STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/GREENVILLE	**2578 WEST FIFTH STREET , GREENVILLE, North Carolina, 27834**

(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
E0000	Initial Comments The survey team entered the facility on 6/2/25 to conduct a recertification and complaint investigation survey and exited on 6/6/25. Additional information was obtained on 6/9/25 through 6/11/25. Therefore, the exit date was changed to 6/11/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# LXBW11.	E0000		
F0000	INITIAL COMMENTS The survey team entered the facility on 6/2/25 to conduct a recertification and complaint investigation survey and exited on 6/6/25. Additional information was obtained on 6/9/25 through 6/11/25. Therefore, the exit date was changed to 6/11/25. The following intakes were investigated NC00230123, NC00230851, NC00230722, NC00230598, NC00229039, NC00231187, and NC00231611. 1 of the 13 complaint allegations resulted in a deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J). The tag F689 constitued Substandard Quality of Care. Immediate Jeopardy began on 5/31/25 and was removed on 6/6/25. An extended survey was conducted.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable	F0584	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilitys allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates	07/07/2025

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

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

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F0584 SS = D	Continued from page 1 and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews with staff, the facility failed to secure a packaged terminal air conditioner (PTAC) unit to the wall on 1 of 5 resident halls reviewed for the environment (Resident #280's room).	F0584	Continued from page 1 indicated. F 584 1. The PTAC (Packaged Terminal Air Conditioner) for resident #280 was secured to the wall. 2. This has the potential to affect all residents. On 6/26/2025 the maintenance staff audited all rooms in the facility to ensure that all PTAC units were secure and that there were no gaps from the unit to the wall. Any units needing securing will be corrected by the maintenance team by 7/2/2025. 3. The Administrator in-serviced the Department Heads including the maintenance dept on 6/27/2025 that when making rounds they are to ensure the PTAC units are secure and there are no gaps from the unit to the wall. 4. The Administrator will audit a sample of room weekly for 4 weeks to ensure all PTAC units are secure and there are no gaps from the unit to the wall. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0584 SS = D	Continued from page 2 The findings included: An observation of Resident #280's room on 6/3/25 at 8:20 AM revealed a packaged terminal air conditioner (PTAC) unit which is a self-contained heat and air conditioning unit was not secured to the wall. An area of outdoor grass was visible through the approximately ½ inch gap. An interview and observation of the PTAC unit in Resident #280's room was conducted on 6/4/25 at 10:50 AM with the Maintenance Director, he revealed the unit was coming away from the wall due to a screw missing which created an approximately ½ inch gap between the unit and the wall which allowed for the grass outside to be visible. The Maintenance Director stated he was not aware of this needed repair as no one had reported it to him. An interview with the Administrator was conducted on 6/6/25 at 8:40 AM. At that time, she revealed the department managers were tasked to conduct room inspections daily. These inspections should have found the unit missing a screw and coming away from the wall and been reported to the Maintenance Director for repair.	F0584		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F0585	F 585 1. Resident # 39 has been discharged from the facility 2. The administrator reviewed the grievances since 6/1/2025 to ensure follow-up and documentation of resolution have been completed. This was completed on 6/26/2025 with no other issues noted. 3. On 6/27/2025 the facility leadership team was in-serviced by the administrator on the grievance process including addressing all concerns and the documentation of corrective actions outlined in the grievance. This education will also be added to the new hire process for any leadership member. 4. Grievances will be addressed in daily stand-up meeting Monday through Friday to ensure department heads are aware of grievances filed. Grievances will be monitored by the Regional Director of Clinical Services weekly x4 weeks. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee	07/07/2025

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F0585 SS = D	Continued from page 3 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary	F0585	Continued from page 3 determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0585 SS = D	Continued from page 4 statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to file a grievance on behalf of a resident when the resident reported a grievance verbally to the Social Worker (SW) related to multiple items missing from her belongings after returning from a short hospital stay. The missing items were not located. This deficient practice affected 1 of 1 resident reviewed for grievances Resident #93). Findings included: A review of the facility policy titled Service Concerns/Grievances dated 3/1/25 indicated that nursing staff, Social Work and Discharge Planners or any other team member receiving questions or issues of concern regarding care and/or services are to immediately respond at the point of service in an effort to satisfactorily resolve issues of concern. The policy stated the patient had the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. Resident #39 was readmitted to facility on 10/15/24 with a diagnosis of non-Alzheimer's dementia.	F0585		

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F0585 SS = D	Continued from page 5 A review of Resident #39's medical record revealed she was sent to the hospital on 4/27/25 and returned on 5/5/25 and was discharged on 5/23/25. A review of Resident #39's admission Minimum Data Set (MDS) dated 5/10/25 revealed she was moderately cognitively impaired. During an interview with the SW on 6/4/25 at 1:12 PM she revealed Resident #39 was admitted to the hospital from the facility on 4/27/25. The SW stated that she packed Resident #39's belongings and put them in storage on facility grounds on 4/28/25. When Resident #39 returned from the hospital on 5/5/25 her belongings were returned to her and put away in her room by staff. The SW was unable to state which staff put the items away. The SW further stated that Resident #39 told her on more than one occasion between the dates of 5/5/25 and her discharge on 5/23/25 that she was missing a small suitcase, a pair of shoes, and two cotton nightgowns. The SW indicated she remembered the suitcase, as she had packed items in it to go to storage. The SW indicated she did not tell other staff Resident #39 reported missing items to her. The SW revealed she did not file a grievance on behalf of Resident #39, nor did she look for the items, as she was waiting for the resident to provide her with a written list including sizes. The SW indicated she would have been responsible for locating the items and that the items were never located. The SW further stated she should have written a grievance on behalf of Resident #39 given her cognitive status and to ensure her concerns were followed up on. Attempts to reach Resident #39 by telephone were unsuccessful. In an interview with the Administrator on 6/4/25 at 1:30 PM she stated she was not aware Resident #39 was missing a small suitcase, a pair of shoes and two cotton nightgowns. She further stated the SW should have made a list of the missing items for Resident #39 given her cognitive status. The Administrator revealed she did not think a grievance should have been filed right away, but rather after the missing items were not located after a week or so.	F0585		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j)	F0641	F641 1. The admission assessment for resident #30 was	07/07/2025

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F0641 SS = D	Continued from page 6 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is 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 review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of high risk drug class medications. This was for 1 of 5 residents reviewed for unnecessary medications (Resident #30). Findings included: Resident #30 was admitted to the facility on 2/13/25.	F0641	Continued from page 6 corrected on June 7,2025 by the Minimum Data Set (MDS) Nurse. 2. The Southeast Regional Director of Reimbursement audited on 6/26/2025 the last 14 days of residents receiving any anticoagulants to ensure their coding on the MDS assessment was correct. Any areas of concern will be corrected by 6/27/2025 by the MDS nurse. 3. The Southeast Regional Director of Reimbursement inserviced the MDS nurses on 6/26/2025 on ensuring correct coding of Section N on the MDS and crossing with the Medication Administration Records. 4. The Southeast Regional Director of Reimbursement will Audit 10% of the assessments weekly for 4 weeks to ensure section N is coded correctly. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0641 SS = D	Continued from page 7 A review of Resident #30's admission Minimum Data Set (MDS) assessment dated 2/18/25 revealed coding that Resident #30 received anticoagulant (blood thinning) medication during the look-back period of the assessment. A review of Resident #30's Medication Administration Record (MAR) for February 2025 did not reveal any documentation indicating a physician's order for anticoagulant medication or that anticoagulant medication was administered to Resident #30 in February 2025 since her admission to the facility. On 6/6/25 at 8:35 AM an interview with MDS Nurse #2 indicated she coded the high risk drug class medication section of Resident #30's MDS assessment dated 2/18/25. She stated although Resident #30 had not taken any anticoagulant medication in the look back period of this assessment since her admission to the facility, she had received heparin (a blood thinning medication) in the hospital in the 2 days prior to her admission. She reported it was her understanding that the anticoagulant medication Resident #30 received in the hospital should be reflected on Resident #30's MDS assessment dated 2/18/25. On 6/6/25 at 8:51 AM an interview with the Director of Nursing indicated it was her understanding that the anticoagulant medication Resident #30 received in the hospital prior to her admission to the facility should be reflected on Resident #30's MDS assessment dated 2/18/25. She reported that resident's MDS assessments should be accurate. On 6/6/25 at 10:00 AM an interview with the Administrator indicated everyone understood that the high risk drug class section of a resident's MDS assessment should be coded based on a 7 day look back period which included any of these medications a resident received outside the facility during a 7 day look back period. She reported MDS assessments should be coded accurately.	F0641		
F0656 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	F0656	F 656 1. A Side Rail Assessment was completed for resident # 94 s by the MDS Nurse. The assessment indicated that side rails were not indicated at this time. On 6/6/2025 the side rails were removed by the maintenance dept. Resident #63 has been discharged from the facility.	07/07/2025

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F0656 SS = D	Continued from page 8 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 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 observations, record review and staff interviews, the facility failed to develop a comprehensive care plan for a resident in the areas of	F0656	Continued from page 8 2. On 6/26/2025 the Assistant Director of Nursing (ADON) audited all current residents to ensure residents using side rails or Continuous Positive Airway Pressure (CPAP) machines had the appropriate care plan for their use. Any care plans needing updating will be completed by 7/2/2025 by the MDS nurses. 3. The Southeast Regional Director of Reimbursement inserviced the MDS nurses and the ADON on 6/26/2025 to ensure residents have the appropriate care plan when using side rails or CPAPs. 4. The ADON will audit 10% of the care plans weekly to ensure the care plans for residents using side rails or CPAPs are accurate weekly for 4 weeks. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0656 SS = D	Continued from page 9 bed rails (Resident #94) and for the use of a Continuous Positive Airway Pressure (CPAP) machine for one resident (Resident #63). This was for 2 of 24 residents reviewed for comprehensive care plans. Findings included: 1. Resident #94 was admitted to the facility on 10/25/24. A review of Resident #94's comprehensive care plan dated 11/3/24 revealed she did not have a care plan that included the use of bilateral quarter length side rails. Resident #94's quarterly Minimum Data Set (MDS) dated 4/16/25 revealed bed rails were not used as a restraint. An observation was conducted on 6/3/25 at 12:43 PM in Resident #94's room. The resident was lying in bed with bilateral quarter length side rails in the raised position. In an interview with Resident #94 on 6/3/25 at 12:43 PM, she stated she had always had the side rails on her bed. An interview with the Admission Nurse was conducted on 6/5/25 at 2:03 PM. She stated she did the admission side rail assessment for Residents #94. The Admission Nurse reviewed the side rail assessment during the interview and revealed that it was marked as not using bilateral quarter length side rails which was not correct. She was unsure why she had marked it as such. In an interview with MDS Nurse #2 on 6/5/25 at 1:46 PM she stated the care plan was updated by MDS coding and any other department in the facility such as nursing, activities or dietary. MDS Nurse #2 further stated MDS coding for side rails comes from the side rail assessment completed by nursing and MDS Nurse's do not go to the residents' room to observe for side rails. An observation and interview was conducted with the	F0656		

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F0656 SS = D	Continued from page 10 Director of Nursing (DON) on 6/3/25 at 2:31 PM. Resident #94 was lying in bed with bilateral quarter length side rails in the raised position. The DON stated Resident #94 should have had a care plan that included the use of bilateral quarter length side rails. In an interview with the Administrator on 6/3/25 at 3:07 PM, she stated Residents #94 should have had a care plan that included the use of bilateral quarter length side rails since the side rails were on the bed. The Administrator further stated she was only aware that the comprehensive care plan was developed automatically based on nursing assessments and other departments can add to it. 2. Resident #63 was admitted to the facility on 3/20/25. Resident #63's hospital discharge summary dated 3/20/25 indicated she brought her CPAP machine from home and used it nightly in the hospital. The admission Minimum Data Set (MDS) assessment dated 3/24/25 for Resident #63 indicated she was cognitively intact and required no CPAP machine usage. An interview with the Admission Nurse was conducted on 6/5/25 at 2:03 PM. She stated she did the admission nursing assessments for Resident #63. The Admission Nurse indicated she was unaware the resident had a CPAP machine. The Admission Nurse stated she did go into the resident's room when she completed the assessment but she did not notice the CPAP machine A review of Resident #63's comprehensive care plan dated 3/24/25 revealed she did not have a care plan that included nightly use of a CPAP machine. On 6/2/25 at 1:15 PM an interview with Resident #63 and an observation of her room was conducted. The resident had a CPAP machine next to her bed, and she stated she brought it with her from the hospital when she was admitted to the facility. Resident #63 further stated it was her personal CPAP machine that she had brought to the hospital before coming to the facility. Resident #63 indicated she used it every night for sleep apnea	F0656		

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F0656 SS = D	Continued from page 11 (when a person has breathing interruptions in their sleep). In an interview with MDS Nurse #2 on 6/5/25 at 1:46 PM, After that, the care plan was updated by MDS coding and any other department in the facility such as nursing, activities or dietary. MDS Nurse #2 further stated MDS coding for side rails comes from the side rail assessment completed by nursing and MDS Nurse's do not go to the residents' room to observe for a CPAP machine. An interview with the Unit Manager (UM) #1 and NA #1 was conducted on 6/5/25 at 1:59 PM. They both stated Resident #63 brought the CPAP machine with her from the hospital and wore it nightly. They indicated she put it on and took it off independently. In an interview with the Administrator on 6/3/25 at 3:07 PM she stated Resident #63 should have had a care plan for the use of the CPAP machine. The Administrator further stated she was only aware that the comprehensive care plan was developed automatically based on nursing assessments and other departments can add to it.	F0656		
F0684 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 observation, record review, and staff and Wound Care Nurse Practitioner (NP) interviews, the facility failed to obtain a provider order for and implement the recommended pressure relief measure of a heel protection boot for 1 of 1 resident reviewed for a non-pressure related heel wound (Resident #62). Findings included:	F0684	F 684 1. Resident # 62 has been discharged from the facility. 2. The ADON has reviewed the last 14 days of the wound care provider s notes to ensure all recommendations have been followed up on. This audit was completed on 6/27/2025 with no other issues. 3. The Director of Nursing (DON) will in-service the ADON & Wound Care Nurse on retrieving the recommendations from the wound care provider and following up appropriately- writing orders, obtaining equipment, updating care plans and completing notifications on 6/27/2025. 4. The DON will audit 7 residents weekly for 4 weeks with wounds and being seen by the wound care provider to ensure recommendations were follow-up on. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis.	07/07/2025

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F0684 SS = D	Continued from page 12 Resident #62 was admitted to the facility on 11/20/2024 with a diagnosis of diabetes mellitus. A review of a Wound Care NP progress note for Resident #62 dated 2/25/25 at 10:50 PM revealed Resident #2 had a new non-thermal blister to his left heel. A review of Resident #62's annual Minimum Data Set (MDS) assessment dated 3/24/25 revealed Resident #62 was moderately cognitively impaired and he had one open lesion on the foot. Resident #62 required moderate assistance with sit to lying position, lying to sitting on the side of the bed, and sit to stand position. Resident #62 was maximal assistance with putting and taking off footwear. Resident #62 was moderate assistance with lower body dressing and setup with upper body dressing. He was moderate assistance with bathing and personal hygiene. A review of a Wound Care NP's progress note for Resident #62 dated 4/21/25 at 9:31 AM revealed Resident #61's left heel wound was an arterial ulcer. A review of a Wound Care NP's progress note for Resident #62 dated 5/13/2025 at 6:14 PM revealed the recommendation to float Resident #62's left heel while in bed using a soft protective boot. Review of the medical record and physician orders view of Resident #62's orders did not reveal a provider order for a protective boot for Resident #62's left heel. On 6/2/25 at 11:00 AM an observation of Resident #62 revealed him to be lying on his back in bed. Resident #62's bilateral heels were observed to be in contact with his mattress. No protective boot was observed on his left heel. On 6/4/25 at 1:30 PM an observation of Resident #62 revealed him to be lying on his back in bed. Resident #62's bilateral heels were observed to be in contact with his mattress. No protective boot was observed on his left heel.	F0684	Continued from page 12 5. Date of compliance: 7/7/2025	

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F0684 SS = D	Continued from page 13 On 6/5/2025 at 2:42 PM an observation of Resident #62's left heel wound was conducted with the facility's Treatment Nurse. This wound was observed to appear clean, with no foul odor, and no drainage was present. An interview completed with the Treatment Nurse at the time of the observation revealed she had been the treatment nurse at the facility for a month and was familiar with Resident #62's left heel wound. She reported the wound was improving. Treatment Nurse stated when she and the Wound Care NP did wound care together the Wound NP informed her of her reccomendation. On 6/05/2025 at 3:29 PM an interview with Nurse Aide (NA) #6 revealed Resident #62 had been in his current room for a couple of months and since Resident #62 had been in his current room she had not placed a protective boot on Resident #62. In an interview on 6/5/2025 at 2:02 PM the Wound Care NP stated when she made a recommendation, the report was sent via e-mail to the Director of Nursing (DON). The DON then printed the report and gave a copy to the facility's treatment nurse. The facility's treatment nurse was then responsible for obtaining a facility provider's order for the recommendation. On 6/5/2025 at 3:18 PM an interview with the DON indicated after each visit, the Wound Care NP e-mailed her a report. She stated this report did not include the Wound Care NP's recommendations. The DON reported these recommendations were provided to the Treatment Nurse at the time of visit with each resident. She went on to say the Wound Care NP would verbally communicate her recommendations to the DON before the Wound Care NP exited the building. The DON stated she was not aware of the recommendation for a soft protection boot for Resident #62's left heel. She reported that if this wasn't part of the conversation she had with the Wound Care NP when she exited the building after seeing Resident #62, or on the e-mail report, then it would have gotten missed. On 6/5/2025 at 3:49 PM an interview with the Administrator indicated the Wound Care NP's recommendation for Resident #82 to have a soft protection boot to his left heel had gotten missed.	F0684		
F0689 SS = SQC J	Free of Accident Hazards/Supervision/Devices	F0689	F 689	07/07/2025

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F0689 SS = SQC-J	Continued from page 14 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 by: Based on observation, record review, and interviews with family, staff, physician, Nurse Practitioner (NP), Medical Director, and the Director of Rehabilitation, the facility failed to prevent a resident with severe cognitive impairment and exit seeking behaviors from exiting the facility without supervision. On Saturday, 5/31/25, the Receptionist observed an elderly male (Resident #76) exit the facility behind a male resident who was discharging from the facility and a female family member who was moving that resident out. She did not recognize the elderly male as Resident #76, and she believed he was part of the discharging resident's family. Later that morning, as Nurse Aide (NA) #1 was driving in the community, she saw an individual who she thought looked like a resident walking without staff accompaniment approximately 0.7 miles away from the facility. She contacted the facility by phone, provided a description of the resident and staff who were working realized Resident #76 was missing. There was a high likelihood of serious harm, injury, or death for Resident #76 as the area he traversed included a well-travelled State Highway immediately outside of the facility's parking lot and multiple intersecting roads including a 4-lane intersection that was a major thoroughfare through the city. In addition, the facility failed to provide care in a safe manner when Resident #85 rolled out of bed during care and sustained a small cut to his forehead. These deficient practices affected 2 of 6 residents reviewed for accidents (Resident #76 and Resident #85). Immediate Jeopardy began on 5/31/25 when Resident #76 exited the facility without supervision. Immediate jeopardy was removed on 6/6/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain	F0689	Continued from page 14 1. Resident # 76 has been discharged from the facility. Resident # 76 was brought back to the facility by the nurse on 5/31/2025. A skin check was completed with no issues on 5/31/2025 by the floor nurse. Resident #76 room was moved on 5/31/2025 off of the front hall to our back hall. STAT labs were drawn. Resident # 85 continues to be assessed for fall risk and interventions implemented as needed. 2. The floor nurses completed a 100% head count of all residents; all were present and accounted for on 5/31/2025.The DON reviewed progress notes for the last 14 days as of 5/31/2025 to identify any other exit seeking behaviors with no other noted. The administrative nurses completed elopement assessments on all residents on 5/31/2025 to identify any resident scoring high on the assessment. The facility placed a sign on the front door on 6/4/2025 to alert family and visitors not to assist residents outside without checking with the receptionist. The facility also placed a Wandering -High Risk book at each station and at the front desk with identified residents that have exit seeking behaviors. A picture board was place in the employee dining room by the Activity Director with pictures of residents with exit seeking behaviors on 6/4/2025. The ADON 6/27/2025 completed an audit of the last 30 days of falls to ensure all have been addressed with an investigation and follow up with no other issues noted. 3. On 5/31/2025, the Administrator & ADON initiated an in-service with all nurses regarding initiating an intervention if residents are exhibiting wandering behaviors or statements about seeking exit and notify the DON/ADON. On 5/31/2025 an in-service was also initiated by the ADON & Administrator with all staff, including agency staff, regarding not assisting any person known or unknown outside of the facility without checking with nursing staff to ensure the resident is safe to be outside unsupervised. The DON started all staff in-services on 6/5/2025 on the wandering books at the nurses stations and the front desk and the notification board in the employee break room. Any new residents identified with exit seeking behaviors will be added to the wandering books and bulletin board along with being added to the Kardex used by the certified nursing assistants for charting care given. The Minimum Date Set (MDS) nurse will update the Kardex as residents are identified to be exit seeking. This	

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F0689 SS = SQC-J	Continued from page 15 out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Example #2 was cited at scope and severity level of D. The findings included: 1. Resident #76 was admitted to the facility on 4/28/25 with diagnoses which included dementia, psychotic disturbance, and anxiety disorder. A review of the elopement risk tool assessment dated 4/28/25 revealed Resident #76 was at low risk for elopement. A review of the care plan dated 4/28/25 revealed a focus area for Resident #76 being at risk for falls related to cognitive impairment, poor balance, and poor safety awareness and a focus area for Resident #76 being at risk for complications related to cognitive impairment with interventions that included reorienting resident as needed to person, place, time, and location. There was also a focus area also for the resident being at risk for adverse reactions related to the use of antipsychotics secondary to the diagnosis of delirium and dementia related behaviors. The Minimum Data Set (MDS) admission assessment dated 5/3/25 revealed Resident #76 had severe cognitive impairment and no wandering or behavioral symptoms. He was assessed as needing moderate assistance walking 10 feet. He received antipsychotic medication and Physical Therapy services. Resident #76 found it very important to go outside to get fresh air when the weather was good. An interview with the Director of Rehabilitation on 6/4/25 at 1:41 PM revealed Resident #76 was provided with physical therapy services from 4/29/25 through 5/28/25. At the time of discharge from physical therapy, he walked 600 feet with supervision for safety. The nursing progress note written by Nurse #1 dated 5/30/25 at 10:23 PM revealed Resident #76 was exit	F0689	Continued from page 15 in-service will be completed by 6/5/2025 and any staff who are not in-serviced will be in-serviced prior to their next shift. The ADON will be responsible for updating the wandering books at the nurses station and front desk and updating the bulletin board in the employee dining room. The nursing staff that identifies the exit seeking behaviors will complete the Elopement Assessment in the electronic medical record as directed by the DON/ADON upon notification. The Regional Clinical Director in-serviced the DON/ADON on 6/5/2025 on steps to direct the nursing staff upon any notification of exit seeking behaviors, these steps will include completing an Elopement Assessment. The ADON will then notify the MDS nurse to update the Kardex. All in-services will be completed by 6/5/2025. The Staff Development Coordinator (SDC) and Scheduler will be responsible for tracking staff needing an in-service prior to working. All in-services will be added to the orientation for all new staff to be completed by the SDC. The Social Worker has drafted a letter to the families of current residents to remind them not to assist residents outside without checking with the nursing staff or the receptionist. This letter will be post marked 6/5/2025 and will be mailed on 6/5/2025 by the Social Worker. On 6/27/2025 the SDC began an in-service for all nurses on the fall policy ensuring follow up with an investigation to determine root cause and starting interventions to prevent future falls. This in-service will be completed by 7/2/2025, any staff not having the in-service will be in-serviced before their next shift. This in-service will also be a part of any new orientation as of 7/2/2025. 4. Ten staff will be interviewed daily for 14 days then weekly for 6 weeks by the Assistant Director of Nursing (ADON) to identify any resident that may be at risk of wandering. The DON will address all concerns identified during the audit to include updating the care plan per facility protocol. The Director of Nursing (DON) will review the staff questionnaires weekly x 4 weeks to ensure all concerns are addressed. The Nursing Admin team to include the DON, ADON & unit Managers, will review progress notes 7 times a week x 6 weeks to include weekends. This audit is to identify residents with exit seeking behaviors to include wandering in and out of resident s rooms, wandering around the facility, attempting to pry open exit doors, and making comments about exiting the facility to ensure appropriate interventions were put into place for the prevention of unsupervised exit. The DON will review and discuss incident reports and	

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F0689 SS = SQC-J	Continued from page 16 seeking, became confused and started yelling at staff and forgot how to get back to his room. Once the resident was back in his room he began to calm down. Telephone interviews with Nurse #1 were conducted on 6/3/25 at 4:15 PM and 6/11/25 at 10:15 AM. She revealed she worked on 5/30/25 from 3:00 PM until 11:00 PM. She went on to say Resident #76 attempted to leave the facility on 5/30/25 at approximately 3:40 PM. She stated the resident was exit seeking, became confused and started yelling at staff and walking to the front exit door. Nurse #1 then placed herself between Resident #76 and the front exit door until the DON was able to redirect him and walk with him back to his room. She stated this was the first time she had witnessed his exit seeking behavior. Nurse #1 indicated she was an agency nurse and had not worked with Resident #76 often. The Director of Nursing (DON) was in the facility at the time Resident #76 exhibited exit seeking behaviors on 5/30/25. Nurse #1 reported that the DON asked Nurse #1 to call Resident #76's family to see if they would come and sit with him. The family did not answer her call. Resident #76 was in his room with a roommate, who was cognitively intact, and she (Nurse #1) checked on him often throughout her shift. Nurse #1 stated she did report Resident #76's exit seeking behaviors to the oncoming nurse. An interview with the DON was held on 6/3/25 at 4:30 PM, she revealed she did not recall Resident #76 exhibiting exit seeking behavior, but she felt he was only upset on 5/30/25. She stated Resident #27 said, "I don't want to go to the pea patch". The DON then went with Nurse #1 to take the resident to his room. She added that she did not ask Nurse #1 to call the family as the facility provided one-to-one service if needed. A telephone interview with Nurse Aide (NA) #1 was conducted on 6/3/25 at 3:20 PM. She revealed on 5/31/25 she had left the facility via her car during her break and while she was enroute back to the facility she saw whom she thought might be a resident walking on the sidewalk towards a fast-food restaurant. She called the facility at 9:11 AM and spoke with the Receptionist to let her know his location and described the clothes he was wearing. She indicated at that point the Receptionist identified the resident as Resident #76. Nurse Aide #1 then turned the car around and sat with Resident #76 until Nurse #2 and the Receptionist arrived to pick him up. Resident #76 was wearing black pants, a purple T-shirt and tennis shoes. He was	F0689	Continued from page 16 progress notes 5 x per week x 4 weeks during the Clinical Morning Meeting to identify residents with falls to ensure an investigation to include collecting witness statements, physician and resident representative notification, documentation in the medical records, determining the root cause, implementation of appropriate interventions and updating the resident care plan has been completed. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0689 SS = SQC-J	Continued from page 17 kneeling on one knee when she saw him. Nurse Aide #1 stated he appeared very tired but not overheated. He was easily redirected into the Receptionist's car. A telephone interview was conducted with the Receptionist on 6/3/25 at 3:30 PM. She indicated that prior to working as the Receptionist, she was an NA at the facility. She revealed there were several discharges at the facility on 5/31/25, the date Resident #76 exited the facility without staff supervision. A male resident was moving out with the assistance of a female family member. The Receptionist stated she observed the male resident and the female family member exiting the facility with an elderly male behind them and did not realize that this elderly male was a resident at the facility. She explained she thought Resident #76 was part of that resident's family. The resident was wearing black pants and a purple t-shirt and walked out behind the family members of the discharged resident. The Receptionist reported that she could not recall what time this happened. The Receptionist stated she went to get Resident #76 with Nurse #2 after NA #1 contacted the facility and the resident seemed very tired but not overheated. She stated Resident #76 was severely cognitively impaired and the road he was walking on was a highly traveled main thoroughfare from downtown Greenville, NC to Falkland, NC. The door that Resident #76 used to exit was the front entrance door to the building which was unlocked every morning at 8:00 AM until 8:00 PM. She added that the facility did not utilize a wander guard system. Follow-up interviews with the Receptionist on 6/4/25 at 10:20 AM and 6/11/25 at 9:30 AM indicated the Admission Nurse would verbally tell the receptionists if there was a resident that they should be on the lookout for exit seeking behaviors. She revealed there was no photo book at the reception desk to identify residents at risk for elopement. The nursing note dated 5/31/25 at 9:15 AM written by Nurse #2 revealed Resident #76 was off the premises of the facility and was returned to the facility with no injuries. An interview with Nurse #2 on 6/3/25 at 2:15 PM revealed she gave Resident #76 his medication on 5/31/25 at 8:30 AM which was the last time she saw him prior to learning of the unsupervised exit. The	F0689		

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F0689 SS = SQC-J	Continued from page 18 Receptionist notified her at approximately 9:11 AM that Nurse Aide #1 had called the facility to make them aware of a resident was walking down the road. The facility staff were unaware Resident #76 was not in the facility. She went on to say she (Nurse #2) remembered Resident #76 coming to the nurse's station prior to this day and said he wanted to go see his family. Nurse #2 went with the Receptionist at approximately 9:15 AM to pick him up and he was located on a grassy area between the sidewalk and a restaurant. Resident #76 was found kneeling on one knee, wearing black pants and a purple t-shirt. When they returned to the facility, Nurse #2 assessed him and identified no injuries noted. A follow up telephone interview was conducted with Nurse #2 on 6/11/25 at 8:45 AM. She revealed she did not know, nor did anyone tell her that Resident #76 had been exit seeking on 5/30/25, the day prior to the elopement on 5/31/25. She went on to say she did not know Resident #76 well enough to know if he would have been safe outside without facility staff supervision, but she felt the road he walked along would have been dangerous for him. A telephone interview was conducted on 6/11/25 at 8:50 AM with NA #11. He stated he worked on 5/31/25 from 7:00 AM to 3:00 PM. He indicated 5/31/25 was his first shift working with Resident #76 and he was unaware the resident had exit seeking behaviors on 5/30/25. He also stated he last saw Resident #76 when breakfast was served but did not know the time. He was not aware Resident #76 was out of the facility prior to NA #1 calling the facility to alert the staff. According to the Global Positioning System (GPS) traffic application, the location Resident #76 was found to be approximately 0.7 miles from the facility. On 6/4/25, beginning at approximately 11:45 AM, the Surveyor walked approximately 0.7 miles from the facility to the location where Resident #76 was picked up by the staff on 5/31/25. The walk revealed the resident would have to walk through the facility's parking lot that contained loose gravel and multiple potholes. Directly outside of the facility's parking lot was a well-traveled 4 lane divided State Highway, NC 43, with a speed limit of 45 miles per hour. The highway had a sidewalk. Resident #76 would then have had to cross over the following intersections: a 2-lane entrance to an apartment complex; a 4-lane intersection	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/GREENVILLE	2578 WEST FIFTH STREET , GREENVILLE, North Carolina, 27834

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F0689 SS = SQC-J	Continued from page 19 at West Arlington Blvd., a major thoroughfare through the city with a traffic light and a crosswalk; an apartment complex entrance road and exit road; and a gated driveway entrance and exit to an assisted living facility. Along the route there were 2 large ditches on the side of the sidewalk: one ditch approximately 3 feet deep partially covered by brush/bush-like vegetation and one ditch approximately 12 feet deep containing water and rock. There was a large volume of traffic observed during this walk. The weather underground website shows it was 66 degrees Fahrenheit in Greenville on 5/31/25 at 9:15 AM. An interview with the Medical Director was conducted on 6/4/25 at 11:07 AM. She stated the facility reported the elopement with no injuries on 5/31/25. She went on to say something failed and there were always risks of injury when someone eloped from a facility. During a follow up interview with the Medical Director on 6/11/25 at 9:05 AM she revealed the Nurse Practitioner was more familiar Resident #76 and indicated she would be able to provide further resident specific information. An interview with the NP on 6/11/25 at 9:10 AM revealed Resident #76 had dementia. She indicated she could not say whether or not Resident #76 was safe to be outside of the facility without supervision, but she did say it was concerning. She stated the roads in the area were dangerous. She reported there was not any medical reason that would have triggered the new exit seeking behavior for Resident #76. In follow-up interviews with the Director of Nursing on 6/4/25 at 2:30 PM and 6/11/25 at 10:30 AM she indicated there was a receptionist at the front desk daily Monday through Sunday from 8:00 AM until 8:00 PM. She reported that the facility did not utilize a wander guard system. She stated prior to 5/30/25, there was no system in place to identify residents that were unsafe to exit the facility unsupervised. She revealed there should have been a picture of anyone with a high risk of elopement at the reception desk to prevent a resident at risk from going outside without supervision. She stated she felt the road Resident #76 traversed would not be a safe walk for someone with cognitive issues. She went on to say it was a	F0689		

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F0689 SS = SQC-J	Continued from page 20 well-traveled road with a high volume of vehicles daily. An interview with the Administrator on 6/4/25 at 4:25 PM revealed there should have been a sign on the door asking families to check with a nurse prior to letting a resident out of the facility to prevent residents from exiting the building. She went on to say a photo book should have been created to let the staff know any resident at risk for elopement. These books should have been at all 3 nurses' stations and at the reception desk. During a follow-up telephone interview with the Administrator on 6/11/25 at 10:51 AM she stated there were not any residents at risk of elopement prior to Resident #76's elopement on 5/31/25, therefore there was not a system in place to identify residents at risk. She revealed she felt the road Residents #76 was walking on was dangerous and that it was well traveled road with a high volume of vehicles daily. The facility provided a corrective action plan that was not acceptable to the State Agency as it did not address the issue of the Receptionist not being able to distinguish between residents and visitors and not being aware of what residents were safe to be outside without supervision. It additionally did not address how the facility would ensure staff were aware of residents who were at risk for wandering and exit seeking. On 6/4/25 at 8:40 AM the Administrator was notified of immediate jeopardy. The facility provided the following Immediate Jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non-compliance: Resident #76 was admitted on 4/28/2025 with a diagnosis of muscle wasting, muscle weakness, dysphagia, anxiety disorder, abnormalities of gait and mobility and unspecified dementia. On 4/28/2025, an initial elopement assessment was completed by the Unit Manager	F0689		

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F0689 SS = SQC-J	Continued from page 21 that resulted in the resident being at low risk for elopement (referring to the act of an older adult leaving a safe environment without supervision). On 5/30/2025, a progress note written by the hall nurse identified Resident #76 as exit seeking. He was given a snack and drink, and he returned to his room to watch TV with his roommate. The hall nurse notified the Director of Nursing. He had no further behavior throughout the shift. At approximately 9:00 a.m. on 5/31/2025, Resident #76 was identified by a staff member driving by and thought she recognized the resident walking on the sidewalk about 0.7 miles from the facility. The resident at that time had not been reported as missing. The staff member that spotted him kept him in eyesight and stayed with him and called the facility. She spoke with the Receptionist and together they realized he was resident at the facility. The Receptionist alerted the nurse and together they immediately went and brought Resident #76 back to the facility. The Receptionist is a certified nursing assistant, however, has not worked as one in this facility since 5/19/2022 and was unfamiliar with the newer residents. The Receptionist observed Resident #76 exit the facility with other individuals who were visiting the facility, but she did not identify that he was a resident and therefore did not stop the resident from exiting. A full skin assessment was performed by the hall nurse on 5/31/2025 with no negative findings. The Responsible Party (RP) and physician were notified by the hall nurse, and new orders were obtained for urinalysis and a psychiatry consultation. The urinalysis resulted negative on 5/31/2025. The psychiatry visit was completed on 6/2/2025 with no new orders. Resident #76 was placed on one-on-one supervision until further notice while the social worker / discharge planner work with the family members to find a memory care unit. On 5/31/2025 the Administrator met with the Assistant Director of nursing, floor nurse and Receptionist and determined staff did not intervene with the resident's exit seeking behavior, nursing staff did not follow up on exit seeking behaviors the night prior to the elopement, and there was no wandering book at the front desk or nursing stations with residents with exit seeking behaviors pictures. The floor nurses completed a 100% head count of all residents; all were present and accounted for. On 5/31/2025, the Director of Nursing (DON) initiated	F0689		

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F0689 SS = SQC-J	Continued from page 22 an audit of resident progress notes to include Resident #76 for the past 14 days. The audit was completed with no other residents' issues identified. On 5/31/2025, the Assistant Director of Nursing (ADON) completed an audit of all wandering assessments to ensure assessments were completed accurately and to ensure all residents who triggered as at risk were care planned for wandering risk. No other residents were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 5/31/2025, the Administrator & ADON initiated an in-service with all nurses regarding initiating an intervention if residents are exhibiting wandering behaviors or statements about seeking exit and notify the DON/ADON. On 5/31/2025 an in-service was also initiated by the ADON & Administrator with all staff, including agency staff, regarding not assisting any person known or unknown outside of the facility without checking with nursing staff to ensure the resident is safe to be outside unsupervised. The DON created on 6/4/2025 wandering books for all nurses' stations and the front desk with pictures and resident demographics for any resident identified to be an elopement risk. The Activity Director has placed pictures of residents from the wandering book on the bulletin board in the employee dining room to assist staff in identifying residents with exit seeking behaviors. The DON started all staff in-services on 6/5/2025 on the wandering books at the nurses' stations and the front desk and the notification board in the employee break room. Any new residents identified with exit seeking behaviors will be added to the wandering books and bulletin board along with being added to the Kardex used by the certified nursing assistants for charting care given. The Minimum Date Set (MDS) nurse will update the Kardex as residents are identified to be exit seeking. This in-service will be completed by 6/5/2025 and any staff who are not in serviced will be in serviced prior to their next shift. The ADON will be responsible for updating the wandering books at the nurses' station and front desk and updating the bulletin board in the employee dining room. The nursing staff that identifies the exit seeking behaviors will	F0689		

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F0689 SS = SQC-J	Continued from page 23 complete the Elopement Assessment in the electronic medical record as directed by the DON/ADON upon notification. The Regional Clinical Director in serviced the DON/ADON on 6/5/2025 on steps to direct the nursing staff upon any notification of exit seeking behaviors, these steps will include completing an Elopement Assessment. The ADON will then notify the MDS nurse to update the Kardex. All in-services will be completed by 6/5/2025. The Staff Development Coordinator (SDC) and Scheduler will be responsible for tracking staff needing an in-service prior to working. All in-services will be added to the orientation for all new staff to be completed by the SDC. A sign was placed on the front door on 6/4/2025 by the Administrator to alert any visitors or other family members not to assist anyone outside and to seek help from the receptionist. The Social Worker has drafted a letter to the families of current residents to remind them not to assist residents outside without checking with the nursing staff or the receptionist. This letter will be post marked 6/5/2025 and will be mailed on 6/5/2025 by the Social Worker. Alleged date of immediate jeopardy removal: 6/6/2025 Onsite validation of the immediate jeopardy removal plan was completed on 6/6/25 as follows: Review of the facility documentation revealed the facility completed an audit of resident progress notes for the past 14 days. Review of the facility education materials and sign-in sheets were reviewed to confirm that education was provided as indicated in the removal plan. Interviews were conducted on 6/6/25 with facility staff to confirm that education was received regarding elopement risk residents.	F0689		

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F0689 SS = SQC-J	Continued from page 24 Observed the elopement risk photo binders located on all 3 nurses' stations and at the reception desk. Observed the signs posted on the interior and exterior of the front door asking all visitors to check with a nurse prior to assisting residents outside. Observed the residents' photos at risk for elopement that were posted in the staff break room. Reviewed evidence of the letters that were sent to the families of current residents asking them not to assist residents outside without checking with a nurse or the receptionist. The facility's immediate jeopardy removal date of 6/6/25 was validated. 2. Resident #85 was re-admitted to the facility on 7/5/24 with a diagnosis of cerebral infarction (disrupted blood supply to the brain). A review of his admission Minimum Data Set (MDS) assessment dated 7/11/24 revealed he was severely cognitively impaired. He had functional limitation in range of motion on both sides of his upper and lower extremities. He required substantial/maximal assistance to roll left and right in bed. Resident #85 was always incontinent of bladder. He had no falls since his re-entry to the facility. On 6/2/25 at 3:37 PM a review of an unsigned incident report provided by the Director of Nursing (DON) dated 10/9/24 at 7:12 PM revealed at 3:30 PM on 10/9/24 staff was assisting Resident #85 with incontinence care, Resident #85 rolled out of bed face down sustaining a small skin tear on his forehead. Resident #85's family member was at his bedside, and Emergency Medical Services (EMS) was called. On 6/5/25 at 3:45 PM a telephone interview with Nurse #5 indicated she responded to Nurse Aide (NA) #4's call for assistance with Resident #85 on 10/9/24. She stated when she entered Resident #85's room, he was lying on the floor on the left side of his bed which was positioned approximately 3 feet from the floor. She	F0689		

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F0689 SS = SQC-J	Continued from page 25 reported she completed vital signs and a head to toe assessment of Resident #85 and observed a small bleeding cut on his forehead. Nurse #5 went on to say Resident #85 was sent to the hospital for evaluation. She stated NA #4 reported to her that while she had been providing Resident #85 with incontinence care, he fell off the bed. Nurse #5 reported she did not recall receiving any in-service education after this incident regarding ensuring residents were positioned in the center of the bed and turning residents towards yourself rather than away from yourself when providing care. Multiple attempts at telephone interview with NA #4 were unsuccessful. NA #4 no longer worked at the facility. A review of Resident #85's hospital record for his admission to the hospital on 10/9/24 revealed in part Resident #85 presented to the Emergency Room at approximately 3:30 PM on 10/9/24 after falling face down while being turned at the facility. He had a small cut on his forehead. Diagnostic imaging studies of his head, spine, wrists, hands and knees did not reveal any abnormalities. Resident #85 returned to the facility on 10/17/24. On 6/2/25 at 3:37 PM an interview with Resident #85's family member indicated there was an instance within the last year where Resident #85 fell out of bed when someone was turning him. She stated she was outside his room at the time, and while she did not witness the incident, she saw Resident #85 on the floor in front of his bed after he fell. She reported he was not complaining of any pain, but he had a small cut on his forehead from his glasses, and she asked that he be sent to the hospital. She indicated she was not aware of any other injuries from the incident. On 6/4/25 at 9:07 AM an interview with the Director (DON) indicated she was not the DON at the time of Resident #85's fall from bed during care on 10/9/25. She stated Nurse #6, who no longer worked at the facility, was the DON at the time of the fall. She went on to say there was an incident report regarding the fall, but she did not have an investigation file for the incident. A review of a Post Fall Investigation report dated	F0689		

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F0689 SS = SQC-J	Continued from page 26 10/12/24 at 5:51 PM completed by Nurse #6 revealed in part Resident #85 had a fall in his room on 10/9/24. There was no additional information related to what steps were taken to investigate this fall. On 6/4/25 at 10:51 AM a telephone interview with Administrator #2 indicated he was the facility's Administrator on 10/9/24. He stated he did not recall Resident #85 having a fall from bed during care. He reported this would have been a serious incident, and an investigation would have been done. Administrator #2 stated residents should not fall out of bed when staff were providing care to them. On 6/4/25 at 2:27 PM a telephone interview with Nurse #6 indicated she had been the DON at the facility on 10/9/24 when Resident #85 fell out of bed during care. She stated an investigation had been conducted but she did not know where the investigation file would be. She reported the investigation revealed NA #4 had been providing Resident #85 with incontinence care by herself, did not have Resident #85 positioned in the middle of the bed, and turned Resident #85 away from herself during the care. Nurse #6 stated Resident #85 had rolled off the left side of his bed face first onto the floor. She went on to say Resident #85 sustained a small cut to his forehead and had been sent to the hospital for evaluation. On 6/5/25 at 3:34 PM a telephone interview with the Medical Director indicated she was Resident #85's facility physician. She stated all residents should receive care in a safe manner and Resident #85 should not have experienced a fall from bed during the provision of care. On 6/6/25 at 11:33 AM an interview with the Administrator indicated she was not the Administrator on 10/9/24. She stated she had looked, but did not have an investigation file for Resident #85's fall incident on that date. She reported residents should receive care in a safe manner and should not experience a fall from bed during the provision of care.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695	F 695 Respiratory/ Tracheostomy Care 1. Nurse #8 was in-serviced on 6/27/2025 on proper glove use per facility guidelines and changing trach ties per the physician (MD) orders by the Staff	07/07/2025

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F0695 SS = D	Continued from page 27 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to ensure infection control standards were followed when Nurse #8 did not remove soiled gloves, perform hand hygiene, and don sterile gloves during tracheostomy (a surgically created opening in the windpipe through the neck to provide an airway for breathing) care for a resident and also failed to change the tracheostomy ties per the Physician's order (Resident #33). In addition, the facility failed to obtain a Physician's order for the use of a Continuous Positive Airway Pressure (CPAP) machine for one resident (Resident #63). This deficient practice affected 2 of 2 residents reviewed for respiratory care (Resident #33 and Resident #63). The findings included: 1. Resident #33 was admitted to the facility on 2/4/2019 with diagnoses that included tracheostomy status. The quarterly Minimum Data Set (MDS) dated 3/14/25 revealed Resident #33 was severely cognitively impaired and was coded as receiving tracheostomy care. Resident #33's current comprehensive care plan dated 8/22/24 revealed a problem of being at risk for complications secondary to tracheostomy. Interventions included tracheostomy care per physician orders. a.) An observation of tracheostomy care was conducted with Nurse #8 on 6/4/25 at 10:51 AM. Nurse #8 washed her hands with soap and water, set up the tracheostomy care supplies on the bedside table. She then opened the container that held sterile supplies and donned sterile gloves. Nurse #8 then opened the sterile drape, placed it on the resident's chest and set the new sterile split sponge on the drape. She proceeded to remove the	F0695	Continued from page 27 Development Coordinator. Resident #63 has been discharged from the facility. 2. The Unit Managers audited all tracheostomy (Trach) ties on 6/27/2025 and all were changed on 6/27/2025 and are being changed per MD order. The ADON audited all residents using a CPAP machine to ensure all have orders for use on the Medication Administration Record. Any found not to have an order were corrected by the ADON by 6/27/2025. 3. The SDC began an in-service on 6/27/2025 on the infection control policy regarding glove use and when to change gloves, risks of cross contamination and hand washing between glove changes for all staff. On 6/27/2025 the SDC began an in-service for the nurses on entering CPAP orders. All in-services will be completed by 7/2/2025, any staff not having the in-service will be in-serviced before their next shift. This in-service will also be a part of any new orientation as of 7/2/2025. 4. The Unit Managers will audit trach care residents weekly for 4 weeks to ensure trach ties are changed per MD order. The unit managers will also observe 10 staff members weekly for 4 weeks to ensure staff changes their gloves and performing hand washing per facility policy. The ADON will audit all residents using a CPAP machine weekly for 4 weeks to ensure the order is in place for the CPAP. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0695 SS = D	Continued from page 28 soiled split sponge from behind the phalange of the tracheostomy cannula with her left hand, then removed the soiled inner cannula from the tracheostomy with both hands by holding the phalange in place with her left hand and removing the inner cannula with her right. She then opened the sterile inner cannula and placed it in the tracheostomy using both hands. Nurse #8 poured sterile water in a sterile cup, opened a sterile cotton swab, dipped it in the sterile water and cleaned around the outside of the tracheostomy with it. Next, Nurse #8 wet a sterile gauze with the sterile water, squeezed out the excess water with her right hand, cleaned around the tracheostomy with her right hand and dried it with a dry sterile gauze with her right hand and then placed sterile split sponge behind tracheostomy phalange with both hands. In an interview with Nurse #8 on 6/4/25 at 11:05 AM she stated she was an agency Nurse, and this was her second day at the facility. She indicated she was trained in infection control practices and tracheostomy care before being allowed to work at the facility. Nurse #8 further stated she did not remove her soiled gloves, perform hand hygiene and don sterile gloves during tracheostomy care because she was nervous and forgot. In an interview with the Infection Preventionist on 6/4/25 at 11:09 AM, she stated Nurse #8 should have removed her soiled gloves, washed her hands with soap and water, then donned new sterile gloves before touching the sterile items needed for tracheostomy care. The Director of Nursing (DON) was interviewed on 6/4/25 at 11:15 AM. The DON stated Nurse #8 should have removed the soiled gloves, washed her hands with soap and water and donned sterile gloves before moving on to the sterile part of tracheostomy care. This was to prevent introducing disease causing bacteria into the respiratory tract of the resident via his tracheostomy. The Administrator was interviewed on 6/4/25 at 11:19 AM. She indicated that in order to prevent bacteria from entering the tracheostomy, Nurse #8 should have removed her soiled gloves, washed her hands with soap and water, then donned sterile gloves to complete the tracheostomy care. On 6/5/25 at 3:12 PM, the Nurse Practitioner (NP) was	F0695		

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F0695 SS = D	Continued from page 29 interviewed. She stated proper infection control practices such as hand hygiene between dirty and sterile procedure is important to cut down on the chance of bacteria getting into the resident's lungs through the tracheostomy and causing illness. The NP indicated Nurse #8 should have removed the soiled gloves, washed her hands with soap and water, then donned new sterile gloves. b.) Resident #33's physician orders an order tracheostomy ties daily written on 6/3/25. An observation of tracheostomy care and interview was conducted with Nurse #8 on 6/4/25 at 10:51 AM. During tracheostomy care, which included replacing the used inner cannula with a new one, changing a used split gauze for a new one, and cleaning around the tracheostomy site, Nurse #8 did not change Resident #33's tracheostomy ties. The ties appeared to have a dried yellow substance near the tracheostomy site. Nurse #8 removed her gown and gloves, performed hand hygiene and exited the resident's room. During the interview Nurse #8 stated she forgot to change the tracheostomy ties when doing tracheostomy care. In an interview with the Director of Nursing (DON) on 6/5/25 at 11:15 AM she stated Resident #33 had been a resident at the facility for several years. The DON indicated she expected Nurse #8 to have followed the physicians order to change the tracheostomy ties. An interview was conducted with the Administrator on 6/5/25 at 3:40 PM. The Administrator indicated she expected that Nurse #8 would have followed the physicians order to change the tracheostomy ties. 2. Resident #63 was admitted to the facility on 3/20/25 with diagnoses that included urinary tract infection, diabetes mellitus II and muscle wasting. There was no diagnosis for sleep apnea (interruptions in breathing while asleep requiring the use of a CPAP machine.) The hospital discharge summary dated 3/20/25 for Resident #63 revealed documentation that the resident brought her CPAP machine to the hospital from home, used it nightly, and was encouraged to take it to the facility with her at discharge.	F0695		

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F0695 SS = D	Continued from page 30 An interview with the Admissions Nurse was conducted on 6/5/25 at 2:03 PM. She stated she did the admission nursing assessments for Resident #63. She indicated she was unaware the resident had a CPAP machine as she did not see the documentation in the hospital discharge summary. The admission Minimum Data Set (MDS) assessment dated 3/24/25 revealed Resident #63 was cognitively intact. The MDS was not coded for the use of a CPAP machine. Resident #63's Physician's orders for the months of March, April, May and June 2025 revealed there was no order written for use of the CPAP machine. An observation and interview were conducted on 6/2/25 at 1:15 PM in Resident #63's room. The resident had a CPAP machine next to her bed, and she stated she brought it with her from the hospital when she was admitted to the facility. Resident #63 further stated it was her personal CPAP machine that she had brought to the hospital before coming to the facility. Resident #63 indicated she used it every night for sleep apnea (a condition where a person has breathing interruptions in their sleep). In an interview with Nurse Aide (NA) #1 on 6/5/25 at 1:59 PM she stated Resident #63 used the CPAP machine nightly and that she brought it with her when she was admitted. She indicated she was familiar with Resident #63 and would see her wearing her CPAP mask when the NA arrived each morning. In an interview with Unit Manager (UM) #1 on 6/5/25 at 1:59 PM she stated Resident #63 used the CPAP machine nightly and she brought it with her when she was admitted. UM#1 reviewed Resident #63's physicians orders and stated there was no order for use of the CPAP machine. UM #1 indicated that use of a CPAP machine should have a physician's order. In an interview with the Administrator on 6/3/25 at 3:07 PM she stated Resident #63 should have had orders for use of the CPAP machine.	F0695		
F0700 SS = D	Bedrails	F0700	F700 Bedrails	07/07/2025

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F0700 SS = D	Continued from page 31 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews the facility failed to attempt alternative interventions, assess for entrapment risk, review the risks and benefits of the use of side rails, and/or obtain consent from the resident or resident representative prior to installing bilateral quarter length side rails (Resident #94 and Resident #172). In addition, the facility failed to attempt alternative interventions prior to installing bilateral quarter length side rails (Resident #63). This deficient practice affected 3 of 3 residents reviewed for side rails (Resident #94, Resident #172, and Resident #63). Findings included: 1. Resident #94 was admitted to the facility on 10/25/24 with diagnoses that included dementia, arthritis and heart failure. Resident #94's Minimum Data Set (MDS) revealed she	F0700	Continued from page 31 1. On 6/27/2025 resident # 94 bedrails have been removed from the bed. Residents 172 & 63 have been discharged from the facility. 2. A facility-wide audit was conducted to identify all residents using side rails by the Unit Managers on 6/26/2025. Any resident with a side rail had a Side Rail Assessment completed on 6/27/2025 by the Unit Managers to address safety, purpose and alternative interventions. If the side rails are still indicated for use the Unit Managers obtain consent from the resident/responsible parties after educating risks verses benefits. 3. On 6/27/2025 the SDC initiated an in-service for nursing staff on the facilities Device Assessment policy ensuring all side rail devices have been appropriately assessed for alternative interventions, safety. If they side rail is still indicated, all consents from our residents/responsible parties are obtained after education on risk and benefits of using sad rails. All in-services will be completed by 7/2/2025, any staff not having the in-service will be in-serviced before their next shift. This in-service will also be a part of any new orientation as of 7/2/2025. 4. The DON will audit all new requests for side rails weekly for 4 weeks to ensure all education, alternative interventions were addressed, assessments completed and consents were received from the resident/family. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0700 SS = D	Continued from page 32 required partial to moderate assistant with bed mobility and that she had impairment to both lower extremities. The MDS indicated Resident #94 was moderately cognitively impaired. Resident #94's comprehensive care plan dated 11/3/24 revealed she did not have a care plan that included the use of side rails. Resident #94's bed side rail tool, dated 1/23/25 and completed by the Admission Nurse, indicated the resident did not use side rails, risks versus benefits and consent were not completed, and there was no assessment for entrapment risk. The bed side rail tool revealed no alternative interventions were tried before the installation and use of bilateral quarter length side rails. An interview with the Admission Nurse was conducted on 6/5/25 at 2:03 PM. She stated she did the admission side rail assessment for Resident #94. The Admission Nurse reviewed the assessment during the interview and revealed it was marked that the resident did not use bilateral quarter length side rails which she confirmed was not correct. The Admission Nurse indicated she could not remember if the side rails were on the bed at the time of her assessment. The Admission Nurse further stated review of risks and benefits, consent, and entrapment risk would not have been completed unless Resident #39 was approved for use of bilateral quarter length side rails. She was unsure why she had marked Resident #39 as not using side rails and was unaware alternative interventions needed to be tried and documented before the installation and use of side rails. An observation was conducted on 6/3/25 at 12:43 PM in Resident #94's room. The resident was lying in bed with bilateral quarter length side rails in the raised position. In an interview with Resident #94 on 6/3/25 at 12:43 PM, she stated she had always had the side rails on her bed and she used them to assist staff to help her roll over or to sit on the side of the bed. In an interview with the Director of Nursing (DON) on 6/3/25 at 2:22 PM she reviewed Resident #94's bed side	F0700		

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F0700 SS = D	Continued from page 33 rail tool assessment and stated that it indicated she did not use side rails. A follow-up observation and interview was conducted with the DON on 6/3/25 at 2:31 PM. Resident #94 was lying in bed with bilateral quarter length side rails in the raised position. The DON stated Resident #94's bed side rail tool should have indicated she did use side rails, an entrapment risk evaluation should have been completed, risks vs benefits should have been reviewed, and consent should have been received. She further stated she was unaware alternative interventions needed to be tried and documented before the installation and use of bilateral quarter length side rails. In an interview with the Administrator on 6/3/25 at 3:07 PM, she stated Residents #94 should have had an accurate bed side rail tool to include the use of bilateral quarter length side rails. The Administrator further stated she was unaware alternative interventions to bilateral quarter length side rails needed to be tried and documented before the installation and use of side rails. 2. Resident #172 was admitted to the facility on 5/28/25 with diagnoses that included acquired loss of left leg below the knee. Resident #172's admission nursing assessment dated 5/28/25 indicated he was cognitively intact. Resident #172's Minimum Data Set (MDS) was not available. Resident #172's bed side rail tool dated 5/29/25 and completed by the Admission Nurse indicated the resident did not use side rails, entrapment risk was not evaluated, risks and benefits were not discussed and consent was not obtained from the resident or his responsible party. The bed side rail tool did not have alternative interventions listed before the installation and use of the side rails. An interview with the Admissions Nurse was conducted on 6/3/25 at 2:07 PM. She stated she did the admission side rail assessment for Resident #172. The Admission	F0700		

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F0700 SS = D	Continued from page 34 Nurse reviewed the assessment during the interview and revealed it was marked that the resident did not use bilateral quarter length side rails which she confirmed was not correct. The Admission Nurse indicated she could not remember if the side rails were on the bed at the time of her assessment. The Admission Nurse further stated review of risks and benefits, consent, and entrapment risk would not have been completed unless Resident #172 was approved for use of bilateral quarter length side rails. She was unsure why she had marked Resident #172 as not using side rails and was unaware alternative interventions needed to be tried and documented before the installation and use of side rails. An observation was conducted on 6/2/25 at 11:30 AM in Resident #172's room. The resident was sitting on the side of his bed with bilateral quarter length side rails in the raised position. In an interview with Resident #172 on 6/2/25 at 11:30 AM he stated the side rails had been on the bed since his admission. In an interview with the Director of Nursing (DON) on 6/3/25 at 2:15 PM she reviewed Resident #172's bed side rail tool assessment and stated that it indicated he did not use side rails. A follow-up observation and interview was conducted with the DON on 6/3/25 at 2:29 PM. Resident #172 was sitting on the side of the bed with bilateral quarter length side rails in the raised position. The DON stated Resident #172's bed side rail tool should have indicated he did use side rails, an entrapment risk evaluation should have been completed, risks vs benefits should have been reviewed, and consent should have been received. She further stated she was unaware alternative interventions needed to be tried and documented before the installation and use of bilateral quarter length side rails. In an interview with the Administrator on 6/3/25 at 3:07 PM, she stated Resident #172 should have had an accurate bed side rail tool completed to include the use of bilateral quarter length side rails. The Administrator further stated she was unaware alternative interventions to bilateral quarter length side rails needed to be tried and documented before the	F0700		

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F0700 SS = D	Continued from page 35 installation and use of side rails. 3. Resident #63 was admitted to the facility on 3/20/25 with diagnoses that included urinary tract infection, diabetes mellitus II and muscle wasting. Resident #63's admission Minimum Data Set (MDS) assessment dated 3/24/25 revealed she was cognitively intact and required partial/moderate assistance with bed mobility. The MDS further revealed she had impairment of both upper and lower bilateral extremities. Resident #63's bed side rail tool dated 3/20/25 and completed by the Admission Nurse did not include documentation regarding the use of alternative interventions before the installation of side rails. The updated care plan for Resident #63 dated 4/2/25 included a focus of short term care: the resident requires assistance with activities of daily living (ADL). The goal was for the resident to improve their ADL functionality through the next review. Interventions included half length bed side rails. An interview with the Admission Nurse was conducted on 6/5/25 at 2:03 PM. She stated she completed the bed side rail tool for Resident #63. She indicated she was unaware alternative interventions needed to be tried and documented prior to the installation and use of bilateral quarter length side rails. An observation of Resident #63 was conducted on 6/2/25 at 10:50 AM. The resident was lying in bed with bilateral quarter side rails in the raised position. A follow up observation and interview was conducted with Resident #63 on 6/3/25 at 1:25 PM. The resident was lying in bed with bilateral quarter side rails in the raised position. Resident #63 indicated she used the side rails to assist her when rolling over or repositioning in bed and they had been in place since her admission. In an interview with the Administrator on 6/3/25 at 3:07 PM she stated she was unaware alternative	F0700		

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F0700 SS = D	Continued from page 36 interventions were required to be tried and documented before the installation and use of bilateral quarter length side rails.	F0700		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes,	F0842	F 842 Resident Records 1. On 6/27/2025 the ADON in-serviced the wound care nurse one-on-one concerning documenting treatments that are completed. 2. On 6/27/2025 the ADON when audited the last 14 days of the treatment administration records (TAR) For current residents receiving wound care to ensure documentation was completed with no other issues noted 3. On 6/27/2025 the SDC began an audit with all nurses concerning documentation after treatments are completed. All in-services will be completed by 7/2/2025, any staff not having the in-service will be in-serviced before their next shift. This in-service will also be a part of any new orientation as of 7/2/2025. 4. The director of nursing will audit 10 TARs weekly for 4 weeks then 5 TARs weekly for 4 weeks to ensure follow up with documentation after treatments are completed. . The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	07/07/2025

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F0842 SS = D	Continued from page 37 research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to document the completion of wound treatments provided to a resident. This was for 1 of 3 residents (Resident #85) reviewed for pressure ulcers. Findings included: A review of Resident #85's physician's orders revealed an order dated 6/5/25 with an order start date of	F0842		

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F0842 SS = D	Continued from page 38 6/5/25 at 7:00 AM indicated to cleanse Resident #85's posterior (further back position) scrotal (a muscular skin covered sack in front of the pelvis covering the testicles) skin tear with soap and water, pat dry, apply collagen particles (a protein that provides support and strength to skin) covered by a thin layer of zinc oxide paste (a medicated cream), and apply bordered gauze (an absorptive dressing) daily and as needed. An additional physician's order dated 6/5/25 with an order start date of 6/5/25 at 12:00 PM indicated to cleanse his right groin (the area where the thigh and abdomen meet) abrasion (a superficial injury to the skin) with wound cleanser, apply calcium alginate with silver (an antimicrobial dressing) and leave open to air three times daily and as needed. On 6/6/25 at 11:00 AM a review of Resident #85's medical record and June 2025 Treatment Administration Record (TAR) did not reveal any documentation indicating that his right groin abrasion or scrotal skin tear wound treatments had been completed on 6/5/25. On 6/6/25 at 11:21 AM an interview with the Wound Care Nurse indicated she completed all Resident #85's right groin abrasion and posterior scrotal skin tear treatments on 6/5/25 as ordered by his physician. She stated she could not say why she had not documented the completion of these treatments in Resident #85's medical record or on Resident #85's TAR for that date, but she should have. In an interview on 6/6/25 at 11:30 AM the Director of Nursing (DON) stated Resident #85's medical record should accurately reflect the wound treatments provided to him by the Wound Care Nurse on 6/5/25. On 6/6/25 at 11:33 AM an interview with the Administrator indicated the Wound Care Nurse should have documented the wound treatments she provided to Resident #85 on 6/5/25 to ensure his medical record was complete and accurate.	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection	F0880	F 880 Infection Control 1. Nurse #3 was educated and suspended on 6/5/2025 by the DON. 2. This action violated standard infection control	07/07/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/GREENVILLE	2578 WEST FIFTH STREET , GREENVILLE, North Carolina, 27834

(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
F0880 SS = D	Continued from page 39 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 39 protocols and safe medication administration practices for all residents. The DON completed an in-service on 6/4 /2025 with the other 4 floor nurses that were working. 3. On 6/27/2025 the SDC initiated an in-service for all nursing staff regarding proper medication handling, including that any medication dropped must be discarded and not administered to residents and when to discard and reorder medications. All in-services will be completed by 7/2/2025, any staff not having the in-service will be in-serviced before their next shift. This in-service will also be a part of any new orientation as of 7/2/2025. 4. The DON & ADON will complete 5 med passes a week for 4 weeks to ensure nurses are following infection control guidelines when passing medications. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. 5. Date of compliance: 7/7/2025	

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F0880 SS = D	Continued from page 40 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and Nurse Practitioner(NP) interviews, the facility failed to ensure infection control standards were followed when Nurse #3 dropped a residents medication on the top of the medication cart, picked it up with her bare fingers, placed it in the medication cup and gave the medications to the resident. This was for 1 of 11 staff members reviewed for infection control practices (Nurse #3). Findings included: An observation was conducted on 6/4/25 at 8:35 AM during medication pass. Nurse #3 was preparing several medications for a resident when she popped a pill out of the back of the bubble pack and it missed the medication cup and landed on the top of the medication cart. Nurse #3 picked the pill up off the medication cart with her bare fingers and placed it in the medication cup. She stated "Ooops, I probably shouldn't have done that. Oh well." Nurse #3 then gave the medications to the resident. She had last performed hand hygiene before starting to prepare the medications for this resident. She had touched 5 bottles of stock medications, 3 bubble pack cards and the drawer handles of the cart while preparing the medications for this resident. She was not observed to clean the top of the medication cart at any time during the medication pass observation.	F0880		

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F0880 SS = D	Continued from page 41 In an interview with Nurse #3 on 6/4/25 at 8:45 AM she stated she knew she should have thrown the pill away after it touched the top of the medication cart and she touched it with her bare hands as that would have been proper infection control procedure. She further stated she didn't know why she continued to put it in the cup and give it to the resident. During an interview with the Infection Preventionist on 6/4/25 at 11:45 AM, she stated Nurse #3 should have thrown the pill away after picking it up from the top of the medication cart with her bare hands. She revealed both the medication cart and her hands could have transmitted a disease causing organism to the resident. On 6/5/25 at 3:12 PM, the NP was interviewed. She stated Nurse #3 should have thrown the pill away after it touched the top of the medication cart and she picked it up with her bare hands. The NP revealed that people's hands are the number one way bacteria and viruses are passed from person to person, either from the person themselves or after touching a contaminated surface such as the top of the medication cart. In an interview with the Director of Nursing on 6/4/25 at 11:50 AM she stated Nurse #3 should have thrown the pill away after it touched the top of the medication cart. She further stated that Nurse #3's hands, or the top of the medication cart, could have been contaminated and that could have been passed to the resident via the pill. An interview with the Administrator and the Director of Clinical Services was conducted on 6/4/25 at 11:55 AM. The Director of Clinical Services stated they did not have a policy directly related to the deficiency of touching a pill with bare hands that had been on top of the medication cart and then giving it to a resident. The Administrator indicated that it would be common nursing practice to throw the pill away and get a clean one for the resident, and that is what she would have expected Nurse #3 to have done.	F0880		