STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/13/25 through 4/16/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #58MB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/13/25 through 4/16/25. Event ID# 58MB11. The following intakes were investigated NC00229204, NC00229332, NC00218894, NC00220439, NC00220845, NC00220969, NC00222192, NC00222288, NC00225576, NC00226030, NC00229125, and NC00229042. 2 of the 26 complaint allegations resulted in deficiency.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		5/12/25

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

Electronically Signed | 05/09/2025

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F 644	Continued From page 1 serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with a newly identified serious mental illness for a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #55). Findings included: Resident #55 was admitted to the facility on 3/9/20. A Level I PASRR determination notification letter dated 3/9/20 indicated "No further PASRR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions." A review of Resident #55's medical record indicated on 6/25/24 the diagnosis of bipolar disorder was added and on 12/24/24 the diagnosis of major depressive and generalized anxiety disorders was added. There was no evidence indicating a Level II PASRR referral had been completed for Resident #55 after the new diagnoses of serious mental illnesses had been identified. An interview with the Social Worker (SW) on 4/14/25 at 11:25 a.m. revealed she was not aware Resident #55 had new serious mental illness	F 644	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F-644 Coordination of PASRR and Assessments 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A Level II PASRR screening request was submitted for resident #55. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents are at risk for this deficient practice. On April 18, 2025, the facility Discharge Planner completed a 100% audit of all residents with mental health diagnosis to ensure that they have received the correct level of screening. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/7/25 the Facility Administrator re-educated the facility discharge planner	

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F 644	Continued From page 2 diagnoses. She further stated it was her responsibility to complete a Level II PASRR screening for the residents. She revealed she would be notified by the Minimum Data Set (MDS) nurse or Director of Nursing (DON) of new identified mental health diagnosis. In an interview with the DON on 4/15/25 at 11:23 a.m. she revealed the medical record system was configured to alert the SW of new identified mental health diagnoses and was not sure why the SW did not receive an alert in the instance of Resident #55. During an interview with the Administrator on 4/16/25 at 9:09 a.m. he revealed he was not aware Resident #55's Level II PASRR referral had not been completed and explained this was a problem. He revealed the SW will be retrained and complete an audit of all residents who may require a PASRR referral.	F 644	regarding the proper procedures for submitting PASRR screening request, including the process for resubmitting resident with new mental health diagnosis. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The facility Discharge Planner will audit residents with mental health diagnosis for the correct level of PASRR screening weekly for four weeks, then monthly for an additional two months. The facility Discharge Planner will report the audit findings weekly to the facility administrator who will provide a summary of findings monthly to the facility□s QAPI Committee for recommendations. 5. Date of Compliance: 5/12/25	
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	F 656		5/12/25

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F 656	Continued From page 3 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 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 and staff interviews, the facility failed to develop a comprehensive care plan from 12/27/24 through 3/13/25 for 1 of 1 resident reviewed for urinary catheter (Resident #37). The facility also failed to update the care plan to reflect the change in the dialysis schedule for 1 of 2 residents reviewed for dialysis	F 656	F656 Develop/Implement Comprehensive Care Plan 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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F 656	Continued From page 4 (Resident #48) and failed to update the care plan to reflect the change in dietary status for 1 of 2 residents reviewed for tube feeding (Resident #79). The findings included: Resident #37 was readmitted to the facility on 12/4/24 with diagnoses which included obstructive and reflux uropathy. She was hospitalized from 11/21/24 through12/4/24 and 3/11/25 through 3/13/25. The Minimum Data Set (MDS) admission assessment dated 10/29/24 revealed Resident #37 was cognitively intact and was coded as frequently incontinent of bladder. The Admission/Readmission Nursing Collection Tool dated 12/4/24 and completed by Nurse #1 revealed that Resident #37 returned to the facility with an indwelling urinary catheter. A care plan for Resident #37's indwelling urinary catheter was originally created on 12/4/24 and resolved on 12/27/24 by MDS Coordinator #1. Interventions included: maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. The Provider Progress note dated 12/18/24 and completed by the Nurse Practitioner revealed that Resident #37 had an indwelling urinary catheter when genitourinary details were reviewed. The infection note dated 1/23/25 at 11:19 PM and completed by Nurse #3 revealed that	F 656	The care plan for resident number #37 was updated to reflect the use of a urinary catheter. The care plan for resident #48 was updated to reflect the change in dialysis schedule and the care plan for resident #79 was updated to reflect the change in dietary status regarding the resident□s tube feeding. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 4/16/2025 the MDS nurses completed a 100% audit of all current residents with a foley catheter, residents receiving dialysis and or receiving tube feeding to ensure accuracy of the care plan. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/8/2025_MDS coordinators were educated by Regional Director of Clinical Reimbursement regarding appropriate and accurate care planning of foley catheter, dialysis, and tube feeding diet orders per RAI manual guidelines. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Regional Director of Clinical Reimbursement will audit 5 Residents with foley catheter, receiving dialysis,	

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F 656	Continued From page 5 Resident #37's indwelling urinary catheter was documented as patent and draining. In an interview with the Minimum Data Set (MDS) Coordinator #1 on 4/16/25 at 9:42 AM, they revealed that if a resident was readmitted with an indwelling urinary catheter, then the care plan should be updated within 14 days to include that focus. She stated she was normally notified in the morning clinical meeting of any changes in a resident's clinical status. Resident #37's care plan was updated on 12/4/24 to include the new indwelling urinary catheter from the hospital, but it was resolved on 12/27/24 because MDS Coordinator #1 did not see any orders in Resident #37's electronic medical record (EMR) or the hospital discharge summary on 12/4/24. MDS Coordinator #1 stated she could not provide a reason why she did not assess the resident visually and reconcile with the electronic medical record. She indicated that she saw so many residents, it was hard to keep track. The indwelling urinary catheter section in the care plan was readded on 3/13/24 when Resident #37 returned from another hospitalization. The care plan for Resident #37 updated on 3/13/25 revealed that the resident requires a urinary catheter related to: obstructive uropathy. Interventions included: change per physician order, empty as needed and record output, maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. A joint interview with the Director of Nursing (DON) and Assistant DON on 4/16/25 at 10:13	F 656	and/or receiving tube feeding for care plan accuracy weekly for 4 weeks, biweekly for 2 weeks, and then monthly until substantial compliance is achieved. The Administrator or designee will report the findings to the Quality Assurance Improvement Committee for further recommendations as indicated. 5. Date of Compliance: 5/12/25	

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F 656	Continued From page 6	F 656		

AM revealed that on 12/4/24, the admitting nurse should have entered urinary indwelling catheter orders. When entering documentation in the admission collection tool, the chosen answers automatically updated the care plan. They stated that the MDS nurses should have visually assessed Resident #37 and provided accurate support with record review.

The Administrator was interviewed on 4/16/25 at 3:58 PM. He stated that MDS Coordinator #1, who resolved the catheter care plan on 12/27/24, should have completed a reassessment to see if the indwelling urinary catheter was still present or removed from Resident #37.

2. Resident #48 was admitted to the facility on 7/29/21 with diagnoses that included kidney transplant failure, end stage renal disease (ESRD) and dependence on renal dialysis.

The quarterly minimum data set (MDS) assessment dated 2/10/25 indicated Resident #48 had severe cognitive impairment. Resident #48 was coded as receiving dialysis.

The comprehensive care plan for Resident #48 was initiated 10/23/24 and last reviewed 2/10/25. The care plan included in part the focus area of Resident #48 was at increased risk for complications secondary to requiring hemodialysis secondary to ESRD. The interventions included Resident goes to dialysis Tuesday, Thursday, and Saturday with an 11:00 AM chair time at the Dialysis Center.

Review of a physician's order dated 2/19/25 revealed Resident #48's dialysis days were Monday, Wednesday, Friday with an 11:00 AM

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F 656	Continued From page 7	F 656		

chair time at the Dialysis Center.

An interview was conducted with MDS Coordinator #1 on 4/16/25 at 1:13 PM. She indicated changes to residents' care was communicated each morning during the clinical meeting. MDS Coordinator #1 stated the care plans were usually updated in the clinical meeting. She further stated the care plan was not updated because the information probably did not get communicated.

An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 3:11 PM. The DON stated information was pulled from the 24-hour report and reviewed each morning during the clinical meeting. She stated the nurse who entered the dialysis order was responsible for making sure changes to Resident #57's dialysis schedule was communicated in the 24-hour report. The DON stated the MDS nurse should have updated the care plan to reflect the change in resident's dialysis scheduled days.

3. Resident # 79 was admitted to the facility on 12/17/24 with diagnoses that included oropharyngeal phase dysphagia and adult failure to thrive.

The quarterly minimum data set (MDS) assessment dated 3/19/25 indicated Resident #79 had severe cognitive impairment with disorganized thinking and inattention. Resident #79 was coded for feeding tube and received more than 51% of her calories from feeding.

The comprehensive care plan for Resident #79 was initiated 12/23/24 and last updated 3/18/25. The care plan included in part a focus area of

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F 656	Continued From page 8 Resident #79 was at risk for complications related to the need for an enteral tube feeding and for possible malnutrition with tube feeding. The interventions included Resident # 79 received a meal tray. Review of a physician's order dated 3/19/25 revealed Resident #79 had a diet order for nothing by mouth (NPO), NPO texture, NPO consistency. An interview was conducted with MDS Coordinator #1 on 4/16/25 at 1:13 PM. She indicated changes to residents' care was communicated each morning during the clinical meeting. MDS Coordinator #1 stated Resident #79 had two different care plans for tube feeding. She indicated the care plan should have been updated to reflect Resident #79's updated diet status of NPO. An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 3:11 PM. The DON stated information was pulled from the 24-hour report and reviewed each morning during the clinical meeting. She stated the nurse who entered the NPO order was responsible for making sure changes to Resident #79's diet was communicated in the 24-hour report. The DON stated the MDS nurse should have updated the care plan to reflect the change in resident's diet to NPO.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		5/12/25

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F 690	Continued From page 9 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to obtain physician orders for the management of an indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter (Resident #37).	F 690	F-690 Bowel/Bladder Incontinence, Catheter, UTI 1. Address how corrective action will be accomplished for those residents found to	

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F 690	Continued From page 10 The findings included: Resident #37 was readmitted to the facility on 12/4/24 with diagnoses which included obstructive and reflux uropathy. She was hospitalized from 11/21/24 through 12/4/24 and 3/11/25 through 3/13/25. The Minimum Data Set (MDS) admission assessment dated 10/29/24 revealed Resident #37 was cognitively intact and was coded as frequently incontinent of bladder. The care plan for Resident #37 was created on 12/4/24 and resolved on 12/27/24 revealed that the resident requires a urinary catheter. Interventions included: maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. The Admission/Readmission Nursing Collection Tool dated 12/4/24 and completed by Nurse #1 revealed that Resident #37 returned to the facility with an indwelling urinary catheter. The Provider Progress note dated 12/18/24 and completed by the Nurse Practitioner revealed that Resident #37 had an indwelling urinary catheter when genitourinary details were reviewed. Review of Resident #37's electronic medical record from 12/4/24 until 3/11/25 revealed no physician orders regarding the care of her indwelling urinary catheter. The skilled note dated 1/14/25 at 3:50 PM and completed by Nurse #2 revealed that urine was	F 690	have been affected by the deficient practice; The facility assessed resident #37 and ensured the correct catheter placement, then an order was obtained for the catheter on this resident. The resident was assessed for complications or adverse effects, and none were identified. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with catheters are risk for this deficient practice. On 4/15/2025 the Director of Nursing performed an audit for all residents with catheters to ensure that all residents with catheters had the proper physician orders. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 4/23/25 the Staff Development Coordinator completed re-education for all licenses nurses, including agency nurses on the admission process, emphasizing the importance of verifying and entering all physician orders for residents with indwelling catheters accurately into the medical records at the time of admissions. 4. Indicate how the facility plans to monitor its performance to make sure that	

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F 690	Continued From page 11 obtained from Resident #37 for diagnostic testing. The infection note dated 1/23/25 at 11:19 PM and completed by Nurse #3 revealed that Resident #37's indwelling urinary catheter was documented as patent and draining. The care plan for Resident #37 created on 3/13/25 revealed that the resident requires a urinary catheter related to: obstructive uropathy. Interventions included: change per physician order, empty as needed and record output, maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. Resident #37 had the following physician orders related to an indwelling catheter dated 3/14/25: - Check indwelling urinary catheter anchor placement each shift - Check indwelling urinary catheter anchor each week and as needed every day shift every 7 days for catheter care - Indwelling urinary catheter care each shift - Change indwelling urinary catheter as needed for clinical indications such as infection, obstruction, or when the closed system is compromised Multiple telephone attempts were made to contact Nurse #1, but she did not return the call. A telephone interview was conducted with Nurse #3 on 4/14/25 at 1:52 PM. She revealed if a resident had an indwelling urinary catheter, then catheter care must be provided each shift or if they are incontinent, whenever they had a bowel	F 690	solutions are sustained; and The Director of nursing or designee will audit new admissions orders 3 times weekly for 4 weeks, twice weekly for 4 weeks then weekly for 4 weeks to ensure compliance. Additional corrective action will be taken as needed. The Director of Nursing will submit a summary of the audit findings to the QAPI monthly for their review and input. 5. Date of Compliance: 5/12/25	

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	345449	A. BUILDING _____ B. WING _____	C 04/16/2025

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F 690	Continued From page 12	F 690		

movement. Also, it was important to make sure the bag was anchored and positioned correctly, and output was monitored. All catheter instructions should be included in the medication administration record (MAR), or treatment administration record (TAR). Nurse #3 stated that Resident #37 had a catheter when she was readmitted to her assigned hall on 12/4/24. She could not remember if the orders were entered at that time or not. Nurse #3 indicated that she knew how to care for an indwelling urinary catheter, even if there were no orders.

During a telephone interview with Nurse #2 on 4/14/25 at 2:16 PM, she revealed that indwelling urinary catheters were monitored to make sure it was draining or had discoloration or sediment present. If the indwelling urinary catheter needed to be changed, then she would do so if it became clogged, not draining, or leakage/comes out. Indwelling urinary catheter care was mainly performed by the nurse aides. If she was helping with incontinence care, then she would assist with catheter care at the end. Nurse #2 stated that Resident #37 was readmitted from the hospital (12/4/24) with the indwelling urinary catheter. Catheter instructions/care were sometimes included on the TAR or on the MAR. Nurse #2 stated that there should always be an order for catheter care and when changing the indwelling urinary catheter. She indicated she had been a nurse for 30 years and if there were not any orders for an indwelling urinary catheter, then she would do what she "normally does" with catheters. She did not realize there was a lack of indwelling urinary catheter orders for Resident #37, but if she did, she should have notified her supervisor.

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F 690	Continued From page 13 An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 8:06 AM. She revealed that she could not find any catheter care/changing orders for Resident #37 prior to 3/14/25, and she could not say the exact date when the indwelling urinary catheter was inserted for Resident #37. The DON stated that when the facility received Resident #37 on 12/4/24 with a newly inserted indwelling urinary catheter, orders for catheter care and changing of the catheter should have been entered immediately by the admitting nurse (Nurse #1). The DON indicated that the orders were not put in for Resident #37's catheter perhaps because nursing staff just assumed that catheter care/changing would be completed, even if the orders were not entered. The Administrator was interviewed on 4/16/25 at 3:56 PM. He stated that none of the nursing staff followed up on Resident #37's hospital discharge summary dated 12/4/24 missing indwelling urinary catheter care orders. Regardless, Nurse #1 should have contacted the Medical Director for clarification orders.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F 693		5/12/25

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F 693	Continued From page 14 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to label a new tube feeding formula bottle when it was hung for 1 of 2 residents with a feeding tube (Resident #245). The findings included: Resident #245 was admitted to the facility on 4/3/25 with diagnoses which included failure to thrive, dysphagia, and gastrostomy status (surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding or drainage). Gastrostomy, feeding tube, and enteral tube feeding are interchangeable descriptions. Review of Resident #245's admission Minimum Data Set (MDS) assessment dated 4/10/25 revealed she was cognitively intact and was dependent on staff with most activities of daily living (ADL). Resident #245 received all nutrition and hydration through the feeding tube. Review of Resident #245's care plan dated 4/3/25 revealed she was at risk for complications related to the need for a feeding tube. Interventions	F 693	F693 Tube Feeding Management/Restore Eating Skills 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The tube feeding bottle for resident #245 was removed and a new bottle was hung and correctly labeled. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents who receive enteral feeding are at risk for this deficient practice. On 4/13/2025 the Director of Nurses completed an audit of all residents that receive enteral feedings. To ensure that all feeding bottles are properly labeled. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 693	Continued From page 15 included: administer tube feedings and flushes per order, head of bed elevated during feedings per order, pause feedings during personal care as indicated, residual checks per order, and tube insertion site care per order. Review of a physician order dated 4/11/25 revealed an order for Resident #245 to receive Glucerna 1.5 at 65 milliliters (ml) per hour (hr) administered continuously over 12 hours (6:00 PM - 6:00 AM) with all shifts required to document in the medication administration record (MAR). Check tube placement prior to administration. Review of the April 2025 MAR revealed that Nurse #2 signed off Resident #245's enteral tube feeding of Glucerna 1.5 at 65 ml/hr was started at 6:00 PM on 4/12/25. An observation of Resident #245's tube feeding formula bottle was conducted on 4/13/25 at 11:52 AM. There were no date, time, or flow rate on the tube feeding bottle. An observation and interview with the Assistant Director of Nursing (ADON) was conducted on 4/13/25 at 11:53 AM. She stated that when nurses hang a new tube feeding formula bottle, they needed to label it with the resident's name, date, time, and flow rate per hour. The ADON stated that Resident #245's tube feeding was started at 6:00 PM on 4/12/25 and completed at 6:00 AM this morning. Nurse #2 was interviewed via telephone on 4/14/25 at 2:25 PM. She revealed that when hanging a new tube feeding bottle, she was supposed to label it with the resident's name,	F 693	recur; On 4/23/25 the Staff Development Coordinator re-educated all licensed nurses, including agency nurses on the facility policy and procedure for labeling tube feeding. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing or designee will perform audits on all residents that receive enteral feeding using feeding bottles 3 times weekly for 4 weeks, twice weekly for 4 weeks then weekly for 4 weeks to ensure compliance. Additional corrective action will be taken as needed. The Director of Nursing will submit a summary of audit findings to the QAPI monthly for their review and input. 5. Date of Compliance: 5/12/25	

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F 693	Continued From page 16 date and time of administration, and the flow rate per hour. Nurse #2 was not sure why she had not labeled Resident #245's tube feeding formula bottle at 6:00 PM on 4/12/25. During an interview with the Director of Nursing (DON) on 4/15/25 at 12:01 PM, she revealed that when a new tube feeding bottle was hung, the nurses should label the bottle with their name, the resident's name, the date and time of administration, and the rate of the tube feeding formula administration. The DON stated that the tube feeding bottle in Resident #245's room should have been properly labeled when hung at 6:00 PM on 4/12/25 by Nurse #2. The Administrator was interviewed on 4/16/25 at 3:59 PM. He stated that Resident #245's tube feeding bottle hung on 4/12/25 by Nurse #2 should have been properly labeled.	F 693		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		5/12/25

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F 755	Continued From page 17 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and the facility policy, the facility failed to ensure a staff member followed facility policy to sign off a controlled medication immediately after administering on the controlled medication count sheet. This occurred for 1 of 4 staff observed during medication administration (Nurse #1). The findings included: Review of the facility policy entitled: Pharmacy Preparation and General Guidelines: IIA6 -Controlled Substances Policy read in part: "When a controlled substance is administered, the licensed nurse immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration 2) Amount administered 3) Remaining quantity 4) Initials of the nurse administering the dose,	F 755	F755-Pharmacy 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The controlled medication count was verified and reconciled. No discrepancies or medication errors found. The nurse involved was counseled and re-educated on the facility policy; as well as the importance of immediately documenting the administration of controlled medications. Additionally, the RN Staff Development Coordinator conducted two routine medication pass observations with Nurse #1 to ensure understanding and to reinforce compliance. 2. Address how the facility will identify	

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F 755	Continued From page 18 completed after the medication is actually administered." During an observation of medication pass on 4/15/25 at 8:40 AM, Nurse #1 was observed administering one controlled medication to Resident #57: Oxycodone 10mg - Give 1 tablet by mouth every 12 hours as needed for pain. Nurse #1 removed the Oxycodone medication from the bubble pack and administered it to Resident #57. Nurse #1 did not document (sign out) the medication on the controlled medication count sheet. An interview was conducted with Nurse #1 with the Assistant Director of Nursing present on 04/15/25 at 10:22 AM. Nurse #1 confirmed she had not completed the narcotic medication count sheet immediately for the controlled medication she administered to Resident #57. Nurse #1 acknowledged she should have pulled the narcotic medication, administered, and signed out the medication as soon as she administered it. An interview was conducted with the DON on 4/15/25 at 3:30 PM. The DON stated Nurse #1 should have pulled the narcotic medication, administered, and immediately signed the medication out on the controlled medication count sheet.	F 755	other residents having the potential to be affected by the same deficient practice; On 4/15/2025 the facility completed a review of all controlled medication count sheets for the past 7 days on all medication carts. No additional instances of delayed or missing signatures were found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 4/23/25 all licensed nurses including agency nurses re-educated by the RN Staff Development Coordinator on the facility□s policy on controlled medication handling, preparation, and documentation. Including a reinforcement of the shift-to-shift narcotic count process with emphasis on signature verifications on all prior entries. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing or designee will perform random audits on controlled substance sheets count sheets 3 times weekly for 4 weeks, twice weekly for 4 weeks then weekly for 4 weeks to ensure compliance. Additional corrective action will be taken as needed. The Director of Nursing will submit a summary of her findings to the QAPI monthly for their review and input. 5. Date of compliance: 5/12/2025	

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired medications 2 of 3 medication carts (D Hall Medication Cart and E Hall Medication Cart) reviewed for medication storage. The findings included: a. An observation of the D Hall medication cart with Medication Aide #1 on 04/16/25 3:55 PM	F 761	F-761 Label/Store Drugs and Biologicals 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; All expired medications were immediately removed from the medication carts and disposed of by the ADON according to facility and pharmacy policies.	5/12/25

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F 761	Continued From page 20 revealed an opened box of Bisacodyl Suppositories (medication used to cause a bowel movement) with an expiration date of 3/31/25. An interview with Medication Aide #1 on 4/16/25 at 4:01 PM revealed she thought the nurses were responsible for checking the medication carts for expired medications. b. An observation of the E Hall medication cart with Nurse #2 on 4/16/25 at 4:06 PM revealed: an opened bottle of CoQ10 (a dietary supplement used in some people with certain conditions)100 with an expiration date of 2/2025 and an opened bottle of Antacid Antigas liquid (medication used to help sooth or relieve heartburn, acid indigestion and sour stomach) with an expiration date of 2/2025. An interview with Nurse #2 on 4/16/25 at 4:09 PM revealed the nurse assigned to the medication cart was responsible for checking the cart for expired medication. Nurse #2 stated she had missed the medications during her cart check. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/16/24 at 4:13PM. The ADON stated the nurses assigned to the medication cart were responsible for checking the cart. The ADON further stated nurses on the management team check the medication carts as well as the pharmacist comes in monthly and does a thorough check of the medication carts.	F 761	The licensed staff responsible for the affected medication carts were re-educated by Staff Development Coordinator on the proper disposal procedures for expired medications. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Inspection of all medication carts, treatment carts, and the medication storage room was conducted by Unit Manager. No additional expired medications were found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Additionally, all licensed staff and contract associates were re-educated by the RN Staff Development Coordinator on the facility□s policies and procedures for medication storage and for the disposal of expired medications with emphasis on the requirement for weekly inspections of all medication storage areas. Education was completed on 4/24/2025. A new Medication Cart Audit Log was implemented to document weekly storage area checks by licensed staff for expired medications. In addition, the consultant pharmacist will verify compliance during monthly inspections. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and	

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F 761	Continued From page 21	F 761	The Director of Nursing or designee will perform weekly audits on all medication carts 3 times weekly for 4 weeks, twice weekly for 4 weeks then weekly for 4 weeks to ensure compliance. Additional corrective action will be taken as needed. The Director of Nursing will submit a summary of her findings to the QAPI monthly for their review and input. 5. Date of Compliance: 5/12/25	
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, policy review and staff interviews, the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean	F 812	F-812 Food Procurement, Store Prepare/Serve Sanitary The steam table shelf was immediately cleaned.	5/12/25

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F 812	Continued From page 22 under the shelf of 1 of 1 steam tables observed. This practice had the potential to affect residents. The findings included: A review of the Live Well Healthcare Solutions Food Service Closing Checklist read as: "All plate warmers, pellet warmers, tray racks and steam tables cleaned and turned off." During the kitchen observation on 04/15/25 at 3:09 PM the steam table was observed. The 5-foot steamtable shelf was observed with dark brown dried food debris. On 4/16/25 at 10:18 AM the 5-foot steamtable shelf was observed with dark brown dried food debris and was sticky to touch. In an interview on 4/16/25 at 10:20 AM the Corporate Dietary Supervisor stated staff should clean the steamtable shelf. In an interview on 4/16/25 at 12:10 PM the Administrator stated the kitchen staff would scrub the steamtable shelf clean. He reported they would add the shelf to the daily sanitation checklist and inspection.	F 812	The Dietary staff were re-educated by the Dietary Manager 5/11/2025 on proper cleaning and sanitation of the steam table including all surfaces. The steam table was added to the daily sanitation inspection list to be completed by the Dietary Manager or her designee. The dietary manager will inspect the steam table daily to ensure that proper sanitation is achieved and maintained daily for 10 days, then weekly for four weeks then monthly for an additional two months. The dietary manager will take additional corrective action as needed. The dietary manager will provide a summary of the findings weekly to the Facility Administrator. The Facility Administrator will provide a summary report to the Quality Assurance Performance Committee. In addition, she will provide a summary of findings to the facility QAPI Committee monthly for their review and input. Date of compliance : 5/12/2025	