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 12/11/2023

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 A complaint investigation was conducted onsite from 12/06/23 through 12/08/23 and additional information was obtained remotely on 12/11/23. The following intakes were investigated: NC00210282, NC00210278, NC00210617, and NC00210636. Intakes NC00210282 and NC00210278 resulted in immediate jeopardy. 2 of 5 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.12 at F600 at a scope and severity (J) CFR 483.12 at F607 at a scope and severity (J) The tags F600 and F607 constituted substandard quality of care. Immediate Jeopardy began for F607 on 11/26/23 and F600 on 11/27/23. Immediate Jeopardy was removed on 12/08/23. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		12/29/23

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

Electronically Signed | 01/04/2024

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Nurse Practitioner interviews, the facility failed to protect residents' right to be free from sexual abuse (Resident #2) and intentional inappropriate touching (Resident #6) perpetrated by Resident #1. In the evening of 11/26/23 the facility was made aware Resident #1 entered another resident's room (Resident #6) uninvited and Resident #6 reported to Nurse #1 that a "strange man" (identified as Resident #1) woke her up and was holding her hand, telling her he was going to care for her and kissed her on the cheek. Resident #6 was upset and scared and was not sure what Resident #1 was doing in the room and told him he did not belong in her room. Resident #6 required Ativan (a medication to treat anxiety) 4 days later because she was still upset. On 11/27/23, the day following the incident with Resident #1 and Resident #6, Resident #1 was found by Nurse Aide #1 in Resident #2's room sitting at his bedside while Resident #2 lay in bed. Resident #1 had his hand down Resident #2's brief and was manually stimulating (moving hand in an up and down motion) Resident #2's penis. Due to the inappropriate act initiated by Resident #1 toward Resident #2, a reasonable person would have experienced intimidation and fear. This was for 2 of 3 residents reviewed for abuse. Immediate Jeopardy began on 11/27/23 at 4:15	F 600	F600 Free from Abuse and Neglect 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was sent for psychiatric and medical evaluation and returned to facility on another unit. Facility Nurse Practitioner assessed Resident #1 on 12/7/23. Resident was at baseline with no new behaviors. Facility Medical Director assessed Resident #1 on 12/12/23. Resident was at baseline with no new behaviors. Resident #1 was assessed by psychiatric provider on both 12/13/23 and 12/20/23 with no change in behavior noted. As of 12/29/23 there have been no further behaviors. Resident #2 has a diagnosis of Alzheimer's Disease and a Brief Interview Mental Status (BIMS) score of 6. Upon interview by the Regional Clinical Consultant on 12/6/23, he has no recollection of the event and has demonstrated no new behaviors. Resident #6 is alert and oriented with a BIMS of 15. Upon interview by the	

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F 600	Continued From page 2 PM when Resident #1 was found by Nurse Aide #1 in Resident #2's room sitting at his bedside while Resident #2 was lying in bed. Resident #1 had his hand down Resident #2's brief and was manually stimulating (moving hand in an up and down motion) Resident #2's penis. Immediate Jeopardy was removed on 12/08/23 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D isolated with potential for more than minimal harm to correct the deficient practice and to ensure that the education and monitoring systems put in place to remove the Immediate Jeopardy were effective. Findings included: 1a. Resident #1 was admitted to the facility on 03/31/21. Diagnoses included pervasive developmental disorder (delay in development of multiple basic functions including socialization and communication), dysarthria (speech disorder), and cognitive communication deficit. The Minimum Data Set (MDS) quarterly assessment dated 09/14/23 revealed Resident #1 was severely cognitively impaired and demonstrated no behaviors. He was independent with bed mobility, transfers, walking in his room and corridor and with all activities of daily living ADLs. He had no impairments and did not use a mobility device. There was no care plan for behaviors for Resident #1 and there was no documentation to support Resident #1 had any prior behaviors.	F 600	Regional Nurse on 12/6/23, she recalls the event and was fearful at the time of the incident because she was asleep and was awakened by a man kissing her cheek. On 12/6/2023 during the interview with the Regional Nurse, she affirms that she feels safe in the facility and has had no further incidents of this type. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 12/6/23, the Regional Nurse Consultant completed a review of progress notes for the last 30 days to identify any incidents that could be interpreted as abuse. As a result of this review, two additional initial reports were filed to the state agency on 12/7/23 and investigations initiated at that time. One report was for the incident of inappropriate sexual touching with Resident #6 and Resident #1 on 11/26/23. The other report was filed as a precautionary measure for a resident-to-resident verbal yelling incident on the memory care unit. The facility Social Worker and the Admissions Coordinator completed trauma care assessments on current residents on 12/7/23 to identify any existing trauma affecting the psychosocial well-being of the resident. The facility Social Worker and the Admissions Coordinator interviewed current alert and oriented residents on 12/7/23 to determine if they felt safe in the	

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F 600	Continued From page 3 Resident #6 was admitted to the facility on 09/15/23. Diagnoses included, in part, anxiety, age related physical debility, tremors, difficulty in walking, and depression. The MDS admission assessment dated 09/21/23 revealed Resident #6 was cognitively intact and required extensive assistance with two person physical assistance with bed mobility and transfers. She had impairment to both sides of lower extremities and used a wheelchair. A nursing progress note written on 11/26/23 at 10:47 PM by Nurse #1 revealed Nurse #1 answered the phone around 7:00 PM and the caller identified herself as the responsible party for Resident #6, stating that the resident had called her and reported a "strange man" in her room. Went to resident's room and a male resident was sitting in a chair beside her bed. Informed male resident that he was in the wrong room and assisted him back to his room. Reported incident to the nurse and the nurse aide on the 400 hall about the male resident being in the room of Resident #6 and that the nurse should inform the Director of Nursing immediately of incident and to notify the responsible party that the male resident had been removed from room. A nursing progress note written on 11/26/23 at 11:26 PM by Nurse #3 revealed at 7:00 PM was told by a Nurse #1 that Resident #1 was sitting in Resident #6's room. Was also told that Resident #6 was upset and the responsible party called to report the incident. This nurse went to speak with Resident #6. Upon entering the room, the resident was tearful and speaking with her responsible party on a cell phone. Resident #6 stated, "A man sat on the side of my bed and told	F 600	facility. There were no other residents who were identified as feeling unsafe. For those residents who are unable to be interviewed, their responsible party will be contacted on 12/7/23 by the Social Worker and Admissions Coordinator to ensure they feel their resident is safe in the facility. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Each morning the oncoming nurse will review the 24-hour report sheet, which is a review of the previous 24 hours with the nursing assistants on each hall and they will sign the report indicating that they have been informed of the previous day's events. This will be a new procedure for the nursing assistants. The DON and /or Administrative Nurse will be completing education with current licensed nurses and nursing assistants on the use of the 24-hour report sheet. Any current licensed nurse and nursing assistant who does not receive this training by 12/7/23 will not be able to work without the training from the DON and/or Administrative Nurse. Newly hired licensed nurses and nursing assistants will receive this training at orientation by DON or ADON. The Administrator and Director of Nursing	

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F 600	Continued From page 4 me he loved me and said he will take care of me. He kissed me on the cheek." Resident #6 stated she was scared and made it clear that his advances were unwelcome so she pushed the call button and called her responsible party and the responsible party contacted the facility. A nursing progress note written by Nurse #3 on 11/27/23 at 3:04 AM revealed at 8:00 PM, Resident #6's responsible party came to the facility. Discussed incident with Resident #6 and her responsible party. Resident #6 was aware that she could move to another room. This nurse would be included in all care for this shift and provided Resident #6 with nurse's personal cell phone number. A Social Service Note written by the Social Worker on 11/27/23 at 1:21 PM revealed he met with Resident #6 in her room and discussed a room change. Resident #6 stated she did not wish to move rooms at this time. A physician's progress note written by the Nurse Practitioner on 11/27/23 at 6:00 PM revealed Resident #6 was requesting Ativan (a medication to relieve anxiety) to help with her anxiety caused by the man coming into her room. A nursing progress note written on 11/27/23 at 6:22 PM revealed Nurse #2 notified responsible party and left message on voicemail to make her aware Resident #6 had a new order for Ativan 0.5 milligrams every 8 hours as needed for anxiety for the next 14 days. Review of Resident #6's physician orders revealed there were no orders for any antianxiety medications prior to 11/27/23.	F 600	were reeducated on Abuse/Neglect policy and procedures including identification of abuse, investigation, protection, reporting/response, prevention, screening and possible psychosocial effects of sexually inappropriate behavior on a resident by the Director of Operations. This training was completed on 12/7/23. The Director of Nursing and Regional Clinical Nurse educated all staff on Abuse/Neglect policy and procedures including identification of abuse, investigation, protection, reporting/response, prevention, screening and possible psychosocial effects of sexually inappropriate behavior on a resident. Staff will be unable to work after 12/7/23 unless training is completed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or administrative nurse will monitor 24-hour report sheets for potential instances of abuse 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 administrative nurse will present the results of the audit monthly in the Quality Assurance Performance Improvement (QAPI) meeting with the interdisciplinary team for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure the facility	

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F 600	Continued From page 5 A review of the medication administration record revealed Resident #6 received the ordered Ativan one time on 11/30/23. An interview was conducted with Nurse #1 on 12/07/23 at 11:15 AM via phone. Nurse #1 stated she responded to a phone call that the responsible party of Resident #6 put into the facility. She stated the responsible party reported to her that some strange man was in Resident #6's room. Nurse #1 stated after she spoke with the responsible party, she went to Resident #6's room and she saw Resident #1 sitting in a chair at the bedside talking with Resident #6. Nurse #1 reported she asked Resident #1 what he was doing in the room and he had replied that Resident #6 told him to get out and that was not his room. Nurse #1 stated she then took Resident #1 to his room. Nurse #1 stated Resident #6 appeared to be upset, but she was not crying. Nurse #1 stated Resident #1 was normally confused. She stated she reported to the Medication Aide and Nurse #3 on the hall what had happened to make sure Nurse #3 followed up with the responsible party and the Director of Nursing. An interview was conducted with Medication Aide (MA) #1 via phone on 12/06/23 at 4:22 PM. MA #1 reported she was assigned to the hall Resident #1 and Resident #6 resided on the night of 11/26/23 and she arrived on her hall at 7:00 PM. When she first arrived on the hall she noticed Resident #1 sitting across the hall from Resident #6 in Resident #'2's room. She stated she did not think much about him visiting with Resident #2 and when she observed them they were just talking. MA #1 stated after about 5	F 600	remains in compliance.	

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F 600	Continued From page 6	F 600		

minutes or so, she noticed Resident #6's call light go off and saw Nurse #1 go into Resident #6's room and saw her bring Resident #1 out of Resident #6's room. MA #1 stated she went into the room to see Resident #6 and the resident shared with her that a strange man had come into her room and was holding her hand and telling her he loved her and he was going to take care of her and he kissed her on the cheek. MA #1 stated Resident #6 stated she was scared. MA #1 stated Resident #1 remained in his bed in his room for the remainder of the night. MA #1 stated she had never seen Resident #1 go into Resident #2's room or any other room until 11/26/23.

An interview was conducted with Nurse #3 via phone on 12/06/23 at 2:38 PM. Nurse #3 reported Nurse #1 told him she received a call from the responsible party of Resident #6 with concerns that a "strange man" was in her room. Nurse #3 stated Nurse #1 went into Resident #6's room at the time of the phone call to investigate and had Resident #1 leave the room. Nurse #3 went and spoke with Resident #6 and she stated she was sleeping and she woke up to see this "strange man" who she did not know and she was upset and scared. Nurse #3 stated she said her responsible party was on the way to the facility. Nurse #3 stated he had asked Resident #6 if she wanted to move to a different hall but she said she was okay and she declined to move. Nurse #3 stated he had explained to Resident #6 that Resident #1 was confused and once he had explained that to her, she did not believe he was trying to hurt her or anything. Nurse #3 stated Resident #6 expressed she did not want him to come into her room again and he made sure to follow up with her through the remainder of the

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F 600	Continued From page 7	F 600		

shift to be sure she felt safe. Nurse #3 stated he called the DON and reported what happened between Resident #1 and Resident #6. The DON instructed him to speak with both families regarding the incident and he (DON) would move the resident in the morning. Nurse #3 reported Resident #6 stated she was fine knowing that Resident #1 was not going to be moved until the next morning. Nurse #3 reported he checked on Resident #1 through the night and he seemed to have his normal baseline confusion and he was not presenting with any signs and symptoms of a urinary tract infection (UTI). Nurse #3 reported he spoke with Resident #1 after the incident and Resident #1 had no recollection at all of what happened. Nurse #3 stated he told him to say in his room and stay out of residents' rooms. He was very agreeable and he seemed very innocent. He added, shortly after the incident, Resident #1 went to bed and remained in his bed through the remainder of the night. Nurse #3 stated he had never known Resident #1 to wander into other resident's rooms. Nurse #3 reported he reviewed the nursing notes a few days later and saw that he had been sent to the hospital for a psychiatric evaluation and it was discovered in the emergency room he had UTI. Nurse #3 reported it made a little more sense that he would have this very out of character behavior if he had a UTI.

An interview was conducted with Resident #6 on 12/06/23 at 2:45 PM. Resident #6 reported a strange man came into her room while she was sleeping on 11/26/23. She stated she had never seen him before and he woke her up when he sat on the bed and was holding her hand. He began to tell her he loved her and he was going to take care of her and she told him he did not belong in

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F 600	Continued From page 8	F 600		

this room and needed to leave. She stated he remained in the room and continued to say he would take care of her and he kissed her on the cheek. Resident #6 stated she was scared and did not know what this man was going to do to her. She continued to tell him he had to leave. She stated he moved to the other side of the bed and sat on a chair beside the bed. Shortly after he moved, a nurse came in and she took him out of the room. She stated she called her responsible party because she as scared. She added, the staff asked her if she wanted to move to another room, but she declined. She stated she just did not want him to come back in her room again. She stated Nurse #3 checked on her frequently throughout the night and she felt safe.

A follow up interview was conducted with Resident #6 on 12/07/23 at 10:35 AM. Resident #6 revealed she was told Resident #1 would be moved in the morning on 11/27/23 and she was glad to hear that he would be getting moved and that that made her feel safer.

An interview with the Director of Nursing on 12/06/23 at 3:43 PM revealed he was made aware of Resident #1 entering Resident #6's room on 11/26/23. He stated during morning meeting on 11/27/23 it was decided since this was a new behavior for Resident #1 we would monitor him to be sure he did not enter Resident #6's room. He stated we did not feel the need to change his room at this time because Resident #6 said she felt safe. He stated we completed an incident report but we did not initiate an abuse investigation. He stated he should have implemented a measure to protect all the residents from Resident #1 after that incident

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F 600	Continued From page 9	F 600		

occurred with Resident #6.

An interview was conducted with the Nurse Practitioner (NP) on 12/07/2023 at 10:00 AM. The NP stated she was notified on 11/27/23 when she reviewed the physician's book which was located at the nurse's station. She stated she went to speak to Resident #6 and she reported Resident #1 was on her bed and he kissed her cheek. The NP stated Resident #6 told her it really scared her and she asked for something for anxiety because it was making her very anxious. The NP added, Resident #6 was not on any antianxiety medications in the past but had asked for something to see if it would help her. The NP could not definitively say his behavior was as a result of the urinary tract infection, but that it could have possibly caused the increased confusion.

An interview with the Administrator on 12/06/23 at 4:00 PM revealed he was made aware of Resident #1 entering Resident #6's room on 11/26/23 and was told that Resident #1 kissed Resident #6 on the cheek and she told him not to do that and he left the room. The Administrator stated he was not aware Resident #6 was scared. He stated on Monday he interviewed her and since she stated she felt safe and did not want her room changed he did not investigate further.

1b. Resident #2 was admitted to the facility on 09/04/23. Diagnoses included, in part, Alzheimer's Disease, cognitive communication deficit, and anxiety.

The MDS quarterly assessment dated 11/08/23 revealed Resident #2 was severely cognitively impaired and demonstrated no behaviors. He

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F 600	Continued From page 10	F 600		

required extensive assistance with 2 staff physical assistance with bed mobility and dressing and was totally dependent with 2 staff physical assistance with toileting and transfers.

A review of Resident #2's care plan dated 09/06/23 revealed a plan of care for decision making related to difficulty making his own decisions. Interventions included, in part, validate thoughts/feelings when confused or anxious and provide an environment that respects privacy.

A nursing progress note written by Nurse #2 on 11/27/23 at 7:09 PM revealed at approximately 4:15 PM, Resident #2 was noted by a staff member that Resident #1's hand was down the front of Resident #2's brief. Nurse #2 was notified by the staff member and observed Resident #1 was sitting in a chair beside Resident #2's bed and Resident #1 had his arms crossed and his hands tucked under his arms. Nurse #2 asked Resident #1 to, "please go to assigned room." The Assistant Director of Nursing and Administrator were made aware. A skin assessment was performed on Resident #2 and there were no noted injuries or impairments. Every 15 minutes safety checks were ordered.

Review of the initial allegation report submitted to the Health Care Personnel Registry on 11/27/23 at 5:38 PM per fax transaction report indicated Resident #1 was observed in another resident's room with his hands down another resident's brief. There was no apparent physical or mental harm.

Review of a hand written statement dated 11/27/23 by Nurse Aide (NA) #1 revealed "About 4:15 PM on 11/27/23, as I was walking to get ice,

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 12/11/2023

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 600	Continued From page 11	F 600		

passing resident's [Resident #2] room, another resident [Resident #1] had his hand in resident's [Resident #2] brief manually stimulating him. When the other resident [Resident #1] saw me he quickly removed his hand. Notified nurse."

Review of a hand written statement dated 11/27/23 by NA #2 revealed "I am the aide on the 400 hall. I did not see anything out of the norm with the residents [Resident #1 or Resident #2]. [Resident #1] had been in his own room today until they had movie day on the 100 hall. Around 2:00 PM he was walking around."

Review of a hand written statement dated 11/27/23 by Nurse #2 revealed "At approximately 4:15 PM, [NA #1] notified of [Resident #1] with his hand down [Resident #2's] brief in the front of his brief. This nurse walked down and [Resident #1] was sitting in a chair at bedside of [Resident #2] with both hands crossed tightly under his arms. When this nurse went in the room and asked "Hey, [Resident #1] what are you doing?" Resident said "nothing" and [Resident #2] stated "He's just talking junk" [Resident #1] said "No I'm not." This nurse asked [Resident #1] to please go to his assigned room until this nurse could come and speak with resident. [Resident #1] got up, closed his right hand to a fist, and went to his room. This nurse notified the Assistant Director of Nursing and Administrator and the Administrator implemented every 15 minute safety checks until further advisement."

A nursing progress note written by ADON on 11/27/23 at 7:54 PM revealed at 5:00 PM notified Psychiatric provider on call regarding sexually inappropriate incident with resident this evening who stated they have 24 hours to do an

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 12/11/2023

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 600	Continued From page 12	F 600		

evaluation and will notify the supervisor on call and contact our Nurse Practitioner to discuss plan of care for resident and will call facility back.

A nursing progress note written by the Assistant Director of Nursing (ADON) written on 11/27/23 at 7:32 PM revealed she notified Resident #2's responsible person regarding a situation earlier this evening where a resident from another room was observed by the Nurse Aide inappropriately touching Resident #2 by reaching under his brief. The ADON informed the responsible party no injuries were noted and the other resident was moved to another hall. The ADON explained to the responsible party she had attempted to process this incident with Resident #2 but was unable due to his confusion.

A nursing progress note written by the ADON on 11/27/23 at 7:48 PM revealed at 6:20 PM notified Resident #1's responsible party regarding an incident that happened this evening where resident was observed by a nurse aide in another resident's room with his hand under the other resident's brief. Explained that this resident will be moved to another room closer to the nurse's station with no roommate and be placed on every 15 minute safety checks as well as be evaluated by Psych Services on call in the next 24 hrs.

A nursing note written by Nurse #4 on 11/28/23 at 1:49 AM revealed Resident #1 continued on 15 minute safety checks; resident moved to room on the 200 hall per management without any issue. Oriented resident to new room location, bathroom, call light, and remote. Resident had been in room all shift with no behaviors noted.

A nursing note written by Nurse #5 on 11/28/23 at

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 12/11/2023

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 600	Continued From page 13	F 600		

5:18 PM revealed a physician order was received to send resident to hospital for psychiatric evaluation. Emergency Medical Services (EMS) called at 3:30 PM. EMS arrived at 3:41 and exited facility with resident via stretcher at 3:49 PM.

The Emergency Room (ER) progress note dated 11/29/23 revealed Resident #1 was seen and evaluated by psychiatry. He was cleared for disposition (dismissed) back to the facility at this time. Resident was started on antibiotics due to moderate leukocytes (elevate white blood cells indicative of infection) on urinalysis. Will continue with antibiotics at facility.

A nursing progress note written by Nurse #4 on 11/29/23 at 7:51 PM revealed Resident #1 returned from hospital at 3:30 PM on 11/29/23 with orders for an antibiotic to treat a urinary tract infection.

A physician's order written on 11/29/23 revealed an order for Cephalexin (antibiotic to treat urinary tract infections) 500 milligrams 3 times daily for 7 days.

A review of the medication administration record revealed Resident #1 received the ordered antibiotic three times daily starting on 11/29/23 and finished on 12/06/23.

Review of the 5 Day investigation report submitted on 12/01/23 at 2:27 PM per fax transaction report to Health Care Personnel Registry indicated Resident #1 was observed in another resident's (Resident #2) room with his hands down his brief. Resident #1 was cognitively impaired and had a diagnosis of

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 12/11/2023

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 600	Continued From page 14	F 600		

pervasive developmental disorder. Resident #1 was observed inappropriately touching Resident #2. Resident #1 was sent for psychiatric evaluation. Findings negative. Medical evaluation revealed presence of urinary tract infection (UTI). Resident #2 who was recipient of touching showed no physical harm or mental anguish related to incident. Resident #1's room moved to different unit and resident was placed on every 15 minute safety checks. No further inappropriate behaviors have been observed at this time. Resident #1 placed on antibiotics for UTI.

An interview was conducted with Nurse Aide (NA) #1 via phone on 12/06/23 at 1:02 PM. NA #1 reported as she was walking by to get ice on the 400 hall she noticed Resident #1 sitting in a chair beside Resident #2's bed and noticed Resident #1 had his hand under the brief of Resident #2 and was manually stimulating (moving hand in an up and down motion) on Resident #2's penis. NA #1 stated Resident #1 noticed that she saw him and he quickly pulled his hand out of the brief. NA #1 stated she went into the room and asked what Resident #1 what he was doing in the room and replied "nothing." She added, she went straight to Nurse #2. NA #1 stated Resident #2 had a surprised look on his face when she entered the room and was calm. She stated Resident #2 was not observed being upset or showing signs of refusing to have Resident #1 touch him. She added he was just laying back in his bed. NA #1 stated she had never seen this behavior before from Resident #1 and that their rooms have always been near each other. NA #1 reported when he was asked to leave the room he kept his hand balled up and tucked in.

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 12/11/2023

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 600	Continued From page 15	F 600		

An interview was conducted with Nurse #2 on 12/06/23 at 1:33 PM. Nurse #2 reported NA #1 quickly had approached her and told her Resident #1 was in Resident #2's room and Resident #1 had his hand down Resident #'2s brief and was stimulating him. Nurse #2 stated she went straight to Resident #2's room and Resident #2 was lying down on his back in his bed and Resident #1 was sitting in a chair right beside Resident #2's bed with his arms tucked under him. Nurse #2 stated she asked what he was doing and Resident #1 replied "nothing," and Resident #2 replied "He's just talking junk" and Resident #1 said "No I'm not." Nurse #2 stated she asked Resident #1 to go to his room and she would be in to speak with him. Nurse #2 stated she did a complete head to toe assessment on Resident #2. She added, Resident #2 did not speak about Resident #1 having his hand down his brief and acted as though it did not happen. Nurse #2 stated she did not see any erection or semen or any signs of stimulation at the time of the assessment. Nurse #2 stated once the residents were separated, she initiated every 15 minute safety checks until Resident #1 could be further evaluated and every 15 minutes safety checks continued after Resident #1's return from the hospital until he finished his antibiotic treatment. She stated his room was moved to the 200 hall as well. Nurse #2 added Resident #2 remained in his room as he usually would not come out of his room and he was monitored as well with every 15 minute safety checks.

An interview was conducted with the ADON on 12/06/23 1:41 PM. The ADON reported that after she was made aware of the incident between Resident #1 and Resident #2 by Nurse #2 she went into Resident #2's room to assess his

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 12/11/2023

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 600	Continued From page 16	F 600		

mental state. The ADON reported that his confusion was at his baseline and it was difficult to process the incident with him because he did not seem to understand what was going on. The ADON reported Resident #2 was not upset or recalling any of the incident. The ADON reported she then went to see Resident #1 who was in his bathroom at the time. She stated it seemed he knew he had done something wrong but that he did not understand; he seemed embarrassed. The ADON spoke to him and told him that that behavior was not acceptable and he needed to stay out of residents' rooms and to keep his hands to himself.

An interview was conducted with Nurse Practitioner (NP) on 12/07/2023 at 10:00 AM. The NP reported she had seen Resident #1 on the morning of the 11/27/23 in his room. She stated he had no signs or symptoms of a urinary tract infection and his confusion seemed at baseline. The NP stated she received a call later on 11/27/23 as to what had happened with Resident #1 and Resident #2 and that the facility was waiting for a psychiatric evaluation. The NP stated a psychiatric provider was unable to come to the facility and it was decided to send Resident #1 to the ER for a psychiatric evaluation. The NP stated he was cleared after the psych evaluation but it was determined he had a urinary tract infection and was started on antibiotics and discharged back to the facility and continued with every 15 minutes safety checks until the antibiotic was completed. The NP stated she assessed Resident #2 and his assessment was benign and he did not share any information of the incident with her nor did he seem to have any recollection.

An interview with the Director of Nursing on

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 12/11/2023

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 600	Continued From page 17	F 600		

12/06/23 at 3:45 PM revealed he was made aware of Resident #1 entering Resident #6's room on 11/26/23 by Nurse #3. He stated during morning meeting on 11/27/23 it was decided since this was a new behavior for Resident #1, the facility would monitor him to be sure he did not enter Resident #6's room. He stated he did not feel the need to change his room at this time because Resident #6 said she felt safe. He stated he completed an incident report, but that he should have implemented a measure to protect all the residents from Resident #1 after the first incident occurred with Resident #6 because if he had followed the abuse policy and procedure the sexual abuse with Resident #2 could have been prevented.

An interview with the Administrator on 12/06/23 at 4:00 PM revealed he was made aware of Resident #1 entering Resident #6's room on 11/26/23 and was told that Resident #1 kissed Resident #6 on the cheek and she told him not to do that and he left the room. The Administrator stated he was not aware Resident #6 was scared. He stated on Monday he interviewed her and since she stated she felt safe and did not want her room changed he did not investigate further. The Administrator stated if he had further investigated the incident with Resident #6, the incident that occurred with Resident #1 and Resident #2 could have been avoided.

An observation of Resident #1 on 12/06/23 at 12:42 PM revealed Resident #1 was an alert resident who was sitting in his room on the 200 hall. He was pleasant and cheerful but confused.

An observation of Resident #2 on 12/06/23 at 12:53 PM revealed Resident #2 was an alert

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 12/11/2023

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 600	Continued From page 18	F 600		

resident lying on his bed in his room on the 400 hall. He was pleasant and cheerful but confused.

The Administrator was notified of Immediate Jeopardy on 12/06/23 at 6:30 PM.

F600 Identify those residents who suffered, or are likely to suffer a serious adverse outcome because of the non-compliance:

The facility failed to protect Resident #6 from inappropriate touching on 11/26/23 and Resident #2 from sexual abuse on 11/27/23 perpetrated by Resident #1.

Resident #1 was evaluated 11/29/23 at the hospital emergency room and was diagnosed with a urinary tract infection and was treated with antibiotics. The hospital completed a psychiatric evaluation and was cleared to return to the facility. He was relocated to be closer to the nurse's station to ensure closer observation on 11/29/23. No further complaints from other residents have been received to date. Resident #1 has been a resident at this facility since 03/31/21 and this was a newly identified behavior for this resident. The facility has scheduled a neurology consult for 12/07/23, to evaluate any current changes to the plan of care.

A review of the updated care plan for Resident #1 revealed on 11/28/23 revealed a plan of care for wandering into other's residents' room with a goal that wandering would not contribute to injury through the next review with interventions to include move resident close to nurse's station, follow up with psychiatry, and implement every 15 minute safety checks.

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 12/11/2023

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 600	Continued From page 19	F 600		

Resident #2 has a diagnosis of Alzheimer's Disease and a Brief Interview Mental Status (BIMS) score of 6. Upon interview by the Regional Clinical Consultant on 12/06/23, he had no recollection of the event and had demonstrated no new behaviors.

Resident #6 was alert and oriented with a BIMS of 15. Upon interview by the Regional Nurse Consultant on 12/06/23, she recalled the event and was fearful at the time of the incident because she was asleep and was awakened by a man kissing her cheek. On 12/06/23, during the interview with the Regional Nurse, she affirmed that she felt safe in the facility and has had no further incidents of this type.

A review of Resident #6's care plan dated 12/07/23 revealed Resident #6 had experienced a trauma in this facility related to another resident entering her room uninvited with a goal that Resident would feel safe through next review and interventions included, in part, resident to be assessed by Physician or Practitioner, offer to change room for resident, provide assurance that she was safe at this facility and monitor resident.

On 12/06/23, the Regional Nurse Consultant completed a review of progress notes for the last 30 days to identify any incidents that could be interpreted as abuse. As a result of this review, two additional initial reports were filed to the state agency on 12/07/23 and investigations initiated at that time. One report was for the incident of inappropriate sexual touching with Resident #6 and Resident #1 on 11/26/23. The other report was filed as a precautionary measure for a resident-to-resident verbal yelling incident on the memory care unit.

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 12/11/2023

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 600	Continued From page 20	F 600		

The facility Social Worker and the Admissions Coordinator completed trauma care assessments on current residents on 12/07/23 to identify any existing trauma affecting the psychosocial well-being of the resident.

The facility Social Worker and the Admissions Coordinator interviewed current alert and oriented residents on 12/07/23 to determine if they felt safe in the facility. There were no other residents who were identified as feeling unsafe. For those residents who were unable to be interviewed, their responsible party would be contacted on 12/07/23 by the Social Worker and Admissions Coordinator to ensure they felt their resident was safe in the facility.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The facility Administrator and Director of Nursing received re-training from the Director of Operations and Regional Clinical Nurse on Abuse/Neglect policy and procedure, including identification of abuse, investigation, protection, reporting/respond, prevention, screening, and the possible psychosocial effects of sexually inappropriate behavior on a resident. This training was completed on 12/07/23.

The DON and Regional Clinical Nurse began education with current facility staff, including contract Housekeeping/Laundry and Rehabilitation, on Abuse/Neglect policy and procedure, including identification of abuse, investigation, protection, reporting/respond,

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 12/11/2023

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 600	Continued From page 21	F 600		

prevention and screening abuse, the reporting of abuse, types of abuse and the possible psychosocial effects of sexually inappropriate behavior on a resident. This training was completed as of 12/07/23. Any current employee who had not received this education as of 12/07/23 would not be allowed to work until education was completed by the facility DON. All newly hired employees would receive this education prior to assignment. The DON and ADON will be responsible for the education and ensure that all staff have received this education. The facility was not using agency staff.

Each morning the oncoming nurse will review the 24-hour report sheet, which was a review of the previous 24 hours with the nursing assistants on each hall and they would sign the report indicating that they have been informed of the previous day's events. This will be a new procedure for the nursing assistants. The DON and /or Administrative Nurse will be completing education with current licensed nurses and nursing assistants on the use of the 24-hour report sheet. Any current licensed nurse and nursing assistant who did not receive this training by 12/07/23 will not be able to work without the training from the DON and/or Administrative Nurse. Newly hired licensed nurses and nursing assistants will receive this training at orientation by DON or ADON.

The facility alleges the removal date of the Immediate Jeopardy was 12/08/23.

The removal plan of the Immediate Jeopardy was validated on 12/08/23.

A sample of staff including the Administrator,

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 12/11/2023

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 600	Continued From page 22 Director of Nursing, nurses, nurse aids, therapists, housekeeping staff, and dietary aides were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding identifying, reporting, and investigating abuse. Additionally, nurses and nurse aides were interviewed regarding the in-services they received for the new process of the 24 hour report sheet which was a tool used to communicate daily events when reporting off or on shift. The removal date of 12/08/23 was validated.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		12/29/23

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 12/11/2023

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 607	Continued From page 23 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to protect Resident #2 from sexual abuse when the Administrator was made aware of Resident #1 entering Resident #6's room uninvited on 11/26/23. Resident #6 reported to Nurse #1 that Resident #1 woke her up and was holding her hand, telling her he was going to care for her and kissed her on the cheek. Resident #6 was upset and scared and was not sure what he was doing in the room and told him he did not belong in her room. The following day 11/27/23, Resident #1 was found by Nurse Aide #1 in Resident #2's room sitting at his bedside while Resident #2 lay in bed. Resident #1 had his hand down Resident #2's brief and was manually stimulating (moving hand in an up and down motion) his penis. Additionally, the facility failed to identify abuse, to report the allegation of abuse to the state agency and to conduct a thorough investigation for Resident #6. This was for 2 of 3 residents observed for abuse. Immediate Jeopardy began on 11/26/23 when the facility failed to implement measures to protect other residents from sexual abuse after Resident #1 entered Resident #6's room uninvited on the evening of 11/26/23 where it was reported to Nurse #1 by Resident #6 that Resident #1 woke her up and was holding her hand, telling her he was going to care for her and kissed her on the	F 607	F607 Develop/Implement Abuse/Neglect Policies 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was sent for psychiatric and medical evaluation and returned to facility on another unit. Facility Nurse Practitioner assessed Resident #1 on 12/7/23. Resident was at baseline with no new behaviors. Facility Medical Director assessed Resident #1 on 12/12/23. Resident was at baseline with no new behaviors. Resident #1 was assessed by psychiatric provider on both 12/13/23 and 12/20/23 with no change in behavior noted. As of 12/29/23 there have been no further behaviors. Resident #2 has a diagnosis of Alzheimer's Disease and a Brief Interview Mental Status (BIMS) score of 6. Upon interview by the Regional Clinical Consultant on 12/6/23, he has no recollection of the event and has demonstrated no new behaviors. Resident #6 is alert and oriented with a BIMS of 15. Upon interview by the	

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	345549	A. BUILDING _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 24 cheek. Immediate Jeopardy was removed on 12/08/23 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D isolated with potential for more than minimal harm to correct the deficient practice and to ensure that the education and monitoring systems put in place to remove the Immediate Jeopardy were effective. Findings included: The facility's abuse policy dated February 2021 titled "Abuse Prevention, intervention, reporting and investigation" read, in part, as follows: #5 Identification: (a) It is our policy that all staff monitor residents and will know how to identify potential signs and symptoms of "abuse" and (d) identifying possible indicators of abuse in residents (injuries, fearfulness, behavioral or social changes). #6 Investigation: (a) It is our policy that reports of "abuse "are promptly and thoroughly investigated. #8 Protection: (a) It is our policy that the residents will be protected from the alleged offender. #9 Reporting: (a) It is our policy that abuse allegations are reported per Federal and State Law and all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse to the Executive Director of the facility and other officials including the State Survey Agency and Adult	F 607	Regional Nurse on 12/6/23, she recalls the event and was fearful at the time of the incident because she was asleep and was awakened by a man kissing her cheek. On 12/6/2023 during the interview with the Regional Nurse, she affirms that she feels safe in the facility and has had no further incidents of this type. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The social worker and director of admissions completed trauma care assessments on current residents to identify any existing trauma. Interviews of alert and oriented residents and responsible parties were conducted to determine if they felt safe in the facility. As a result of this audit two initial reports were made at this time. One relating to an incident that occurred on 11/29/23 and one relating to an incident of residents yelling at one another on the Memory care unit. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Each morning the oncoming nurse will review the 24-hour report sheet, which is a review of the previous 24 hours with the nursing assistants on each hall and they	

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F 607	Continued From page 25 Protective Services where state law provides for jurisdiction in long term care facilities. 1. Resident #1 was admitted to the facility on 03/31/21. Diagnoses included pervasive developmental disorder (delay in development of multiple basic functions including socialization and communication), dysarthria (speech disorder), and cognitive communication deficit. The Minimum Data Set (MDS) quarterly assessment dated 09/14/23 revealed Resident #1 was severely cognitively impaired and demonstrated no behaviors. a. Resident #6 was admitted to the facility on 09/15/23. The MDS 5 day assessment dated 09/21/23 revealed Resident #6 was cognitively intact. A nursing progress note written on 11/26/23 at 11:26 PM by Nurse #3 revealed at 7:00 PM was told by a Nurse #1 that Resident #1 was sitting in Resident #6's room. Was also told that Resident #6 was upset and the responsible party called to report the incident. This nurse went to speak with Resident #6. Upon entering the room, the resident was tearful and speaking with her responsible party on a cell phone. Resident #6 stated, "A man sat on the side of my bed and told me he loved me and said he will take care of me. He kissed me on the cheek." Resident #6 stated she was scared and made it clear that his advances were unwelcome so she pushed the call button and called her responsible party and the responsible party contacted the facility. An interview was conducted with Nurse #1 on 12/07/23 at 11:15 AM via phone. Nurse #1 stated	F 607	will sign the report indicating that they have been informed of the previous day's events. This will be a new procedure for the nursing assistants. The DON and /or Administrative Nurse will be completing education with current licensed nurses and nursing assistants on the use of the 24-hour report sheet. Any current licensed nurse and nursing assistant who does not receive this training by 12/7/23 will not be able to work without the training from the DON and/or Administrative Nurse. Newly hired licensed nurses and nursing assistants will receive this training at orientation by DON or ADON. The Administrator and Director of Nursing were reeducated on Abuse/Neglect policy and procedures including identification of abuse, investigation, protection, reporting/response, prevention, screening and possible psychosocial effects of sexually inappropriate behavior on a resident by the Director of Operations. This training was completed on 12/7/23. The Director of Nursing and Regional Clinical Nurse educated all staff on Abuse/Neglect policy and procedures including identification of abuse, investigation, protection, reporting/response, prevention, screening and possible psychosocial effects of sexually inappropriate behavior on a resident. Staff will be unable to work after 12/7/23 unless training is completed.	

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F 607	Continued From page 26 she was assigned to another hall and she responded to a phone call that the responsible party of Resident #6 put into the facility. She stated the responsible party reported to her that some strange man was in Resident #6's room. Nurse #1 stated after she spoke with the responsible party, she went to Resident #6's room and she saw Resident #1 sitting in a chair at the bedside talking with Resident #6. Nurse #1 reported she asked Resident #1 what he was doing in the room and he had replied that Resident #6 told him to get out and that that was not his room. Nurse #1 stated she then took Resident #1 to his room. Nurse #1 stated Resident #6 appeared to be upset, but she was not crying. Nurse #1 stated Resident #1 was normally confused. She stated she reported to the Medication Aide and Nurse #3 on the hall what had happened to make sure Nurse #3 followed up with the responsible party and the Director of Nursing. Nurse #1 reported she recognized Resident #1's action as being abuse and that was why she told Nurse #3 to be sure to call the Director of Nursing immediately. Nurse #1 stated she has been in serviced on abuse annually through the facility's computer program. An interview was conducted with Nurse #3 via phone on 12/06/23 at 2:38 PM. Nurse #3 went and spoke with Resident #6 and she stated she was sleeping and she woke up to see this "strange man" who she did not know and she was upset and scared. Nurse #3 stated he had asked Resident #6 if she wanted to move to a different hall but she said she was okay and she declined to move. Nurse #3 stated Resident #6 expressed she did not want him to come into her room again and he made sure to follow up with her through the remainder of the shift to be sure she felt safe.	F 607	4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or administrative nurse will monitor 24 hour report sheets for potential instances of abuse 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 administrative nurse will present the results of the audit monthly in the Quality Assurance Performance Improvement (QAPI) meeting with the interdisciplinary team for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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F 607	Continued From page 27	F 607		

Nurse #3 stated he called the DON right after Nurse #1 had informed him and he had spoken with Resident #6 on 11/26/23 and informed the DON of the abuse. Nurse #3 stated the DON instructed him to speak with both families regarding the incident and he (DON) would move the resident in the morning. Nurse #3 reported Resident #6 stated she was fine knowing that Resident #1 was not going to be moved until the next morning. Nurse #3 reported Resident #1 was brought to his room and remained in his room the remainder of the night and he and Medication Aide did frequent checks on both residents throughout the shift. Nurse #3 stated he also gave Resident #6 his personal cell phone number to call him if she needed him through the rest of the shift. Nurse #3 reported he called the DON because he felt what Resident #1 did to Resident #6 was abuse and it needed to be reported. Nurse #3 stated he got training annually regarding abuse.

An interview with the Director of Nursing on 12/06/23 at 3:43 PM revealed he was made aware of Resident #1 entering Resident #6's room on 11/26/23. He stated during morning meeting on 11/27/23 it was decided since this was a new behavior for Resident #1 we would monitor him to be sure he did not enter Resident #6's room. He stated we did not feel the need to change his room at this time because Resident #6 said she felt safe. He stated we completed an incident report but we did not initiate an abuse investigation because it was a new behavior for Resident #1 and Resident #6 stated she felt safe. He stated he should have implemented a measure to protect all the residents from Resident #1 after that incident occurred with Resident #6.

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F 607	Continued From page 28	F 607		

b. Resident #2 was admitted to the facility on 09/04/23. The MDS quarterly assessment dated 11/08/23 revealed Resident #2 was severely cognitively impaired and demonstrated no behaviors.

A nursing progress note written by Nurse #2 on 11/27/23 at 7:09 PM revealed at approximately 4:15 PM, Resident #2 was noted by a staff member that Resident #1's hand was down the front of Resident #2's brief. Nurse #2 was notified by the staff member and observed Resident #1 was sitting in a chair beside Resident #2's bed and Resident #1 had his arms crossed and his hands tucked under his arms. Nurse #2 asked Resident #1 to, "please go to assigned room." The Assistant Director of Nursing and Administrator were made aware. A skin assessment was performed on Resident #2 and there were no noted injuries or impairments. Safety checks every 15 minutes were ordered.

An interview was conducted with Nurse Aide (NA) #1 via phone on 12/06/23 at 1:02 PM. NA #1 reported as she was walking by to get ice on the 400 hall she noticed Resident #1 sitting in a chair beside Resident #2's bed and noticed Resident #1 had his hand under the brief of Resident #2 and was manually stimulating (moving hand in an up and down motion) his penis. NA #1 stated Resident #1 noticed that she saw him and he quickly pulled his hand out of the brief. NA #1 stated she went into the room and asked what Resident #1 was doing in the room and replied "nothing." She added, she went straight to Nurse #2. NA #1 stated she received annual training on abuse and knew she needed to report this immediately to a supervisor.

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F 607	Continued From page 29	F 607		

An interview was conducted with Nurse #2 on 12/06/23 at 1:33 PM. Nurse #2 reported NA #1 quickly had approached her and told her Resident #1 was in Resident #2's room and Resident #1 had his hand down Resident #'2s brief and was stimulating him. Nurse #2 stated she went straight to Resident #2's room and Resident #2 was lying down on his back in his bed and Nurse #2 stated she asked Resident #1 to go to his room and she would be in to speak with him. Nurse #2 stated she did a complete head to toe assessment on Resident #2. She added, Resident #2 did not speak about Resident #1 having his hand down his brief and acted as though it did not happen. Nurse #2 stated once the residents were separated, she initiated 15 minute safety checks until Resident #1 could be further evaluated and the safety checks continued after Resident #1's return from the hospital. She stated his room was moved to the 200 hall on 11/28/23. Nurse #2 added Resident #2 remained in his room as he usually would not come out of his room and he was monitored as well with every 15 minute safety checks. Nurse #2 stated she reported the sexual abuse to the Assistant Director of Nursing and the Administrator. Nurse #2 stated she received annual training regarding abuse.

An interview was conducted with the ADON on 12/06/23 1:41 PM. The ADON reported that after she was made aware of the incident between Resident #1 and Resident #2 by Nurse #2 on 11/27/23 at about 4:15 PM she went into Resident #2's room to assess his mental state. The ADON reported that his confusion was at his baseline and it was difficult to process the incident with him because he did not seem to understand what

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	345549	A. BUILDING _____ B. WING _____	C 12/11/2023

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F 607	Continued From page 30	F 607		

was going on. The ADON reported Resident #2 was not upset or recalling any of the incident. The ADON reported she then went to see Resident #1 who was in his bathroom at the time. She stated it seemed he knew he had done something wrong but that he did not understand; he seemed embarrassed. The ADON spoke to him and told him that that behavior was not acceptable and he needed to stay out of residents' rooms and to keep his hands to himself. The ADON reported she received annual training regarding abuse through the facility's computer program.

An interview with the Director of Nursing on 12/06/23 at 3:45 PM revealed he should have implemented a measure to protect all the residents from Resident #1 after the first incident (11/26/23) occurred with Resident #6 because if he had followed the abuse policy and procedure the sexual abuse with Resident #2 could have been prevented.

An interview with the Administrator on 12/06/23 at 4:00 PM revealed he was made aware of Resident #1 entering Resident #6's room on 11/26/23 and was told that Resident #1 kissed Resident #6 on the cheek and she told him not to do that and he left the room. The Administrator stated he was not aware Resident #6 was scared. He stated on Monday he interviewed her and since she stated she felt safe and did not want her room changed he did not investigate further. The Administrator stated if he had further investigated the incident with Resident #6, the incident that occurred with Resident #1 and Resident #2 could have been avoided.

The Administrator was notified of the Immediate

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	345549	A. BUILDING _____ B. WING _____	C 12/11/2023

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UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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F 607	Continued From page 31 Jeopardy on 12/06/23 at 6:30 PM. F607 FAILURE TO IMPLEMENT THE ABUSE POLICY Identify those residents who suffered, or are likely to suffer a serious adverse outcome because of the non-compliance: The facility failed to follow their abuse policy and procedure to investigate allegations of abuse and to protect other residents from abuse following an incident of inappropriate touching, kissing, and unwanted advancements by Resident #1 into the personal space of Resident #6 on 11/26/23. The Regional Clinical Nurse completed an interview 12/07/23 with Resident #6. Resident #6 stated Resident #1 did enter her room on 11/26/23 and gave her a kiss. She told him to go sit in the chair across the room until someone came for him. He did comply. She added that she felt safe in the facility and has had no further incidents. An initial report was completed and filed with the state agency on 12/07/23. Adult Protective Services (APS) and police were called on 12/07/23 by the Administrator. This investigation was opened and completed on 12/07/23 by Regional Clinical Nurse. Resident #1 was moved closer to the nurse's station on 11/27/23. He was transferred to the emergency department on 11/28/23 for medical and psychiatric evaluation where he was diagnosed with a urinary tract infection. Antibiotics were prescribed for 7 days. Resident #1 completed his course of antibiotics on 12/07/23.	F 607		

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F 607	Continued From page 32	F 607		

The Regional Clinical Nurse completed a review of current resident electronic medical records, including progress notes and incident reports for the last 30 days to determine if there were any other incidents that would require further investigation and reporting of abuse on 12/06/23. The results of the audit identified one incident that had occurred on 11/29/23. This investigation was opened and completed on 12/07/23 by the Regional Clinical Nurse. The facility Administrator completed an initial report on 12/07/23, including notification of law enforcement, APS, and report to the State Agency on 12/07/23. This was related to a yelling incident between two residents.

The facility Social Worker and the Admissions Coordinator interviewed current alert and oriented residents on 12/07/23 to determine if they felt safe in the facility. There were no other residents who were identified as feeling unsafe. For those residents who are unable to be interviewed the responsible party will be contacted on 12/07/23 by the Social Worker and Admissions Coordinator to ensure they felt their resident was safe in the facility.

Specify action the facility will take to alter the process or system failure to prevent a serious outcome from occurring or recurring and when the action will be completed:

The facility Administrator and Director of Nursing received re-training from the Director of Operations and Regional Clinical Nurse on Abuse/Neglect policy and procedure, including identification of abuse, types of abuse, investigation, protection, reporting/respond, prevention, screening, and the possible

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F 607	Continued From page 33	F 607		

psychosocial effects of sexually inappropriate behavior on a resident.

The Administrator and DON were trained in the steps to follow in a facility investigation. This training was completed on 12/07/23.
The 24-hour report will be reviewed by the oncoming nurse and shared with the nursing assistants at the beginning of the shift. The nursing assistants will sign the 24-hour report indicating that they have been informed of the previous day's events. The 24-hour report was a review of the last 24 hours any resident change in condition, behaviors, or other acuities. This will be a new process for the nursing assistants.

The DON and /or Administrative Nurse will be completing education with current licensed nurses and nursing assistants on the use of the 24-hour report sheet. Any current licensed nurse and nursing assistant who does not receive this training by 12/07/23 will not be able to work without the training from the DON and/or Administrative Nurse. Newly hired licensed nurses and nursing assistants will receive this training at orientation by DON or ADON.

The DON and Regional Clinical Nurse began education with current facility staff, including contract Housekeeping/Laundry and Rehabilitation on Abuse/Neglect policy and procedure, including identification of abuse, investigation, protection, reporting/respond, prevention and screening. abuse, the reporting of abuse and the possible psychosocial effects of sexually inappropriate behavior on a resident. Staff were also educated that the cognitive status of the resident does not rule out abuse. This training was completed as of 12/07/23. Any

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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 607	Continued From page 34 current employee who has not received this education as of 12/07/23 will not be allowed to work until education was completed by the facility DON. All newly hired employees will receive this education during orientation and prior to assignment. The DON will be responsible for the education. The DON is responsible for the tracking of the education to ensure completion. The facility does not utilize agency staff. The facility alleges the removal date of the Immediate Jeopardy was 12/08/23. The removal plan of the Immediate Jeopardy was validated on 12/08/23. A sample of staff including the Administrator, Director of Nursing, nurses, nurse aids, therapists, housekeeping staff, and dietary aides were interviewed regarding in services they received related to the deficient practice. All staff interviewed stated they had been in serviced regarding identifying, reporting, and investigating abuse. Additionally, nurses and nurse aides were interviewed regarding the in-services they received for the new process of the 24 hour report sheet which was a tool used to communicate daily events when reporting off or on shift. The removal date of 12/08/23 was validated.	F 607		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including	F 867		12/29/23

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	345549	A. BUILDING _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 35	F 867		

adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after

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F 867	Continued From page 36	F 867		

implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects

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F 867	Continued From page 37 conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following the complaint survey of 05/10/21 for one deficiency that was originally cited in area of abuse (F600), and during a recertification survey of 10/26/21 for two deficiencies that were originally cited in the areas of abuse (F600) and not following abuse policy (F607). These	F 867	F867 QAPI/QAA Improvement Activities: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There were no identified residents named in this alleged deficient practice. 2. Address how the facility will identify	

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F 867	Continued From page 38 deficiencies were subsequently recited on the current complaint survey on 12/11/23. The continued failure during 2 or more surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F600: Based on observations, record review, staff and Nurse Practitioner interviews, the facility failed to protect residents' right to be free from sexual abuse (Resident #2) and intentional inappropriate touching (Resident #6) perpetrated by Resident #1. In the evening of 11/26/23 the facility was made aware Resident #1 entered another resident's room (Resident #6) uninvited and Resident #6 reported to Nurse #1 that a "strange man" (identified as Resident #1) woke her up and was holding her hand, telling her he was going to care for her and kissed her on the cheek. Resident #6 was upset and scared and was not sure what Resident #1 was doing in the room and told him he did not belong in her room. Resident #6 required Ativan (a medication to treat anxiety) 4 days later because she was still upset. On 11/27/23, the day following the incident with Resident #1 and Resident #6, Resident #1 was found by Nurse Aide #1 in Resident #2's room sitting at his bedside while Resident #2 lay in bed. Resident #1 had his hand down Resident #2's brief and was manually stimulating (moving hand in an up and down motion) Resident #2's penis. Due to the inappropriate act initiated by Resident #1 toward Resident #2, a reasonable person would have experienced intimidation and fear. This was for 2 of 3 residents reviewed for abuse.	F 867	other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. On 12/28/23, the facility department managers conducted a review of the action plans implemented at the completion of the survey on 12/11/23 to determine the root cause of the repeat deficiencies. The root cause was determined to be a change in key leadership staff. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Regional Clinical Consultant reeducated Administrator, Director of Nursing, Social Work, Director of Nursing, Business Office Manager, Activities Director, Housekeeping Manager, Maintenance Director, Admissions Director, Medical records coordinator, Rehab Director, MDS nurses, Human Resources, and Central Supply received education on 12/9/23 by the regional clinical nurse on F867 and the facility QAPI program. Any new facility department manager will receive this training during their orientation. Monthly Quality Assurance Process Improvement (QAPI) minutes will now be reviewed by the Regional Director of	

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F 867	Continued From page 39 During the complaint survey of 05/10/21, the facility failed to protect a resident's right to be free from abuse. During the recertification survey of 10/26/21, the facility failed to protect a resident's right to be free from sexual abuse when a cognitively impaired resident was observed in a resident's room who was also cognitively impaired, masturbating to the point of ejaculation. F607: Based on record review, and staff interviews, the facility failed to protect Resident #2 from sexual abuse when the Administrator was made aware of Resident #1 entering Resident #6's room uninvited on 11/26/23. Resident #6 reported to Nurse #1 that Resident #1 woke her up and was holding her hand, telling her he was going to care for her and kissed her on the cheek. Resident #6 was upset and scared and was not sure what he was doing in the room and told him he did not belong in her room. The following day 11/27/23, Resident #1 was found by Nurse Aide #1 in Resident #2's room sitting at his bedside while Resident #2 lay in bed. Resident #1 had his hand down Resident #2's brief and was manually stimulating (moving hand in an up and down motion) his penis. Additionally, the facility failed to identify abuse, to report the allegation of abuse to the state agency and to conduct a thorough investigation for Resident #6. This was for 2 of 3 residents observed for abuse. During the recertification survey of 10/26/21, the facility failed to implement their abuse policy by not reporting allegation of sexual abuse to the state agency within 2 hours, to conduct a thorough investigation for an allegation of sexual abuse, submit an investigation report to the state	F 867	Operations and Regional Clinical Consultants to ensure that all performance improvement plans are effective and address areas of self-identified and cited deficiencies. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Regional Director of Operations and/or Regional Clinical Nurse will review Quality Assurance Process Improvement (QAPI) minutes monthly for 3 months, then quarterly for three quarters.	

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F 867	Continued From page 40 agency within 5 days, and to report an allegation of resident to resident physical abuse within 24 hours and submit an investigation report within 5 days. An interview was conducted with the Administrator on 12/18/23 at 2:00 PM. The Administrator stated he believed the Quality Assurance (QA) process needed to be lengthened when monitoring abuse and the facility would continue to receive education to follow the abuse policy and procedure to include identifying, investigating, protecting and reporting abuse.	F 867		