STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115467	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Nursing & Rehab Center	180 Epps Bridge Road 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and review of the facility's policy titled DATING AND LABELING POLICY, the facility failed to ensure that food items were properly labeled, dated, and discarded in accordance with facility policy to prevent potential foodborne illness. This deficient practice had the potenitial to affect all 98 residents receiving an oral diet.Findings include:During tour of the kitchen on 05/11/2026 from 9:40 AM to 10:00 AM, and interview with the Dietary Manager (DM) revealed the following concerns:Observation of the walk-in freezer revealed a bag with french toast with use by date of 05/7/2026, a bag with hash brown patties, dated 04/19 with no use-by date indicated, a plastic-wrapped hash brown patties labeled with an open date of 04/19 with no use-by date indicated, and a bag uncooked french fries, dated 05/2/2026 and use by date 05/6/2026.Review of the facility's policy titled, DATING AND LABELING POLICY, revised date 01/1/2026, revealed under Policy: Kitchen will assure food safety by maintaining proper dates and labels to all ready to eat food products. Under Procedure: 9. Follow Label and date Protocol chart for all for all perishable foods. 10. Discard all foods that expire immediately.During the tour and interview, the Dietary Manager acknowledged the expired and improperly labeled food items and stated the items would be discarded immediately.

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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Self-Administration of Medications, the facility failed to offer and assess a resident for administering her own calcium and medicated mouthwash for one of 49 sampled residents (R) (R48). This deficient practice had the potential to cause the resident to leave medication at her bedside until she was ready to take it and could endanger other residents who wander and are confused. Findings include: Review of the facility's policy titled Self-Administration of Medications, revised 01/2026, section 1, revealed that if the resident expressed his/her desire to self-administer medications, as part of their overall evaluation, the staff and or practitioner shall assess the resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.Review of the electronic medical record (EMR) revealed resident R48 was admitted to the facility on [DATE] with pertinent diagnoses, including but not limited to bipolar disorder, severe with psychotic features, generalized anxiety disorder, Alzheimer's disease, Parkinson's disease with dyskinesia, and schizoaffective disorder.Review of R48 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated R48 had little to no cognitive impairment.Section GG, functional status, revealed R48 was independent of activities of daily living (ADLs).Review of R48 care plan dated 03/2026 indicated a problem of gastroesophageal reflux disease (GERD) and at risk for adverse reactions.Goals-R48 will remain free from discomfort, complications, or signs/symptoms (s/sx) related to the diagnosis or GERD through the review date.Interventions: Give medications as ordered. Monitor/document side effects and effectiveness. Monitor/document/report PRN (as needed) s/sx of GERD: Belching, coughing/choking when lying down, heartburn, dyspepsia, N/V, indigestion, regurgitation, increased salivation, swallowing problems, bitter taste in mouth, dysphagia, substernal chest pain, increased gag response.Review of assessments- There is no assessment present for medication self-administration in R48 EHR.Review of the Physician's Orders for R48 included, but was not limited to:Tums Oral Tablet Chewable 500mg (Calcium Carbonate). Give 2 tablets by mouth every 6 hours as needed for GERDPrilosec OTC oral tablet Delayed Release 20mg. Give 1 tablet by mouth twice daily to treat reflux disease.Calcium Carbonate Oral Tablet: Give 1500mg by mouth one time a day for Calcium deficiency.Pepcid tablet 20mg: Give 20mg by mouth at bedtime for GERD.An observation and interview on 05/11/2026 at 11:44 am with R48 revealed 2 large chewable tablets inside a medication cup on the resident's bedside table. The resident states that they are TUMS for her low calcium. The nurse gives them to her, but she likes to take them later.An observation made on 05/13/2026 at 10:15 AM of R48 revealed that the resident had 2 medication cups on her bedside table: one contained 2 large, orange-colored tablets that were smooth and intact, and the other cup contained 5ml of a clear substance. When asked, the resident said that the liquid is her mouthwash, which the nurse gives her every morning, and the other is for calcium. Both cups were set there by the medication nurse. She stated that she does not take them right away.An interview with Certified Medication Technician (CMT) BB on 05/13/2026 at 10:20 AM revealed and confirmed the presence of the medication at the bedside, and she stated, She must have spit them back in the cup after I gave them to her. CMT BB then picked up the cup with the Tums in it and handed it to R48 for her to take. The resident took the tablets. CMT BB then turned and walked out of the room, leaving the mouthwash in the cup at the resident's bedside.An interview with a Licensed Practical Nurse (LPN) AA Unit manager on 05/13/202 at 10:30 AM revealed she was surprised that the CMT left the medication at the bedside. LPN AA stated that the CMT in question was always very thorough when administering medications and that they are trained the same way nurses are. An interview with the Director of Nursing (DON) and the Administrator on 05/14/2026 at 1:30 PM revealed that the practice of leaving medications at the bedside is unacceptable, and that education would be provided to the CMTs and the nursing staff.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's poliies titled Care Plans-Baseline, the facility failed to provide an updated baseline care plan for one of 49 residents sampled (R) (R8). This deficient practice had the potential to cause a lapse in care for Foley catheter care, JP (Jackson Pratt) drain, and surgical incision care. Findings include:Review of the facility's policy titled Care Plan-Baseline, revised 09/20/2023, section 1 revealed that to ensure the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission. Section 2a and b state that the baseline care plan will include initial goals based on admission orders and Physician orders.Review of the electronic medical record (EMR) revealed R8 was admitted to the facility originally in 2023, but was hospitalized for a hernia repair surgery and was admitted on [DATE], with pertinent diagnoses, including but not limited to encounter for surgical aftercare following surgery on the digestive system, incisional hernia without obstruction, resolution of an ileus, and failed catheter protocol twice with urinary retention. Review of R8's most recent, before his hospitalization, Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated R8 had moderate cognitive impairment.The review of R8s care plan dated 03/26/2026 was the last review date, and there is no mention of care for a Foley catheter, a JP drain, or a surgical incision.Review of the Physician's Orders for R8 included, but was not limited to: Order dated for 05/9/2026 Enhanced Barrier Precautions: Wear gowns and gloves Order dated for 05/09/2026: Full Liquids diet, other texture, regular consistency Order dated for 05/11/2026 Record JP drain output Order dated 05/14/2026: Foley catheter care every shift.Observation and interview on 05/11/2026 at 11:23 AM with R8 revealed the resident was in discomfort; he was agitated and had expressive aphasia, so he was unable to fully communicate his needs. Observation revealed he had a Foley catheter connected to a bedside drainage bag that had over 800 ml of clear amber urine in it. R8 pulled up his covers to show his midline abdominal incision with multiple staples and a JP drain located on the lower quadrant of his abdomen. There was no cover on the drainage bag, but the tubing was secured to the resident's right leg by a Foley securement device.Observation made on 05/13/2026 at 9:00 AM of R8 revealed that the R8 had been shaved, and the catheter bag had a privacy cover. There is no mention of the Foley catheter, JP drain, or midline incision in the care plan.An interview with the Registered Nurse (RN) MDS coordinator on 05/13/2026 at 12:30 PM revealed that the R8 care plan had not been updated with his new admission information and should have been updated within 48 hours of his admission. Neither his Foley catheter, the JP drain, nor the surgical incision care is addressed. She stated that this deficient practice can prevent timely care for the resident's needs.An interview with the Director of Nursing (DON) and Administrator on 05/14/2026 at 1:30 PM revealed that they expect every resident's care plan to include a baseline within 48 hours of admission. The negative consequences of not having a baseline care plan include delays in care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Oxygen Administration, the facility failed to ensure a physician's order was obtained for oxygen therapy administration for one resident of 13 residents (R) (R19) reviewed who were receiving oxygen therapy. This deficient practice had the potential to affect resident safety by administering oxygen without a current physician order.Findings include:Review of the electronic medical record (EMR) for R19 revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD).Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.Review of the care plan initiated 07/17/2025 revealed a focus stating, Staff explained to me that I need to keep O2 cannula on with humidifier bottle in place to prevent another nosebleed. Interventions included, Encourage me to wear O2 nasal cannula.Further review of the EMR revealed no active physician order for oxygen administration.Observation on 05/11/2026 at 10:20 AM revealed R19 receiving oxygen via nasal cannula from an oxygen concentrator set at 3 liters per minute (LPM).Review of the facility policy titled Oxygen Administration undated revealed under Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.Observation on 05/13/2026 at 10:30 AM revealed R19 sitting in a geri-chair in the hallway while receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed the oxygen flow rate was set at 3 LPM.Interview with LPN AA on 05/13/2026 at 11:33 AM confirmed R19 did not have an active physician order for oxygen therapy. Review of the electronic medication administration record (eMAR) also revealed no active order for oxygen administration.Interview with the Director of Nursing (DON) on 05/13/2026 at 11:40 AM revealed her expectation that all residents receiving oxygen therapy should have an active physician order. The DON stated nurses were responsible for verifying physician orders.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative interview, staff interviews, and review of the facility policy titled Infection Prevention and Control Program, the facility failed to ensure one of five residents (R) (R10) reviewed for immunizations were provided education regarding influenza and pneumococcal immunizations and failed to ensure documentation related to vaccine administration, refusal, contraindication, consent, and/or declination for sampled residents reviewed for influenza and pneumococcal immunizations. The deficient practice had the potential to place the 98 residents at increased risk of vaccine-preventable illnesses, including influenza and pneumococcal disease.Findings included:Review of the facility policy titled Infection Prevention and Control Program, revised 09/2023, revealed, in part, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals. The policy further revealed, Policies and procedures are utilized as the standards of the infection prevention and control program. The policy additionally revealed infection prevention practices included implementation of measures intended to prevent and reduce the transmission of communicable diseases within the facility.Record review revealed R10 was admitted on [DATE] with a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident was not cognitively intact.Record review revealed R10 had no documented evidence the influenza vaccine had been offered since the last documented consent dated 10/1/2025. Further record review revealed no current documentation related to influenza vaccine administration, refusal, contraindication, consent, education, and/or declination at the time of review.During an interview 05/12/2026 at 3:04 PM, R10's responsible representative/daughter stated she declined the pneumococcal immunizations vaccine only for R10.Further record review revealed no documented evidence R10 and/or the responsible representative was provided education regarding influenza and/or pneumococcal immunizations, and no documented evidence the influenza and/or pneumococcal vaccines were administered, refused, contraindicated, consented to, and/or declined at the time of review.During an interview conducted on 05/13/2026 at 1:00 PM, the Infection Control Preventionist Nurse (ICPN) stated she reviewed the Georgia Registry of Immunization Transactions and Services (GRITS) and was unable to locate documentation related to Influenza and pneumoccal vaccine offering, administration, refusal, contraindication, and/or consent for R10 prior to 05/14/2026.Further record review revealed no documented evidence R10 had previously been offered the vaccine or educated regarding the risks and benefits of the vaccine prior to 05/14/2026.Further record review revealed no documented evidence R10 had previously been offered the influenza and/or pneumococcal immunizations vaccine or educated regarding the risks and benefits of the vaccine prior to 5/14/2026.During a joint interview conducted on 05/14/2026 at 1:00 PM, the Director of Nursing (DON) and Administrator stated residents are educated regarding immunizations upon admission. The DON and Administrator acknowledged documentation related to pneumococcal immunizations vaccine offering, education, administration, refusal, contraindication, and/or consent for R10 could not be located at the time of review. The DON and Administrator further acknowledged the facility was unable to provide documentation demonstrating R10 was timely offered the pneumococcal immunizations vaccine or educated regarding the risks and benefits of vaccination prior to 05/14/2026. The DON and Administrator stated the importance of timely offering, educating, and documenting pneumococcal immunizations is to reduce the risk for transmission of communicable disease and protect vulnerable residents from complications associated with pneumococcal immunizations infection. The DON further stated the potential negative outcome of failing to timely offer and document pneumococcal immunizations could place residents at risk for contracting, transmitting, and experiencing complications related to pneumococcal immunizations within the facility.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Infection Prevention and Control Program, the facility failed to ensure residents were timely offered the COVID-19 vaccine, educated regarding the risks and benefits of the COVID-19 vaccine, and failed to ensure documentation related to COVID-19 vaccine administration, refusal, contraindication, and/or consent for one of five sampled residents (R) (R9) reviewed for COVID-19 immunizations. This deficient practice had the potential to place R9 at increased risk of medical complications related to COVID-19. Findings include:Review of the facility policy titled Infection Prevention and Control Program, revised 09/2023, revealed, in part, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals. The policy further revealed, Policies and procedures are utilized as the standards of the infection prevention and control program. The policy additionally revealed infection prevention practices included implementation of measures intended to prevent and reduce the transmission of communicable diseases within the facility.Record review revealed R9 was admitted on [DATE] and readmitted on [DATE] with a Brief Interview for Mental Status (BIMS) score of 11, indicating R9 was cognitively intact. Further record review revealed no documented evidence R9 had previously been offered the COVID-19 vaccine or educated regarding the risks and benefits of the vaccine prior to 05/14/2026.During an interview conducted on 05/13/2026 1:00 PM, the Infection Control Preventionist Nurse (ICPN)/ Regional Consultant reviewed the Georgia Registry of Immunization Transactions and Services (GRITS) and was unable to locate documentation related to COVID-19 vaccine administration, refusal, contraindication, and/or consent for R9 prior to 05/14/2026.During an interview conducted on 05/14/2026 1:33PM, R9 stated he had not been offered the COVID-19 vaccine until 05/14/2026. R9 stated he authorized the facility to administer the COVID-19 vaccine at that time.During a joint interview conducted on 05/14/2026 at 11:06 AM, the Director of Nursing (DON) and Administrator stated residents are educated regarding immunizations upon admission. The DON and Administrator acknowledged documentation related to COVID-19 vaccine offering, education, administration, refusal, contraindication, and/or consent for R9 could not be located at the time of review. The DON and Administrator further acknowledged the facility was unable to provide documentation demonstrating R9 was offered the COVID-19 vaccine or educated regarding the risks and benefits of vaccination prior to 05/14/2026. The DON and Administrator stated the importance of offering education, and documentation of COVID-19 immunizations. The DON further stated the potential negative outcome of failing to timely offer and document COVID-19 immunizations would place residents at risk for contracting, transmitting, and experiencing complications related to COVID-19 within the facility.