STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		7/6/18

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

Electronically Signed | 07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and record review the facility failed to treat a resident with respect and dignity by telling a resident to go to the bathroom in their brief rather than assisting them to the toilet for 1 of 1 sampled residents (Resident #284). Findings included: Record review revealed that Resident #284 was admitted to the facility on 06/14/18 with diagnoses that included acute and chronic respiratory failure, muscle weakness, and difficulty walking. The admission plan of care dated 06/14/18 for Resident #284 documented that she required the assistance of two staff members for toileting and that she was continent of bowel and bladder. Review of the resident's admission assessment dated 06/14/18 documented that Resident #284 was alert and oriented, independent in decision making, had clear speech, was able to understand and was always understood by others. In an interview conducted with Resident #284 on 06/18/18 at 12:47 PM she stated that she was told by Nurse Aide #1 on 06/16/18 to "go to the bathroom in her brief and she would clean her up later because there wasn't enough staff on duty to take her to the bathroom." She reported that she had been able to wait until another staff member was able to help Nurse Aide #1 assist her to the bathroom. She said she had not had to wet in	F 550	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause The facility failed to treat a resident with respect and dignity by telling Resident #284 to go to the bathroom in their brief rather than assisting them to the toilet. Immediate Action On 06/16/2018, Resident #284 was assisted to the restroom by two nurse aides. On 06/18/2018, Director of Nursing counseled Nurse Aide #1 regarding the complaint. Identification of Others On 07/05/2018, the Director of Nursing completed an audit of all alert and oriented residents to determine if residents were being toileted appropriately and treated with dignity and respect. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 550	Continued From page 2 her brief but that it had hurt her feelings. She commented that she didn't feel it was right for a person to be told to wet on herself. The resident's roommate, Resident #287, was present during the interview on 06/18/18 at 12:47 PM. She stated that she had witnessed Nurse Aide #1 tell Resident #284 to wet herself and be cleaned up later. She reported that she thought it was "terrible". In an interview conducted with Nurse Aide #1 on 06/20/18 at 3:20 PM she stated that she made rounds every two hours during her shift. She said she was able to answer call bells within a minute unless she was in another room in which case she would answer the bell as soon as she was able. She said that she had been assigned part of the 100 hall on 06/16/18. She stated that she had felt overwhelmed during her shift because she was not familiar with the residents and was trying to meet their needs. She reported that she had never told any resident to wet on themselves. In an interview conducted with the Director of Nursing on 06/20/18 at 4:00 PM she stated that she investigated the concern filed by Resident #284. She reported that she had suspended Nurse Aide #1 on Sunday, 06/17/18, pending her investigation that was conducted on 06/18/18. She reported that she explained to Nurse Aide #1 the importance of customer service. She commented that she did not expect a staff member to tell a resident to wet him or herself ever and that it was not acceptable behavior. She said that both Resident #284 and Resident #287 were interviewable and reliable historians.	F 550	audit revealed that no other residents had issues with being toileted appropriately and being treated with dignity and respect. Systematic Changes On 07/05/2018, Administrator and Assistant Director of Nursing re-education all staff on resident rights, respect and dignity, as well as appropriate toileting. Those who have not completed the in-service will not be allowed to work until they have completed it. Effective 07/05/2018, Respect and Dignity in-service will be added to facilities orientation process and will be provided annually. Monitoring Process Effective 07/05/2018, Director of Nursing and/or Assistant Director of Nursing will conduct random audits of 10 call lights for toileting needs to determine if resident were toileted appropriately and treated with dignity and respect. The audit will be completed daily (Monday – Friday) for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. The audit will be reviewed and documented in clinical stand up meeting. Effective 07/05/2018, Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 550	Continued From page 3	F 550	any additional monitoring or modification of this plan monthly x3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party Effective 07/05/2018, the Executive Director, Director of Nursing, and Assistant Director of Nursing will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 07/06/2018	
F 641 SS=D	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 staff interviews and record review the facility failed to accurately document the correct discharge date, discharge destination and end date for most recent Medicare stay for 1 of 3 residents whose closed records were reviewed, (Resident #84). Findings included: Record review revealed that Resident #84 had been admitted to the facility on 11/06/17 and discharged on 03/30/18. Diagnoses included	F 641	Root Cause MDS Nurse #1 and the facility Executive Director discussed with the Consultant from the contracted facility management and consulting company on 6/20/2018 to identify the root cause of this alleged noncompliance. The root cause analysis concluded that, Minimum Data Set nurse #1 failed to verify and code the correct discharge date, discharge destination, and end date for most recent Medicare stay for resident #84 in Section A. MDS	7/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 641	Continued From page 4 pneumonia, bacteremia, and fracture of the upper end of the left humerus (arm). Review of the Minimum Data Set (MDS) Discharge assessment dated 03/31/18 documented in Section A: Line A2000-a discharge date of 03/31/18; Line A2100-a discharge status of acute hospital; and Line A2400C-an end date of most recent Medicare stay as ongoing. Review of a general nursing note for Resident #84 dated 03/30/18 documented, "Resident discharged from facility at 11:30 AM with family in personal vehicle." Review of a physician progress note dated 03/30/18 documented that Resident #84 was discharged to home on 03/30/18 to live with her sister. Home health was in place. In an interview with Nurse #4 on 06/19/18 at 3:35 PM she stated that the MDS Discharge Assessment dated 03/31/18 had been coded incorrectly. She said the correct discharge date for Resident #84 was 03/30/18 and that the resident went home with family. She said the resident did not go to the hospital as documented in the assessment. She also stated that Line A2400C had been coded incorrectly as "ongoing" when the end date for her most recent Medicare stay had been 12/27/17. In an interview with the Administrator on 06/19/18 at 3:45 PM he stated that the correct discharge date for the resident according to records was 03/30/18. He reported that the resident went home with her family. He said that he expected the MDS assessments to be coded correctly	F 641	Nurse #1 stated that it is was an honest mistake and it was coded incorrectly by accident. Immediate Action The MDS assessment for resident #84 ARD 03/31/2018 was modified on 06/19/2018 to reflect that the resident discharged home and not to the hospital. The assessment was transmitted on 06/19/2018. Identification of Others A 100% audit of residents whom had discharged in the last 30 days was completed on 06/19/2018 by MDS Nurse #1 and Regional Clinical Nurse Consultant to determine if any other residents had incorrect discharge information coded in Section A. The results indicated that no other residents with discharge assessments in the last 30 days had information coded incorrectly in Section A of the MDS 3.0. Findings of this audit tool can be located in the facility compliance binder. Systematic Changes Effective 07/01/2018, residents who require a discharge assessment will have correct discharge information coded in Section A per RAI guidelines utilizing the MDS 3.0 data collection tool. On 06/29/2018, Regional Clinical Nurse Consultant conducted re-education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 641	Continued From page 5 according to the actual events that had occurred.	F 641	regarding correct coding specifically in Section A of the MDS 3.0 for MDS #1, MDS #2, Social Worker, Activities, and Dietary Manager. Any staff members not educated will not be allowed to work until they have been. Monitoring Process Effective 07/02/2018, prior to submission, MDS nurse #1 and MDS Nurse #2 will review section A of MDS 3.0 completed by MDS nurse #2 and (vice versa) to ensure that residents needing a discharge assessment have accurate information coded. These reviews will take place daily (Monday-Friday) for 2 weeks, then weekly for 2 weeks, then monthly for 3 months. Any inaccurate coding identified will be noted and promptly corrected prior to submission by MDS Nurse #1 or #2. Findings of this monitoring process will be documented on the MDS accuracy monitoring tool located in the facility compliance binder. Effective 06/29/2018, MDS nurse #1 or #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 641	Continued From page 6	F 641	Effective 06/29/2018, the Executive Director, Director of Nursing, and MDS nurse #1 and #2 will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 07/06/2018	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide a nutritional supplement ordered by the physician to promote wound healing for 1 of 2 residents (Resident #40) with pressure ulcers. Findings included: Record review revealed Resident #40 was admitted to the facility on 12/20/17. The resident's documented diagnoses included pressure ulcers, anemia, hypertension,	F 686	Root Cause The facility failed to provide a nutritional supplement ordered by the physician to promote wound healing for Resident #40. Nursing failed to provide a communication slip to the dietary department to indicate new order for nutritional supplement, dietary was unable to update tray card system.	7/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 686	Continued From page 7 hyperlipidemia, and dementia with behavioral disturbances. 12/20/17 Wound Assessment Reports documented Resident #40 was admitted to the facility with pressure ulcers to his sacrum/buttocks and right heel. 12/26/17 lab results documented Resident #40's albumin level was compromised at 3.1 grams per deciliter (g/dL) with normal being 3.6 - 5.1 g/dL. A 01/18/18 physician order documented, "Provide frozen nutritional teats with all meals to aid with halting weight loss and wound healing." A 01/22/18 physician order documented, "Large meat portions due to weight loss" (which would also provide protein for wound healing). Record review revealed Resident #40 was admitted to hospice on 01/29/18. Resident #40's care plan, last reviewed and updated on 02/06/18, identified, "I have a stage 4 pressure ulcer to sacrum" as a problem. Interventions to this problem included, "Offer me supplemental nutritional support as ordered by MD (physician), Encourage my good nutritional intake for healing, I need a referral to a dietitian to evaluate nutritional status, and Obtain my albumin level to evaluate protein." Resident #40's 05/04/18 quarterly minimum data set (MDS) documented the resident had short and long term memory impairment, the resident's decision making skills were severely impaired, the resident exhibited no behaviors including rejection of care, the resident required limited	F 686	Immediate Action On 06/20/2018 at 12:25 PM, Resident #40 received physician ordered nutritional supplement. A new dietary slip was completed and then updated in the tray card system. Identification of Others On 07/05/2018, Certified Dietary Manager and Unit Coordinator completed a 100% audit of all residents receiving physician ordered nutritional supplements to ensure that the physician orders matched the tray card system. The audit revealed that all other residents with physician ordered supplements were receiving them as ordered. Systematic Changes Effective 07/05/2018, Dietary Manager and/or Assistant Dietary Manager will bring all dietary recommendations to clinical meeting (Monday-Friday) to ensure that nursing has received and entered it appropriately into the electronic health record so then Dietary Manager can update new recommendation into tray card system. Effective 07/05/2018, the nursing department will complete a dietary communication slip when they receive dietary recommendations and hand deliver it to the dietary staff to ensure that tray card system can be updated. On 07/05/2018, Administrator and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 686	Continued From page 8 assistance from a staff member with eating, the resident's weight was stable, the resident was on a mechanically altered diet, and the resident had one stage II and one stage IV pressure ulcer. A 05/15/18 12:08 PM progress note documented, "Writer rendered (treatment) to resident. Areas to right outer heel and sacrum increase in size noted. New area observed to top of left foot...soft eschar 2.5 cm (centimeters) x 1 cm (90% eschar and 10% granulation tissue)." A 06/08/18 physician order started Keflex (antibiotic) 500 (milligrams three times daily) x 10 days for Resident #40's right heel wound A 06/13/18 Registered Dietitian (RD) Note documented, "Resident receives (treatment) to (unstageable) to left upper foot with positive healing noted per skin assessment. (Unstageable) to (right) heel, stage 4 to sacrum, and (skin tear) to outer thigh. Receives a non-therapeutic diet with pureed textures and HTL (honey thick liquids). Frozen Nutritional Treats added to all meals to aid with meeting nutritional needs. Large portions of meats added to all meals to aid with wound healing. PO intake (intake by mouth) appears to e good at 75 - 100% of meals...No new labs or weights as resident continues with hospice services. Honor preferences when able and encourage po intake." During an observation on 06/20/18 at 8:28 AM Resident #40 was eating his breakfast in the restorative dining room, he ate 100% of his breakfast, but received no Nutritional Treat. Large protein portions were documented on the resident's tray slip, and were present on the resident's plate. However, there was no	F 686	Director of Nursing re-educated nursing staff and dietary staff on proper procedure regarding communication of new dietary recommendations/orders. Those who have not completed the in-service will not be allowed to work until they have completed it. Monitoring Process Effective 07/05/2018, Dietary Manager and/or Assistant Dietary Manager will bring and review all dietary recommendations to the clinical meeting to ensure that the dietary department has received a dietary communication slip to update new recommendation into tray card system daily (Monday-Friday) for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. The recommendations will be kept in the Dietary Recommendations Binder. Effective 07/05/2018, Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party Effective 07/05/2018, the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 686	Continued From page 9 documentation on the tray slip that the resident was to receive a Nutritional Treat with meals. During an observation on 06/20/18 at 11:50 AM a restorative aide placed Resident #40's tray in front of him. He was eating lunch in the restorative dining room with a family member present. The resident finished eating his lunch at 12:18 PM, ate 100%, but received no Nutritional Treat. He received a large meat portions which was documented on his tray slip. His family member stated the resident liked ice cream and dairy products. She brought the resident Greek yogurt, and he ate 100% of this during the 06/20/18 lunch meal. There was no documentation on his lunch tray slip that the resident was to receive Nutritional Treats at meals. On 06/20/18 at 12:22 PM Nurse #1, who was assigned to care for Resident #40 on 06/20/18 first shift, stated the resident resided on one hall, but went to another hall for restorative dining. She reported she did not visualize the resident receive a frozen nutritional treat today at breakfast or lunch. She explained when a nurse received a physician order for a nutritional supplement, the nurse was responsible for placing the order into the electronic medical record system which caused the order to appear on the medication administration record (MAR). She added that the receiving nurse then completed a Diet Order Form, a triplicate form used to relay the order to other disciplines in the facility. She reported the white copy went in the hard chart, the yellow copy went to the dietary department, and the pink copy went to the pharmacy.	F 686	Director, Director of Nursing, and Assistant Director of Nursing will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 07/06/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 686	Continued From page 10	F 686		

On 06/20/18 at 2:28 PM the facility's RD stated she was asked to reassess Resident #40 on 06/13/18 because he had a new pressure ulcer. She reported the resident had not been weighed regularly due to his hospice status, but she wanted a current weight to help determine if she should make any new nutrition recommendations. She commented the resident's weight was actually up from his admission weight of 174 pounds on 01/03/18 so she was not so much concerned about weight loss, but instead making sure that the resident was getting adequate protein to promote wound healing. According to the RD, the resident had a low albumin level back in January 2018. She commented the resident had a new pressure ulcer so the 300 calories and 9 grams of protein provided by each Nutritional Treat would definitely promote a healthy diet and protein intake conducive to wound healing. She stated the direct care staff had informed her that the resident's intake was close to 100% at most meals. The RD reported that once the nurse entered the supplement order in the electronic medical record system, it should print out on the MAR, and the nurse should catch that the resident was not getting the nutritional treat when she went to initial off its administration on the MAR.

On 06/20/18 at 2:39 PM the Dietary Manager (DM) stated the nurse who took the physician order for nutritional supplements completed a Diet Order Form with the white copy going in the hard chart and the yellow copy going to dietary. She reported that she or her assistant entered nutritional supplements or diet order changes into the tray tracker system from these yellow copies. She commented in auditing their yellow copies of diet orders for Resident #40 they found no yellow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 686	Continued From page 11 copy of one documenting the resident was to be receiving Nutritional Teats at meals. According to the DM, direct care staff could add the Nutritional Treat to meal trays, but they would not know about this nutritional supplement unless it was printed on the tray slips that were provided at meals. The DM reported Resident #40 would have received a Nutritional Treat anytime the dessert for the meal was ice cream since he was on honey thick liquids. However, she commented he would not be receiving the Nutritional Treat from direct care staff every meal every day unless documented on the tray slips. On 6/20/18 at 2:43 PM the Treatment Nurse stated Resident #40's sacral pressure ulcer was healing, but it was a slow process. She reported she was pleasantly surprised about the healing due to the amount of time the resident was out of bed per family request. She commented the resident received a nutritional snack which she felt helped with wound healing. On 06/21/18 at 11:12 AM the Director of Nursing (DON) stated if a resident was ordered a nutritional supplement/snack to promote wound healing she expected the resident to receive the product.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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	F 842		7/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 842	Continued From page 12 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 842	Continued From page 13 (i) The period of time required by State law; or (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(i)(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 observation, staff interview, and record review the facility failed to accurately document the administration status of a nutritional supplement for 1 of 2 residents (Resident #40) with pressure ulcers. Findings included: Record review revealed Resident #40 was admitted to the facility on 12/20/17. The resident's documented diagnoses included pressure ulcers, anemia, hypertension, hyperlipidemia, and dementia with behavioral disturbances. 12/20/17 Wound Assessment Reports documented Resident #40 was admitted to the facility with pressure ulcers to his sacrum/buttocks and right heel. A 01/18/18 physician order documented, "Provide	F 842	Root Cause The facility failed to accurately document the administration status of a nutritional supplement for Resident #40. Nurse #1 failed to ensure that Resident #40 received a nutritional supplement and inaccurately documented in the electronic medical record. Immediate Action On 06/20/2018 at 12:30 PM, Registered Nurse visualized that Resident #40 received the physician ordered nutritional treat and correctly entered it into the facility electronic health record. Identification of Others On 07/02/2018, Director of Nursing and Assistant Director of Nursing completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 842	Continued From page 14 frozen nutritional teats with all meals to aid with halting weight loss and wound healing." A 01/22/18 physician order documented, "Large meat portions due to weight loss" (which would also provide protein for wound healing). A 05/15/18 12:08 PM progress note documented, "Writer rendered (treatment) to resident. Areas to right outer heel and sacrum increase in size noted. New area observed to top of left foot...soft eschar 2.5 cm (centimeters) x 1 cm (90% eschar and 10% granulation tissue)." During an observation on 06/20/18 at 8:28 AM Resident #40 was eating his breakfast in the restorative dining room, he ate 100% of his breakfast, but received no Nutritional Treat. During an observation on 06/20/18 at 11:50 AM a restorative aide placed Resident #40's tray in front of him. He was eating lunch in the restorative dining room with a family member present. The resident finished eating his lunch at 12:18 PM, ate 100%, but received no Nutritional Treat. Review of Resident #40's medication administration record (MAR) revealed Nurse #1 documented Resident #40 received a Nutritional Treat at both breakfast and lunch on 06/20/18. On 06/20/18 at 12:22 PM Nurse #1, who was assigned to care for Resident #40 on 06/20/18 first shift, stated the resident resided on one hall, but went to the restorative dining room on another hall for meals. She reported she did not visualize the resident receive a frozen Nutritional Treat at his 06/20/18 breakfast or lunch. She commented	F 842	an 100% audit of all residents receiving a physician ordered nutritional treat, to ensure that the licensed nurse had correctly documented in the facility electronic health record that the resident received them. Findings of the audit revealed that all other nurses had documented correctly that residents had received the nutritional treats. Systematic Changes On 07/05/2018, Director of Nursing and/or Assistant Director of Nursing re-educated all licensed nursing staff on the facilities accuracy documentation policy and procedure. Those who have not completed the inservice will not be allowed to work until they have completed it. Effective 07/05/2018, all physician ordered nutritional supplements will be not be given with meals and be ordered for in-between meals. Monitoring Process Effective 07/05/2018, Director of Nursing and/or Assistant Director of Nursing will audit all residents receiving physician ordered nutritional supplements daily (Monday-Friday) X 2 weeks, then weekly x 2 weeks, then monthly x 3 months or until a pattern of compliance is maintained, to ensure the residents received the physician ordered nutritional supplement and that the licensed nurse correctly entered the receipt of the nutritional supplement. The audit will be completed on the nutritional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 842	Continued From page 15 she should not have initialed off on the MAR that the resident received the supplement on 06/20/18 because she did not visualize it herself on his meal trays. She commented she should not have relied on other staff to confirm the resident's receipt of the Nutritional Treats. On 06/21/18 at 11:12 AM the Director of Nursing (DON) stated nutritional supplements printed out on the MAR, even if they were actually provided by dietary, and they were to be initialed off by nursing when they were received by residents. However, she reported nurses should not initial supplements off on the MAR until they had personally visualized their receipt on meal trays.	F 842	supplement/EMAR sign off audit form and kept in the facility compliance binder. Any negative findings identified will be corrected promptly. Effective 07/05/2018, Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party Effective 07/05/2018, the Executive Director, Director of Nursing, and Assistant Director of Nursing will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date:07/06/2018	