

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  University Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  180 Epps Bridge Rd Athens, GA 30606	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 11599</p> <p>Based on observations and interviews, the facility failed to provide necessary maintenance to five of 49 rooms creating an unsafe, uncomfortable, and unhomelike environment for eight of eight residents (Resident (R) 11, R48, R71, R43, R49, R64, R19, and R25) reviewed for the environment of 29 sample residents. This failure had the potential to affect the residents' homelike environment.</p> <p>Findings include:</p> <p>During observations and interviews on 3/31/2025 from 10:11 am to 11:30 am; at 4:58 pm; and on 4/1/2025 at 10:27 am, the following was observed:</p> <p>a. The end of the handrail was missing outside room [ROOM NUMBER] which exposed a sharp end creating the potential for injuries when residents utilized the rail.</p> <p>b. The call light bulb outside room [ROOM NUMBER] was burnt out. Staff would not know if R11, R48, or R71 turned on their call light for assistance if they were not at the nurses' station, at the opposite end of the hall, to hear the light ringing on the call board.</p> <p>c. There was no call light available for R43. R43's roommate, R49, stated on 3/31/2025 at 10:32 am, I push the call light for [R43] when needed. I watch out for her. Neither R43 nor R49 knew how long the call light had been missing.</p> <p>d. The light above R64's bed did not work. R64 stated, on 3/31/2025 at 11:10 am, It's been out for two months. I'd really like to have a light above my bed. My bedside lamp is too hard to get to sometimes. Additionally, the window had a film like substance on it which prevented one from looking outside.</p> <p>e. There was no screen on the window in R19's room. The window was open approximately three inches. Leaves and dead bugs were observed on the windowsill inside the room.</p> <p>f. There was no screen on the window in R25's room. R25 stated, on 3/31/2025 at 11:22 am, I would really like to have some fresh air, but I'm told I can't open the window.</p> <p>During observations and interview on 4/2/2025 at 4:00 pm, of the identified concerns, the Corporate Maintenance Director stated, This will be fixed. We haven't had a Maintenance Director stay.</p> <p>(continued on next page)</p>

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 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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/3/2025 at 10:02 am, the Administrator stated, We have had three Maintenance Directors in four months. They just don't stay.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39857</p> <p>Based on observations, record review, interviews, and review of the facility policy titled, Nail Care, the facility failed to ensure nail care was provided for two of three residents (Residents (R) 85 and R8) reviewed for activities of daily living (ADL). This failure had the potential to cause R85 and R8 to have unmet care needs.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Nail Care, revised 02/18, documented The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and prevent infections . General guidelines, nail care includes daily cleaning and regular trimming . Proper nail care can aid in the prevention of skin problems around the nail bed .Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments .</p> <p>1. Review of R85's Face Sheet located under the Profile tab of the electronic medical record (EMR), revealed R85 was admitted to the facility on [DATE] with diagnoses which included hypertension, acute kidney failure, and cerebellar stroke syndrome.</p> <p>Review of R85's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/2024, located under the Resident Assessment Instrument (RAI) tab, revealed a Brief Interview for Mental Status (BIMS) of eight out of 15 which indicated R85 had moderately impaired cognition.</p> <p>Review of R85's Care Plan located in the EMR under the Care Plan tab and last revised 2/27/2025, revealed R85 Resident is resistive to care .Refusing medication and ADLs at times .Provide me with opportunities for choice during care provision.</p> <p>During an observation and interview on 3/31/2025 at 10:35 am, R85 was observed lying in his bed watching television. R85's fingernails were noted to be greater than half an inch over his fingertips. His toenail on his left foot was greater than two inches past the tip of his toe. When asked if he preferred his fingernails and toenails to be this long, R85 stated no I really want them trimmed.</p> <p>During an observation on 4/1/2025 at 9:30 am, R85's nails remained greater than half an inch over his fingertips, and toenails greater than two inches over tip of toe.</p> <p>During an interview on 4/1/2025 at 11:25 am, Licensed Practical Nurse (LPN) 6 was asked to verify what R85's toenails look like. She stated yes, they are very long and need trimming.</p> <p>2. Review of R8's Face Sheet located under the Profile tab of the EMR revealed R8 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, hypertension, type two diabetes, and heart failure.</p> <p>Review of R8's significant change MDS with an ARD of 2/28/0225, located under the RAI tab, revealed R8 had a BIMS of six out of 15 which indicated R8 had severely impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R8's Care Plan located in the EMR under the Care Plan tab and last revised 3/27/2025, revealed R8 Resident is experiencing difficulty in performing task of daily living such as feeding self, dressing, bathing, toileting .</p> <p>During an observation on 3/31/2025 at 10:40 am, R8 had whiskers (facial hair around chin), and fingernails were greater than one inch over fingertips, chipped red nail polish, and thick whitish/brown debris underneath every fingernail. R8's toenails were greater than 1/2 inch over tips of toes.</p> <p>During an observation 4/2/2025 at 12:24 pm, R8 continued to have whiskers (facial hair around chin), fingernails were greater than one inch over fingertips, chipped red nail polish, and thick whitish/brown debris underneath every fingernail. R8's toenails were greater than 1/2 inch over tips of toes.</p> <p>During an interview on 4/2/2025 at 3:30 pm, Certified Nursing Assistant (CNA) 12 was asked who was responsible for trimming resident's fingernails, and toenails, she stated CNA's during their shower, and anytime it's needed. CNA12 stated facial hair should be removed during the resident's shower.</p> <p>During an interview on 4/2/2025 at 4:45 pm, LPN6 was asked who was responsible for trimming resident's fingernails, and toenails, and taking care of resident's facial hair. She stated primarily the CNAs, but everyone here should assist the residents with their needs.</p> <p>During an interview on 04/03/25 at 10:45 AM, the Director of Nursing (DON) was asked who was responsible for trimming resident's fingernails, toenails, and taking care of resident's facial hair. She stated primarily the CNAs during showers, but everyone there should assist the residents with their needs.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>11599</p> <p>Based on observations, interviews, and cleaning schedule review, the facility failed to maintain the cleanliness of the kitchen creating the potential for contaminated food to be served to 97 of 102 residents that received an oral diet.</p> <p>Findings include:</p> <p>1. During the initial tour of the kitchen and interview on 3/31/2025 from 8:30 am to 9:15 am, the following was observed:</p> <p>a. The floor in the dish room was missing a section of tiles which measured approximately 11 inches by six inches making it an uncleanable surface. Several more tiles were missing underneath the counter in the dish room. The wall underneath the counter had a dark black substance on the entire wall. The Dietary Manager (DM) stated, We try to clean the wall with a power washer each week. It [wall] needs to be replaced.</p> <p>b. A plastic cover over the cart with the large baking pans had a buildup of grime and was sticky to touch. The cover was over the clean baking pans.</p> <p>c. The air conditioning unit, next to the cart with clean baking pans, was observed with a heavy buildup of dust, dirt, and an unidentifiable sticky substance. Two large vents had areas of torn tape and a heavy buildup of dirt, dust, and grime.</p> <p>d. A floor fan was observed to have food particles on the outside of the fan.</p> <p>e. A fan next to the microwave had a heavy buildup of dust, dirt, and grime. The fan was pointed toward the steamtable; however, it was not turned on during meal service observations.</p> <p>f. A wall plug, located above the clean dishes, near the dish room, was not secured into the wall and had no cover plate.</p> <p>g. A fan located near the hand sink was observed to have a heavy buildup of dust, dirt, and grime. At the time of the observation, the fan was not turned on; however, it was pointed toward the food preparation table.</p> <p>h. The vent above the three-compartment sink was observed to have a black substance on it. The DM stated that the Maintenance Director (MD) was supposed to clean the fans and vents. The DM stated a bid for the floor was to be requested, however the facility had been without an MD for months.</p> <p>2. During the second tour of the kitchen on 4/2/2025 at 11:10 am, the following was observed:</p> <p>a. The conditions identified above remained.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b. There was a metal fence-like apparatus hanging on the end of the stove next to the deep fryer. The apparatus had a heavy build-up of grease, dirt, and grime. The DM said he thought the MD was supposed to clean that.</p> <p>c. The walls were observed to have peeling and chipped paint, dust, dirt, and black substance throughout.</p> <p>Review of the undated Cleaning Schedule, provided by the DM, noted the kitchen staff were to clean the equipment, floors, appliances, etc. The items identified during the kitchen tours were not on the schedule to be cleaned by the kitchen staff.</p> <p>During an interview on 4/2/2025 at 4:30 pm, the Corporate Maintenance Director (CMD) said he thought the kitchen staff was to clean the kitchen, and the MD would clean the fans, and fix the air conditioning ducts, and the dish room floor.</p> <p>During an interview on 4/3/2025 at 10:02 am, the Administrator stated, We have had three Maintenance Directors in four months. They just don't stay. The Administrator provided the contract for the kitchen staff to show the responsibilities for cleaning, dated 4/19/2022 and updated 4/5/2024. The contract failed to include the identified concerns for cleaning.</p>