STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Lillington	1995 East Cornelius Harnett Boulevard Lillington, NC 27546

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observation, resident interviews, and staff interviews, the facility failed to protect a resident's right to be free from physical abuse when a resident (Resident #8) was punched in the face multiple times with a closed fist by a resident who resided in the Assisted Living Facility (ALF) on the same campus. On the evening of 4/22/24 while in facility's courtyard, Resident #8 and the ALF resident engaged in a verbal disagreement that escalated into a resident-to-resident physical altercation that resulted in Resident #8 sustaining a small laceration to the left upper eye lid. This deficient practice was for 1 of 3 residents reviewed for physical abuse. Findings included: Resident #8 was admitted to the facility on [DATE] with diagnoses including anxiety, depression and non-Alzheimer's dementia. The care plan for Resident #8 dated 12/5/2023 included a focus for manipulative and inappropriate behaviors. Interventions included monitoring and documenting behaviors, not arguing with Resident #8 and talking in a calm voice when disruptive behaviors occurred. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was moderately cognitively impaired, exhibited disorganized thought processes, used a wheelchair and was independent with ambulation for 10 feet, 50 feet, and 150 feet. The MDS did not report Resident #8 displaying any behaviors toward others in the 7-day look back period. An observation conduced on 4/22/2024 at 12:28 p.m. revealed the facility's campus consisted of two separate buildings, the ALF and the Skilled Nursing Facility (SNF) that were connected by a long kitchen corridor. There was a keypad lock on the door to access the SNF from the kitchen corridor. ALF residents entered the SNF through the front entrance. The courtyard was located in the center of the SNF building. An incident report dated 4/22/2024 at 7:00p.m. completed by Nurse #1 reported there was a resident-to-resident altercation outside in the courtyard between Resident #8 and a resident who resided in the ALF. Resident #8 reported he had a disagreement with the ALF resident and then he (the ALF resident) walked up to him and punched him in the eye multiple times. Resident #8 had no complaints of pain and a small abrasion was noted to left eye with bruising. The left eye was cleaned with normal saline, antibiotic ointment and a bandaid was applied. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Universal Health Care/Lillington		STREET ADDRESS, CITY, STATE, ZIP CODE 1995 East Cornelius Harnett Boulevard Lillington, NC 27546	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated 4/22/2024 at 10:10 p.m. by Nurse #1 reported while Resident #8 was outside in the courtyard, a disagreement occurred between Resident #8 and the ALF resident, who resided in the adjoining Assisting Living Facility (ALF). The two residents were separated and the ALF resident went back to his home at the ALF. Resident #8 reported the ALF resident walked up and punched him in the eye multiple times. Nurse #1 documented treatment was provided to a small abrasion observed to Resident #8's bruised left eye. Nurse #1 further recorded Resident #8 had no complaints of pain, he did not feel threatened, he felt safe at the facility, and stated he did not want to press charges against the ALF resident. Nurse #1 further recorded the Director of Nursing was informed of the incident. On 4/24/2024 at 4:44 p.m. in an interview with Nurse Aide #5, she stated when she observed Resident #8 and the ALF resident fighting they were standing up and swinging with closed fists at each other in the courtyard on 4/22/2024. She indicated she ran out to the courtyard and separated the two residents with help of other staff members. She explained she helped Resident #8 back into his wheelchair and had him (Resident #8) report to the nurse's station for treatment of the cut on his left eyelid, and Nurse #4 was informed of the incident. She said she told the ALF resident, who was ambulatory and did not use a mobility device, to go back to the ALF and was escorted by a staff member to the front door of the SNF On 4/23/2024 at 3:45 p.m. in an interview with Nurse #4, she didn't know anything about the altercation between Resident #8 and the ALF resident on 4/22/2024 until Resident #8 came up to the nurse's station requesting something to cover his left eye and stated the ALF resident had hit him. She stated she called Nurse #1 to report the incident. On 4/23/2024 at 3:47p.m. in an interview with Nurse #1, she stated Nurse #4 called on 4/22/2024 at 7:05 p. m. to report the resident-to-resident altercation between Resident #8 and the ALF resident. She said she spoke to Resident #8 on the morning on 4/23/2024 who stated he was fine. She stated Resident #8 reported that although he thought about hitting the ALF resident first, he didn't because he decided violence was not the answer. On 4/23/2024 at 3:55 p.m. during an interview with Resident #8, a half inch laceration to the outside left eye lid was observed. The area was slightly swollen and observed red coloration to the corner of the left eye and side of his face. Resident #8 stated there were a bunch of people in the courtyard on the evening of 4/22/2024 and explained when he said something to Resident #25 on the other side of the courtyard, Resident #25 told him to mind his own business and that's when the ALF resident got up from the chair and walked over to him and started swinging his fist. He stated the ALF resident hit him several times with his closed fist and he raised his arms to block the punches. He explained he did not know he was bleeding until someone told him and that's when he went back inside from the courtyard to the nurse's station to receive treatment for the cut to the left eye. He stated he felt safe at the facility. Resident #8 denied having any other resident-to-resident altercations in the past with the ALF resident or other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/2024 at 2:09 p.m. in an interview with Resident #25, she stated the ALF resident, Resident #57 and herself were outside in the courtyard on 4/22/2024 in the evening. She described Resident #8 as being loud verbally although he was sitting on the other side of the courtyard with other SNF residents. She stated when she asked Resident #8 if he could quiet down, he asked her if she could take her hearing aids out. She stated the ALF resident told Resident #8 to come over where he (the ALF resident) was sitting and say that. Resident #8 walked over to where they were sitting and the ALF resident hit Resident #8 several times. She stated Resident #8 and the ALF resident had stopped fighting when she saw staff at the entrance door to the courtyard to help Resident #8 back into the facility. She stated the ALF resident went back to the ALF where he resided. On 4/23/2024 at 4:21 p.m. in an interview with Resident #57, he stated the ALF resident, Resident #25 and himself were outside in the courtyard talking about the birds on 4/22/2024. He stated Resident #8 butted into their conversation from across the courtyard and the ALF resident told Resident #8 we didn't need his two-cents worth. Resident #8 told the ALF resident to shut his d*** ear. He stated when Resident #8 started to get up on the other side of the courtyard to walk over to where they were sitting, Resident #57 told Resident #8 not to start anything. He stated the ALF resident got out of his chair and met Resident #8 in the middle of the courtyard and told Resident #8 to say it again. He explained that was when Resident #8 swung at the ALF resident with a closed fist but did not hit the ALF resident because he moved out of the way. He stated the ALF resident defended himself and punched Resident #8 two to three times with his closed fist in the face. On 4/23/2024 at 2:55 p.m. in an interview with the Resident Care Coordinator of the ALF, she stated when the ALF resident went to the [NAME] nursing facility (SNF) on 4/22/2024 he was visiting a friend that used to live in the ALF. She explained she was notified by Nurse #1 about the resident-to-resident altercation between the ALF resident and Resident #8 sometime after 6:00 p.m. and was informed the ALF resident had been sent back to the ALF. She described the ALF resident as alert and oriented with some confusion at times (not knowing what town he lived in). He was able to independently perform his activities of daily living. She stated the ALF resident had been in an altercation with another resident in the past. On 4/23/2024 at 3:12 p.m. in an interview with the ALF resident, he stated he went to the SNF to visit Resident #57 and was the at SNF on 4/22/2024. He explained he (the ALF resident) and Resident #57 had gone into the courtyard to smoke and Resident #25 had joined them. He stated when Resident #8 started yelling at Resident #25 to hush, he told Resident #8 to hush and to leave Resident #25 alone. He stated Resident #8 informed the ALF resident that he knew karate and started walking toward him. Resident stated he told Resident #8 to leave him alone but Resident #8 came over to where he was sitting. He explained after Resident #8 swung his arm toward him and missed hitting him, he hit Resident #8 in the head a few times with his closed fist. He stated a nurse (name unknown) came out to the courtyard and directed him to return to his living quarters in the ALF. He stated no one had told him he could not go back to the SNF to visit. (continued on next page)

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	345213	A. Building B. Wing	04/26/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/2024 at 4:08 p.m. in an interview with the DON, she stated she was notified by Nurse #1 on 4/22/2024 around 7:00p.m. of the physical resident-to-resident altercation between Resident #8 and the ALF resident. The DON explained residents from the ALF could visit SNF residents and be in the facility courtyard, and the facility was responsible in keeping all residents' safe. She said the ALF resident was sent back to the ALF after the altercation between the residents for the safety of the residents in the SNF, and Nurse #1 spoke with the Resident Care Coordinator at the ALF and informed her that the ALF resident was not allowed to come back to the SNF to visit. The DON stated based on her past experiences of abuse, physical abuse was when there was staff to resident abuse. She explained abuse was not when a resident-to-resident physical altercation occurred between two residents with behaviors and impaired judgments. She reported Resident #8 was known to speak stern and loud when talking with others and was not aware of Resident #8 having any past resident-to- resident physical altercations. On 4/23/2024 at 2:55 p.m. in an interview with the Administrator, he stated he was aware of the resident-to-resident physical altercation between Resident #8 and the ALF resident on the evening of 4/22/2024. He explained the ALF resident was the attacker, and Resident #8 was the victim. He stated the ALF resident was cognitively impaired and was not allowed to return to the skilled nursing facility. On 4/26/2024 at 5:40 p.m. in an interview with the Administrator, he stated a resident-to-resident altercation could be considered abuse if the act was performed willfully. He explained with the resident-to-resident altercation on 4/22/2024 resulting in a laceration to Resident #8's eyelid, it indicated willfulness and would be defined as abuse. He stated the nursing staff would need education on how to differentiate resident-to-resident altercations as abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review and staff interviews, the facility failed to implement the facility's abuse policy in the areas reporting, investigating, and/or protection in response to allegations of physical abuse. This deficient practice affected 2 of 3 residents reviewed for abuse (Resident #6 and Resident #8). Findings included: The facility's policy abuse, prevention, intervention, reporting and investigation dated February 2021 defined abuse as willful infliction of injury resulting in physical harm, pain or mental anguish, and stated abuse may be resident to resident, staff to resident or visitor to resident. The policy stated staff were state mandated reporters and must comply with state regulations regarding reporting suspected abuse with federal regulations regarding reporting any reasonable suspicion of crime against a resident or other individual receiving care by the facility. It stated all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to the Executive Director of the facility, and other officials (state agency, adult protective services). In addition, local law enforcement will be notified of any reasonable suspicion of crime against a resident in the facility. In staff to resident investigations, the accused employees were to be removed from resident contact immediately and may be suspended from duty until the results of the investigation were reviewed by Human Resource policy. If the investigation should reveal abuse occurred, the Executive Director reports the findings to the local police department, ombudsman, state agency, and other required by state, federal and local laws within required time frame. 1. Resident #6 was admitted to the facility on [DATE]. Review of Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed she had moderate cognitive impairment. Review of Resident #6's nursing notes completed by Nurse #5 dated 4/02/24 revealed the resident requested to see the nurse because the nursing assistant (NA) had pushed her into bed. Nurse #5 noted Resident #6 said she requested NA #2 and NA #3 to assist her to bed. Resident #6 stated that NA #2 instructed her to get close to the bed and move her bedside table. Resident #6 rolled her wheelchair parallel to the bed. Resident #6 then stated NA #2 got behind her wheelchair and started counting to three. Resident #6 thought that NA #2 was going to help her up by putting her arms under Resident #6's arms to help her stand. Resident #6 said NA #2 pushed Resident #6 out of the chair and she fell across the bed. She stated that both NAs then left the room. Nurse #5 noted Resident #6's room was reassigned to another NA and Nurse #5 had the staff write statements of what occurred. Nurse #5 noted she called the Director of Nurses (DON), left a message, and then texted the DON about the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/26/24 at 1:08 AM, Nurse #5 said she was the night shift supervisor on 4/2/24. Nurse #5 said she was told by Medication Aide (MA) #4 that Resident #6 said she wanted to speak with the nurse. Resident #6 told her (Nurse #5) that the NA pushed her in the midback and Resident #6 fell sideways into the bed. Nurse #5 assessed the situation and had concerns about Resident #6's accusations. There were no injuries or marks on Resident #6's back. Nurse #5 moved Resident #6's room assignment from NA #2 to another NA as a safety precaution. Nurse #5 did not want NA #2 to be hurt or for another accusation to come out against her. Nurse #5 said she called the DON but the call was not answered. Nurse #5 texted the DON as well. The DON called Nurse #5 back approximately an hour or so later. Nurse #5 explained what Resident #6 said and said she moved the NA's room assignment. Nurse #5 said the DON understood the interventions put in place and did not provide any further guidance or instructions. Nurse #5 was not sure what the abuse policy said because she was a new employee. Nurse #5 said she did not notify the Administrator, just the DON. In an interview on 4/25/24 at 08:35 PM, MA #4 said she was told by NA #2 that night that Resident #6 said someone pushed her. MA #4 did not know details of the incident. MA #4 said that Resident #6 made accusations about a staff member talking to her rudely, saying things such as I'm not going to babysit you. Resident #6 also confused the day and night shift, blaming one shift about something that happened on the other shift. In an interview on 4/26/24 at 3:54 PM, the DON said she received a missed call at 2:38 AM and a text message at 2:39 AM from Nurse #5 saying to call her when the DON received the message. The DON called Nurse #5 at 5:42 AM and found out Resident #6 alleged staff had pushed her. The DON sent a message to the Administrator at 6:03 AM saying that Resident #6 alleged that staff pushed her. The DON called Nurse #5 again at 6:04 AM and went to the facility. The DON clocked in at the facility at 7:17 AM. The DON spoke with Resident #6, who did not allege that she was pushed, just that the transfer was bad and the staff should be retrained. The DON wanted to address the issue with the resident, who had been going through significant emotional distress due to a family situation, but address it in a way that the staff would feel they were being protected as well. The DON did not want the staff upset at an allegation, which could potentially cause staff to treat Resident #6 with an attitude or to not want to help her when she needed it. The DON did not feel that a formal investigation was needed because Resident #6 said it was a training concern. If Resident #6 had told the DON she was pushed, it would be considered an allegation of abuse. Due to Resident #6 saying it was a training concern, the DON and Administrator decided to address the issue as a grievance. In an interview with the Administrator on 4/23/24 at 3:47 PM, he said he was notified of the incident at 6:03 AM. He said the DON went to talk with Resident #6, and the resident told her it was a bad transfer and that staff needed retraining. He said it was a grievance and not an abuse allegation. He said Resident #6 had a history of being manipulative with staff and they felt the grievance was appropriate. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a further interview with the Administrator on 04/26/24 at 5:41 PM, he said that due to Resident #6 withdrawing her statement about being pushed, the facility did not feel it was an allegation of abuse. The Administrator confirmed that until the time Resident #6 spoke with the DON, Nurse #5 had an allegation from Resident #6 of being pushed at 1:45 AM and he, the abuse prohibition coordinator, was not notified until 6:03 AM. The Administrator acknowledged that he was not notified for more than 4 hours. The Administrator said he did not feel the staff should have been suspended because the statement was retracted. The Administrator confirmed that NA #2 continued working at the facility since the allegation. The Administrator acknowledged and agreed that the facility's abuse policy said when there was an abuse allegation, the staff involved should be suspended. The Administration said no one had interviewed Resident #6's roommate or other residents who worked with NA #2 or NA #3 about the incident and about care provided. 41387 2. Resident #8 was admitted to the facility on [DATE]. On 4/23/2024 at 2:30 p.m. a review of nursing documentation dated 4/22/2024 at 10:10 p.m. by Nurse #1 reported while Resident #8 was outside in the courtyard, a disagreement occurred between Resident #8 and a resident who resided in the adjoining Assisting Living Facility (ALF). The two residents were separated and the ALF resident went back to his home at the ALF. Resident #8 reported the ALF resident walked up and punched him in the eye multiple times. Nurse #1 documented treatment was provided to a small abrasion observed to Resident #8's bruised left eye. Nurse #1 further recorded Resident #8 did not feel threatened and he felt safe at the facility. Nurse #1 further recorded the Director of Nursing (DON) was informed of the incident. A resident incident report dated 4/22/2024 at 7:00p.m. was completed by Nurse #1 and reported a resident-to-resident altercation. Resident #8 stated he was outside in the courtyard when he had a disagreement with an ALF resident. He stated the ALF resident walked up to him and punched him in the eye multiple times. Resident #8 had no complaints of pain and a small abrasion was noted to his left eye with bruising. On 4/23/2024 at 4:31 p.m. in an interview with Nurse #1, she explained she sent the Administrator a text message at 7:10 p.m. on 4/22/2024 informing him of a resident-to-resident altercation and requested a return call. She stated she did not receive a call from the Administrator and spoke to the Administrator about the incident upon reporting to work before 8:00a.m on 4/23/2024. She stated based on past abuse training resident-to-resident altercations were not considered abuse. On 4/24/2024 at 4:44 p.m. in an interview with Nurse Aide #5, she stated following the incident between Resident #8 and the ALF resident on 4/23/2024 the ALF resident was instructed to return to the ALF section of the facility and not return to the nursing home section of the facility. On 4/23/2024 at 4:08 p.m. in an interview with the DON, she stated Nurse #1 called her around 7:00 pm on 4/22/2024 to report the altercation between Resident #8 and the ALF resident. She explained the two residents were having a verbal altercation in the courtyard that ended up in a physical altercation, and she informed Nurse #1 to notify the Administrator of the incident. She stated it was her understanding that a resident-to-resident altercation due to impaired mental function was not considered abuse and did not require the facility to report to the state agency unlike a staff member hitting a resident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/2024 at 2:40 p.m. in an interview with the Administrator, he stated he had not submitted an initial allegation report to the state agency for abuse at the present time because it was an altercation between two residents. He stated since the ALF resident attacked Resident #8 and Resident #8 was the victim, he had 24 hours to report the incident to the Department of Social Services (DSS) under ALF regulations. An Initial Allegation Report for reasonable suspicion of a crime related to the incident between Resident #8 and the ALF resident was submitted to the state agency and Division of Social Services on 4/23/2024 at 3:07 p.m. It reported the facility was aware of an incident on 4/22/2024 at 7:00 p.m. when the ALF resident punched Resident #8 in the eye multiple times following a disagreement between the two residents in the courtyard. Resident #6 did not want to press charges and did not feel threatened. The report indicated the incident was reported to the law enforcement on 4/23/24 at 3:04 p.m. In a follow up interview with the Administrator on 4/23/2024 at 4:45 p.m., he explained he became aware of the incident on 4/22/2024 at 7:10 p.m. in a text message. He explained the incident with Resident #8 was not viewed as abuse or a suspected crime since the attacker was from the ALF and not the skilled nursing facility. He explained this did not require the facility to report the incident to the state agency in two hours. On 4/26/2024 at 5:40 p.m. in an interview with the Administrator, he stated a resident-to resident altercation could be abuse and as the Administrator he was responsible for reporting allegations of abuse to the state agency within two hours under the skilled nursing requirements in reporting abuse. He explained with the resident-to-resident altercation resulting in a laceration to Resident #8's eyelid it indicated willfulness and would be defined as abuse.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations, Responsible Party interview, staff interviews, and a Physician interview, the facility failed to provide wound management to a skin tear that was recorded occurring initially on 3/12/2024 and reoccurring on 3/30/2024 for a resident. The resident's skin tear was reported infected on 4/3/2024 and was treated with antibiotics. There were no treatments for wound care ordered until 4/9/2024, and there were no weekly wound assessments (appearance and measurements of the wound) documented on the skin tear as of 4/26/2024 in the resident's medical record. This deficient practice occurred for 1 of 3 residents reviewed for skin conditions (Resident #118). Findings included: Resident #118 was admitted to the facility on [DATE] with diagnoses including a stroke. The care plan dated 2/23/2024 for Resident #118 included a focus for the risk for skin alterations and recorded there were scabbed wounds to the left lower extremity. Interventions included to assess the skin daily with routine care with baths and showers. Resident #118's care plan also included a focus for a potential in bleeding and bruising due to anticoagulation (receiving medications that prevent or break down blood clots) therapy. Interventions included gently handling the skin, observing for signs of bleeding that included changes in skin color, bruising and bleeding, and notifying the physician of bleeding or changes in skin condition. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #118 was severely cognitively impaired, and there was no limitation of mobility to her lower extremities. The MDS further indicated Resident #118 had no skin conditions. A facility's incident report dated 3/12/2024 completed by Nurse #1 recorded Resident #118 had a small skin tear to right shin after a fall. Nurse #1 recorded the area was cleaned with normal saline, and a dressing was applied. Resident #118's weekly skin assessment since 3/15/2024 reported skin was not intact. Nursing documentation on 3/15/2024 at 4:33 p.m. by unknown nurse reported a right lower leg skin tear was covered with an ABD pad (non-woven thick absorbent dressing) and wrapped with kerlix (a gauze bandage used to dress wounds or absorb fluids) at the request of Resident #118's Responsible Rarty, and Treatment Nurse #1 was notified. Nursing documentation on 3/30/2024 at 6:12 p.m. by Nurse #2 reported the scab of an old skin tear to the right lower leg was removed with some bleeding when Resident #118 slipped out of her wheelchair to the floor. Nurse #2 documented cleansing the right lower leg with wound cleanser and applying a bandage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Nursing documentation on 4/3/2024 at 5:40 p.m. by Nurse #3 reported Resident #118's Responsible Party reported to Nurse #3 the right lower dressing was coming off. Nurse #3 documented there was serosanguineous drainage observed on the right lower leg dressing, and there was odor from a small open, whitish/yellow area to the right lower leg. Nurse #3 recorded the right lower leg was cleansed with wound cleaner, covered with an ABD pad, and wrapped with kerlix. Nurse #3 documented an order for doxycycline, an antibiotic, was received from Physician #1 for an infected wound. There were no further nursing assessments of Resident #118's right lower leg skin tear wound documented in her medical record. There was no assessment of Resident #118's right lower leg skin tear wound located in the physician progress notes in the medical record. There were no wound treatments recorded for Resident #118's right lower leg on the March 2024 Treatment Administration Record (TAR). A physician order dated 4/3/2024 requested Resident #118 receive doxycycline hyclate (an antibiotic) 100 milligrams(mg) twice a day for ten days for a wound infection. On 4/9/2024, a physician order was written by Treatment Nurse #1 to cleanse skin tear to Resident #118's left (should be right) lower leg with normal saline or wound cleanser, apply xeroform and cover with a dry dressing every other day. Resident #118's April 2024 Medication Administration Record recorded doxycycline hyclate 100mg was administered twice a day from 4/4/24 to 4/13/2024. The April 2024 Treatment Administration Record (TAR) recorded Resident #118's left (should be right) lower leg skin tear was cleansed with normal saline or wound cleanser, xeroform was applied and covered with a dry dressing every other day. On 4/26/2024 at 4:10 p.m., Nurse #4 and NA #1 were observed changing Resident #118's right lower leg dressing. An outer right lower leg wound was observed as an oblong shaped superficial area measuring 2 by 1 centimeters (cm) with light pink granulation tissue. An inner right lower leg wound was observed as a linear shaped open area measuring 3 by 1 cm with red granulated tissue. Both areas were cleansed with wound cleaner and patted dry, and xeroform and a kerlix dressing was applied. In an interview with Resident #118's Responsible Party (who was present during the dressing change of the right lower leg) on 4/26/2024 at 4:10 p.m., she stated on 4/3/2024 it was the outer right lower leg wound that was covered with pus. She explained the inner right lower leg wound was there also on 4/3/2024 and became infected later. She explained both wounds were looking better than a couple weeks ago. In a phone interview with Nurse #2 on 4/26/2024 at 3:25 p.m., she explained Resident #118 was on a blood thinner (prevent blot clots) medication and had a dark blue discolored area the size of a baseball to her right lower leg on 3/30/2024. She stated on 3/30/2024, a scabbed area in the center of the dark blue area came off with some bleeding. She explained she cleansed the skin tear to the right lower leg with wound cleanser and applied a dressing. She stated she reported Resident #1's skin tear directly to Treatment Nurse #1 verbally. She explained Treatment Nurse #1 was responsible for wound management (assessing the wound, ordering and providing treatments, and evaluating wound care) once a skin tear or wound was communicated. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a phone interview of 4/26/2024 at 6:34 p.m. with Nurse #3, she explained on 4/3/2024 she was not aware of Resident #118's right leg wound until Resident #118's Responsible Party reported the dressing to the right lower leg was off. She described the right lower leg wound as infected with a white material covering the wound. She explained she cleansed the area, applied a dressing and texted the physician. She stated based on her assessment of the wound Physician #1 started Resident #118 on antibiotics and did not order any further wound care. She stated she also notified either Treatment Nurse #1 or Nurse Aide #1 (NA who assisted Treatment Nurse #1 with wound care) who was in the facility at the time, Nurse #1 and the Director of Nursing of the wound. She stated the nursing staff had standard orders for wound care but since Resident #118's right leg wound was infected, she needed more than the standard wound care. She explained it was Treatment Nurse #1's responsibility to assess the wound, determine the type of wound care and obtain a physician order for wound care. In an interview with Nurse #1 on 4/26/2024 at 10:03 a.m., she explained there was a treatment communication binder at the nurse's station to notify Treatment Nurse #1 of changes in a residents' skin, and Treatment Nurse #1 was to assess and order treatments. Nurse #1 stated there was no documentation in the treatment communication binder Treatment Nurse #1 was notified of Resident #118's right lower leg skin wound. In an interview with Nurse Aide #1 on 4/26/2024 at 2:37p.m, she explained she helped Treatment Nurse #1 in providing wound care, and Treatment Nurse #1 was responsible for assessing Resident #1 wounds and calling the physician to develop a plan of care. She stated she only provided and documented the wound care as ordered, and since 4/9/2024 when an order was written, she had performed Resident #118's wound care to the right lower leg. She stated she was not able to recall whether she was informed about Resident #118's right lower leg skin tears prior to 4/9/2024. In an interview with Treatment Nurse #1 on 4/26/2024 at 9:47 a.m., she explained nursing staff were to notify her of skin tears or wounds by recording the wounds in the treatment communication book at the nurse's station, and she couldn't recall the staff notifying her of Resident #118's right lower leg wound. She stated Resident #118's treatments to the right lower leg started (4/9/2024) after she assessed the wounds. Treatment Nurse #1 stated she was unable to recall the exact date of her assessment of Resident #118's right lower leg wound. She stated skin tear wound assessments were not documented in the electric medical record under wound assessments, and she did not have any records documenting the appearance or measurement of Resident #118's right lower leg wounds. She explained when Resident #118's wound became infected that changed the requirement for assessing and documenting of Resident #118's right lower leg wounds, and she should had assessed and documented Resident #118's right lower leg wounds for wound management weekly in the nurse notes or under wound assessments in the electrical medical record. She stated there were standing physician's orders to use for treatment of skin tears. She explained Resident #118 was not followed by the wound physician and could not say that Physician #1 had seen the wounds to her right lower leg. In an interview with the Director of Nursing (DON) on 4/26/2024 at 9:45 a.m., she explained the nursing staff were to assess skin tears, apply a dressing and notify Treatment Nurse #1 by recording the skin tear or wound in the treatment communication binder at the nurse's station. She stated Treatment Nurse #1 was to assess the skin tear or wound and initiate wound care as indicated. After reviewing Resident #118's electric medical record, the DON stated she was unable to locate nursing documentation of the weekly assessments (appearance and measurements) of Resident #118's right lower leg skin tear wound by Treatment Nurse #1. She stated there was not a physician order for wound care written until 4/9/2024, and wound care had been documented as provided since 4/9/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a follow up interview with the Director of Nursing on 4/26/2024 at 5:10 p.m., she recalled discussing Resident #118's use of antibiotics in clinical morning meetings for a comprised skin condition and explained Treatment Nurse #1 missed managing Resident #118's skin tear wound because Nurse #2 did not report the skin injury on the treatment communication book for Treatment Nurse #1, and the skin injury was not visual to the staff due to Nurse #1 applying a dressing. She stated nursing staff were to report changes in skin conditions to Treatment Nurse #1 by using the treatment communication book and not verbally communicating the changes because Treatment Nurse #1 could forget about the skin change. She explained based on the facility's plan of correction for wound management Treatment Nurse #1 was monitoring the treatment communication book at the nurse stations for reported changes in residents' skin daily and the shower sheets were checked daily for any new skin conditions observed on residents. The Director of Nursing stated she had not conducted any wound care monitoring to ensure a resident's wound care was initiated and/or conducted as ordered. In a phone interview with Physician #1 on 4/26/2024 at 9:31 a.m., he explained the effects of not assessing and implementing wound care to a skin tear would depend on the appearance of the skin tear wound and said he could not say that Resident #118 not receiving wound care to the right lower leg skin tear caused the skin tear to become infected. He stated when Resident #118's right lower leg was reported infected, she was started on antibiotics. He explained the Treatment Nurse #1 should had assessed Resident #118's open wound initially to implement wound care and continued to assess and document the appearance of Resident #118's right lower leg that would have shown the progression of healing or signs of infection.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43332 Based on record review, staff interviews, and a physician interview, the facility failed to schedule an appointment for a urology consult as ordered by the physician for 1 of 1 resident (Resident #17) reviewed for medically related social services. Finding included: Resident #17 was initially admitted to the facility on [DATE] and his latest admitted was 1/22/2024. Resident #17 had diagnoses that included obstructive uropathy. Review of Resident #17's physician's orders showed an order dated 1/23/24 read follow up with urology. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was moderately cognitively impaired, and he had an indwelling catheter. Review of Resident #17's electronic medical record revealed no evidence of a urology appointment after 1/23/2024. An interview conducted on 4/24/24 at 3:19 P.M. with Medical Records Coordinator revealed she was responsible for scheduling appointments for Resident #17. She stated she was made aware residents needed to be scheduled for outside the facility appointments during clinical meetings and when she reviewed physician orders. Medical Records Coordinator stated she scheduled several appointments for Resident #17 and the follow up with urology was overlooked. An interview was conducted on 4/24/24 at 3:38 P.M. with the Director of Nursing (DON) who stated she was unaware Resident #17's appointment had not been scheduled and she explained the appointment should have been scheduled when the physician placed the order. The DON stated when a resident returned to the facility, all follow up appointments for the resident were discussed in the morning clinical meeting. During the interview, the DON stated the Medical Records Coordinator attended the meetings and further explained the follow up appointment information was written down in a book and available to the Medical Records Coordinator if she hadn't attended the meeting. The DON stated she felt as though the appointment for the urologist was overlooked and that's why it hadn't been scheduled. An interview was conducted on 4/26/24 at 10:45 A.M. with the Administrator who stated he expected Resident #17's urology appointment to be scheduled when the order was placed in January 2024. The Administrator stated the appointment was not scheduled because of an oversite. An interview was conducted on 4/26/24 at 9:26 A.M. with the Physician who stated the appointment should have been scheduled when the order was entered for Resident #17 to see the urologist. The Physician stated Resident #17's urology appointment was for evaluation of an enlarged prostate. The Physician further stated the urology appointment wasn't for an imminent problem and the appointment not being scheduled until April did not cause any harm to Resident #17.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50234 Based on a lunch meal tray line observation, staff interviews and record review the facility failed to: 1) ensure there was a pre-approved renal diet menu for 8 of 8 residents on a renal diet; 2) follow the approved pureed diet menu and serve pureed bread to 7 of 7 residents on a pureed diet; 3) serve residents on a mechanical soft diet the correct amount of meat. A 3-ounce scoop of ground meat was served instead of 4 ounces as per the menu; and serve residents the correct portion of potatoes. The facility served only 3 ounces of diced potatoes instead of 4 ounces as per the menu to 106 of 121 residents who ate a regular or mechanical soft diet. The findings included: 1. Continuous observation on 4/24/24 from 11:00 AM - 12:35 PM of lunch service revealed Cook #1 served residents on a renal diet meatloaf without providing a ketchup packet, black eyed peas, and mixed vegetables. In an interview on 4/24/24 at 12:36 PM, Cook #1 confirmed residents on a renal diet received meatloaf without providing a ketchup packet, black eyed peas, and mixed vegetables. Review of the facility's pre-approved Spring/Summer 2024 menu revealed there was no pre-approved diet for residents on a renal diet. Review of the facility Diet Order Roster dated 4/22/24 revealed there were 8 residents on a renal diet. Review of daily renal diet menu for 4/24/24 revealed residents were to receive meatloaf with no tomato sauce, buttered noodles, and vegetable blend. In an interview on 4/26/24 at 1:25 PM with the Certified Dietary Manager (CDM), she said the facility did not have a pre-approved menu for renal diets. She said the corporation changed food suppliers, and the new food supplier did not provide renal diet menus. The CDM said she and the cooks use their experience in choosing what to serve the residents. The CDM also said they had handouts about what foods were appropriate for renal diets. Review of Foods To Avoid For Renal Diets posting (undated), residents on a renal diet were to not eat dried beans or peas at all due to the amount of phosphorus in the beans. In an interview on 4/27/24 at 4:53 PM, the Registered Dietitian (RD) confirmed the facility did not have a pre-approved renal diet menu. The RD acknowledged black eyed peas could be problematic for renal diet residents due to the level of phosphorus but that she would have to do additional research. 2. Review of the facility's pre-approved Spring/Summer 2024 menu revealed residents on a pureed diet were to receive pureed bread, pureed meatloaf, mashed potatoes, and pureed tomatoes and okra. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continuous observation on 4/26/24 from 11:00 AM - 12:25 PM of lunch service revealed Cook #1 served residents a pureed meal. The pureed meal served was pureed meat, mashed potatoes, and pureed okra. In an interview on 4/26/24 at 12:36 PM, Cook #1 said she did not prepare or serve any pureed bread that meal. She said she did not add any bread to any of the pureed food items. She said she normally made the bread but that it was just missed that day. In an interview on 4/27/24 at 4:53 PM, the RD stated the residents on a pureed diet needed the pureed bread served per the menu to consume the calculated number of calories. 3. Review of the facility's pre-approved Spring/Summer 2024 menu revealed residents on a mechanical soft diet were to receive 4 ounces (one #8 scoop) of ground meatloaf. Continuous observation on 4/26/24 from 11:00 AM - 12:35 PM of lunch service revealed Cook #1 served residents on a mechanical soft diet 3 ounces (one #12 scoop) of meatloaf. In an interview on 4/26/24 at 12:36 PM, Cook #1 said she served one scoop of a #12 scoop of ground meat to residents on a standard mechanical soft diet. In an interview on 4/27/24 at 4:53 PM, the RD stated the residents on a mechanical diet needed the correct serving sized served per the menu to consume the calculated number of calories and protein. 4. Review of the facility's pre-approved Spring/Summer 2024 menu revealed residents on a regular and mechanical soft diet were to receive 4 ounces (one #8 scoop) of diced potatoes. Continuous observation on 4/26/24 from 11:00 AM - 1:15 PM of lunch service revealed Cook #1 served residents on a regular and residents on a mechanical soft diet 3 ounces (one #12 scoop) of diced potatoes. In an interview on 4/26/24 at 1:15 PM, Cook #1 said she served one scoop of a #12 scoop of potatoes to residents on a standard regular and mechanical soft diet. In an interview on 4/27/24 at 4:53 PM, the RD stated the residents needed the correct serving size served per the menu to consume the calculated number of calories.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50234 Based on observation and staff interviews, the facility failed to prevent ice build-up on boxes of frozen food stored for use in 1 of 1 walk-in freezer. This practice had the potential to affect frozen foods served to residents. The findings were: During an initial tour of the facility kitchen on 4/22/24 at 9:41 AM, it was observed that the pipe from the condenser was insulated and had two large icicles and 3 small icicles attached to it. The largest icicle was attached to a box underneath labeled [NAME] Sweet Peas. Another box of [NAME] Sweet Peas was in front of the other. On the top of the first box, the box flaps were open approximately 2 inches. There were icicles coming from the freezer condenser unit pipe above and reaching the top of the box. There was a large section of ice covering approximately 75% of the boxes top and into the box through the open lid. On the second box of green sweet peas, approximately 25% of the box top was covered in ice. The second box top was open approximately half an inch and the ice was collected below the top of the box. In an observation on 4/24/24 at 1:25 PM with the Certified Dietary Manager (CDM) and Cook #2, the boxes with ice were examined. There were four boxes in total with ice on them. Cook #1 opened the first box of green sweet peas and the peas were in a large storage bag. The bag was not sealed but the top of the bag was folded over on itself. There was ice on top of the folded section of the bag. The second bag of peas was sealed by the manufacturer. There was a box of frozen corn with ice on top of approximately 50% of the top. The flaps of the box top were open approximately 1 inch and there was ice going through the flaps of the top. Cook #2 opened the box and there was ice buildup on the storage bag. The bag was not sealed and the top of the bag was folded over on itself. The third box was labeled asparagus. The asparagus box was stuck with ice onto another box (unable to see label). In an interview on 4/24/24 at 1:35 PM, the CDM said she was not aware of the ice formations on the box or the icicles in the freezer and that she would alert maintenance. Cook #2 said the ice had been there for awhile but she did not know for how long. The CDM confirmed that the leaking pipe and ice in the boxes of vegetables could contaminate the food and had Cook #2 throw out the 4 boxes of food. In an interview on 4/28/24 at 7:00 PM, the Administrator confirmed the boxes should not have the ice on them. The Administrator called the Maintenance Director on his speaker phone. The Maintenance Director said he was not aware of the freezer pipe leaking ice. He said he did checks on the freezer monthly but did not report when he did the last check.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on observation, staff interviews, and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee following the recertification and complaint investigation surveys of [DATE] and [DATE]. This was for four deficiencies that were recited on the current recertification and complaint investigation survey of [DATE] in the areas of Freedom from Abuse and Neglect (F600), Quality of Care (F684), Provision of Medically Related Social Services (F745), and Food and Nutrition Service (F812). The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F600: Based on record review, observation, resident interviews, and staff interviews, the facility failed to protect a resident's right to be free from physical abuse when a resident (Resident #8) was punched in the face multiple times with a closed fist by a resident who resided in the Assisted Living Facility (ALF) on the same campus. On the evening of [DATE] while in facility's courtyard, Resident #8 and the ALF resident engaged in a verbal disagreement that escalated into a resident-to-resident physical altercation that resulted in Resident #8 sustaining a small laceration to the left upper eye lid. This deficient practice was for 1 of 3 residents reviewed for physical abuse. During the recertification and complaint survey of [DATE], the facility was cited for failure to protect a severely cognitively impaired resident from injury of unknown origin. F684: Based on record review, observations, Responsible Party interview, staff interviews, and a Physician interview, the facility failed to provide wound management to a skin tear that was recorded occurring initially on [DATE] and reoccurring on [DATE] for a resident. The resident's skin tear was reported infected on [DATE] and was treated with antibiotics. There were no treatments for wound care ordered until [DATE], and there were no weekly wound assessments (appearance and measurements of the wound) documented on the skin tear as of [DATE] in the resident's medical record. This deficient practice occurred for 1 of 3 residents reviewed for skin conditions (Resident #118). During the recertification and complaint survey of [DATE], the facility was cited for failure to recheck a low blood pressure of ,d+[DATE] complete and document an admission assessment and vital sign data and failed to assess a resident after a fall before assisting back to bed. During the recertification and complaint survey of [DATE], the facility was cited for failure to have a nurse assess a severely cognitively impaired resident from an injury of unknown origin. F745: Based on record review, staff interviews, and a physician interview, the facility failed to schedule an appointment for a urology consult as ordered by the physician for 1 of 1 resident (Resident #17) reviewed for medically related social services. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the recertification and complaint survey of [DATE], the facility was cited for failure to ensure a resident's medical appointment was rescheduled. F812 Based on observation and staff interviews, the facility failed to prevent ice build-up on boxes of frozen food stored for use in 1 of 1 walk-in freezer. This practice had the potential to affect frozen foods served to residents. During the recertification and complaint survey of [DATE], the facility was cited for failure to label, date and close open food items stored in the kitchen refrigerator and freezer. During the recertification and complaint survey of [DATE], the facility was cited for failure to label, date, and/or remove expired food items stored in nourishment rooms. In an interview on [DATE] at 06:30 PM, the Administrator said the QAA Committee monitored issues that were cited on previous surveys. However, he believed the issues with the freezer were more related to an equipment failure, which had not been cited before. He reported the QAA Committee had implemented and monitored for the cleanliness of the kitchen.