STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW , RALEIGH, North Carolina, 27616**

(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 8/04/25 to conduct a recertification and complaint investigation survey and exited on 8/07/25. Additional information was obtained remotely on 8/18/25. The survey team returned to the facility on 8/19/25 to investigate additional complaint intakes and exited on 8/20/25 Therefore, the exit date was changed to 8/20/25.The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D2435.	E0000		08/28/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 8/04/25 to conduct a recertification and complaint investigation survey and exited on 8/07/25. Additional information was obtained remotely on 8/18/25. The survey team returned to the facility on 8/19/25 to investigate additional complaint intakes and exited on 8/20/25 Therefore, the exit date was changed to 8/20/25.. Event ID# 1D2435. The following intakes were investigated: 2587642, 2582567, 2580122, 2580702, 2572683, 2569244, 2562595, 799392, 799397, 799341, 2563774, 799400, 799424, 799423, 799422, 799421, and 799394. 39 of the 39 complaint allegations did not result in a deficiency.	F0000		08/28/2025
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A	F0636	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F636 The admission Minimum Data Set (MDS) assessment was	09/09/2025

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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F0636 SS = D	Continued from page 1 facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in	F0636	Continued from page 1 completed on 8/21/25 for resident #89. The Regional Director of Clinical Reimbursement (RDCR) audited all admission MDS assessments and noted 12 admission MDS assessments that needed to be completed. These assessments will be completed by 9/8/25 by the MDS nurses. The MDS nurses' were educated by the RDCR regarding the importance of completing MDS admission assessments timely. This education was completed on 8/25/25. Any new MDS nurse hired after 8/25/25 will receive this education during orientation. The RDCR will audit 5 new admission MDS assessments weekly x 12 weeks to ensure the assessments are completed timely. Results will be reported by the MDS Director to the Quality Assurance Performance Improvement Committee (QAPI) x3 months for further resolution as needed Date of compliance: 9/9/2025	

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F0636 SS = D	Continued from page 2 paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with staff, the facility failed to complete an admission Minimum Data Set (MDS) assessment within 14 days of admission for 1 of 3 residents reviewed for MDS assessments (Resident #89). The findings included: Resident #89 was readmitted to the facility on 7/31/25 with diagnoses including cerebral vascular accident (stroke). An admission MDS assessment with an Assessment Reference Date (ARD) of 8/6/25 was noted to be “in process” when reviewed on 8/20/25. In an interview on 8/20/25 at 2:03 PM, the MDS Coordinator stated the MDS assessment should have been done within 14 days after admission. He stated the MDS was not completed due to the volume of MDS assessments the facility had pending and they were trying to hire another full time MDS nurse. In an interview on 8/20/25 at 3:34 PM, the Administrator stated Resident #89’s MDS assessment should have been completed on time. She stated because they were needing another full time MDS nurse, the corporate office had been helping part-time and another part-time employee had been hired, but not all the assessments were up to date yet.	F0636		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j)	F0641	F641 On 8/8/25, the inaccurate assessment was modified and	09/09/2025

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F0641 SS = D	Continued from page 3 §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 facility staff interviews, the facility failed to accurately code a Minimum Data Set Assessment for Antipsychotic Medication Review for 1 of 5 residents reviewed for unnecessary medications (Resident #117). The findings included: Resident #117 was admitted to the facility on 7/7/25 with diagnoses which included dementia with delusions. A review of Resident #117's July 2025 Medication	F0641	Continued from page 3 transmitted by the Regional Director of Clinical Reimbursement. All residents on an antipsychotic medication have the potential to be affected. An audit was completed by the Regional Director of Clinical Reimbursement on 8/8/25. There were 20 residents noted on an antipsychotic and no other incorrect coding noted. The MDS Coordinator and MDS nurse were educated by the Regional Director of Clinical Reimbursement on the importance of coding MDS accurately. This education was completed on 8/8/25. The Regional Director of Clinical Reimbursement or designee will audit 5 MDS assessments 3 x weekly for 4 weeks, 3 x weekly for 4 weeks and once weekly for 4 weeks for coding antipsychotic accurately on the MDS assessment. Results of the audits will be reported by the MDS Coordinator to the QAPI Committee x 3 months for further resolution as needed. Date of Compliance: 9/9/25.	

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F0641 SS = D	Continued from page 4 Administration Record (MAR) documented Quetiapine Fumarate 0.5 milligrams (mg) was administered 7/7/25, 7/8/25 and 7/10/25 through 7/30/25. A review of Resident #117's admission Minimum Data Set Assessment (MDS) dated 7/13/25 revealed she received antipsychotic medications. The Antipsychotic Medication Review was coded as not receiving antipsychotics on a scheduled or routine basis. During an interview with the Regional MDS Consultant on 8/6/25 at 10:30 a.m., she stated the MDS should have indicated Resident #117 had received antipsychotic medications on a regular basis, and this had been an error. She verified the Minimum Data Set Assessment was inaccurate and that antipsychotic use should have been coded correctly. During an interview with the Administrator on 8/7/25 at 2:00 pm, she stated the MDS assessments should have been coded accurately to reflect the use of antipsychotics.	F0641		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the	F0761	F761 1. The bisacodyl suppositories found in the Unit 2 Medication storage room were discarded on 8/7/25. 2. All medication storage rooms were inspected by the Unit Managers on 8/7/25 and there were no additional expired medications found. 3. The SDC (Staff Development Coordinator) or designee will educate all licensed nurses, and medication aides, including agency staff members, on medication storage to include labeling, dating, and removing expired medications. This education will be completed on or before 9/8/2025. Any nurse or medication aide not receiving education will not be allowed to work until received. All new nurses or medication aides hired after 9/8/25 will receive this education during orientation. 4. Unit Managers or designees will inspect Medication Rooms weekly x12 weeks to ensure there are no expired medications in the facility. Results will be reported by the Director of Nursing (DON) to the QAPI Committee x 3 months for further resolution as needed	09/09/2025

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F0761 SS = D	Continued from page 5 facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to remove a box which contained 40 bisacodyl (a laxative) suppositories that were expired in 1 of 3 medication storage rooms (Unit 2 Medication Storage Room) reviewed for medication storage and labeling. The findings included: An observation of Unit 2 Medication Storage Room on 8/7/25 at 9:49 am revealed an opened box of bisacodyl suppositories, originally containing 40 suppositories, with an expiration date of 4/2025. In an interview with the Unit Manager #2 on 8/7/25 at 9:49 am, she stated the opened box of expired bisacodyl suppositories should have been discarded in April 2025. During an interview with the interim Director of Nursing (DON) on 8/7/25 at 2:00 pm, she stated the nursing staff was responsible for regularly checking the medication storage rooms and removing expired medications. The Administrator was interviewed on 8/7/25 at 2:00 pm and she indicated all nursing staff were responsible for regularly checking the medication storage rooms and removing expired medications.	F0761	Continued from page 5 5. Date of compliance: 9/9/2025	
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 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.	F0880	F880 1. Resident #89 is no longer on contact precautions. On 8/5/2025 Nurse #1 was educated by the SDC on the policy and procedures for Contact Isolation. 2. All residents with contact isolation orders and signage are at risk. 3. Education was started by the SDC on 8/5/2025 to all staff members, including agency, regarding contact precautions and appropriate Personal Protective Equipment (PPE) to use while providing care, and in the room with patient on Contact Isolation. All staff	09/09/2025

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F0880 SS = D	Continued from page 6 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 (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.	F0880	Continued from page 6 members will be educated by 9/8/25 by the SDC or designee. Any staff member not receiving education will not be allowed to work until received. All staff members hired after 9/8/25 will receive this education during orientation. 4. The Infection Preventionist (IP) or designee will conduct 10 observations for contact isolation rooms for appropriate PPE use 5 x weekly for 4 weeks, 3 x weekly x 4 weeks and weekly for 1 month. Results will be reported by the DON (Director of Nursing) to the Quality Assurance Committee x3 months for further resolution as needed 5. Date of compliance: 9/9/2025	

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F0880 SS = D	Continued from page 7 §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 interviews, the facility failed to implement infection control policies and procedures when Nurse #1 failed to apply all the required Personal Protective Equipment (PPE) before entering a room with a resident on contact precautions. This occurred for 1 of 7 staff observed for infection control practices. The findings included: The facility's Infection Prevention and Control Program policy last revised on 2/6/2020 read in part: "for patients documented as suspected to be infected with highly transmissible important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission, contact precautions may be utilized for diseases that have multiple routes of transmission that can be transmitted by direct contact or when performing patient care activities that require touching the resident." Review of the facility's contact precautions signage read in part: "All healthcare personnel must: Clean hands before entering and when leaving room. Wear gloves when entering room and remove before leaving room. Wear a gown when entering room and remove before leaving." A review of Resident #89's physician order dated 8/5/25 revealed an order for contact isolation precautions related to conjunctivitis (an inflammation of the conjunctiva, the thin, transparent membrane covering the white part of the eye and the inner surface of the eyelids) for 10 days. An observation on 8/5/25 at 9:13 am of Resident #89's room revealed a sign posted on the right side of the door "Contact Precautions". A storage cart was located outside the resident's room beside his door containing PPE to include gloves and gowns.	F0880		

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F0880 SS = D	Continued from page 8 An observation was conducted on 8/5/25 at 2:57 pm of Nurse #1. Nurse #1 was observed administering medications to Resident #89 via gastrostomy tube (a tube inserted in the abdomen to provide nutrition and medications) with no gloves or gown on for contact precautions. During an interview on 8/5/25 at 3:11 pm with Nurse #1, she stated she did not realize Resident #89 was on contact precautions. Nurse #1 indicated she was busy on the unit; however, she knew she was supposed to wear PPE for a resident on contact precautions. In an interview with Unit Manager #1 on 8/5/25 at 3:00 pm, she stated Nurse #1 should have had her PPE on going in to Resident #89's room. The Staff Development Coordinator (SDC) nurse was interviewed on 8/5/25 at 3:01 pm. The SDC nurse stated the facility had on-going in-services for infection control prevention on transmission-based precautions (TBP). During an interview on 8/7/25 at 2:00 pm with the interim Director of Nursing (DON), she stated Nurse #1 had been in-serviced on this day on infection control prevention and PPE usage. The interim DON further stated Nurse #1 should have had her PPE on for a resident on contact precautions. In an interview on 8/7/25 at 2:00 pm with the Administrator, she stated her expectations were the nursing staff to read the signs on the residents' doors prior to entering the rooms and use the appropriate PPE supplies indicated by the signage posted.	F0880		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the	F0883	"Past Noncompliance - no plan of correction required"	08/28/2025

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F0883 SS = E	Continued from page 9 resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and resident and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the	F0883		

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F0883 SS = E	Continued from page 10 pneumococcal vaccinations for 4 of 5 residents (Resident #37, #67, #98, and #118) and offer annual influenza vaccine for 1 of 5 (Resident #118) residents reviewed for immunizations. The findings included: The facility policy for Pneumococcal Vaccination with the effective date 8/4/2023 read in part “Vaccinations against pneumonia will be offered to center patients as indicated. Contraindications for receiving a pneumococcal vaccination were severe allergy to any component of the vaccine. Patient pneumococcal vaccine tracking will be maintained by the Infection Preventionist using the Immunization Tracking in the electronic medical record.” The facility policy for Influenza Vaccination with the effective date 5/1/2023 read in part “Influenza vaccine should be offered annually. The optimal time to administer influenza vaccine is in late September or early October of each year. The center will check the immunization status of patients admitted during flu season. Those who have not had a flu vaccine will be offered one upon admission unless contraindicated. The patient influenza vaccine tracking will be maintained by the Infection Preventionist using the Immunization Tracking in the electronic medical records.” 1. Resident #37 was admitted to the facility on 7/3/2023 with diagnoses that included osteoarthritis and gout. The annual Minimum Data Set (MDS) assessment dated 6/11/2025 revealed Resident #37 was cognitively intact and was coded as being offered and declining the pneumococcal vaccine. Review of Resident #37’s immunization record revealed no documentation that he had been offered, given, or refused the pneumococcal vaccine. An interview was completed on 8/7/2025 at 10:30 am with Resident #37. Resident #37 stated he was unable to recall if he was offered the pneumococcal vaccine by the facility and declined it. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse. The Nurse verified she was responsible for ensuring facility residents were offered and received the pneumococcal and influenza vaccine. The Quality Assurance Nurse revealed she began working at the facility approximately 1 ½ months ago. The Nurse stated she audited all residents’ medical	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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F0883 SS = E	Continued from page 11 records to verify who had not been offered or received the influenza and pneumococcal vaccinations. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of vaccinations in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. 2. Resident #67 was admitted to the facility on 7/11/2024 with diagnoses that included arthritis and asthma. The annual MDS assessment dated 6/20/2025 revealed Resident #67 was cognitively intact and was coded as not receiving her pneumococcal vaccination. Review of Resident #67's immunization record revealed no documentation that she had been offered, given, or refused the pneumococcal vaccine. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and received the pneumococcal and influenza vaccine. The Quality Assurance Nurse revealed she began working at the facility approximately 1 ½ months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the influenza and pneumococcal vaccinations. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of vaccinations in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. 3. Resident #98 was admitted to the facility on 12/17/2023 with diagnoses that included asthma and congestive heart failure.	F0883		

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F0883 SS = E	Continued from page 12 The annual MDS assessment dated 6/25/2025 revealed Resident #98 was cognitively intact and was coded as being offered and declining the pneumococcal vaccination. Review of Resident #98's immunization record revealed no documentation that she had been offered, given, or refused the pneumococcal vaccine. An interview was completed on 8/7/2025 at 10:40 am with Resident #98. Resident #98 stated she was unable to recall if she was offered the pneumococcal vaccine by the facility and declined it. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and received the pneumococcal and influenza vaccine. The Quality Assurance Nurse revealed she began working at the facility approximately 1 ½ months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the influenza and pneumococcal vaccinations. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of vaccinations in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. 4. Resident #118 was admitted to the facility on 10/11/2024 with diagnoses that included a history of a stroke. The quarterly MDS assessment dated 7/14/2025 revealed Resident #118 was severely cognitively impaired and was coded as not being offered nor receiving the pneumococcal or influenza vaccination. Review of Resident #118's immunization record revealed no documentation that she had been offered, given, or refused the pneumococcal vaccine. The review also revealed she was documented as not being eligible to receive the influenza vaccination. Multiple attempts made to interview the Resident Representative were unsuccessful.	F0883		

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F0883 SS = E	Continued from page 13 Review of Resident #118's medical record revealed no contraindications to receiving the influenza vaccination. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and received the pneumococcal and influenza vaccine. The Quality Assurance Nurse revealed she began working at the facility approximately 1 ½ months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the influenza and pneumococcal vaccinations. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of vaccinations in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. The Quality Assurance Nurse stated she was unable to state why Resident #118 was documented as not being eligible to receive the influenza vaccination. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. The facility provided the following corrective action plan with a completion date of 8/1/2025. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to document and/or administer immunizations and/or vaccinations for residents in the electronic medical record (EMR). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On July 8, 2025, the Infection Preventionist (IP) reviewed all residents' EMR for immunizations and/or vaccinations. Out of the 114 residents in-house, 33 were vaccinated, 29 refused, 23 received partial vaccination, 24 consented and had not yet received the vaccinations, 3 voicemail messages were left for consent from the Resident Representative with no return call, and 2 unable to reach the guardian for the COVID	F0883		

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F0883 SS = E	Continued from page 14 vaccination. Out of the 114 in-house residents, 37 refused, 40 were vaccinated, 4 voicemail messages were for consent from the Resident Representative with no return call, 2 have consented, and 31 were not eligible based on their admission date and/or received prior to admission the Influenza vaccination. Out of the 114 in-house residents, 40 refused, 24 were vaccinated, 41 have consented, and 9 voicemail messages were left for consent from the Resident Representative with no return call for the Pneumococcal vaccination. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Staff Development Coordinator Nurse initiated education on July 8, 2025, to all licensed nurses to document available immunizations and/or vaccinations upon admission and was completed on July 31, 2025. Any that has not received the education by July 31,2025, will be educated prior to the start of his/her next scheduled shift. All newly licensed nurses will be educated during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. On July 8, 2025, the newly hired Infection Preventionist (IP) was educated by the Regional Director of Clinical Services on immunization/vaccination requirements and documentation standards. The Infection Preventionist (IP) will review each new admission and administer the vaccination and/or immunization per the consent and document the administration in the EMR. The Infection Preventionist (IP) will audit all new admissions for immunization/vaccination documentation and/or administration daily, Monday through Friday for 12 weeks. Monitoring began on July 8, 2025, and initial results of these audits were reviewed on July 31, 2025, during the facility's Quality Assurance Performance Improvement (QAPI) meeting. The continued audits will be reviewed at the Quarterly QAPI meeting for 3 meetings for further problem resolution if needed. The Administrator will review the results of the weekly audits to ensure any issues are identified and corrected. Alleged date of compliance: 8/1/2025	F0883		

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F0883 SS = E	Continued from page 15 Onsite validation was completed on 8/7/2025 through staff interviews and record reviews. Inservice education was confirmed to be provided on immunization/vaccination requirements and documentation standards. Staff were interviewed to validate the in-service education was completed. Review of education conducted with Infection Preventionist regarding immunization/vaccination requirements and documentation standards was completed. Audits were reviewed with no concerns noted. An interview was completed on 8/7/2025 at 2:35 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she received education regarding vaccination requirements and documentation. The Nurse stated she reviewed new admissions daily for vaccinations. An interview was completed on 8/7/2025 at 2:57 pm with Unit Manager #2. The Unit Manager #2 verified she received education regarding the documentation of prior vaccinations residents had upon admission to the facility. The facility's corrective action plan completion date of 8/1/2025 was validated.	F0883		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires	F0887	"Past Noncompliance - no plan of correction required"	08/28/2025

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F0887 SS = D	Continued from page 16 multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and resident and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the COVID-19 vaccinations for 1 of 5 residents (Resident #67) reviewed for immunizations. The findings included: The facility policy for COVID-19 vaccination with the effective date 3/11/2024 read in part “Vaccinations against COVID-19 will be offered to center patients as	F0887		

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F0887 SS = D	Continued from page 17 indicated. Contraindications for receiving the COVID-19 vaccination include severe allergic reaction to any component of the vaccine. COVID-19 vaccination tracking will be maintained by the Infection Preventionist or designee." Resident #67 was admitted to the facility on 7/11/2024 with diagnoses that included arthritis and asthma. The annual MDS assessment dated 6/20/2025 revealed Resident #67 was cognitively intact and was coded as not being up to date for the COVID-19 vaccination. Review of Resident #67's immunization record revealed no documentation that she had been offered, given, or refused the COVID-19 vaccination. An interview was completed on 8/6/2025 at 12:07 pm with Resident #67. The Resident revealed she was unable to recall being offered the COVID-19 vaccination. An interview was completed on 8/7/2025 at 2:05 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she was responsible for ensuring facility residents were offered and received the COVID-19 vaccination. The Quality Assurance Nurse revealed she began working at the facility approximately 1 ½ months ago. The Nurse stated she audited all residents' medical records to verify who had not been offered or received the COVID-19 vaccination. The Quality Assurance Nurse revealed she contacted all residents and their responsible parties that had no documentation of the vaccination in their medical record to obtain their consent or refusals for them. The Nurse stated she was now at the point of obtaining Physician orders to administer the vaccinations. An interview was completed on 8/7/2025 at 3:33 pm with the Administrator. The Administrator stated there had been a recent change in leadership that contributed to residents not being offered and receiving vaccinations timely. The facility provided the following corrective action plan with a completion date of 8/1/2025. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to document and/or administer immunizations and/or vaccinations for residents in the electronic medical record (EMR).	F0887		

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F0887 SS = D	Continued from page 18 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On July 8, 2025, the Infection Preventionist (IP) reviewed all residents' EMR for immunizations and/or vaccinations. Out of the 114 residents in-house, 33 were vaccinated, 29 refused, 23 received partial vaccination, 24 consented and had not yet received the vaccination, 3 voicemail messages were left for consent from the Resident Representative with no return call, and 2 unable to reach the guardian for the COVID vaccination. Out of the 114 in-house residents, 37 refused, 40 were vaccinated, 4 voicemail messages were for consent from the Resident Representative with no return call, 2 have consented, and 31 were not eligible based on their admission date and/or received prior to admission the Influenza vaccination. Out of the 114 in-house residents, 40 refused, 24 were vaccinated, 41 have consented, and 9 voicemail messages were left for consent from the Resident Representative with no return call for the Pneumococcal vaccination. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Staff Development Coordinator Nurse initiated education on July 8, 2025, to all licensed nurses to document available immunizations and/or vaccinations upon admission and was completed on July 31, 2025. Any that has not received the education by July 31,2025, will be educated prior to the start of his/her next scheduled shift. All newly licensed nurses will be educated during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. On July 8, 2025, the newly hired Infection Preventionist (IP) was educated by the Regional Director of Clinical Services on immunization/vaccination requirements and documentation standards. The Infection Preventionist (IP) will review each new admission and administer the vaccination and/or immunization per the consent and document the administration in the EMR. The Infection Preventionist (IP) will audit all new admissions for immunization/vaccination documentation and/or administration daily, Monday through Friday for 12 weeks.	F0887		

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F0887 SS = D	Continued from page 19 Monitoring began on July 8, 2025, and initial results of these audits were reviewed on July 31, 2025, during the facility's Quality Assurance Performance Improvement (QAPI) meeting. The continued audits will be reviewed at the Quarterly QAPI meeting for 3 meetings for further problem resolution if needed. The Administrator will review the results of the weekly audits to ensure any issues are identified and corrected. Alleged date of compliance: 8/1/2025 Onsite validation was completed on 8/7/2025 through staff interviews and record reviews. Inservice education was confirmed to be provided on immunization/vaccination requirements and documentation standards. Staff were interviewed to validate the in-service education was completed. Review of education conducted with Infection Preventionist regarding immunization/vaccination requirements and documentation standards was completed. Audits were reviewed with no concerns noted. An interview was completed on 8/7/2025 at 2:35 pm with the Quality Assurance Nurse/Infection Preventionist. The Nurse verified she received education regarding vaccination requirements and documentation. The Nurse stated she reviewed new admissions daily for vaccinations. An interview was completed on 8/7/2025 at 2:57 pm with Unit Manager #2. The Unit Manager #2 verified she received education regarding the documentation of prior vaccinations residents had upon admission to the facility. The facility's corrective action plan completion date of 8/1/2025 was validated.	F0887		