**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>345549</td>
<td>A. BUILDING _____________________________</td>
<td>C 08/13/2015</td>
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<td>B. WING _____________________________</td>
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**NAME OF PROVIDER OR SUPPLIER**

UNIVERSAL HEALTH CARE / BRUNSWICK

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1070 OLD OCEAN HIGHWAY
BOLIVIA, NC 28422

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed 08/18/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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**SUMMARY STATEMENT OF DEFICIENCIES**

_F000 INITIAL COMMENTS_

This facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care facilities. (General Health Survey). Event ID 1TWB11. No deficiencies were cited as a result of the complaint investigation.

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
<thead>
<tr>
<th>ID</th>
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<tr>
<td>F000</td>
<td>INITIAL COMMENTS</td>
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Event ID: 1TWB11
Facility ID: 050906
If continuation sheet Page 1 of 1