STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification and complaint investigation survey was conducted from 12/02/24 through 12/05/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BMCH11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/02/24 through 12/05/24. Event ID# BMCH11. The following intakes were investigated : NC00212386, NC00213398, NC00214200, NC00214662, NC00214765, NC00217309, NC00218093, NC00218551, NC00218638, NC00219502, NC00219823, NC00220612, NC00220650, NC00221639, NC00223564, NC00223566, NC00223971, NC00224105, NC00224382 and NC00224540. 12 of the 72 complaint allegations resulted in deficiency	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		1/2/25

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

Electronically Signed | 01/01/2025

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F 565	Continued From page 1 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews with Resident Council members and staff and review of Resident Council minutes, the facility failed to resolve concerns voiced by the Resident Council members for 1 of 6 months reviewed (July 2024). The findings included: Resident Council Meeting minutes from January 2024, February 2024, March 2024, July 2024, August 2024, and September 2024 were reviewed. A review of Resident Council minutes dated 7/9/24 indicated residents voiced concerns regarding not being able to get out of bed or get	F 565	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F-565 1. Resident Council Meeting was held on 12-24-24. All unresolved Resident Council concerns were addressed by the IDT at that time. 2. On 12-24-24 the Administrator	

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F 565	Continued From page 2 showers on their scheduled shower days due to staffing. Two administrative responses to the Resident Council form were reviewed dated 7/9/24. One stated the residents were being told they could not get out of bed due to staffing. There was no resolution listed. A second form revealed residents were concerned about not being able to get showers on their scheduled shower days due to staffing. There was no resolution listed. Review of Resident Council minutes dated 8/13/24 revealed there were no administrative resolutions from the July 2024 meeting. An interview was conducted on 12/4/24 at 2:00 PM with the facility's Resident Council. There were 12 residents present. During the meeting residents expressed concern with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there was no explanation as to why the grievances were not resolved. The residents stated at each meeting they discussed the same concerns. Residents stated the Activities Director was present at the Resident Council meetings and communicated their concerns to the Administration. Residents stated they continued to have concerns about getting out of bed and receiving showers on their scheduled shower days. An interview was conducted with the Director of Nursing (DON) on 12/5/24 at 11:54 AM. She stated she was never advised of any concerns from the Resident Council for July 2024. The DON stated it was her responsibility to resolve Resident Council concerns related to nursing.	F 565	completed an audit of resident council meeting minutes for the last 6 months to identify any unresolved concerns. There were no unresolved concerns. 3. On 12-27-24 the administrator educated all department managers to promptly investigate and provide written responses to resident council concerns. All concerns must be addressed prior to the next scheduled resident council meeting. 4. The administrator will review resident council responses monthly for 3 months. The administrator will present results of responses to QAPI Committee monthly to ensure continued compliance. 5. Compliance date: 1/2/2025	

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F 565	Continued From page 3 Attempts to contact the former Activities Director were not successful. An interview was conducted with the Administrator on 12/5/24 at 12:05 PM who stated resolution of Resident Council concerns should be forwarded by the Activities Director to the appropriate department head and resolutions should be shared at the next Resident Council meeting. She stated the Activities Director resigned on 11/11/24.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		1/2/25

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F 578	Continued From page 4	F 578		

entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide written advance directive information and/or an opportunity to formulate an advance directive for 2 of 21 residents reviewed for advance directive (Residents #14 and Resident #17).

The findings included:

a. Resident #14 was admitted to the facility on 10/16/2024 with diagnoses that included acute respiratory failure, dysphagia, and end stage renal disease.

There was no documentation in Resident #14's medical record for education regarding the formulation of an advanced directive and/or an opportunity to formulate an advance directive was offered.

An interview was conducted with the Director of

F-578

1. The responsible party for resident #14 and resident #17 were educated on formulating advanced directives on 12/27/24 by the Administrator. Both parties declined.
2. The Social Services Director completed an audit of each resident□s Advanced Directives on 12/30/2024.
3. The Social Work department was in-serviced on 12/27/24 by Administrator that Advanced Directives will be formulated during admission and/or the baseline care plan review within 48 hours of admission.
4. The IDT team will review advanced directives for new admissions weekly x 12 weeks. The DON will present the results of the audit to the QAPI Committee to ensure continued compliance.

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F 578	Continued From page 5 Social Services on 12/04/2024 at 3:51 PM. She revealed that during care plan meetings or as needed, code status was discussed. However, the conversation never went further into detail to include advance directive. During an interview with the Admissions Director on 12/05/24 at 8:22 AM, she revealed that prior to the change of ownership in June 2024, residents/families were only educated on code status. This was included in the admissions packet at the time. Beginning June 2024, the new company moved the advance directive discussion responsibility to Social Services. An interview was conducted on 12/05/2024 at 11:15 AM with the Director of Nursing (DON). The DON revealed it was her expectation for the resident's advanced directives to be discussed with the residents or resident responsible party during admission. She indicated Resident #14's advanced directive should have been filed in the residents' medical records. On 12/05/2024 at 2:12 PM an interview was conducted with the Administrator who stated she expected all residents to have an advanced directive indicated in their electronic medical record when admitted or readmitted to the facility. b. Review of Resident #17's medical record revealed the Resident was readmitted to the facility on 12/21/23 with diagnoses that included dementia, stroke, and diabetes. The review revealed a do not resuscitate (DNR) order was placed on 8/5/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.	F 578	5. Date of compliance: 1/2/2025	

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F 578	Continued From page 6 An interview was conducted with the Director of Social Services #1 on 12/04/24 at 3:51 PM. She revealed that during care plan meetings or as needed, code status was discussed. However, the conversation never went further into detail to include advance directive. During an interview with the Admissions Director on 12/05/24 at 8:22 AM, she revealed that prior to the change of ownership in June 2024, residents/families were only educated on code status. This was included in the admissions packet at the time. Beginning June 2024, the new company moved the advance directive discussion responsibility to Social Services. An interview was conducted with the Regional Director of Clinical Services on 12/05/24 at 8:26 AM. She revealed that the conversation about advance directive was not being done but rather only code status. The Regional Director of Clinical Services stated that the advance directives discussion/education needed to be completed upon admission, and the responsibility was now assigned to the Director of Social Services #1. She stated there was now a statement about advance directive included in the current admissions packet.	F 578		
F 584 SS=B	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 and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		1/2/25

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F 584	Continued From page 7 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 observations, resident and staff interviews the facility, failed to replace stained privacy curtain in resident room (304), failed to remove the black greenish substance from the	F 584	F-584 1. The Maintenance Department removed black greenish substance and caulked base of commode in rooms 304,	

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F 584	Continued From page 8 commode base caulking in resident rooms (304, 309, 708, 713, and 714), failed to repair damaged drywall in resident rooms (306, 309, 503, 605, and 713), failed to repair a broken bedside dresser handle in resident room (403), failed to replace a broken off towel rack in resident bathroom (304), and failed to replace missing resident's overhead bed light covers in rooms (714 and 718). These failures occurred on 2 of 8 hallways (300 Hall and 700 Hall) observed for a safe, clean, homelike environment. Findings included: 1a. An initial observation on 12/02/24 at 11:30 AM revealed large stains on privacy curtain, a broken bedside dresser handle, and a broken off towel rack in resident room (304). 1b. An observation on 12/04/24 at 12:35 PM revealed resident commodes (304, 309, 708, 713, and 714), were noted to have missing caulking or black greenish substance located around the base of the commodes. 1c. An observation on 12/04/24 at 12:35 PM revealed residents' walls (306, 309, 503, 605, and 713), were noted to have damaged or scratched up drywall. 1d. An observation on 12/3/24 at 1:30 PM revealed residents' overhead bed lights that were missing light covers, in rooms (714 and 718). An interview and observation were conducted on 12/2/24 at 1:30 PM with the Housekeeping Supervisor. She stated there were multiple areas on the 300 and 700 halls that still needed to be addressed, repaired, or replaced. She said she	F 584	309, 708, 713, & 714. The drywall was repaired in rooms 306, 309, 503, 605, and 713. The broken dresser handle was repaired room 404, tower rack repaired in bathroom 304, and overhead bed light covers replaced in rooms 714 and 718. 2. All residents have the potential to be affected by this deficient practice. The maintenance director inspected all resident rooms for possible repairs on 12/27/2024. 3. The Maintenance Director was educated by the Administrator on 12/27/2024 on conducting maintenance rounds monthly to observe any physical environment areas in need of repair. The housekeeping director was educated on the cleaning of privacy curtains monthly according to the deep cleaning schedule on 12/27/2024. 4. An audit will be conducted by the Administrator weekly to review repair requisitions to ensure that a repair has been completed for the task has been scheduled to be completed in a timely manner. This auditing will occur weekly for 4 weeks and then monthly for 2 months. The Administrator will present the results of the audit to the QAPI Committee to ensure continued compliance. 5. Date of compliance: 1/2/2025	

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F 584	Continued From page 9	F 584		

did not know what the black greenish substance was around some of the commodes on the 300 and 700 halls was. She said she was responsible for replacing the privacy curtains and maintenance was responsible for re-caulking commodes, replacing or repairing items in the facility, and that the damaged walls needed to be repaired, along with the other items that were pointed out to her during the 300 and 700 hall tour. She said no one reported room 304's privacy curtain stains to her and should have. She said the privacy curtain in room #304 needed to be replaced, and she would replace it by the end of the day.

A follow-up facility tour was conducted on 12/03/24 at 1:30 PM of the 300 and 700 halls with the Reginal Director of Clinical Services. The tour revealed: Black greenish substance around the base of resident commodes (304, 309, 708, 713, and 714), damaged drywall in residents' room (306, 309, 503, 605, and 713), missing above bed light covers in rooms (714 and 718), stained privacy curtain in room (304), broken bedside dresser handle in room (304), and broken bathroom towel rack in room (304). She stated the areas observed in the 300 and 700 halls needed to be addressed and fixed.

An interview and observation were conducted on 12/4/24 at 12:45 PM with the Maintenance Director (MD). The MD stated there were multiple areas on the 300 and 700 halls that still needed to be addressed, repaired, or replaced. He stated he had an assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes on the 300 and 700 halls. He said maintenance was responsible for repairing or

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F 584	Continued From page 10 replacing items in the facility, re-caulking commodes, and repairing damaged walls as needed, along with the other items that were pointed out to him during the 300 and 700 hall tour. An interview was conducted on 12/05/24 at 10:11 AM with the Administrator. She revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. She said there were still areas in the facility that still needed to be addressed. The Administrator stated it was her expectation for all the residents to have a safe and homelike environment that was clean and in good repair.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to protect residents' right to be free from misappropriation of resident property for 2 of 21 residents reviewed for misappropriation of resident property (Resident #152 and Resident # 97). Findings included:	F 602	F-602 1. The agency staff employee was terminated and is no longer providing services at the facility. 2. All alert and oriented residents and responsible parties for those with cognitive impairment were interviewed by the social worker on 10/28/2024. There were no other missing items identified.	1/2/25

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F 602	Continued From page 11 a. Resident #152 was admitted to the facility on 08/30/2024 with diagnoses that included hypertension, respiratory failure and fracture of facial bone. The resident was discharged from the facility on 11/01/2024. An admission Minimum Date Set (MDS) dated 09/01/2024 revealed that Resident #152 was cognitively intact. A review of the initial facility report dated 10/28/24 at 11:45 AM documented that a resident (Resident #152) reported that his air pods (wireless Bluetooth earbuds designed by apple) had been removed from his room. The resident reported he left the facility at approximately 4:30 PM on Friday 10/25/2024 and returned at 12:00 AM on 10/26/2024. Resident #152 reported he left the air pods charging on his bedside table. The air pods were tracked to an address in another town. The address was linked to Nurse #14. The report indicated that the corrective actions following the incident was the resident was given a new nightstand which can be locked to secure his valuables. All staff received education on misappropriation of resident property. The Police Department Incident Report dated 12/28/2024 by Officer #1 was reviewed. On Monday, October 28,2024, approximately 11:43 AM, Officer #1 was dispatched to Resident #152 room in reference to a larceny. Officer #1 spoke with the Administrator at the facility who stated that Resident # 152 had his air pods missing at the facility. The report revealed the air pods had been entered into the National Crime Information Center (NCIC) and the case was inactive pending the recovery of the items and charges for	F 602	3. All staff were educated by the SDC on the abuse policy, specifically misappropriation, on 11/4/2024. All newly hired employees will receive this training in orientation. All agency employees will receive this education prior to assignment in the facility. 4. Background checks for all employees to include agency employees will be reviewed and approved by the Administrator prior to the employee being assigned to the facility. This will be an ongoing process. During angel rounds, department heads will interview the resident or responsible party for their assigned area daily Monday through Friday about any alleged missing items. Any alleged misappropriations will be reported to the administrator immediately for investigation. The administrator will present audit results to QAPI Committee monthly to ensure continued compliance. 5. Compliance date: 1/2/2025	

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suspected larceny.

On 12/04/2024 at 1:05 PM a phone interview was attempted with the alleged perpetrator, Nurse #14, but the attempt was unsuccessful

On 12/04/2024 at 2:35 PM a phone interview was attempted with Resident #152, but the attempt was unsuccessful.

On 12/05/2024 at 11:05 AM a phone interview was attempted with the police, but the attempt was unsuccessful.

An interview was conducted with the Administrator on 12/05/2024 at 1:14 PM and revealed She investigated the incident that was reported on October 28, 2024, that involved misappropriation of property with Resident #152. The police were notified about Resident# 152's air pods missing in his room. The police were able to track the air pods to an address in another town. (air pods can be tracked by going to Find My app on an iPhone or iPad that was previously paired with the Air Pods.). The address belonged to Nurse #14 who was assigned to Resident #152 on 10/25/2024. The Administrator added that Nurse #14 was found to be in possession of Resident # 152's air pod by the police. The Administrator indicated that Nurse #14 was agency staff, and she had been terminated. The administrator also revealed they completed 24-hour and 5-day reports and faxed the information to the state agency. The Administrator stated that all staff were trained in resident abuse and misappropriation of property at the facility. She reported a background check was completed for Nurse #14 prior to hire and the facility had no concerns related to any criminal

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activity. The Administrator also revealed that Nurse #14 should not have taken the air pod from Resident #152 and the nurse failed to follow the policy of misappropriation of property.

b. Resident #97's medical record revealed Resident #97 was admitted to the facility on 10/18/24 with diagnoses that included diabetes mellitus and hypertension. The resident was discharged from the facility on 10/31/24.

An admission Minimum Date Set (MDS) dated 10/20/24 revealed that Resident #97 was assessed as having moderate cognitive impairment.

A review of the initial facility report dated 10/28/24 at 1:00 PM documented that Resident #97's family member reported Resident #97's debit card had been removed from his wallet. Resident #97 kept his wallet in his front shirt pocket. When she came to visit his wallet was lying on his bed. The family member discovered two transactions totaling approximately $29 were made. The debit card transactions were used to pinpoint times to review video surveillance at a local gas station. A photo was shared to determine if the employee on the staffing sheets matched the photo. The report indicated that the corrective actions following the incident was Resident #97's wallet was sent with family and locked boxes will be used to secure valuables when requested. All staff received education on misappropriation of resident property.

The Police Department Incident Report dated 10/28/24 by Officer #1 was reviewed. On Monday, 10/28/24, at approximately 1:03 PM, Officer #1 was dispatched to Resident #97's room

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in reference to a larceny. Officer #1 spoke with the Administrator at the facility who stated that Resident # 97 had his debit card missing at the facility and charges were made. The report revealed the case was inactive pending charges for suspected larceny.

On 12/04/2024 at 1:05 PM a phone interview was attempted with the alleged perpetrator, Nurse #14, but the attempt was unsuccessful.

On 12/05/2024 at 11:05 AM a phone interview was attempted with the police, but the attempt was unsuccessful.

On 12/4/24 at 12:15 PM a phone interview was conducted with Resident #97's family member who stated she discovered the bank card was missing and the charges made on the bank card. She stated she notified the facility and met with Police Officer #1. The family member stated she was satisfied with the facility's response to the incident by immediately notifying the police. and initiating an investigation. She reported the next court date for Nurse #14 was in January 2024.

An interview was conducted with the Administrator on 12/05/2024 at 1:14 PM and revealed she investigated the incident that was reported on 10/28/24 that involved misappropriation of property with Resident #97. The police were notified about Resident# 97's debit card missing in his room. After speaking with Resident #97's family member and being informed of transactions at a local gas station the police officer was able to track the use of the debit card to a local gas station and review video footage of Nurse #14 in the gas station. The Administrator indicated that Nurse #14 was

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F 602	Continued From page 15 agency staff, and she had been terminated. The Aministrator also revealed they completed 24-hour and 5-day reports and faxed the information to the state agency. The Administrator stated that all staff were trained in resident abuse and misappropriation of property at the facility. She reported a background check was completed for Nurse #14 prior to hire and the facility had no concerns related to any criminal activity. The Administrator also revealed that Nurse #14 should not have taken the debit card from Resident #97 and the nurse failed to follow the policy of misappropriation of property.	F 602		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		1/2/25

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 17 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed provide to the Resident Representative and Ombudsman a written notification for the reason for transfer to the hospital for 2 of 2 residents reviewed for hospitalization (Resident #56 and #21).	F 623	F-623 1. Resident #56 and Resident #44 have returned to the facility, no actions required. 2. An audit was completed by the administrator on 12/4/2024 of residents	

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F 623	Continued From page 18 Findings included: 1. Resident #56 was admitted into the facility on 4/16/19. A review of Resident #56's medical record revealed that the resident was discharged to the hospital on 6/20/24. Resident #56 re-admitted to the facility on 6/24/24. The medical record revealed no written notice of transfer was documented to have been provided to the Resident Representative or Ombudsman. An interview with the Resident Representative on 12/2/24 at 3:28 PM revealed that she knew why Resident #56 went to the hospital because she was at the facility. The Resident Representative further revealed that she had not received written notice of the discharge. An interview conducted with the facility Social Worker on 12/5/24 at 9:35 AM revealed she had not notified the Ombudsman of any discharges for the month of June 2024, nor had she notified Resident #56's Resident Representative in writing of the discharge for Resident #56's discharge/transfer to the hospital. The Social Worker stated that she had started at the facility within the last two weeks of June 2024 and was not aware of who the Ombudsman was at that time. She further stated that she was not aware of the requirement to send a written notification for discharge to a resident's representative. An interview conducted with the Administrator on 12/5/24 at 9:37 AM indicated that she expected that discharge notifications were sent to the	F 623	transferred to the hospital in the past 14 days to ensure Notice of Discharge/Transfer were issued. None were completed. The Ombudsman was notified on 12/4/2024 by the Social Worker. 3. The Regional Director of Clinical Services educated the Administrator and Social Services Director regarding completing the written Notice of Transfer/Discharge next business day to the hospital and instructed to keep a copy for facility records on 12/27/24. All transfers to the hospital will be reviewed on the next business day to ensure that a written Notice of Transfer/Discharge is presented to the resident and /or resident representative along with the ombudsman monthly. 4. The Social Worker Assistant will complete the audit weekly x 8 weeks then monthly x 1 month. The Social Worker Assistant will present audit results to QAPI Committee monthly to ensure continued compliance. 5. Date of compliance: 1/2/2025	

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Ombudsman monthly. The Administrator said she was not aware the Ombudsman had not been notified of the discharges for June 2024. The Administrator further indicated she was not aware of the regulation that written notification was to be provided to the resident representative with the reason a resident was transferred/discharged to the hospital.

2. Resident #21 was admitted into the facility on 6/9/23.

A review of Resident #21's medical record revealed that the resident was discharged to the hospital on 11/14/24. Resident #21 re-admitted to the facility on 11/20/24.

The medical record revealed no written notice of transfer was documented to have been provided to the Resident or Ombudsman. Resident #21 was her own representative.

An interview with the Resident #21 on 12/2/24 at 3:09 PM revealed she was sent to the hospital due to concerning laboratory results. She stated she never received any written notice of transfer or discharge.

An interview conducted with the facility Social Worker on 12/5/24 at 9:35 AM revealed she had not notified the Ombudsman of any discharges for the month of June 2024, nor had she notified Resident #21 in writing of the discharge for Resident #21's discharge/transfer to the hospital. The Social Worker stated that she had started at the facility within the last two weeks of June 2024 and was not aware of who the Ombudsman was at that time. She further stated that she was not aware of the requirement to send a written

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F 623	Continued From page 20 notification for discharge to a resident's representative. An interview conducted with the Administrator on 12/5/24 at 9:37 AM indicated that she expected that discharge notifications were sent to the Ombudsman monthly. The Administrator said she was not aware the Ombudsman had not been notified of the discharges for June 2024. The Administrator further indicated she was not aware of the regulation that written notification was to be provided to the resident or resident representative with the reason a resident was transferred/discharged to the hospital.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 areas of Hospice (Resident #6), "Hearing, Speech and Vision" (Resident #13), "Functional abilities and Goals" (Resident #56) and Dialysis (Resident #350) for 4 of 21 residents reviewed for MDS accuracy. The findings included: Resident #6 was readmitted to the facility on 3/16/22 with diagnoses that included stroke, hypertension, and heart failure. Review of a hospice visit note dated 6/13/24	F 641	F641 1. The MDS Coordinator modified assessments for resident #6, #13, #56 and #350 on 12/4/2024. 2. A 100 % audit was conducted by the Regional MDS nurse to review the MDS Coding Accuracy of all residents: receiving Hospice services, experiencing hearing/speech/vision deficits, receiving dialysis, and functional abilities & goals on 12/4/2024. There were no other discrepancies noted. 3. The Regional MDS nurse educated the MDS Coordinators on reviewing 100% of residents record when coding any MDS assessment, utilizing all related	1/2/25

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F 641	Continued From page 21 revealed that Resident #6 was seen by hospice services as a follow-up evaluation. Review of the quarterly MDS assessment dated 6/21/24 coded Resident #6 as not receiving hospice care services. MDS Nurse #1 was interviewed on 12/04/24 at 2:24 PM, and she revealed that the hospice services in section O of the 6/21/24 quarterly MDS assessment should have been coded as "YES." MDS Nurse #1 stated she must have miscoded the hospice details by accident. Resident #6 had a hospice visit on 6/13/24, and she was still on hospice at that time. An interview was conducted with the Director of Nursing (DON) on 12/05/24 at 11:31 AM. She revealed that if MDS Nurse #1 had any question about any resident, she should have reviewed the chart or asked the DON directly. The DON stated that her expectation was for MDS to find out all correct information before miscoding anything. During an interview with the Administrator on 12/05/24 at 12:16 PM, she revealed that Resident #6's hospice details in the quarterly MDS assessment dated 6/21/24 should have been coded accurately. 2. .Resident #13 was admitted to the facility on 10/6/23 with diagnoses which included: absolute glaucoma bilateral, legal blindness, and diabetes mellitus. Review of optometrist note dated 12/1/23 revealed Resident #13 was legally blind and recommended access to audiobooks.	F 641	information within the lookback period on 12/27/2024. 4. Prior to signing off for Completion of assessments coded with: Hospice Services Heating/Speech/Vision Deficits, Dialysis Services, and Functional Abilities/Goals, the DON will verify accuracy of these assessments daily x 12 weeks. The DON will present audit results to QAPI Committee monthly to ensure continued compliance. 5. Date of compliance : 1/2/2025	

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Review of Resident #13's quarterly Minimum Data Set (MDS) dated 8/21/24 revealed Resident #13 had moderate cognitive impairment and was noted with adequate vision (sees fine detail, such as regular print in newspapers/books).

Resident #13's care plan dated 8/23/24 revealed a focus area for blindness.

Resident #13 was interviewed on 12/5/24 at 8:35 a.m. and she stated she was blind.

During an interview on 12/5/24 at 8:38 a.m. with Nurse #9, she stated Resident #13 was unable to see. She was dependent upon staff for activities of daily living (ADL).

In an interview on 12/5/24 at 8:45 a.m., CMA #1 stated Resident #13 was blind and could not see. CMA #1 further stated Resident #13 understood directions and made her needs known but was dependent on staff for her ADL.

During an interview on 12/5/24 at 8:58 a.m. with the MDS Nurse #1, she stated Resident #13's vision assessment was coded incorrectly because of her diagnosis of absolute glaucoma and the optometrist documentation indicating blindness.

In an interview on 12/5/24 at 9:01 a.m. with the Administrator, she indicated the MDS should be coded accurately.

3. Resident #56 was admitted into the facility on

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4/16/2019 with a re-entry on 1/3/24 with diagnoses of a cerebrovascular accident.

A review of Resident #56's physician orders revealed an order dated 7/1/24 for bilateral multi podus boots (a boot used to treat and prevent ankle and foot contractures) up to four hours daily for ankle stiffness.

A review of Resident #56's most recent quarterly Minimum Data Set (MDS) dated 10/2/24 revealed he had functional limitations of his upper extremities. A review of Resident #56's most recent Annual MDS indicated that he had functional limitations of his upper and lower extremities.

An observation on 12/3/24 at 1:10 PM of Resident #56 noted that he had difficulty raising the front part of both feet.

An interview with Resident #56's family member was conducted on 12/3/2024 at 1:13 PM revealed that the podus boots were ordered to help with Resident #56's foot drop.

An interview with the MDS Coordinator was conducted on 12/4/24 at 10:10 AM which revealed that she was aware of Resident #56's functional limitations of his lower extremities and that it was not marked accurately on the quarterly MDS dated 10/2/24. She also acknowledged that it was her responsibility to ensure that the MDS was filled out accurately in all areas.

An interview was conducted with the Administrator on 12/4/24 at 10:25 AM and she said that the MDS should be filled out accurately and that accuracy should be verified prior to

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F 641	Continued From page 24 submission. 4. Resident #350 was admitted to the facility on 01/25/2024. The admission Minimum Data Set (MDS) dated 01/27/2024 indicated Resident #350 wascognitively intact but was not coded for end stage renal disease (ESRD) and dialysis. The diagnosis list revealed ESRD 01/25/2024 and was active. An interview with the Minimum Data Set (MDS) Nurse was conducted on 12/04/2024 at 10:23 AM. The Nurse stated another MDS nurse completed the MDS assessment for Resident #350 but was not available. He did have ESRD and was on dialysis. They were transitioning electronic systems, and it was an oversite. The MDS should have been coded correctly. An interview with the Administrator was conducted on 12/04/2024 at 11:25 AM. The Administrator stated Resident #350 had a diagnosis of ESRD and was on dialysis. She also stated that she expected the MDS nurses to code the assessments correctly.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		1/2/25

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F 656	Continued From page 25	F 656		

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.

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F 656	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a comprehensive care plan to include application of splints or multi podus boots for 1 of 32 residents (Resident #56) reviewed for comprehensive care planning. Findings included: Resident #56 was admitted into the facility on 4/16/2019 with a re-entry on 6/24/2024. A review of Resident #56's most recent quarterly Minimum Data Set (MDS) dated 10/2/2024 revealed Resident #56 was severely cognitively impaired. A review of Resident #56's physician orders indicated on 7/1/2024 an order for bilateral multi podus boots up to four hours daily and on 10/8/24 an order for apply left hand splint when sitting up in wheelchair daily, remove when going back to bed. Resident #56's was to wear bilateral elbow extension splints daily, applied with afternoon care once back in bed and removed at PM care for effective contracture management. A review of Resident #56's comprehensive care plan revised on 10/22/2024 did not have a care plan related to the application of splints or multi podus boots. An interview was conducted on 12/4/2024 at 10:10 AM with the MDS Coordinator who stated that Resident #56's current comprehensive care plan interventions did not include the application of splints or multi podus boots. The MDS Coordinator further stated that when the	F 656	F-656 1. The care plan for resident #56 was updated by the MDS Coordinator on 12/4/2024. 2. The Regional MDS nurse audited the care plans for all residents identified with a splint or multipodus boots on 12/4/2024. All care plans were in place. 3. The Regional MDS Nurse educated the MDS nurses on developing care plans with each MDS assessment on 12/27/2024. 4. The MDS nurses will audit care plans for those identified residents weekly x 12 weeks. 5. The MDS nurse will present audit results to QAPI Committee monthly to ensure continued compliance. 6.. Date of compliance: 1/2/2025	

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F 656	Continued From page 27 computer system was switched from one system to another the care plan related to the application of splints and multi podus boots had not carried over for some reason. The MDS Coordinator was able to provide the care plan from the prior system which had the application of splints and the multi podus boots as interventions. An interview was conducted with the Administrator on 12/4/2024 at 10:25 AM during the interview she stated that Resident #56's current comprehensive care plan should have included the use of splints and multi podus boots as an intervention.	F 656		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/2/25

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F 657	Continued From page 28 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, and Resident Representative (RR) and staff interviews, the facility failed to conduct care plan meetings or invite residents to their care plan meetings for 1 of 31 residents reviewed for care plans (Resident #47). Findings included: Resident #47 was admitted to the facility on 09/04/2023 with a diagnosis which included Alzheimer's disease. The quarterly Minimum Data Set assessment dated 11/15/24 indicated that Resident #47 was severely cognitively impaired. An interview on 12/04/24 at 11:13 AM with Resident #47's RR revealed she had not been invited to a care plan meeting since Resident #47's admission. She stated she would like to attend a care plan meeting. An interview on 12/05/24 at 9:39 PM with the Social Worker (SW) revealed that based on Resident #47's record, it appeared the RR had not been invited to attend Resident # 47's care plan meetings. The SW indicated she was aware of the requirement to hold care plan meetings quarterly and Resident #47's care plan was last updated 11/11/24. The SW indicated she	F 657	F-657 1. The care plan meeting for Resident #47 was held on 12/11/2024. 2. An audit was conducted by the social services director of residents with care plan reviews in the next 30 days to ensure that the resident and/or their representative have been invited to attend on 12/6/2024. 3. The Social Worker and Discharge Planning assistant was educated on 12/27/24 by the Administrator regarding care plan invitations and documentation of care plan meetings. 4. An audit by the Discharge Planning assistant will be conducted weekly of residents who have a care plan review scheduled in the next 7 days to ensure that the resident and/or their representative were invited to attend and that the care plan meeting is scheduled. This will be an ongoing process. 5. The Discharge Planning assistant will present audit results to QAPI Committee monthly to ensure continued compliance. 6. Date of compliance: 1/2/2025	

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F 657	Continued From page 29 reviewed the care plan with other staff members that included the Director of Nursing, Activity Director but was not aware she was required to invite the RR or the residents to attend the care plan. An interview on 12/05/24 at 1:20 PM with the Administrator revealed she was unaware that Resident #47's RR had not been invited to attend Resident #47's care plan meetings. She reported SW was responsible for inviting the RR and the residents to the care plan meetings.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to apply left hand splint, elbow extender splints and multi podus	F 688	F-688 1. A schedule was added to the order for splints for resident #56 on 12/3/2024 by	1/2/25

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F 688	Continued From page 30 boots as ordered for 1 of 3 sampled residents with limited range of motion/contractures (Resident #56). The findings included: Resident #56 was admitted into the facility on 4/16/19 and readmitted on 6/24/24. A review of Resident #56's quarterly Minimum Data Set (MDS) dated 10/2/24 indicated that he was severely cognitively impaired. A review of Resident #56's physician orders indicated on 7/1/2024 an order for bilateral multi podus boots (an orthotic to treat and prevent ankle and foot contractures) up to four hours daily and on 10/8/24 an order to apply left hand splint when sitting up in wheelchair daily, remove when going back to bed. Resident #56's was to wear bilateral elbow extension splints daily (an orthotic to help increase elbow extension in patients with non-fixed contractures), applied with afternoon care once back in bed and removed at PM care for effective contracture management. Observations for the application of the left-hand splint when he was in his wheelchair and for elbow extender splints when he was in bed were conducted on 12/3/24 at 9:00 AM, 11:00 AM, 1:00 PM and 3:00 PM and it was noted that the splints and multi podus boots had not been applied. An interview Resident #56's Family Member on 12/3/24 at 3:00 PM indicated that the multi podus boots and the hand and elbow splints had not been applied to Resident #56 during the time she had been in the room from 9:15 AM until now. The Family Member also indicated that the splints	F 688	the Regional Director of Clinical Services. Res #56 is wearing his splints as ordered. 2. The DON and unit managers completed an audit of all splint orders on 12/27/2024 to ensure they had been assigned a schedule and were transferred to the Medication Administration Record. There were no other discrepancies. 3. The SDC educated all nurses, medication aides and nursing assistants on applying splints as ordered and ensuring that a schedule had been attached to each order. All new employees will receive this education on orientation prior to assignment, All agency nurses will receive this education prior to working on a medication cart. 4. The DON and unit managers will monitor splint application and orders 5x/week x 2 weeks, 3x/week x 4 weeks and weekly x 6 weeks for 10 residents each week. The DON will present audit results to QAPI Committee monthly to ensure continued compliance 5. Compliance date: 1/2/2025	

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F 688	Continued From page 31	F 688		

were not put on most days and that she visited every day from about 9:00 AM until usually around 6:00 PM.

Observations for the application of a left-hand splint when he was in his wheelchair and for multi podus boots and elbow extender splints when he was in bed were conducted on 12/3/24 at 9:00 AM, 11:00 AM and 1:00 PM and it was noted the splints had not been applied.

An interview with Resident #56's Family Member revealed that there had been no splints or multi podus boots put on Resident #56 since she had been in the room around 9:30 AM and the splints or multi podus boots had not been applied by the time she left yesterday around 5:30-6:00 PM

Observations for the application of a left-hand splint when he was in his wheelchair and for multi podus boots and elbow extender splints when he was in bed were conducted on 12/4/24 at 8:30 AM, 10:00 AM and 12:30 PM and it was noted the splints had not been applied.

An interview conducted with Nursing Assistant #30 on 12/3/24 at 10:10 AM revealed that either licensed nursing staff or nursing assistants put on any splints that were ordered. Nurse Assistant #30 indicated that the application of splints was on a resident's information sheet and listed as a daily task on the nursing assistant required charting in the electronic medical record. Nurse Assistant #30 further indicated that she had not been aware Resident #56 required the application of any splints.

An interview with Licensed Nurse #31 on 12/3/24 at 10:30 AM indicated that either nursing

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F 688	Continued From page 32	F 688		

assistants, licensed nursing staff, or physical therapy applied splints to the residents who had orders. She stated that it was on the resident's information sheet which residents had splints applied and if the licensed nursing staff were to apply the splints, they would show up on the medication administration sheet. She further stated that she was unaware Resident #56 required the application of splints but was aware he had an order for multi podus boots.

An interview with COTA (Certified Occupational Therapy Assistant) #1 on 12/3/24 at 11:00 AM revealed that Resident #56 was not currently on the therapy caseload and the nursing staff was responsible for applying and taking off any ordered splints. He stated that the therapy department had trained the unit supervisors on the application of splints and/or braces so that they would be able to instruct any new nursing staff on their unit.

An interview with the MDS (Minimum Data Set) Coordinator on 12/4/24 at 10:10 AM indicated that the splints and multi podus boots and not been care planned for Resident # 56 so the task had not been linked to the resident information sheet or the nursing assistants' task which was the only way the nursing assistants and licensed nursing staff would be aware of Resident #56's need for splint application.

An interview with the Administrator on 12/4/24 at 10:25 AM indicated that by not having the left-hand splint, elbow extender splint and multi podus boot care planned it caused a system failure which resulted in no documentation of them being applied or of the nursing staff being made aware of the needed application.

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F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 25 of 61 days reviewed for sufficient staffing. Findings included: Review of the daily assignment schedules from April 01, 2024, to May 28, 2024, revealed the facility failed to provide 8 hours of Registered Nurse (RN) coverage on the following dates: 04/01/24, 04/03/24, 04/05/24, 04/06/24, 04/07/24, 04/13/24, 04/20/24, 04/21/24, 04/22/24, 04/26/24, 04/27/24, 04/30/24, 05/04/24, 05/06/24, 05/09/24, 05/10/24, 05/11/24, 05/14/24, 05/18/24, 05/19/24, 05/20/24, 05/21/24, 05/24/24, 05/25/24, and 05/28/24. An interview was conducted with the facility Scheduler on 12/04/2024 at 9:30 AM. During the	F 727	F 727 1. The Administrator reviewed the current schedule on 12/24/24. 4 RNs have been hired in the month of December. 2. All residents have the potential to be affected. The Administrator and scheduler reviewed the monthly schedule on 12/29/2024. 3. The DON educated the scheduler on 12/27/24 on the regulation requiring 8 hours of consecutive RN coverage daily. A daily labor meeting will be held by the Administrator, DON and scheduler Monday through Friday to review future schedules and ensure that there is RN coverage. 4. The HR director will compile an audit of RN coverage monthly for review by the QAPI committee. The HR Director will present audit results to QAPI Committee monthly to ensure continued compliance.	1/2/25

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F 727	Continued From page 34 interview the Scheduler reported she was not aware that she needed to schedule an RN for at least 8 consecutive hours every day. The Scheduler explained that there had been a large amount of staff turnover, including RNs, since the facility changed ownership in June-July 2024. She further explained the facility had been using staffing agencies but at times could not get 8 hours of RN coverage when it was needed, however the facility was in the process of hiring RNs. During the interview the above schedules were reviewed with the facility Scheduler to verify there had been at least 8 consecutive hours of RNs scheduled to work on those days. An interview was conducted on12/04/24 at 12:15 PM with the Director of Nursing (DON). She had been the DON since 11/25/24. During the interview the DON reported she was aware there had been issues related to RN staffing, including the lack of RNs in supervisory roles. She explained the facility was in the process of hiring RNs, including an Assistant Director of Nursing (ADON). An interview was conducted on12/04/24 at 12:20 PM with the Administrator. She revealed she was aware RN coverage had been an issue at the building before and after it changed ownership. The Administrator reported that many nurses, including RNs, had left or changed roles and the facility was utilizing agency staff including Medication Aides. The Administrator explained she was not aware the Scheduler had difficulty filling the 8-hour RN spots, and the facility was in the process of hiring additional RNs.	F 727	5. Date of compliance: 1/2/2025	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		1/2/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 35 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to ensure Resident #64 was scheduled for a neurology appointment for 1 of 1 resident reviewed for medical appointments (Resident # 64). The findings included: Resident #64 was admitted to the facility on 1/5/23 with diagnoses that included Parkinson's disease, hypothyroidism and failure to thrive. Resident #64's most recent Minimum Data Set (MDS) assessment dated 10/7/24 indicated the resident was cognitively intact. An interview was conducted with Resident #64 on 12/2/24 at 12:21 PM. She reported she had a referral to a neurologist and an appointment was never made. Resident #64 stated she questioned her diagnosis of Parkinson's disease and wanted a neurology appointment to confirm the diagnoses. Record review revealed a referral was made to neurology on 3/1/24 by the facility scheduler. A letter written to the facility by the Referral Coordinator at the local neurology office addressed to the Scheduler at the facility dated 3/26/24 read in part, "notes did not provide sufficient information about the Parkinson's	F 745	F 745 1. The DON rescheduled resident #64's neurology appointment. 2. A 100% Audit performed by the DON on 12/26/2024 on all new admissions and readmissions for the last 30 days. There were no referrals or appointments missed. 3. Education to IDT was provided by the SDC to review all admission and readmissions for referrals or follow up appointments on the next clinical day and to make the MD aware of referrals. , The Scheduler will be given the referral within 24/48 hours to schedule appropriately. This education will be completed by 12/31/2024. All newly hired administrative nurses will receive this education during orientation prior to assignment. 4. All admissions/ readmissions will be reviewed daily, Monday through Friday, in clinical meeting x 12 weeks by the unit managers for referrals and follow up appointments. 5. The DON will compile an audit and present to QAPI Committee monthly to ensure continued compliance 6. Compliance Date: 1/2/2025	

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	345561	A. BUILDING _____ B. WING _____	C 12/05/2024

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F 745	Continued From page 36 disease." There was no appointment made. A facility progress note dated 4/20/24 stated Resident #64 contacted 911 and stated she wanted to see a neurologist. The resident was transferred to a local hospital. Review of discharge instructions from Resident #64's hospital visit on 4/20/24 dated 4/20/24 stated for Resident #64 to schedule an appointment with a Neurology provider as soon as possible. An interview was conducted with the Scheduler on 12/4/24 at 1:30 PM who stated she let the doctor know about the notice dated 3/26/24. She stated she did not send a referral to the Neurology provider after Resident #64's hospital visit on 4/20/24 because she was advised by Nurse #9, she had already been referred to neurology. She reported she received a handwritten note from Nurse #9 which was left on her desk. Review of a handwritten note written by Nurse #9, dated 4/20/24 read, the doctor called to inform the facility he has a referral for Resident #64 already. Nurse #9 was unavailable for interview. An interview was conducted with the Director of Nursing on 12/5/24 at 11:55 AM who stated the Scheduler, or the Nurse #9 should have ensured Resident #64 had a neurology appointment scheduled.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		1/2/25

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F 761	Continued From page 37 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to dispose/discard expired medications in 1 of 3 medication carts (Rehab Medication Cart) observed. The findings included: During an observation of the Rehab Medication Cart on 12/04/24 at 9:34 A.M., one bottle of aspirin 325 milligrams (mg) tablets with an expiration date of 09/2024 and one bottle of	F 761	F-761 1. THE EXPIRED MEDICATIONS WERE REMOVED AND DISCARDED ON 12/4/2024 BY THE HALL NURSE. 2. ALL REMAINING MEDICATION CARTS AND MEDICATION ROOMS WERE INSPECTED BY THE UNIT MANAGERS ON 12/4/2024. THERE WERE NO OTHER EXPIRED MEDICATIONS.	

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F 761	Continued From page 38 Allergy Relief tablets with an expiration date of 04/2024 were observed in the top drawer of the cart. During an interview with Certified Medication Aide (CMA) #1 on 12/04/24 at 9:36 A.M., CMA #1 confirmed she had been working the Rehab Medication Cart that day. She stated it was the responsibility of the nurses to check the medication carts for expired medications. During an interview with Nurse #8 on 12/04/24 at 9:45 A.M., Nurse #8 stated it was his responsibility to check the Rehab Med Cart for expired medications. When asked if he was sole person responsible for checking the medication carts for expired medications, Nurse #8 clarified and stated that it was the responsibility of all nurses to check their medication carts for expired medications. An interview was conducted with the Administrator on 12/04/24 at 1:50 P.M. The Administrator stated it is her expectation that nursing staff check the medication carts and medication storage rooms for expired medications and to discard them.	F 761	3. THE SDC EDUCATED ALL NURSES AND MEDICATION AIDES ON MEDICATION STORAGE TO INCLUDE LABELING, DATING AND REMOVING EXPIRED MEDICATIONS. THIS EDUCATION WAS COMPLETED ON 12/27/2024.. ALL NEWLY HIRED NURSES AND MEDICATION AIDES WILL RECEIVE THIS EDUCATION DURING ORIENTATION AND PRIOR TO ASSIGNMENT. ALL AGENCY EMPLOYEES WILL RECEIVE THIS EDUCATION PRIOR TO PASSING MEDICATIONS. 4. UNIT MANAGERS WILL INSPECT MEDICATION ROOMS AND CARTS WEEKLY X 12 WEEKS TO ENSURE THERE ARE NO EXPIRED MEDICATIONS IN THE FACILITY. THE DON WILL PRESENT THE AUDIT RESULTSTO THE QAPI COMMITTEE MONTHLY TO ENSURE CONTINUED COMPLIANCE. 5. COMPLIANCE DATE: 1/2/2025	
F 842 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	F 842		1/2/25

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F 842	Continued From page 39	F 842		

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, 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

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F 842	Continued From page 40 (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 have a complete and accurate medication and administration record for 2 of 5 residents reviewed for medical record accuracy (Resident #250 and Resident #350). Findings included: 1. Resident #250 was admitted to the facility 07/19/24. Review of Resident #250's Emergency Department (ED) Note revealed she was sent to the hospital on 08/09/24 for evaluation and transferred to the hospital. Review of Resident #250's medical record revealed there was no entry to indicate the resident was transferred to the hospital on 08/09/24 or the resident's condition at the time of	F 842	F842 1. Resident #250 is no longer in the facility; Resident #350 is no longer in the facility. 2. The DON audited the last 30 days of MARS and TARS on 12/262024 with no missing documentation noted. The DON audited all unplanned transfers to hospital in the last 30 days for missing E interact transfer and change in condition documentation on 12/26/2024. All documentation was complete to include orders to transfer out of the facility. 3. The SDC educated all nurses on the discharge and transfer process per policy and to check MAR and TAR prior to leaving shift ensuring all documentation is complete. 100% education completed on 12/31/2024. This education will be	

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F 842	Continued From page 41 transfer. The only documentation in the medical record was a nurse blood pressure vital sign 120/70 dated 08/09/24 at 10:04 AM written by Nurse #2 regarding Resident #150's hospital transfer. An interview was conducted on 12/04/24 at 1:45 PM with Nurse #2 revealed she was working as a floor nurse on the 700-hall on 08/08/24 and 08/09/24. Nurse #2 said Resident #250 told her that she had just called her family member and told her to call 911 because she was mad and did not want to stay there anymore. Nurse #2 said she took the resident's vital signs, which were all within normal ranges. Nurse #2 stated emergency medical services (EMS) soon arrived, and took their own vital signs, also within normal ranges. Nurse #2 explained the resident and family member were still demanding that the resident go to the ED due to being tired and short of breath (SOB). Nurse #2 said she called the MD and documented her notes in the electronic chart. She said later, when she checked her charting, the resident's information had already been removed from the electronic system. Nurse #2 stated she did not know why resident's discharge information was not available in their electronic medical record system, thinking once she was discharged to the hospital, her discharge notes and information were lost due to a computer glitch, after the resident was changed from an active resident to a discharged resident. Nurse #2 stated she had been trained to write a nurse's note any time a resident was transferred to the hospital which included what time the resident left the facility, why the resident needed to be transferred to the hospital, how they were transported, and their condition at the time of the transfer. She stated Resident #250 not having a	F 842	provided to all new Nurses during the orientation process prior to assignment by the SDC. 4. The DON and Unit Managers will review all discharges, MAR and TAR documentation during the clinical meeting Monday through Friday x 12 weeks for completion . 5. The DON will present audit results to QAPI Committee monthly to ensure continued compliance. 6. Compliance date: 1/2/2025	

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progress note regarding her transfer to the hospital on 08/09/24 was due to miscommunication or computer error, she did not really know.

An interview was conducted on 12/04/24 at 11:40 AM with Nurse #4. She stated Nurse #2 was new to the facility, and on 08/09/24 she should have asked a charge nurse for assistance with getting Resident #250 sent to the hospital on 08/09/24 and that they would assist her by gathering the required paperwork and arranging for transportation to the hospital. Nurse #4 stated that she was not Resident #250's assigned nurse on 08/09/24 and it was the responsibility of the assigned nurse to complete documentation detailing why the resident was transferred.

An interview was conducted on 12/04/24 at 12:15 PM with the Director of Nursing (DON). She revealed that any time a resident was transferred to the hospital the nurse caring for the resident was responsible for writing a note which included when and how the resident left, their condition when they left the facility, and any other information relevant to the situation. She stated she was unsure why there was no note in Resident #250's medical record regarding his transfer to the hospital on 08/09/24. The DON reviewed the physician's orders for Resident #4 and confirmed there was no transfer order documented.

An interview was conducted with the Administrator on 12/04/24 at 3:22 PM. The Administrator stated the nurse should have documented an order for Resident #250 to be transferred to the emergency department once she received the verbal order for transfer.

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2. Resident #350 was admitted to the facility on 01/25/2024.

The admission Minimum Data Set (MDS) dated 01/27/2024 had Resident #350 coded as cognitively intact.

A review of the Physicians order dated 02/12/2024 revealed an order for sevelamer (A medication used to treat high phosphate levels in the blood for patients with chronic kidney disease who are on dialysis) 800 milligrams (mg) by mouth three times daily and was discontinued on 03/15/2024.

The February 2024 Medication Administration Record (MAR) revealed an order for sevelamer 800 MG tablet by mouth three times daily. The medication was not signed as administered on 02/02/2024 times 2 (x2), 02/05/2024, 02/07/2024, 02/08/2024 x2, 02/09/2024, 2/10/2024, and 02/17/2024.

The March 2024 MAR revealed sevelamer 800 mg tablet by mouth three times a day. The medication was not signed as administrated on 03/01/2024, 03/02/2024, 03/06/2024 x2, and 03/15/2024.

An interview with Nurse #5 was conducted on 12/04/2024 at 02:51 PM. The Nurse stated Resident #350s sevelamer 800 mg was taken with food and was administered as ordered but was not documented at times and is now checking to make sure all medications are documented as administered when given.

An interview with Nurse # 7 was conducted on

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F 842	Continued From page 44 12/05/2024 at 09:48 AM. The Nurse stated Resident #350 would want the sevelamer 800 mg without meals, but he got it with meals as ordered. The Nurse also stated he had missed documentation that the medication was administered but Resident #350 received his medications. An interview with the Director of Nursing (DON) was conducted on 12/04/2024 at 09:44 AM. The DON stated she had noticed some of the nurses have missed some of their documentation. She was checking the charts but some days the documentation was missing but the medications were administered.	F 842		
F 880 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. 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	F 880		1/2/25

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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.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 46 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 observations and staff interviews, facility staff failed to implement infection control policy and procedures when Physical Therapist Assistant (PTA #1) and Physical Therapist (PT #2) did not don Protective Equipment (PPE) for Enhanced Barrier Precautions (EPB) to include a gown when providing high-contact resident care activities for Resident #251 who had indwelling upper chest dialysis catheter. The deficient practice was identified for 2 of 2 staff members observed for infection control practices (PTA #1 and PT #2). The findings included: Review of the facility's policy titled "Enhanced Barrier Precautions (EBP)" dated 03/26/24 read in part: EBPs require use of gown and gloves by staff during high-contact patient care activities as defined below: Transferring. During an observation on 12/02/24 at 10:35 AM an EBP sign was posted by Resident #251's room door that read in part: Enhanced Barrier precautions, and providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care or use of a central line, urinary catheters, feeding tubes, and wound care.	F 880	F880 1. PT #1 and #2 have been reeducated by the DON on Enhanced Barrier precautions and PPE use on 12/27/2024. 2. The DON performed an audit on 12/3/2024 of all residents who require EBP ensuring they had signs on the doors and PPE bins in close proximity of the door. 3. The SDC educated all staff on the Enhanced Barrier Policy and the PPE requirements with direct care on 12/27/2024. 4. The nurse managers will make observation rounds daily 5x/week x 5 residents x 2 weeks, 3x/week x 5 residents x 2 weeks, then weekly x 5 residents x 8 weeks to ensure staff is wearing PPE in EBP rooms during direct patient care. 5. The DON will present audit results to QAPI Committee monthly to ensure continued compliance. 6. Date of compliance: 1/2/2025	

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47	F 880		

During an observation from the hall on 12/02/24 at 10:45 AM Physical Therapist Assistant (PTA #1) and Physical Therapist (PT #2) were observed in Resident #251's room transferring resident from wheelchair to bed using a Hoyer lift without gowns on. Resident #251 was sitting at the bedside in his wheelchair. PTA #1 and PT #2 had on gloves when transferring Resident #251 but were not wearing gowns. A bin with PPE (personal protective equipment) supplies was by the door, including one time use disposable gowns.

An interview was conducted on 12/04/24 at 12:55 PM with PTA #1. PTA #1stated he and PT #2 did not put on gowns when they transferred Resident #251. He stated they were both trained on EPB in October/2024 and knew Resident #251 was on EPB (due to having an upper chest wall dialysis port) and should have donned gowns during Resident #251's transfer, but they both just forgot.

An interview was conducted on 12/04/24 at 10:40 AM with the Regional Director of Clinical Services. She revealed on 12/02/24 at 10:35 AM the two-therapy staff should have both donned gowns during Resident #251's transfer, while being on Enhanced Barrier Precautions.

An interview was conducted on 12/04/24 at 12:15 PM with the Administrator. She stated staff should wear the appropriate personal protective equipment PPE when providing direct care to residents on enhanced barrier precautions. She also stated that all the staff knew to abide by the different types of precautions posted on the residents' door and to follow the assigned personal protective equipment (PPE). She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 education would be provided to therapy staff.	F 880		