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 _____	C 02/04/2023

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

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F 000	INITIAL COMMENTS An unannounced follow-up survey and complaint investigation was conducted from 02/01/23 through 02/04/23. Event ID# AFPH11. The following intakes were investigated NC00196625 and NC00196622. 2 of the 5 complaint allegations resulted in defiicency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		3/1/23

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

Electronically Signed | 02/24/2023

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F 584	Continued From page 1 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and Plumber interviews the facility failed to maintain hot water temperatures in 1 of 2 shower rooms (300-hall shower room #1) reviewed for safe, clean, comfortable, homelike environment. The findings included: An observation of the 500-hall shower room was completed on 02/01/23 at 1:30 P.M. with the Maintenance Director. The shower water temperature was 105 degrees Fahrenheit when he began to monitor the water and dropped to 100 degrees F after 3 minutes of continuous hot water monitoring. An interview with the Maintenance Director occurred on 02/01/23 at 1:35 P.M. The Maintenance Director stated that the hot water temperature in the facility should be between 100 degrees F and 116 degrees F to prevent burning the residents. He further stated that the Nurse Assistants were not able to give back-to-back showers all day because the water temperatures would drop. He indicated that when a nurse	F 584	1. No resident was named in this alleged deficient practice. A certified plumber was engaged to assess the facility boiler on 2/1/23. The report confirmed that water exiting the boiler room and water returning after circulating the facility was found to be in compliance with water temperature regulations. He also confirmed, point monitoring of water temperatures at faucets and whirlpool tubs were, to be in compliance with temperature regulations. Point testing at showerheads revealed that water temperature fluctuated below acceptable levels. The issue with the water temperature was traced to the showerheads on 2/3/23. Replacement shower cores were obtained and installed on 2/6/23. 2. All residents had the potential to be affected by, this alleged deficient practice. 3. All 3 of the facility shower cores were replaced on 2/6/23, by Maintenance Director to ensure water temperatures in showers remain with guidelines.	

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F 584	Continued From page 2 assistant or resident complained of the water being cold in the showers that he or the Assistant Director of Maintenance would adjust the temperature at the boiler. The Maintenance Director stated that the facility had been monitoring the hot water temperatures since December when a resident's family member had filed complaints with the Health Department, Social Services, and the State. He further stated that the Health Department had followed up on the complaint on 12/30/22 and the temperature on the 100 hallway registered 105 degrees F. The Maintenance Director indicated that the Health Department had not tested the hot water temperatures in the shower rooms. An interview occurred with the Administrator, Maintenance Director, and the Director of Nursing (DON) on 02/01/23 at 1:45 P.M. The Administrator stated that the facility was going to call a plumber to come check the hot water temperature. A telephone interview was conducted with the Plumber on 02/03/23 at 08:48 A.M. The Plumber stated that he had checked the hot water temperatures outside at the boiler on 02/02/23. He further stated the hot water temperature was recorded at 130 degrees F leaving the boiler and the water was 105 degrees F on the return. He further stated that he was not aware the water temperatures were dropping in the showers. The Plumber indicated that there could be several different reasons inside the building that could be causing the water temperatures to drop in the shower. He stated that he would need to come back to the facility and check the hot water temperatures in the shower rooms and run more tests to determine the cause of the problem.	F 584	4. Maintenance Staff was educated by the facility Administrator on acceptable water temperature levels for resident care areas per regulations The Maintenance Director/ designee will audit water temperature from showerheads 5 times per week for 2 weeks then 3 times per week for 2 weeks, then monthly for 2 months to ensure proper water temperatures are present at showerheads. Administrator will complete a summary of the audit results and present at the facility monthly QAPI meeting, to ensure continued compliance.	

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F 584	Continued From page 3 An observation of the 300-hall shower room was completed on 02/03/23 at 12:25 P.M. with the Maintenance Director. The shower hot water temperature was 106 degrees F when he began to monitor the water and dropped to 96.6 degrees after 9 minutes of continuous hot water monitoring. An interview with the Maintenance Director was completed on 02/03/23 at 12:35 P.M. The Maintenance Director stated that the water temperature should not be below 100 degrees for showers. He further stated that prior to December 2022 the facility had never had an issue with hot water temperatures. An interview was conducted with the Administrator and the Director of Nursing and the Regional Clinical Consultant on 02/03/23 at 2:15 P.M. The Administrator stated that he expected the shower hot water temperatures to be between 100 degrees F and 116 degrees F. He further stated that a plumber was going to come and fix the hot water in the shower rooms on 02/06/23.	F 584		
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 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		3/1/23

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F 842	Continued From page 4	F 842		

§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-
(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

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F 842	Continued From page 5 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 record review and Responsible Party, and staff interviews the facility failed to maintain an accurate medical record that included an unwitnessed fall for 1 of 1 resident (Resident #3) reviewed for resident records, identifiable information. The findings included: Resident #3 was admitted to the facility on 10/27/22. Review of Resident #3's electronic medical record (EMR) did not reveal any notes or nursing assessment from Resident #3's fall on 01/03/23. An interview was conducted with the Director of Nursing (DON) on 02/03/23 at 12:30 P.M. The DON stated that he was made aware on 01/04/23 during morning rounds with the nurses, that Resident #3 was found on the floor the night before. The DON further stated that he had asked Nurse #1 on the phone on 01/04/23 to document	F 842	1. Resident #3 is no longer a resident at the facility as of 1/8/2023. 2. On 2/20/23, The Director of Nursing and Unit Manager completed a review of the medical records & incident reports of current residents to determine if there were any other residents who had a fall that did not have follow up, including notification of the resident family. No other residents were identified. 3. On 2/17/23, the Director of Nursing and Administrative Nurses began education with the licensed nurses on documentation of falls and completing an incident report with each fall via in person or by phone. Any nurse who has not been educated by 3/1/23 will not be allowed to work until they have been educated on the required falls documentation. This education will be included in the clinical orientation process for new nurses. Director of Nursing or designee will complete clinical orientation process.	

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F 842	Continued From page 6 a note in the chart about the fall and to fill out an incident report when she returned to work. The DON indicated that when he was reviewing Resident #3's chart on 01/09/23 that he noted that Nurse #1 had not documented in the nurses' notes or completed an incident report regarding Resident #3 being found on the floor on 01/03/23. The DON stated that he had again asked Nurse #1 to document in the nurses' notes and to fill out an incident report regarding Resident #3 being found on the floor on 01/03/23. He stated that he should have followed up with Nurse #1 to ensure that a note was documented in the chart and an incident report had been completed. A telephone interview was conducted with Nurse #1 on 02/03/23 at 3:37 P.M. Nurse #1 stated that Resident #3 was found on the floor on 01/03/23 at 09:10 PM by a nurse aid (NA). She further stated that Resident #3 was found with her upper body on the floor mat and did not appear to have any injuries or mental status changes. Nurse #1 indicated that she had obtained a set of vital signs for Resident #3, and they were within normal limits. Nurse #1 stated that Resident #3 was assisted back to bed by the NA's. She further stated that it had been a very busy night and she forgot to document the assessment in the nurses' notes, and she had not filled out an incident report. Nurse #1 further stated that the DON had told her on 01/04/23 to fill out an incident report and to document a note regarding the fall in the chart when she came back to work. Nurse #1 indicated that she had forgotten to document in the chart and to fill out an incident report regarding Resident #3 being found on the floor on 01/03/23.	F 842	The Director of Nursing and Administrative Nurses will review the 24-hour reports, 5 days/week in the morning clinical meeting to identify falls that have occurred. The residents' medical record will be reviewed status post a fall during the clinical meeting to ensure there is a nursing note and incident report completed. 4. The Director of Nursing or designee will audit the documentation of falls and the completion of incident reports process 5 (five) times per week for 4 (four) weeks, then 3 (three) times per week for 4 (four) weeks, the 1 (once) a week for 4 weeks. The Director of Nursing or designee will present the results of these audits, monthly in the Quality Assurance Performance Improvement (QAPI) meeting to the interdisciplinary team to ensure continued compliance. The QAPI committee can modify this plan to ensure the facility remains in compliance	
F 885 SS=D	Reporting-Residents,Representatives&Families	F 885		3/1/23

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F 885	Continued From page 7 CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and family interviews, the facility failed to notify residents representatives and family members by 5:00 P.M. the next calendar day when a confirmed case of Covid-19 was identified for 1 of 3 residents (Resident #3) reviewed for reporting. Findings included: Resident #3 was admitted to the facility on	F 885	1. Resident #3 is no longer a resident at the facility as of 1/8/2023. 2. On 2/22/23, the Nurse Consultant completed an audit of all residents who had positive COVID result to ensure RP and family members were notified of their residents' positive test results. No other residents were identified. 3. On 2/17/23, the Director of Nursing and Administrative Nurses began	

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F 885	Continued From page 8 10/27/22. Review of the nurses' progress notes for Resident #3 from 01/01/23 through 01/03/23 did not reveal any entries by nursing staff regarding Resident #3's positive Covid-19 test. Review of the EMR for Resident #3 revealed a progress note written by the Nurse Practitioner dated 01/02/23. The progress note read in part, "Patient seen today for positive COVID test." Review of the EMR for Resident #3 revealed a progress note written by the Physician dated 01/03/23, which read in part, "Resident #3 was diagnosed with Covid-19 on 01/01/23. She is at very high risk of complications from Covid." An interview was completed with the Infection Preventionist on 02/02/23 at 1:05 P.M. The Infection Preventionist stated that Resident #3 tested positive for Covid-19 on 01/01/23. She further stated that it did not appear that the positive test result was documented in the nurses' progress notes. The Infection Preventionist indicated that Resident #3's Responsible Party (RP) was not notified of the positive Covid-19 results. An interview was conducted with the Director of Nursing (DON) on 02/02/23 at 2:17 P.M. The DON stated that Resident #3's RP was not notified of positive Covid-19 test results.	F 885	education with the licensed nurses on notifying the family member/Responsible Party of their residents' positive COVID test results. This education is being conducted either in person or by phone. Any nurse who has not been educated by 3/1/23 will not be allowed to work until they have been educated on the required COVID positive test result notification process. This education will be included in the clinical orientation process for new nurses. 4. The Director of Nursing or designee will audit the notification and documentation of responsible party/family members being notified of their residents' COVID positive result. This audit will be done weekly for 4 weeks, then monthly for 2 months to ensure that at the time of a resident covid + result that notification is completed. The Director of Nursing or designee will present the results of this audit, monthly in the Quality Assurance Performance Improvement (QAPI) meeting to the interdisciplinary team to ensure continued compliance. The QAPI committee can modify this plan to ensure the facility remains in compliance.	