital on 3/24/2025. A care plan revised on 3/27/2025 indicated Resident #98 was a risk for falls related to the cognitive impairment. An intervention dated 3/23/2025 included fall mats upon return to the	F 656	F656 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #98 was found in bed without both fall mats on either side of the bed. The fall mats were placed on both sides of the bed for resident #98 as careplanned by the mds nurse on 5/22/25. The MDS nurse ensured all fall interventions on the careplan were implemented on 5/22/25. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who have had a fall during the past 90 days was included in the audit. The care plans for these residents were reviewed to ensure that all fall-related interventions have been appropriately implemented and are in place. This audit was completed by DON, MDS Nurse, and SDC Nurse on 6/17/25. All residents who were identified	

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F 656	Continued From page 24 facility. Nursing documentation dated 3/27/2025 recorded Resident #98 returned to the facility from the hospital after having surgery for repair of a right hip fracture. The significant change Minimum Data Set assessment dated 3/31/2025 indicated Resident #98 was severely cognitively impaired and was coded for recent surgery for repair of a fracture to the pelvis, hip, leg, knee or ankle. There was no documentation in the electronic medical record of any falls since re-admission on 3/27/2025. On 5/22/2025 at 6:35 am, Resident #98 was observed resting in the center of the bed with the bed positioned in the lowest position. There were no fall mats on the floor to either side of Resident #98's bed. On 5/22/2025 at 8:33 am, Resident #98 was observed still resting in the bed with no fall mats positioned on the floor on either side of Resident #98's bed. Fall mats were observed folded up in the left corner of the room. Medication Aide #1 was observed outside Resident #98's room at the medication cart. On 5/22/2025 at 8:33 am in an interview with the day shift (7:00 am to 7:00 pm) Medication Aide #1, she stated she had not been into Resident #98's room since receiving her assignment at 7:00 am and the fall mats should have been positioned down on the floor beside Resident #98's bed. Medication Aide #1 was observed entering Resident #98's room, gathering the	F 656	as not having their care planned fall interventions implemented and in place had corrective action taken with the interventions being put into place as care planned. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; All MDS nurses were in-serviced by the administrator that the care planned interventions for falls must be in place. This in-service was completed on 6/16/25. All new MDS nurses will receive this education during orientation. MDS nurses will not be allowed to work until this education is received. The Director of Nursing, unit manager, staff development coordinator and MDS nurses will conduct audits to ensure that current residents care planned falls-related interventions are in place and are being implemented appropriately 3x per week for 12 weeks. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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F 656	Continued From page 25 folded fall mats from the left corner of the room and placing the fall mats to each side of Resident #98's bed. On 5/22/2025 at 8:35 am in an interview with Nurse #2, she stated Resident #98 was care planned for the use of fall mats at the side of the bed and she was not sure why the fall mats were not beside Resident #98's bed. She stated it was the responsibility of the nursing staff to ensure fall mats were positioned beside the bed when Resident #98 was in bed. On 5/22/2025 at 8:40 am in an interview with the Director of Nursing, she stated fall mats should have been beside the bed when Resident #98 was in the bed and it was the responsibility of all nursing staff to ensure fall mats were on the floor beside the bed.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews and Nurse Practitioner interview, the facility failed to change a chronic wound dressing as ordered by the provider for 1 of 1 resident reviewed for venous wound care (Resident # 40).	F 684	F684 1. How corrective action will be accomplished for those residents found to have been affected by the deficient	6/20/25

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F 684	Continued From page 26 Findings included: Resident #40 was admitted to the facility on 7/11/2023 with diagnoses including chronic idiopathic (arising spontaneously with unknown cause) venous hypertension with ulcer to the left lower extremity and pyoderma gangrenosum (a rare condition that causes large painful sores on the skin). Resident's #40's revised care plan dated 1/7/2025 included a focus for a chronic left lower leg vascular wound. Interventions included treatments per the Treatment Administration Record (TAR). The care plan also included a focus for behaviors due to Resident #40 refusing care that included wound care. The quarterly Minimum Data Set (MDS) assessment dated 2/25/2025 indicated Resident #40 was moderately cognitively impaired. The MDS was coded for one venous/arterial ulcer and treatments included application of ointments, medications and nonsurgical dressings. A review of physician orders indicated on 3/20/2025 Resident #40 was ordered daily wound care that included to cleanse the left lower extremity wound with wound cleanser, pat dry, apply collagen soaked gauze followed by calcium alginate with silver to the open area, cover with ABD pads (highly absorbent pads for large wounds) and apply Kerlix (crinkle-weave bandage used for wound care). Physician orders dated 5/9/2025 included a change in the wound care order to cleanse the left lower extremity wound with Vashe (a pure	F 684	practice; Resident #40 wound care was completed on 5/19/25 by the wound nurse. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with wounds that are documented on the treatment administration record are at risk. An audit of all residents with wounds on the treatment administration record was completed by the director of nursing, infection preventionist and staff development coordinator to ensure that wound care orders were completed. This was completed on 6/17/2025. Any discrepancies were corrected immediately. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; Licensed nursing staff, including FT, PT, and PRN were educated by the director of nursing, staff development coordinator, unit manager or infection preventionist regarding completing wound care as ordered and signing off the Treatment Administration Record. In service began on 6/12/25 and will be completed on 6/19/25. " All new hires after 6/19/25 will receive training during orientation. " Nurses will not be allowed to work until this education is received. Treatment administration records will be audited by the director of nursing, infection preventionist and/or the unit manager 5x per week for 8 weeks, then 3x per week for 4 weeks to ensure that	

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F 684	Continued From page 27 hypochlorous acid solution used to fight bacteria and infection), pat dry, apply collagen particles (provides support for cell organization and faster tissue formation, helps maintain a moist environment and stimulated new tissue growth), cover with Xeroform (sterile, non-adherent wound dressing that prevent air for reaching the wound) and infections), apply ABD pads and wrap the wound with Kerlix every day shift. The Nurse Practitioner's wound documentation dated 5/14/2025 reported the left lower ulcer wound was improving without complications and measurements were recorded as 14.5 centimeters (cm) by 25 cm by 0.30cm with moderate odorless serosanguineous drainage. The frequency of dressing changes was recorded for daily dressing changes. A review of Resident #40's May 2025 TAR recorded the following order for wound care: Cleanse left lower extremity wound with Vashe, pat day, apply collagen particles, cover with Xeroform, apply ABD pads then wrap with kerlix every day shift for wound care and the order date was recorded as 5/9/2025 at 10:20 am. There was no wound care recorded provided to Resident #40's left lower leg wound for the following dates on Resident #40's May 2025 TAR: 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025. There was no documentation in the electronic medical record (EMR) that wound care was provided to Resident #40 or Resident #40 refused wound care on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025. On 5/22/2025 at 8:54 am in a phone interview with Nurse #3, she explained she served as the	F 684	the treatments are completed and documented on the treatment administration record. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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F 684	Continued From page 28	F 684		

nurse supervisor for nursing station #2 that included Resident #40's room. Nurse #3 explained on weekends there were medication aides assigned to Resident #40 to administer medications and as nurse supervisor she was responsible for Resident #40's wound care. Nurse #3 stated on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025 she did not provide or offer to provide wound care to Resident #40 because she thought Resident #40 received wound care on Monday, Wednesday and Friday. Nurse #3 stated she was not aware of the new order for left lower extremity wound care written on 5/9/2025 and explained the resident would communicate when there were new orders for wound care and nurses reviewed Resident #40's EMR for new wound care orders. Nurse #3 stated she had not checked Resident #40's EMR for wound care orders.

On 5/23/2025 at 9:20 am in an interview with Nurse #2, she stated she had been the unit manager for nurse's station #2 that included Resident #40's room since the end of March 2025. Nurse #2 stated Resident #40's left lower extremity wound care had been ordered daily since March 2025 and could not recall a change in the frequency of Resident #40's wound care.

On 5/19/2025 at 12:52pm, Resident #40's left lower extremity wound dressing was observed with moderate amount of dried light brown drainage to the outer wound dressing and moderate amount of dried yellowish brown stains to the under pad on the bed underneath the left lower extremity. There was no date or initials on the dressing indicating when the dressing was last changed.

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F 684	Continued From page 29	F 684		

On 5/19/2025 at 12:52 pm, Resident #40's Representative stated the dressing to the left lower extremity was not changed on the weekend. Resident #40 confirmed that the left lower wound dressing was not changed on the weekend (5/17/2025 and 5/18/2025).

On 5/20/2025 at 11:26 am, Nurse #6 and Nurse #7 were observed educating Resident #40 on the importance of daily wound care before Resident #40 consenting to treatment. Nurse #7 was observed assisting Resident #40 in participating in the wound care and wound care was conducted as ordered by the provider. The large open wound area to the left lower leg was observed with dark burgundy-red color tissue covered with a thin clear to white slough in areas. There was no odor noted.

On 5/20/2025 at 12:02 pm in a interview with Nurse #7, she stated when she changed Resident #40's left lower extremity wound dressing on 5/19/2025, there was no date or initials on the old dressing and the wound dressing appeared to not have been changed on the weekend.

On 5/22/2025 at 9:03 am in a phone interview with the Wound Nurse Practitioner, she stated Resident #40's refused wound care at times and had refused debridement of the left lower extremity wound to remove the slough. She explained Resident #40 was scheduled wound care three times a week (Monday, Wednesday and Friday) at one time and because Resident #40 would refuse wound care, she had changed the frequency of Resident #40's left lower extremity wound dressing from three times a week (Monday. Wednesday and Friday) to daily.

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F 684	Continued From page 30 She explained when Resident #40 was receiving wound care three times a week and refused wound care, the dressing to the left lower extremity wound would go three to four days without treatment. Therefore, to ensure Resident #40 was receiving lower extremity wound care more consistently, the wound nurse practitioner increased the wound care to daily to capture the performance of wound care more routinely. She explained the resident had been more cooperative and there was less time in between wound care dressing changes even when Resident #40 refused wound care with daily wound care. The Nurse Practitioner stated Nurse #3 should have attempted to perform wound care as ordered for Resident #40 on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025. On 5/23/2025 at 9:03 am in an interview with the Director of Nursing, she stated the nurse assigned to nursing station #2 was responsible for performing wound care to the assigned area on weekends. She stated Nurse #3 should have verified Resident #40 wound care orders and offered Resident #40 wound care as ordered on 5/10/2025, 5/11/2025, 5/17/2025 and 5/18/2025.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		6/20/25

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F 689	Continued From page 31 by: Based on observations, record review, and staff interviews, the facility failed to ensure a severely impaired resident with a diagnosis of dysphagia (difficulty swallowing) and a physician order for a pureed diet (foods that are smooth and pudding-like texture) did not have access to mechanically chopped food. A nursing assistant realized the resident had received mechanically chopped breakfast sausage on a meal tray and left it with the resident who was able to feed himself independently. This deficient practice occurred for 1 of 3 residents reviewed for accidents. The findings included: Resident #84 was admitted to the facility on 8/5/24 with diagnoses which included Progressive Supranuclear Palsy (a neurodegenerative disease involving the gradual deterioration of the brain), secondary Parkinsonism, and dysphagia (difficulty swallowing). Record review indicated Resident #84 had a Physician's Order, dated 1/16/25, for a Regular Diet, pureed texture, thin liquids consistency, and double protein for all meals. A review of Resident #84's quarterly Minimum Data Set (MDS), dated 03/24/25, revealed the resident to have the ability to understand others and to make himself understood. The MDS indicated he was severely cognitively impaired. He had no impairment in his upper extremities and required set up or clean-up assistance when eating. The MDS indicated Resident #84 had a swallowing disorder and was on a mechanically altered diet.	F 689	F689 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 5/23/25 a tray with mechanically altered sausage was delivered to resident #84. After it was discovered that the resident was consuming a tray that had the incorrect diet, the tray was removed from the resident. The physician was made aware. The resident was monitored for any adverse effects. No adverse effects were noted. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; Residents in the facility on pureed diets have the potential to be affected by this alleged deficient practice. A facility audit was completed by the director of nursing on 5/23/25 to ensure residents on pureed diets received the correct diet as prescribed by the physician. No other residents on pureed diets received the incorrect diet. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; The director of nursing, staff development coordinator, assistant director of nursing, infection preventionist will in-service nursing staff on the importance of ensuring that the residents receive the diet that is ordered by the physician. This in-service began on 6/11/25 and will be completed by 6/19/25. All new hires after	

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F 689	Continued From page 32 A review of Resident #84's Care Plan, last revised on 4/16/25, indicated the following focuses: 1) at risk for injury related to his medical diagnoses and stated he pockets food at times (holding food in the mouth without swallowing it); 2) refuses to allow staff to assist with meals and eating; and 3) requires assistance with his Activities of Daily Living. Interventions included, in part, a therapeutic diet as ordered, staff assistance with meal setup, encouragement by staff to allow with assistance with his meals, cues and reminders to improve his meal intake, assurance that he is safe and if he became distressed to listen to him and try to calm him. An observation of Resident #84 was conducted on 5/23/25 at 8:36 AM. He was sitting up in his bed and was observed eating. A small bowl that contained grits, scrambled eggs and sausage had been placed on his overbed table which was positioned across his lap. The eggs and sausage appeared to have a mechanically chopped texture (foods that are ground into very small pieces making it easier for people who have difficulty chewing or swallowing eat) instead of pureed texture (foods that are smooth and pudding-like texture). He was observed using an adaptive spoon (a utensil with an easy-grip handle) to eat the grits. There was no tray or meal ticket on the table or in his room. Resident #84's nursing assistant (NA), NA #1, entered the room, introduced herself as the NA assigned to his care that day, and asked him if he was done eating and the resident indicated he was. An interview was conducted with NA #1 on 5/23/25 at 12:05 PM. NA #1 stated Resident #84 had orders for a pureed diet with double portions.	F 689	6/19/25 will receive this education in orientation. Staff that have not received this training will not be allowed to work. All dietary staff were educated that all residents must be sent the correct diet according to the physician□s order. This in-service began on 6/11/25 and will be completed by 6/19/25. All new hires after 6/19/25 will receive this education in orientation. Staff that have not received this training will not be allowed to work. The director of nursing, assistant director of nursing, staff development coordinator or infection prevention will audit residents on pureed diet to ensure the correct diet is received. This audit will be done 5x a week for 4 weeks, 1x a week for 4 weeks and 1 time a month for one month. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/2025	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(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 689	Continued From page 33	F 689		

When asked about his breakfast, NA #1 claimed she knew the resident's likes and dislikes very well and because she had fed him most of his breakfast, she had asked if he would like to eat some more, by himself and said he indicated he would like to do that. Instead of leaving everything, she had taken some of the remaining eggs and sausage from his plate and put them into his bowl of grits, placed the bowl on his overbed table and gave him his spoon. She then removed the tray and left him to eat on his own. When asked about the texture of the foods in the bowl, NA #1 explained that grits and eggs always had that consistency, but the sausage appeared to have been a mechanically chopped texture. NA #1 further explained she realized the sausage had not been pureed when she sat down to feed him and removed the dome from his plate. She stated she had planned on going to the kitchen to get him the pureed version of sausage, but said the resident told her that he did not want any sausage that morning, so she did not go to the kitchen. NA #1 could not explain why she put the sausage into the bowl of grits that she had left with the resident except for saying that because he had said he did not want to eat any sausage that morning she knew he would not eat it. When asked if she had reported Resident #84 received a mechanically chopped diet that morning, she initially said she had reported it to the Resource Nurse on the hall and then admitted she had not.

An interview was conducted with the Resource Nurse, Nurse #4, on 5/23/25 at 11:15 AM. Nurse #4 explained Resident #84 had orders for a pureed diet and could feed himself, but it took a long time for him to eat. Nurse #4 stated he was unaware Resident #84 had received a mechanically chopped breakfast meal that

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F 689	Continued From page 34 morning and stated he would talk with the dietary department about the error. She stated she was unaware Resident #84 had received a mechanically chopped breakfast that morning. Cook #1 said she had placed the pureed sausage right beside the mechanically chopped sausage in the steam table and that they definitely looked different. An interview was conducted with the Director of Nursing (DON) on 5/23/25 at 11:50 AM. The DON stated it was her expectation that residents receive the food that had been ordered for them. An interview was conducted with the Administrator on 5/23/25 at 11:51 AM. The Administrator stated it was her expectation that residents receive the correct food consistency as ordered. The Administrator also stated a resident's safety should always be a priority for staff.	F 689		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by 4 errors out of 33 opportunities observed. The medication error rate was 12.12%.	F 759	F759 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?	6/20/25

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F 759	Continued From page 35 Findings included: 1. Resident #101 had a doctor's order dated 4/18/25 for omeprazole oral suspension 10 milliliter via Gastrotomy (G) -tube two times a day for gastroesophageal reflux disease (GERD) and scheduled to be administered at 9:00 AM and 9:00 PM. On 5/20/25 at 9:33 AM, Resident #101 was observed during the medication administration. Nurse #4 was observed preparing and administering Resident #101's scheduled 9:00 AM medications. During this medication administration, Nurse #4 did not administer omeprazole oral suspension which was scheduled for 9:00 AM. On 5/20/25 at 10:01 AM, Nurse #4 was interviewed. He stated that he had not realized that Resident #101's omeprazole was out and needed to be refilled/reordered and he was going to call the provider about it after this interview. According to the manufacturers' instructions insulin lispro should be injected under the skin within 15 minutes before or right after a meal and a meal should be consumed within 10-20 minutes after insulin aspart is administered. 2a. Resident #59 had a doctor's order dated 2/28/25 for Humalog Kwik Pen subcutaneous solution pen injector 100 unit/milliliter (Insulin Lispro) inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 Units; 351 - 400 = 16 Units subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with diabetic neuropathy.	F 759	The physician was notified that a medication error occurred with Resident #101. The resident was monitored for any change in condition following missed medication. No change in condition occurred. The physician was notified that a medication error occurred with Resident #59, Resident #21, and Resident #76. Resident #59, Resident #21, and Resident #76 were monitored for change in condition after administration of fast acting insulin with delay of meal for more than 30 minutes. No changes in condition occurred. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. 100 percent of the medication carts were audited on 5/21/25 and no other residents were found to be out of their medications. All residents that received fast acting insulin on 5/21/25 prior to lunch were monitored for changes in condition. No changes in condition occurred. 3. The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur. A. On 5/21/25 Nurse #5 was in-serviced that fast acting insulin must be administered 15 minutes before or right after a meal and a meal is consumed within 10-20 minutes after fast acting insulin administration. B. On 6/19/25 all licensed nurses were in-serviced that fast-acting insulin must be administered 15 minutes before	

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F 759	Continued From page 36 On 5/21/25 at 11:20 AM, Nurse #5 was observed checking Resident #59's blood sugar which was noted to be 244. Nurse #5 administered 5 units of insulin lispro to Resident # 59 at 11:24 AM. Resident #59 was observed receiving his lunch tray at 12:54 PM which was 1 hour 30 minutes after insulin was administered. Resident #59 sat up in bed and ate his lunch when he received his tray. 2b. Resident #21 had a doctor's order dated 2/25/25 for Insulin Lispro Injection Solution (Insulin Lispro) inject as per sliding scale: 150 - 169 = 1 unit; 170 - 189 = 2 units; 190 - 209 = 3 units; 210 - 229 = 4 units; 230 - 249 = 5 units; 250 - 269 = 6 units; 270 - 289 = 7 units; 290 - 300 = 8 units; 301+ = 9 units & notify provider, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with other specified complication. On 5/21/25 at 11:30 AM, Nurse #5 was observed checking Resident #21's blood sugar which was noted to be 180. Nurse #5 administered 2 units of insulin lispro to Resident #21 at 11:35 AM. Resident #21 was observed receiving her lunch tray at 1:03 PM which was 1 hour 28 minutes after insulin was administered. Resident #21 sat up in bed and ate her lunch when she received her tray. 2c. Resident #76 had a doctor's order dated 12/12/24 for Novolog Injection Solution 100 unit/milliliter (Insulin aspart) Inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 units; 351 - 400 = 16 units subcutaneously before meals and at bedtime for diabetes mellitus.	F 759	or right after a meal and a meal is consumed within 10-20 minutes after fast-acting insulin administration. On 6/19/25 all licensed nurses were in-serviced that medications must be reordered in a timely manner to ensure medications are available. All licensed nurses hired after 6/19/25 will receive this education during orientation. Licensed nurses will not be allowed to work until this education is received. C. The director of nursing, assistant director of nursing, staff development coordinator, and infection preventionist will audit fast acting insulin administration weekly for three months then randomly once compliance is met to ensure that insulin is given per protocol. If compliance is not met, the licensed nurse will be in-serviced again by the staff development coordinator and random medication audits will continue until compliance is met. D. The director of nursing, assistant director of nursing, staff development coordinator, and infection preventionist will audit all medications weekly for three months then randomly once compliance is met to ensure that all medications that need to be reordered have been ordered timely. If compliance is not met, the licensed nurse will be in-serviced again by the staff development coordinator and random medication audits will continue until compliance is met. 4.How does the facility plan to monitor its performance to make sure that solutions are sustained?	

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F 759	Continued From page 37 On 5/21/25 at 11:42 AM, Nurse #5 was observed checking Resident #76's blood sugar which was noted to be 335. Nurse #5 administered 12 units of insulin aspart to Resident #76 at 11:48 AM. Resident #76 was observed receiving her lunch tray at 1:11 PM which was 1 hour 23 minutes after the insulin was administered. Resident #76 sat up in bed and ate her lunch when she received her tray. During an interview on 5/21/25 at 1:22 PM, Nurse #5 stated that since the blood sugar checks were scheduled for 11:00 AM she went ahead and checked the blood sugars and administered insulin at that time thinking the trays would be out shortly, but she was not sure of the exact time when the trays would be delivered to the residents. Nurse #5 indicated that now that she had thought about it, she should not have administered the insulin more than 30 minutes before the meal was served to the residents. During an interview on 5/21/25 at 1:32 PM with the facility Director of Nursing (DON), she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins before she saw trays in the hallway because it was indicated to be administered before meals. The DON stated she expected fast acting insulin to be administered 15 - 30 minutes before the meal and that Nurse #5 needed to be reeducated regarding insulin timeframes. The DON verbalized Nurse #4 should have ensured Resident #101 had all her 9:00 AM scheduled medications and if there was an issue with reordering the medication the expectation was for nurses to reach out to the physician. During an interview on 5/22/25 at 2:13 PM with	F 759	All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x6 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: June 20, 2025	

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F 759	Continued From page 38 the facility Administrator, she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins until the meal trays were within vicinity. The Administrator indicated she expected nurses to request medication refills from pharmacy ahead of time so that the residents did not run out of medications. She also indicated that if there was an issue obtaining the medication from the pharmacy, nurses should reach out to the physician for guidance ahead of time.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Medical Director interviews, the facility failed to assure the facility was free of significant medication errors when fast acting insulin (insulin lispro and insulin aspart) that starts to work approximately 15 minutes after injection to lower blood sugar levels was administered to 3 residents more than 1 hour before their meal tray was delivered. The significant medication errors could have resulted in adverse side effects for 3 of 8 residents observed for medication administration (Resident #59, Resident #21 and Resident #76). Findings included: According to the manufacturers' instructions insulin lispro should be injected under the skin within 15 minutes before or right after a meal and a meal should be consumed within 10-20 minutes	F 760	F760 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician was notified that a medication error occurred with Resident #59, Resident #21, and Resident #76. Resident #59, Resident #21, and Resident #76 were monitored for change in condition after administration of fast acting insulin with delay of meal for more than 30 minutes. No changes in condition occurred. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents that receive fast acting	6/20/25

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F 760	Continued From page 39 after insulin aspart is administered. 1a. Resident #59 had a doctor's order dated 2/28/25 for Humalog Kwik Pen subcutaneous solution pen injector 100 unit/milliliter (Insulin Lispro) inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 Units; 351 - 400 = 16 Units subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with diabetic neuropathy. On 5/21/25 at 11:20 AM, Nurse #5 was observed checking Resident #59's blood sugar which was noted to be 244. Nurse #5 administered 5 units of insulin lispro to Resident # 59 at 11:24 AM. Resident #59 was observed receiving his lunch tray at 12:54 PM which was 1 hour 30 minutes after insulin was administered. Resident #59 sat up in bed and ate his lunch when he received his tray. 1b. Resident #21 had a doctor's order dated 2/25/25 for Insulin Lispro Injection Solution (Insulin Lispro) inject as per sliding scale: 150 - 169 = 1 unit; 170 - 189 = 2 units; 190 - 209 = 3 units; 210 - 229 = 4 units; 230 - 249 = 5 units; 250 - 269 = 6 units; 270 - 289 = 7 units; 290 - 300 = 8 units; 301+ = 9 units & notify provider, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with other specified complication. On 5/21/25 at 11:30 AM, Nurse #5 was observed checking Resident #21's blood sugar which was noted to be 180. Nurse #5 administered 2 units of insulin lispro to Resident #21 at 11:35 AM. Resident #21 was observed receiving her lunch tray at 1:03 PM which was 1 hour 28 minutes	F 760	insulin are at risk for the alleged deficient practice. All residents that received fast acting insulin on 5/21/25 prior to lunch were monitored for changes in condition. No changes in condition occurred. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; A. On 5/21/25 Nurse #5 was in-serviced that fast acting insulin must be administered 15 minutes before or right after a meal and a meal is consumed within 10-20 minutes after fast acting insulin administration. B. On 6/19/25 all licensed nurses were in-serviced that fast acting insulin must be administered 15 minutes before or right after a meal and a meal is consumed within 10-20 minutes after fast acting insulin administration. All licensed nurses hired after 6/19/25 will receive this education during orientation. Licensed nurses will not be allowed to work until this education is received. C. The director of nursing, staff development coordinator, and infection preventionist will audit fast acting insulin administration weekly for three months then randomly once compliance is met. If compliance is not met, the licensed nurse will be in-serviced again by the staff development coordinator and random medication audits will continue until compliance is met. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality	

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F 760	Continued From page 40 after insulin was administered. Resident #21 sat up in bed and ate her lunch when she received her tray. 1c. Resident #76 had a doctor's order dated 12/12/24 for Novolog Injection Solution 100 unit/milliliter (Insulin aspart) Inject as per sliding scale: 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 12 units; 351 - 400 = 16 units subcutaneously before meals and at bedtime for diabetes mellitus. On 5/21/25 at 11:42 AM, Nurse #5 was observed checking Resident #76's blood sugar which was noted to be 335. Nurse #5 administered 12 units of insulin aspart to Resident #76 at 11:48 AM. Resident #76 was observed receiving her lunch tray at 1:11 PM which was 1 hour 23 minutes after the insulin was administered. Resident #76 sat up in bed and ate her lunch when she received her tray. During an interview on 5/21/25 at 1:22 PM, Nurse #5 stated that since the blood sugar checks were scheduled for 11:00 AM she went ahead and checked the blood sugars and administered insulin at that time thinking the trays would be out shortly, but she was not sure of the exact time when the trays would be delivered to the residents. Nurse #5 indicated that now that she had thought about it, she should not have administered the insulin more than 30 minutes before the meal was served to the residents. During an interview on 5/21/25 at 1:32 PM with the facility Director of Nursing (DON), she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins before she saw trays in the hallway	F 760	Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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F 760	Continued From page 41 because it was indicated to be administered before meals. The DON stated she expected fast acting insulin to be administered 15 - 30 minutes before the meal and that Nurse #5 needed to be reeducated regarding insulin timeframes. An interview was conducted on 5/22/25 at 8:46 AM with the facility Medical Director. The Medical Director stated that nurses should not be administering insulin before residents' meals are ready. He indicated that the window for administering fast acting insulin should be 15-30 minutes before meals. The Medical Director explained that if the residents' blood sugar was well controlled and insulin was administered before the resident is ready to eat there was potential for the blood sugar to get really low, the resident to develop hypoglycemia, become unconscious and develop associated complications. During an interview on 5/22/25 at 2:13 PM with the facility Administrator, she indicated Nurse #5 should not have administered Resident #21, Resident #59 and Resident #76 insulins until the meal trays were within vicinity.	F 760		
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	F 761		6/20/25

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F 761	Continued From page 42 §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 secure medications on an unattended wound care cart that stored topical medications. The facility also failed to secure an unattended blood glucose cart that stored insulin. The blood glucose cart was not only observed to be unsecured and unattended but also had the key inserted into the lock. This deficient practice was found for 2 of 8 medication storage carts (wound cart and blood glucose cart). Findings included: 1. On 5/20/2025 at 11:25 am, Nurse #7 was observed gathering supplies from the wound care cart in preparation for Resident #40's wound care, proceeded to enter Resident #40's room, and allowed the door to remain open. The wound care cart was observed with the lock extended outward with tattered medical tape wrapped around the extended lock. The wound care cart	F 761	F761 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to secure medications on an unattended wound cart that stored topical medications and an unattended blood glucose cart that stored insulins. These carts were immediately secured when this was identified on 5/20/25. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the alleged deficient practice. All medications carts were audited on 5/20/25 and no other carts were found to be unsecured.	

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F 761	Continued From page 43 was positioned in the hallway with the drawers and tape covered lock facing toward Resident #40's open door. Self-propelling residents in wheelchairs were observed around the nursing station located approximately twenty-two feet from the wound care cart. On 5/20/2025 at 11:25 am Nurse #6 (the designated Wound Nurse who was assisting Nurse #7 with Resident #40's wound care) was observed entering Resident #40's room behind Nurse #7 and closing Resident #40's door. On 5/20/2025 at 11:25 am in an interview with Nurse #6, she explained topical medications were stored in the wound care cart and the wound care cart would not lock. She stated in the last three weeks as the wound nurse she had been leaving the wound care cart unlocked in the hallway when providing residents' wound care in the room, and at times the resident door would be closed. She stated she did not have a key to the wound care cart and the Director of Nursing had the only key to the wound care cart. Nurse #6 could not explain why the medical tape was wrapped around the extended outward lock on the wound care cart. On 5/20/2025 continuous observation was conducted from 11:26 AM through 12:05 PM, Nurse #6 and Nurse #7 were observed to go into Resident #40's room while the wound care cart was left in the hallway and unlocked. Resident #40's door was observed closed while Nurse #6 and Nurse #7 were in Resident #40's room and the wound care cart was out of their sight while they were in Resident #40's room. Nurse #6 and Nurse #7 were observed providing Resident #40 wound care. At 12:05 pm, Nurse #6 and Nurse #7	F 761	3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; The Staff Development Coordinator, infection preventionist, director of nursing, and assistant director of nursing initiated an in-service to all licensed nursing staff on 6/17/25 regarding security of medication carts while unattended. This will be completed by 6/19/25. No staff will work after 6/19/25 until they have received the in-service. After 6/19/25 all newly hired licensed nurses will receive this education during orientation. The Staff Development Coordinator, infection preventionist and Director of Nursing will randomly audit 10 unattended medication carts to ensure carts are locked when not in visual sight of the nurse. Audits will occur weekly x 4 weeks, then monthly x 3 months. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x4 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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opened the resident door and exited Resident #40's room. The wound care cart remained in the same position, in front of the resident room door, and remained unlocked. Self-propelling residents in wheelchairs were observed approximately twenty-two feet from the wound care cart at the nurse's station.

On 5/20/2025 at 12:06 pm an observation was conducted of the wound care cart in the presence of Nurse #7. The following medications were observed in the unlocked wound care cart: Nystatin powder (antifungal medication), topical fungal and bacterial creams, topical bacterial ointments, wound cleanser (solution used to clean wounds and promote healing), betadine solution (antiseptic solution to disinfect wounds), Dakin's solution (topical antiseptic to clean infected wounds) and topical anesthetic spray.

On 5/20/2025 at 12:25 pm in an interview with Nurse #7, she stated there was no key to lock the wound care cart when left unattended to perform wound care in residents' room and explained the wound care cart was kept in a locked medication room when not in use. She explained during the 2-3 times she had been assigned wound care in the last couple of weeks; the medical tape was wrapped around the extended outward lock which prevented the lock on the wound care cart to be pressed inward to lock and she was not able to lock the wound care cart when leaving the wound care cart unattended. Nurse #7 stated she had not mentioned to anyone the wound care cart would not lock when left unattended. Nurse #7 stated when the wound care cart was left unattended and not in sight, the wound care cart should have been locked due to storage of medications on the wound care cart.

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On 5/202/2025 at 12:41pm in an interview with the Director of Nursing, she explained the wound care cart should have been locked when left unattended and stated she did not know why or who placed the medical tape around the lock on the wound care cart. She stated the wound care nurse should have a key to the wound care cart and she had an extra key to unlock the wound care cart as needed.

2. On 5/21/2025 at 7:55 am, the blood glucose cart was observed on the 400 hall outside room 413 unattended with the lock extended outward (unlocked) with a key inserted into the lock. Self-propelling residents in wheelchairs were observed in the 400 hall. Nurse #5 was observed exiting room 414 and approaching the blood glucose cart.

On 5/21/2025 at 7:57 am, Nurse #5 was observed exiting room 414 and approaching the blood glucose cart.
In an interview with Nurse #5, she explained residents' insulin was stored on the blood glucose cart. Sixteen residents' insulin flex pens were observed on the blood glucose cart. There were no vials of insulin or syringes observed on the blood glucose cart. Nurse #5 stated the blood glucose cart should have been locked when unattended. Nurse #5 was unable to provide a reason why the blood glucose cart was left unlocked with the key in the lock.

On 5/21/2025 at 8:50 am in an interview with the Director of Nursing (DON), she stated residents' insulin pens were stored on the blood glucose cart. The DON stated the blood glucose cart should have been locked and the key to the blood

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F 761	Continued From page 46 glucose cart should have been with Nurse #5 any time the blood glucose cart was left unattended.	F 761		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to have sufficient dietary staff to serve the breakfast meal on time on 5/22/2025 for 7 of 7 halls. The findings included: Based on review of the meal serving times for the facility, breakfast was scheduled between 7:00 AM and 8:00 AM. On 05/22/2025 observations between 9:00 AM	F 802	F802 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 05/22/2025 It was identified that breakfast meals were late related to the dietary cook calling out of work outside of the two-hour requirement resulting in insufficient staffing. The regional dietary	6/20/25

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F 802	Continued From page 47 and 9:40 AM revealed breakfast carts arriving on the halls. On 5/23/2025 at 11:02 AM An interview was conducted with Cook #1. Cook #1's name was not on the schedule for 5/22/2025. Cook #1 (who prepared breakfast on 5/22/2025) revealed she usually did not work at the facility in the dietary department and only helped to fill the needs in the dietary department. She explained the facility called her on 5/22/2025 at 6:00 am to help because the facility did not have a cook on the morning of 5/22/2025. She explained she lived two hours away from the facility and arrived at 7:30 am on 5/22/2025 to help prepare the breakfast menu. On 5/22/2025 at 11:04 AM an interview with the Dietary Manager revealed the cook was scheduled to arrive at 5:30 am to start preparing breakfast meals. He stated on 5/22/2025 there were 3 dietary staff that included 1 cook and 2 dietary aides scheduled for 5/22/2025. The scheduled cook did not report to work, and he had to call in a cook from a sister facility in Oxford to help cover the dietary department on 5/22/2025. He explained due to the cook not reporting to work and the cook from the sister facility not arriving at the facility until 7:34 am, the breakfast meal on 5/22/2025 did not arrive to the resident halls as scheduled. On 5/23/2025 at 2:11 pm an interview with the Administrator revealed her concerns with the dietary department and the elimination of some dietary staff. Due to the staff turnover in the dietary department and having to re-educate new dietary staff, the facility has been unable to obtain a consistent improvement in resident satisfaction	F 802	manager had employees come in from a sister facility to assist with staffing on 05/22/2025. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice. The dietary manager audited scheduling and staffing on 5/23/2025 for the rest of the week and scheduled support staff. No call outs were reported. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; Education was provided on 05/22/2025 from the regional dietary director to the dietary manager on enforcing the two hour call out requirements and scheduling sufficient staff to ensure dietary department is running smoothly and efficiently. The Dietary manager educated all staff regarding the two hour call out requirement on 6/19/25. All new hires after 6/19/25 will receive this education during orientation. Staff will not be allowed to work until this education is received. The dietary manager will audit the schedule to ensure adequate staffing for compliance and that the two hour call out requirement is followed 5 days a week for 12 weeks. All negative findings will be corrected/addressed immediately. 4.How the facility plans to monitor its performance to make sure that solutions	

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F 802	Continued From page 48 with the dietary services.	F 802	are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family and staff interviews, the facility failed to serve food in a form that met the resident's needs for 1 of 1 resident (Resident #84) reviewed. Resident #84 had been ordered food that was pureed texture and was observed eating a mechanically chopped breakfast meal. The findings included: Resident #84 was admitted to the facility on 8/5/24 with diagnoses which included Progressive Supranuclear Palsy (a neurodegenerative disease involving the gradual deterioration of the brain), secondary Parkinsonism, and dysphagia (difficulty swallowing). Record review indicated Resident #84 had a	F 805	F805 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Resource Nurse monitored Resident #84 on 5/23/2025 for any adverse side effects from receiving the incorrect diet. There were no adverse side effects. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents that have a pureed diet have the potential to be affected by the deficient practice. The Director of Nursing, Staff Development Coordinator and unit managers audited all residents with	6/20/25

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F 805	Continued From page 49 Physician's Order, dated 1/16/25, for a Regular Diet, pureed texture, thin liquids consistency, double protein for all meals. A review of Resident #84's quarterly Minimum Data Set (MDS), dated 03/24/25, revealed the resident to have the ability to understand others and to make himself understood. The MDS indicated he was severely cognitively impaired. He had no impairment in his upper extremities and required setup or clean-up assistance when eating. The MDS indicated Resident #84 had a swallowing disorder and was on a mechanically altered diet. A review of Resident #84's Care Plan, last revised on 4/16/25, indicated the following focuses: 1) at risk for injury related to his medical diagnoses and stated he pockets food at times (holding food in the mouth without swallowing it); 2) refuses to allow staff to assist with meals and eating; and 3) requires assistance with his Activities of Daily Living. Interventions included, in part, a therapeutic diet as ordered, staff assistance with meal setup, encouragement by staff to allow with assistance with his meals, cues and reminders to improve his meal intake, assurance that he is safe and if he became distressed to listen to him and try to calm him. An interview was conducted with Resident #84's Responsible Party (RP) on 5/19/25 at 1:34 PM. The RP stated he and another family member visit the resident at the facility almost daily and while there, assist him with his lunch and supper meals. He explained the resident ate a pureed diet and took a long time to eat. The RP expressed concern that the resident had been brought solid food for a couple of his meals in	F 805	pureed diets on 5/23/2025 to ensure they received the correct diet consistency. There were no other discrepancies. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; The Regional Dietary Director educated the Dietary Manager on providing the correct diet to include the proper consistency on 6/16/2025. The dietary manager educated the dietary staff on providing the correct diet to include proper consistency. This education will be completed by 6/19/2025. All new dietary employees will receive this education during orientation. The dietary manager will audit 5 trays 5x/week x 2 weeks, 5 trays 3x/week x 2 weeks and 5 trays weekly x 8 weeks to ensure the resident is receiving the correct diet. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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January 2025.

An observation of and interview with Resident #84 was conducted on 5/20/25 at 11:38 AM. He was observed sitting up in his wheelchair, in his room beside his bed. He was awake, alert and able to respond to yes and no questions by giving a thumbs-up for a yes answer and a thumbs-down for a no answer. When he was asked if he had ever been served food that was not in pureed form, he gave a thumbs up. When asked if that had happened often, he gave a thumbs down. When asked if the staff who had brought that regular consistency food to him in the past had realized the error and replaced it with the pureed version of that food, he gave a thumbs up.

An observation of Resident #84 was conducted on 5/23/25 at 8:36 AM. He was sitting up in his bed and was observed eating. A small bowl that contained grits, scrambled eggs and sausage had been placed on his overbed table which was positioned across his lap. The eggs and sausage appeared to have a mechanically chopped texture (foods that are ground into very small pieces making it easier for people who have difficulty chewing or swallowing eat) instead of a pureed texture (foods that are smooth and pudding-like texture). He was observed using an adaptive spoon (a utensil with an easy-grip handle) to eat the grits. There was no tray or meal ticket on the table or in his room. Resident #84's nursing assistant (NA), NA #1, entered the room, introduced herself as the NA assigned to his care that day, and asked him if he was done eating and the resident indicated he was.

An interview was conducted with NA #1 on

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5/23/25 at 12:05 PM. NA #1 stated Resident #84 had orders for a pureed diet with double portions. When asked about his breakfast, NA #1 claimed she knew the resident's likes and dislikes very well and because she had fed him most of his breakfast, she had asked if he would like to eat some more, by himself, and said he indicated he would like to do that. Instead of leaving everything, she had taken some of the remaining eggs and sausage from his plate and put them into his bowl of grits, placed the bowl on his overbed table and gave him his spoon. She then removed the tray and left him to eat on his own. When asked about the texture of the foods in the bowl, NA #1 explained that grits and eggs always had that consistency, but the sausage appeared to have been a mechanically chopped texture. NA #1 further explained she realized the sausage had not been pureed when she sat down to feed him and removed the dome from his plate. She stated she had planned on going to the kitchen to get him the pureed version of sausage, but said the resident told her that he did not want any sausage that morning, so she did not go to the kitchen. NA #1 could not explain why she put the sausage into the bowl of grits that she had left with the resident except for saying that because he had said he did not want to eat any sausage that morning she knew he would not eat it. When asked if she had reported Resident #84 received a mechanically chopped diet that morning, she initially said she had reported it to the Resource Nurse on the hall and then admitted she had not.

An interview was conducted with the Resource Nurse, Nurse #4, on 5/23/25 at 11:15 AM. Nurse #4 explained Resident #84 had orders for a pureed diet and could feed himself, but it took a long time for him to eat. He explained that

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nursing staff would assist him, if he allowed it, and said the resident would sometimes push away staff who are trying to feed him. Nurse #4 stated when the resident wants to feed himself, staff will make frequent checks on his progress and offer him verbal cues and encouragement to eat. Nurse #4 stated he was unaware Resident #84 had received a mechanically chopped breakfast meal that morning and stated he would talk with the dietary department about the error.

An interview was conducted with the Dietary Manager (DM) on 5/23/25 at 11:27 AM. The DM explained the difference between a mechanically chopped food item and a pureed one. He stated that for mechanically chopped food, they have a machine that grinds the food into very small pieces. For pureed food, the food is blended to the consistency of applesauce and is smooth. The DM stated a resident's diet order is entered into their computer system and tray tickets that contain the order are printed out for each meal. He explained at mealtimes, one staff member calls out the diet order from the ticket and another staff member puts the correct consistency foods on the trays. The DM stated he had prepared all the breakfast trays that morning and could not offer an explanation as to how Resident #84 received a mechanically chopped diet that morning. The DM stated he had thought the pureed food appeared grainy instead of smooth that morning but did not question Cook #1 who had prepared the food that morning.

An interview was conducted with Cook #1 on 5/23/25 at 11:34 AM. Cook #1 stated that you could see the difference between the different types of textures of the foods she prepared, explaining that mechanically chopped food was

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F 805	Continued From page 53 ground up food that had a bumpy texture while pureed food looked smooth, like baby food. She stated she was unaware Resident #84 had received a mechanically chopped breakfast that morning. Cook #1 said she had placed the pureed sausage right beside the mechanically chopped sausage in the steam table and that they definitely looked different. An interview was conducted with the Director of Nursing (DON) on 5/23/25 at 11:50 AM. The DON stated it was her expectation that residents receive the food that had been ordered for them. An interview was conducted with the Administrator on 5/23/25 at 11:51 AM. The Administrator stated it was her expectation that residents receive the correct food consistency as ordered.	F 805		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative	F 809		6/20/25

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F 809	Continued From page 54 meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident interviews and staff interviews, the facility failed to provide the breakfast meal on 5/22/2025 at times comparable to normal, scheduled mealtimes at the facility. This affected all residents that received food by mouth on 7 of 7 halls (Halls, 100,200, 300, 400, 500, 600 and 700). The facility had a census of 141. The findings included: Based on review of the meal serving times for the facility, breakfast was scheduled as follows: -the 700-hall breakfast time was 07:20 AM -the 200-hall breakfast time was 07:40 AM -the 300-hall breakfast time was 07:50 AM - the 400-hall breakfast time was 08:00 AM - the 100-hall breakfast time was 07:35 AM -the 500-hall breakfast time was 07:00 AM On 05/22/2025 at 09:00 AM an observation was made that 100 hall breakfast trays had not arrived at the 100 hall. Further observation revealed that the only trays that had arrived on any halls were 500 hall trays. Nursing staff were observed offering cereal and milk to residents due to the delay in receiving breakfast meal trays and there were no issues identified with diabetic residents receiving breakfast meal trays later than regularly scheduled The following carts arrived on the halls as follows: -700 hall breakfast cart arrived on the hall at	F 809	F809 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 05/22/2025 all meal trays were delivered late. The dietary manager had cereal and milk delivered to residents as substantial snack before breakfast meal was served on 05/22/2025. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice. On 05/23/2025 the dietary manager audited mealtimes and meal trays were prepared and delivered on time. No late meals were observed. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; Education was provided from the regional dietary director to the dietary manager on 05/23/2025 on dietary mealtimes, the 14 hour state regulation on serving timely nutritious meals to residents, and if meals are late adequate snack must be delivered to residents. All staff were educated on 6/19/25 by the dietary manager regarding: 1. 14 hour meal state regulation regarding	

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	345213	A. BUILDING _____ B. WING _____	C 05/23/2025

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F 809	Continued From page 55 09:10 AM on 5/22/2025 -200 hall breakfast cart arrived on the hall at 09:19 AM on 5/22/2025 -the second breakfast cart for the 200-hall arrived at 0923 AM on 5/22/2025 -the 300/400 hall breakfast cart arrived at 09:27 AM on 5/22/2025 -the 400-hall breakfast cart arrived at 09:33 AM on 5/22/2025 -the 100-hall breakfast cart arrived at 09:40 AM on 5/22/2025 On 5/22/2025 at 09:13 AM a brief interview with the Dietary Manager revealed that two cooks had called out from work to the Dietary Manager. 05/22/25 at 09:06 AM an interview with Nurse Aide (NA) staff NA #1 revealed that breakfast trays normally were delivered to the hall between 08:00 AM and 08:15 AM. On 5/22/2025 at 11:52 AM an interview with the Dietary Manager revealed the reason the breakfast meal was late today was because two scheduled cooks called out and there was not enough time to schedule another staff. The Dietary Manager stated he was made aware at 7:00 AM. The Dietary Manager revealed that another team from a sister facility arrived and they were able to get started at 800 AM. On 5/23/2025 10:31 AM an interview with the Director of Nursing (DON) revealed that every staff understood when the trays were supposed to be on the hall. If trays are not seen and are late, staff would use the group chat on their phones to text management to communicate if trays were late as well as ask if snacks were available, for instance cereal and milk for	F 809	meals to residents. 2. If meals are late adequate snack must be provided to residents. The Dietary Manager or assistant manager will audit mealtimes in the dietary department and snack deliveries to ensure compliance 5 days a week for 12 weeks. All new hires after 6/19/25 will receive this education during orientation. Staff will not be allowed to work until this education is received. The dietary manager will review the audits, and negative findings will be corrected/addressed when noted. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	

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F 809	Continued From page 56 breakfast. On 5/22/2025 02:09 AM An interview with the Administrator revealed that food trays are expected to be delivered on time. If the food trays are late, a snack should be offered to the residents.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove leftover food stored past the use by date in 1 of 2 refrigerators observed (reach-in refrigerator). This practice had the potential to affect food served to residents. The findings included:	F 812	F812 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The dietary manager discarded all	6/20/25

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F 812	Continued From page 57 On 5/19/25 at 09:50 AM during the observation of the kitchen area with the Dietary Manager (DM) revealed leftover prepared food in the reach in refrigerator. The Dietary Manager reported leftover food was good for 48 hours after being prepared. The following leftover items observed were: - chicken soup in a stainless-steel container covered with plastic wrap dated 5/10/25 - diced ham in a stainless-steel container covered with plastic wrap dated 5/13/25 - spinach in a stainless-steel container covered with plastic wrap dated 5/13/25 - cauliflower puree in a stainless-steel container covered with plastic wrap dated 5/15/25 - sliced turkey in a stainless-steel container covered with plastic wrap dated 5/15/25 On 05/20/25 08:53 AM an interview with the Dietary Manager (DM) revealed that if there were leftovers, the leftovers were cooled down, wrapped and dated for the day the leftovers were prepared. The DM reported the leftovers were dated using a date dot label, that included the item name, date of prep, date of holding time (how long it was to be kept) and name of the staff who dated the item. The leftovers were kept no more than 48 hours per the DM. The DM indicated the cooks were responsible for checking the refrigerators daily and disposing of the leftover food after 48 hours. On 05/22/25 02:09 PM Interview with the Administrator revealed food storage should be done according to the facility's policy and food safety guidelines were followed.	F 812	outdated leftovers on 5/19/2025. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice. The dietary manager audited the walker in cooler on 5/19/2025 for any further outdated food. All remaining food was dated appropriately. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; The Regional Dietary Manager educated the Facility Dietary manager on 6/16/2025 on labeling, dating and adhering to dates on expired foods. All dietary staff were educated by the dietary manager on 6/19/25 on labeling, dating and proper storage of food in the walk-in cooler. All new hires after 6/19/25 will receive this education during orientation. Staff will not be allowed to work until this education is received. The dietary manager will audit the walk-in cooler for labeling, dating and expired leftovers 5x/week x 2 weeks, 3x/week x 2 weeks and weekly x 8 weeks to ensure compliance. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further	

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F 812	Continued From page 58	F 812	systemic changes. Date of Compliance: 6/20/25	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to close doors on the dumpsters to prevent possible pest and rodents entry for 4 of 4 dumpsters reviewed. The findings included: On 5/19/25 at 09:50 AM during an observation with the Dietary Manager of the dumpster area, all doors to the four dumpsters were open. Debris was observed on the ground to the left of dumpster #4 consisting of paper and blue plastic gloves. On 5/19/25 at 10:38 AM, an observation of the dumpster area revealed the doors were still open on 4 of the 4 dumpsters. On 5/20/25 at 8:51 AM, an observation from the facility breezeway revealed the doors of dumpster #4 were open. On 5/20/25 at 8:53 AM, an interview with the Dietary Manager revealed he had not had any issues with pests, rodents or roaches, but had seen cats in the area. He stated that dietary and housekeeping were responsible for cleanliness and door closure of the dumpster area.	F 814	F814 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 05/19/2025 and 5/20/25 it was identified that the dumpster doors were left open. The dietary manager closed the doors on the dumpster on 5/19/2025 and 5/20/25. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice. The dumpsters were audited twice daily on 5/21/25, 5/22/25, and 5/23/25. No open dumpster lids were found. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur; In-service was provided by the regional dietary director to the dietary manager on 05/20/2025 on the dumpster lids and doors must remain closed when not in immediate use. All dietary staff were educated on 6/19/25 by the dietary manager that dumpster lids	6/20/25

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F 814	Continued From page 59 On 05/21/25 at 9:21 AM, an interview with the Housekeeping Manager revealed that dietary and housekeeping were responsible for cleanliness and door closure of the dumpster area. On 5/22/2025 at 2:09 PM, an interview with the Administrator revealed her expectation that staff needed to maintain cleanliness around the dumpster area and close the doors of the dumpsters. The dietary staff and housekeeping staff were responsible for the dumpster areas. Dietary was mostly responsible for the dumpster areas since they are located closest to the dumpster area.	F 814	and doors must always remain closed when not in immediate use. All housekeeping staff were educated on 6/19/25 by the dietary manager that dumpster lids and doors must always remain closed when not in immediate use. The dietary manager, assistant manager, and dietary cook will audit the dumpsters twice daily for 8 weeks. All new hires after 6/19/25 will receive this education during orientation. Staff will not be allowed to work until this education is received. 4.How the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 6/20/25	