ENTERS F	OR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-03
TEMENT OF E	DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY
		345549	B. WING			C 10/12/2017
AME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NIVERSAL	HEALTH CARE / BRU	INSWICK	· ·	1070 OLD OCEAN HIGHWAY		
				BOLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
SS=D (I	OTIFY OF CHANG NJURY/DECLINE/F FR(s): 483.10(g)(14	ROOM, ETC)	F 157			10/31/17
(g)(14) Notification of	Changes.				
CC	 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; 					
re						
m de st	ental, or psychosoc eterioration in health	nge in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or c);				
a tro	need to discontinue	eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or				
	sident from the faci	sfer or discharge the lity as specified in				
(1 al is	4)(i) of this section, I pertinent informati	ification under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ided upon request to the				
re		also promptly notify the dent representative, if any,				
DRATORY DIR						

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

program participation.

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

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/21/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345549	B. WING		C 10/12/2017
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	·
				1070 OLD OCEAN HIGHWAY	
UNIVERS	AL HEALTH CARE / BRU	INSWICK		BOLIVIA, NC 28422	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 157 Continued From page 1 (A) A change in room or roommate assignmen as specified in §483.10(e)(6); or		or roommate assignment	F 15	7	
	 (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must a update the address (a phone number of the This REQUIREMENT by: Based on record rev facility failed to notify responsible party (RF origin that was identifi 1 of 3 sampled reside Findings included: Resident #1 was adm 6/14/17 with a readm Diagnoses included, 	ent rights under Federal or ins as specified in paragraph record and periodically mailing and email) and resident representative(s). T is not met as evidenced iew and staff interviews, the the physician and the P) of an injury of unknown fied during evening hours for ents (Resident #1).		This plan of correction constitutes written allegation of compliance. Preparation and submission of this correction does not constitute an admission or agreement by the pri- the truth of the facts alleged or the correctness of the conclusions set on the statement of deficiencies. To of correction is prepared and subri- solely because of requirement und and federal law, and to demonstration good faith attempts by the provide improve the quality of life of each	s plan of ovider of t forth The plan nitted der state ate the er to
	was severely cognitiv noted as having beha inattention and disorg care 1-3 days, wande behaviors not directe The resident requirec two staff members wi transfers, dressing, to and extensive assista with ambulating, loco	21/17 revealed the resident vely impaired. She was aviors continuously with ganized thinking, rejection of ering 1-3 days, and other d toward others for 1-3 days.		ROOT CAUSE Licensed nurse #1, notified on-cal physician and Responsible party a hours from the time the alleged br unknown origin was reported to he was caused by nurse #1 clinical judgement that notifying the respo party and physician wasn the pr and when a condition does not co life threatening condition. Nurse # not aware of the regulatory require	about 12 uise of er. This nsible riority if nstitute 1 was

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				PRINTED: 11/21/20 FORM APPROVE OMB NO. 0938-039
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
	345549	B. WING		10/12/2017
ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
AL HEALTH CARE / BRU	INSWICK			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO
Continued From page	e 2	E 157		
was not steady and o assistance with balan A review of a nursing 1:40 am by Nurse #1 no signs or symptoms currently resting in be note stated when the were undressing Res 10/03/17) they notice upper arm. The note to the room where sh performed range of m stated there was pain Nurse #1 noted there and purple and meas centimeters (cm) leng indicated Nurse #1 w obtained the bruise, b	note written on 10/4/17 at revealed the resident had s of distress or pain and was ed with eyes closed. The nursing assistants (NAs) ident #1 for bed (on d a large bruise on the right stated Nurse #1 was called e measured the bruise and notion and Resident #1 on the right lower arm. was a bruise which was red ured approximately 11 gth and 9 cm wide. The note as not sure how the resident but prior to going to bed she	F 157	 that requires the facility to immediat inform the resident; consult with the residents physician; and notify, conswith his or her authority, the resident representative(s) when there is- An accident involving the resident which results in injury and has the potentiar requiring physician intervention. In the case resident had an injury of unknows ource that require medical intervention. Nurse #1 was re-educated by the D of nursing on 10/12/17 on the require specifically for notification of change residents, physician and resident is responsible party. IMMEDIATE ACTION On 10/04/2017, at 8:13 AM, the on- 	sistent it h al for his own ition. irector rement es to
8:13 am by Nurse #1 to the on-call physicia about the large bruise indicated the resident not known what could The note reported the of the right humerus a was placed to the mo note indicated the Dir the Assistant Director site to examine the br notified. A review of the reside 10/4/17 at 8:15 am re hematoma to the right	revealed a call was placed an to explain the situation e on Resident #1. The note t was ambulatory and it was d have caused the bruise. e physician ordered an x-ray and shoulder and that a call oble x-ray company. The rector of Nursing (DON) and of Nursing (ADON) were on ruise and the RP was ent incident report dated evealed the resident had a it upper arm measuring		bruise noted on resident #1. X-ray or right humerus and shoulder was or by the on-call physician and obtained the licensed mobile X-ray Company resident #1 a bedside. Resident #1 sent to hospital for evaluation and treatment on 10/04/17. Nurse #1 no Resident #1 responsible party of the bruise, x-ray orders and the hospital transfer on 10/04/2017 at 8:13AM. No further actions taken for this res IDENTIFICATION OF OTHERS 100% audit of all current residents clinical documentation within the las	of the dered ed by at was tified e l sident.
	S FOR MEDICARE & OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER AL HEALTH CARE / BRU SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page was not steady and c assistance with balar A review of a nursing 1:40 am by Nurse #1 no signs or symptom: currently resting in be note stated when the were undressing Res 10/03/17) they notice upper arm. The note to the room where sh performed range of m stated there was pair Nurse #1 noted there and purple and meass centimeters (cm) leng indicated Nurse #1 w obtained the bruise, t was noted leaning in A review of a nursing 8:13 am by Nurse #1 to the on-call physicia about the large bruise indicated the resident not known what could The note reported the of the right humerus a was placed to the mode note indicated the Dir the Assistant Director site to examine the bruise Notified. A review of the resident Notified.	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345549 ROVIDER OR SUPPLIER AL HEALTH CARE / BRUNSWICK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 was not steady and only able to stabilize with assistance with balance. A review of a nursing note written on 10/4/17 at 1:40 am by Nurse #1 revealed the resident had no signs or symptoms of distress or pain and was currently resting in bed with eyes closed. The note stated when the nursing assistants (NAs) were undressing Resident #1 for bed (on 10/03/17) they noticed a large bruise on the right upper arm. The note stated Nurse #1 was called to the room where she measured the bruise and performed range of motion and Resident #1 stated there was pain on the right lower arm. Nurse #1 noted there was a bruise which was red and purple and measured approximately 11 centimeters (cm) length and 9 cm wide. The note indicated Nurse #1 was not sure how the resident obtained the bruise, but prior to going to bed she was noted leaning in a chair on her right side. A review of a nursing note written on 10/4/17 at 8:13 am by Nurse #1 revealed a call was placed to the on-call physician to explain the situation about the large bruise on Resident #1. The note indicated the resident was ambulatory and it was not known what could have caused the bruise. The note reported the physician ordered an x-ray of the right humerus and shoulder and that a call was placed to the mobile x-ray company. The note indicated the Director of Nursing (DON) and	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING Continued From page 2 was not steady and only able to stabilize with assistance with balance. F 157 A review of a nursing note written on 10/4/17 at 1:40 am by Nurse #1 revealed the resident had no signs or symptoms of distress or pain and was currently resting in bed with eyes closed. The note stated when the nursing assistants (NAs) were undressing Resident #1 for bed (on 10/03/17) they noticed a large bruise on the right upper arm. The note stated Nurse #1 was called to the room where she measured the bruise and performed range of motion and Resident #1 stated there was pain on the right lower arm. Nurse #1 noted there was a bruise which was red and purple and measured approximately 11 centimeters (cm) length and 9 cm wide. The note indicated Nurse #1 revealed a call was placed to the on-call physician to explain the situation about the large bruise on the right side. A review of a nursing note written on 10/4/17 at 8:13 am by Nurse #1 revealed a call was placed to the on-call physician to explain the situation about the large bruise on the right side. A review of the resident mobile x-ray company. The note indicated the Director of Nursing (DON) and the Assistant Direc	SFOR MEDICARE & MEDICAID SERVICES PF DEFIDENCIES (X1) PROVIDERSUPPLIERCIAN ALBUIDING A BUIDING 345549 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IDENTIFICATION NUMBER B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IDENTIFICATION NUMBER STREET ADDRESS, CITY, STATE, ZIP CODE IDENTIFICATION NOT COR CITERET CONTRECTIFICATION NOT CORTECT Continued From page 2 IDENTIFICATION Was not steady and only able to stabilize with assistance with balance. F157 The one regoon Stat

Facility ID: 050906

If continuation sheet Page 3 of 21

		MEDICAID SERVICES				<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345549	B. WING			С
		345349				0/12/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / BRU	NSWICK		1070 OLD OCEAN HIGHWAY		
				BOLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 157	Continued From page	e 3	F 15	57		
		undressing the resident for		Nursing, Assistant Director of N	Jursina	
		7 and they noticed a large		and/or Nurse Supervisor to del	•	
		per arm. The nurse was		identified need for notification of	-	
		ere it was measured and		was completed in a timely mar	•	
		performed. The report		audit revealed no other incider		
		t stated she had pain on the		missing/delayed notification of		
	lower arm and the bru	uise was red and purple in		both physician and responsible	e party. This	
	color. The note report	rted the nurse was not sure		audit was completed on 10/23/	17 Findings	
	-	the bruise, but she was		of this audit is documented on		
	-	he table on that side. The		records audit tool located at the	e facility	
	-	OON was notified at 8:05 am,		compliance binder.		
		was notified at 8:16 am, and				
	the family was notified	d at 8:25 am.		On 10/11/2017 1000/ audituus	-	
	An interview was een	ducted with Nurse #1 on		On 10/11/2017, 100% audit wa		
		ne at 11:25 am. Nurse #1		completed by the Director of N incidents reports completed wi	-	
		t her to bed around 9:00 pm		30 days to ensure notification v		
		ey noticed the bruise on		a timely manner.		
		upper arm and notified her.		The audit revealed no other inc	cident of	
	-	was a large bruise, red and		missing/delayed notification of		
		the arm over towards the		both physician and responsible	-	
		no skin breakdown or		audit was completed on 10/23/		
		Nurse #1 stated she did not		Findings of this audit is docum		
		ian until 8:15 am the next		incident reports audit tool local	ted at the	
		ecause she thought it was		facility compliance binder.		
		e. Nurse #1 reported that				
	the physician ordered			SYSTEMIC CHANGES		
		er at that time. The nurse				
		tify the RP when the bruise		Effective 10/30/2017, the center		
		3/17 and added the staff only		administrative team, which incl		
		ring the night shift if there		ADON, and/or SDC, initiated a		
	that calling the RP at	situation. Nurse #1 stated		reviewing clinical documentation last 24 hours, 24 hour report sl		
		ut she decided to wait until		incident reports for the last 24		
		vas not life threatening.		Physician orders written in the		
		was aware that she was		hours to ensure any needed no		
		e DON, family and physician		changes to the physician, and/		
	if there was a new co			responsible party was done in		
		tated she was going to notify		manner. This systemic process		

Facility ID: 050906

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/21/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345549	B. WING		C 10/12/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE
UNIVERS	AL HEALTH CARE / BRU	INSWICK		1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE ICIENCY)
F 157	the DON in the morni resident had no comp night and when she c hours or so, she was An interview with the conducted on 10/12/ ⁷ stated her expectatio her, the provider on-c as soon as possible i injury of unknown orig A phone interview was physician at 10/12/17 message was left with An interview with the 10/12/17 at 2:20 pm the nurses was to no physician if it was afte unknown origin. An interview with the pm revealed her expen- notify the physician a was identified. The E feel that 9:00 pm was call the RP and expen-	Ing. The nurse stated the blaints of pain through the checked on her every two sleeping. Nurse Practioner (NP) was 17 at 1:30 pm. The NP n of the nurses was to notify call or the facility physician f there was an identified gin. Its attempted with the on-call of at 2:05 pm. A voice mail h no return call received. facility physician on revealed her expectation of	F1	 57 place daily (Monday the identified issues will be promptly and approprime implemented by the D and/or Registered Numprocess will be incorplated in the clinical rounds. Any near be documented on the and maintained in the meeting binder. Effective 10/30/201, we Nurse supervisor and licensed nurse will reverse documentation for the hour report sheets, inclust 24 hours and Phy in the last 24 hours and Phy in the last 24 hours and Phy in the last 24 hours to notification of changes and/or responsible patimely manner. This sy take place every Satuid identified issues will be promptly and approprime process will be incorpled in the meeting binder. Director of Nursing (D Director of Nursing (A Development Coordin complete 100% education was on the education was on the education was on the process of the education was on the education was on the process with the education was on the education was on the education was on the process of the education was on the process of the education was on the education was on the education was on the process of the education was on the process of the education was on the education was on the process of the education was on the process of the education was on the process of the education was on the education was on the process of the education was on the process of the education was on the process with the education was on the process of the education was on the process will be process of the education was on the process will be process of the education was on the process with the education was on the process of the education was on the proces of the education was on the process with the educat	e addressed iate actions will be DON, ADON, SDC rse supervisor. This orated in a daily egative findings will e daily checklist form daily clinical veek end Registered /or designated /iew clinical e last 24 hours, 24 cident reports for the rsician orders written ensure any needed s to the physician, rty was done in a ystemic process will rday & Sunday. Any e addressed iate actions will be DON, ADON, SDC rse supervisor. This orated in a daily egative findings will e daily checklist form daily clinical

Event ID: K94Q11

Facility ID: 050906

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-039 TE SURVEY	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	3	CO	MPLETED	
		245540	B. WING			С	
	ROVIDER OR SUPPLIER	345549		STREET ADDRESS, CITY, STATE, ZIP COI		0/12/2017	
INAME OF PI	VUNDER OR SUPPLIER			1070 OLD OCEAN HIGHWAY	<i>у</i> с		
UNIVERS	AL HEALTH CARE / BRU	INSWICK		BOLIVIA, NC 28422			
(X4) ID		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG				(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE	
F 157	Continued From page	e 5	F 15	57			
	Continued i rom puge			notifying Physician and the re	esponsible		
				party in a timely manner for a	•		
				incident/accidents, resident			
				condition, change of			
				treatment/intervention and/or unknown source. This educa			
				completed by 10/31/2017. Ar			
				nurse not educated by 10/31	-		
				be allowed to work until educ			
				education will also be added			
				orientation process for all new nurses effective 10/31/2017.	w Licensed		
				MONITORING PROCESS			
				Effective 10/30/2017, Directo	•		
				Assistant Director of Nursing Development Coordinator, w			
				compliance with notification of			
				Physician and/or responsible			
				conducting clinical meeting d			
				review the daily clinical meet	-		
				to ensure completion and pro through, will review any	pper tollow		
				admission/discharges occurr	ed from the		
				last clinical meeting and/or a			
				or accidents occurred from th	ne prior		
				clinical meeting. Any issues i			
				during this monitoring proces addressed promptly. Finding			
				meeting will be documented			
				clinical report form and filed i			
				meeting binder in Director of			
				office after proper follow ups			
				Director of Nursing will review			
				completion of daily clinical re daily clinical checklist forms of			
				2weeks, weekly x 2 more we			
			1	· · · · · · · · · · · · · · · · · · ·	-,	1	

Event ID: K94Q11

Facility ID: 050906

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	S FUR MEDICARE &	MEDICAID SERVICES				D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		345549	B. WING		C 10/12/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE / BRU	INSWICK		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 CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	F 157 Continued From page 6		F 157	compliance is maintained. Effective 10/31/2017, Director of I	Nursing	
				will report findings of this monitori process to the facility Quality Assi and Performance Improvement Committee for any additional mon or modification of this plan monthl months, or until the pattern of con is maintained. The QAPI committee modify this plan to ensure the faci remains in substantial compliance	ng urance litoring ly X3 npliance ee can lity	
				RESPONSIBLE PARTY Effective 10/31/17, the center Exe Director and the Director of Nursin be ultimately responsible to ensur implementation of this plan of corr for this alleged noncompliance to the facility remains in substantial compliance.	ng will e rection	
F 225 SS=D		VIDUALS	F 225	5		10/31/17
	483.12(a) The facility					
	(3) Not employ or oth who-	nerwise engage individuals				
		guilty of abuse, neglect, opriation of property, or ourt of law;				
		g entered into the State oncerning abuse, neglect, ment of residents or				

Facility ID: 050906

If continuation sheet Page 7 of 21

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	APPROVED
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345549	B. WING				C 12/2017
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE / BRUNS	SWICK			70 OLD OCEAN HIGHWAY DLIVIA, NC 28422		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI> TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
or her professional licen body as a result of a fine exploitation, mistreatmen misappropriation of resid (4) Report to the State r licensing authorities any actions by a court of law which would indicate un nurse aide or other facil (c) In response to allega exploitation, or mistreath (1) Ensure that all allega abuse, neglect, exploita including injuries of unk misappropriation of resid reported immediately, b after the allegation is ma cause the allegation is ma cause the allegation inv serious bodily injury, or the events that cause th abuse and do not result the administrator of the officials (including to the adult protective services for jurisdiction in long-te accordance with State la procedures.	r property; or action in effect against his use by a state licensure ding of abuse, neglect, ent of residents or dent property. nurse aide registry or y knowledge it has of y against an employee, fitness for service as a ity staff. ations of abuse, neglect, ment, the facility must: ed violations involving tion or mistreatment, nown source and dent property, are ut not later than 2 hours ade, if the events that olve abuse or result in not later than 24 hours if he allegation do not involve in serious bodily injury, to facility and to other e State Survey Agency and s where state law provides erm care facilities) in aw through established all alleged violations are	F 2	225			

Facility ID: 050906

If continuation sheet Page 8 of 21

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				FORM	D: 11/21/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	· · · /	E SURVEY PLETED
	345549	B. WING			C / 12/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1070 OLD OCEAN HIGHWAY		
UNIVERSAL HEALTH CARE / BRUN	SWICK		BOLIVIA, NC 28422		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
administrator or his or l representative and to c with State law, includin Agency, within 5 workin if the alleged violation i corrective action must This REQUIREMENT by: Based on record revie facility failed to submit 5-day report to the stat sampled residents (Re injury of unknown origin Findings included: Resident #1 was admit 6/14/17. Diagnoses in osteoporosis, and fract humerus. The Minimum Data Set assessment dated 9/27 was severely cognitive noted as having behav inattention and disorga care 1-3 days, wanderi behaviors not directed The resident required e two staff members with transfers, dressing, toil and extensive assistan with ambulating, locom	tment while the ress. of all investigations to the her designated other officials in accordance ig to the State Survey ing days of the incident, and is verified appropriate be taken. is not met as evidenced w and staff interviews, the a 24 hour report and a the agency for 1 of 3 sident #1) reviewed for an n. tted to the facility on cluded, in part, dementia, ture to upper end of right t (MDS) quarterly 1/17 revealed the resident ly impaired. She was iors continuously with inized thinking, rejection of ing 1-3 days, and other toward others for 1-3 days. extensive assistance with	F2	F225D ROOT CAUSE This alleged noncompliance was res from the Center □s Director of Nursin misinterpretation of regulatory requirements related to reporting an of unknown source. The DON stated way she understood for an injury of unknown origin to be reported, one co criteria was that the resident was not ambulatory. The DON stated since Resident #1 was ambulatory then the criteria would not have been met, an therefore, it would not be necessary complete the 24-hour and 5-day repor nor report it to the State Survey Ager Regional Nurse Consultant re-educa the Center Administrator and the Dire of Nursing on 10/23/2017 on reportin expectation if there is an injury of unknown origin noted for any resider the facility. IMMEDIATE ACTION	g injury I the f the d d ort cy. ted ector g	

Facility ID: 050906

If continuation sheet Page 9 of 21

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/21/201 MAPPROVE 0. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345549	B. WING				C / 12/2017
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				107	70 OLD OCEAN HIGHWAY		
UNIVERSA	AL HEALTH CARE / BRU	INSWICK		вс	DLIVIA, NC 28422		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From page	e 9	F 2	25			
	assist with balance.			20	day report were sent to the Departme Health and Human Services, for resi	dent	
	1:40 am by Nurse #1	note written on 10/4/17 at revealed the resident had s of distress or pain and was			#1⊡s injury of unknown source ident in 10/03/2016. These reports were completed and submitted by the	ified	
	currently resting in be note stated when the	ed with eyes closed. The nursing assistants (NAs)			Administrator. No further actions take resident #1.	en for	
	a large bruise on the	ident #1 for bed they noticed right upper arm. The note called to the room where			IDENTIFICATION OF OTHERS		
	motion and Resident	uise and performed range of #1 stated there was pain on			100% audit of all current residents□ clinical documentation within the last	30	
	bruise which was red	Nurse #1 noted there was a and purple and measured			days was completed by the Director Nursing, Assistant Director of Nursin	g	
	• •	ntimeters (cm) length and 9 ndicated Nurse #1 was not			and/or Nurse Supervisor to determin there is any injuries of unknown sour		
	sure how the residen	t obtained the bruise, but			documented in any resident s medie	cal	
	prior to going to bed s chair on her right side	she was noted leaning in a e.			records, and if any determine whether 24 hours and 5 days investigation re were completed and reported to the	ports	
	A review of a nursing	note written on 10/4/17 at			agency and other officials as require		
		revealed a call was placed			regulation and/or Elder Justice Act. 1		
		an to explain the situation e on Resident #1. The note			audit revealed no other incident of in of unknown source documented in	jury	
		t was ambulatory and it was			resident⊡s medical records. This au	dit	
		have caused the bruise.			was completed on 10/23/17. Finding	s of	
		e physician ordered an x-ray and shoulder and that a call			this audit is documented on clinical records audit tool located at the facili	it.	
	was placed to the mo	bile x-ray company. The rector of Nursing (DON) and			compliance binder.	irà	
		r of Nursing (ADON) were on ruise and the family was			100% audit was completed by the Di of Nursing of all incidents reports completed within the last 30 days to identify any injuries of unknown sour		
	A review of the reside	ent incident report dated			and ensure that a proper investigatio		
	10/4/17 at 8:15 am re	evealed the resident had a			was completed and a 24 hours as we		
	÷	t upper arm measuring			5 days reports are completed and		
		escription of the incident undressing the resident for			submitted to the state agency as req by regulation and Elder Justice Act.		

Facility ID: 050906

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/21/201 RM APPROVEI O. 0938-039
STATEMENT O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRU		(X3) DAT	E SURVEY IPLETED
		345549	B. WING_			1	C)/12/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	•	
				1070 OLD O	DCEAN HIGHWAY		
UNIVERS	AL HEALTH CARE / BRU	INSWICK		BOLIVIA, M	NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225		a 10	Í	225			
F 225	right upper arm. The room where it was m was performed. The stated she had pain of bruise was red and p reported the nurse wa got the bruise, but sh the table on that side call physician, the far A review of a nursing 10/4/17 at 1:29 pm re s family member (FM this shift. The note si resident ' s bruise, the be evaluated by the e The note indicated R via Emergency Medic hospital at 1:10 pm. A review of a nursing 10/5/17 at 2:56 pm in returned to facility at	oticed a large bruise on the nurse was called to the easured and range of motion report indicated the resident on the lower arm and the urple in color. The note as not sure how the resident e was leaning in a chair at . The report indicated the on mily, and DON were notified. note written by Nurse #2 on evealed one of the resident ') had arrived to visit during tated upon seeing the e FM requested the resident emergency department (ED). esident #1 was transported cal Service (EMS) to the note written by Nurse #3 on dicated Resident #1 1:38 pm in stable condition he right shoulder with blue	F	of unka comple audit is audit tu binder 100% comple active of Nurs and/or other i source on 10// 100% resider Nursin and/or other r source incider noted.	audit of skin assessments eted within the last 30 days residents completed by the sing, Assistant Director of I r Nurse Supervisor to identi resident with a documented with a	udit was gs of this reports ompliance s of all e Director Nursing ify any d injury of aled no wn npleted tive tor of rsing ify any aknown her urce	
	on 10/5/17 revealed t	arge summary from the ED he resident had an x-ray of he impression showed an		10/23/ SYSTE	/2017. EMIC CHANGES		
	impacted proximal rig discharge plan indica comorbidities and set fracture may be treat	ted with the residents other vere osteoporosis, the ed as closed fracture and a would be appropriate.		admini ADON review last 24	ive 10/30/2017, the center i istrative team, which includ I, and/or SDC, initiated a priving clinical documentation 4 hours, completed skin	les DON, rocess for for the	
	10/12/17 at 11:25 am	ducted with Nurse #1 on . Nurse #1 reported that at the aides reported to her		24 hou the las	sments, incident reports for urs, and Physician orders w st 24 hours to ensure any ir ied is thoroughly investigat	vritten in njuries	

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		345549	B. WING			С
	ROVIDER OR SUPPLIER	343343		STREET ADDRESS, CITY, STATE, ZIP COI		10/12/2017
	ROVIDER OR SUPPLIER			1070 OLD OCEAN HIGHWAY	DE	
JNIVERS	AL HEALTH CARE / BRU	INSWICK		BOLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETIC DATE
	1			DEFICIENCY)	
F 225	Continued From page	e 11	F 22	25		
		rge bruise on the right arm.		the source of injury is unknow	wn the	
	The nurse stated whe			Director of Nursing will repor		
		asurements and performed		Administrator to ensure a 24		
	range of motion and v	•		five days reports are comple		
		esident complained of pain		submitted to the State agence		
		se reported the resident had		by regulation. This systemic		
		onary chair for a couple of		take place daily (Monday thr		
	•	ea prior to going to bed on		Any identified issues will be a		
		noted to be leaning to her		promptly and appropriate act		
		ndicated Resident #1 was		implemented by the DON, Al		
	-	a fall or bumping her arm.		and/or Registered Nurse sup		
				process will be incorporated		
	An interview with the	DON on 10/12/17 at 4:45		clinical rounds. Any negative	-	
		'17 at 7:30 am, Nurse #2		be documented on the daily	-	
	•	nd made her aware of the		checklist form and maintaine		
		n on Resident #1. The DON		clinical meeting binder.	,	
	-	I the ADON went to the				
		valuate the bruising. The		Effective 10/30/2017, week e	end	
		e bruise on the inside of the		Registered Nurse supervisor		
	-	e in color with a red border.		designated licensed nurse w		
	-	e resident was somnolent		clinical documentation for the		
		be in any pain at this time.		hours, completed skin asses		
		ne investigated the injury of		incident reports for the last 2		
		DON stated she interviewed		Physician orders written in th		
	•	d the bruise at 9:00 pm on		hours to ensure any injuries		
		no assessed the bruise at		thoroughly investigated and i		
		and the nurse who assessed		of injury is unknown the supe		
		ft, as well as the day shift		notify the Director of Nursing		
	nurses who worked o	-		Administrator. The DON and		
	reported after the inve	estigation was completed,		Administrator will ensure a 2	4 hours and a	
	they were unable to c	letermine the cause of the		five days reports are comple	ted and	
	bruising. The DON pr	ovided evidence that she		submitted to the State agence	y as required	
	obtained written state	ements, implemented audits		by regulation. This systemic		
	-	vices regarding notification		take place every Saturday ar	-	
	on all the staff involve	ed. The DON reported she		Any negative findings will be		
	did not complete the	24-hour report or the 5-day		on the week end supervisor	report form	
		ne state agency. The DON		and maintained in the daily c	linical	
		nderstood for an injury of		meeting binder.		
	unknown origin to be	reported, one of the criteria				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 APPROVED D: 0938-0391
				TIPLE	(X3) DATE SURVEY COMPLETED		
		345549	B. WING		C 10/12/2017		
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE / BRU	INSWICK		10	070 OLD OCEAN HIGHWAY		
				В	OLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 225	DON stated since Re then the criteria would therefore, it would no the 24-hour and 5-da State Survey Agency An interview was con Administrator on 10/1 Administrator indicate there was an injury of resulted in harm, the	was not ambulatory. The sident #1 was ambulatory d not have been met, and t be necessary to complete y report nor report it to the ducted with the 2/17 at 4:45 pm. The ed that his expectation was if f unknown origin that facility was responsible for ed forms and reporting the	F	225	Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Sta Development Coordinator (SDC) will complete 100% re-education on the facility s abuse/neglect policy includir notification protocols. This education w be provided for all employee, to include full time, part time and as needed staft This education will be completed by 10/31/2017. Any employee not educate by 10/31/2017 will not be allowed to w until educated. This education will also added on new hires orientation process for all new employees effective 10/31/2017, and will also be provided annually. MONITORING PROCESS Effective 10/30/2017, Director of Nursi Assistant Director of Nursing, and/or S Development Coordinator, will monitor compliance with investigation and reporting of injuries of unknown source by conducting clinical meeting daily (M This meeting will allow the team to re the daily clinical meeting checklist to ensure completion and proper follow through, incidents or accidents occurre from the prior clinical meeting to ensure any injury of unknown source was not investigated and reported per abuse policy. The nursing administrative tear will also review completion of skin assessments from prior day and ensure any documented injury of unknown so was followed through per policy. Any issues identified during this monitoring process will be addressed promptly.	ng vill le f. cork o be ss ing, Staff - Staff - F). view ed re ed re ed m in re urce	

Event ID: K94Q11

Facility ID: 050906

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION				
ND PLAN OF			A. BUILDING	A. BUILDING				
			B. WING	C 10/12/2017				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1			
UNIVERSAL HEALTH CARE / BRUNSWICK				1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO			
F 225 F 225 SS=D	Continued From page DEVELOP/IMPLMEN POLICIES CFR(s): 483.12(b)(1)	NT ABUSE/NEGLECT, ETC	F 225	 Findings from this meeting will be documented on a daily clinical report and filed in clinical meeting binder a proper follow ups are done. This monitoring process will take place of (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or the pattern of compliance is maintated. Effective 10/31/2017, Director of Nu will report findings of this monitoring process to the facility Quality Assurt and Performance Improvement Committee for any additional monthly months, or until the pattern of compliance. RESPONSIBLE PARTY Effective 10/31/17, the center Exect Director and the Director of Nursing be ultimately responsible to ensure implementation of this plan of corre for this alleged noncompliance to eat the facility remains in substantial compliance. 	after daily until ined. ursing g ance oring X3 oliance e can y utive g will ction			
	483.12	develop and implement						

Event ID: K94Q11

Facility ID: 050906

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/21/20 RM APPROVE <u>O. 0938-039</u>	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	345549		B. WING			C 10/12/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE / BRU	INSWICK			070 OLD OCEAN HIGHWAY OLIVIA, NC 28422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 226	exploitation of resider resident property,	nts and misappropriation of	F	226				
	(2) Establish policies investigate any such(3) Include training as §483.95,							
	the freedom from aburrequirements in § 483	nd exploitation. In addition to use, neglect, and exploitation 3.12, facilities must also eir staff that at a minimum						
		onstitute abuse, neglect, appropriation of resident at § 483.12.						
		reporting incidents of abuse, or the misappropriation of						
	prevention. This REQUIREMENT	agement and resident abuse is not met as evidenced						
	facility failed to follow	iew and staff interviews, the rits abuse and neglect policy an injury of unknown origin			F226D ROOT CAUSE			
	and did not report it to for 1 of 3 sampled res	o the State Survey Agency sidents (Resident #1).			This alleged noncompliance was rest from the Center's Director of Nursing misinterpretation of regulatory			
	Findings included:				requirements related to reporting an of unknown source. "The DON state			
	dated March, 2017 (r	e Policy and Procedure evised) in the investigation evealed, in part, "All alleged			way she understood for an injury of unknown origin to be reported, one o criteria was that the resident was not	f the		

Event ID: K94Q11

Facility ID: 050906

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345549	B. WING			C 12/2017	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE / BRU	NSWICK			070 OLD OCEAN HIGHWAY OLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	mistreatment, includir source and misappro- are reported immedia hours after the allegat that cause the allegat in serious bodily injur- if the events that caus involve abuse and do injury, to the executiv to other officials inclue Agency." Resident #1 was adm 6/14/17 with a readmi Diagnoses included, i osteoporosis, and fra- humorous. The Minimum Data S assessment dated 9/2 was severely cognitiv noted as having beha inattention and disorg care 1-3 days, wande behaviors not directed The resident required two staff members wi transfers, dressing, to and extensive assista with ambulating, locol had no impairment ar	buse, neglect, exploitation or ng injuries of unknown priation of resident property tely, but not later than 2 tion is made, if the events ion involve abuse or result y, or not later than 24 hours se the allegation do not not result in serious bodily e director of the center and ding to the State Survey hitted to the facility on ission date of 10/5/17. n part, dementia, cture to upper end of right et (MDS) quarterly 21/17 revealed the resident ely impaired. She was inviors continuously with panized thinking, rejection of ering 1-3 days and other d toward others for 1-3 days. extensive assistance with	F	226	ambulatory. The DON stated since Resident #1 was ambulatory then the criteria would not have been met, and therefore, it would not be necessary is complete the 24-hour and 5-day repor- nor report it to the State Survey Ager Regional Nurse Consultant re-educa- the Center Administrator and the Dire- of Nursing on 10/23/2017 on reportin expectation if there is an injury of unknown origin noted for any resider the facility. IMMEDIATE ACTION On 10/12/2017, the 24 hour report and day report were sent to the Departmet Health and Human Services, for resider 10/03/2016. These reports were completed and submitted by the Administrator. No further actions take resident #1. IDENTIFICATION OF OTHERS 100% audit was completed on new-th over the last 30 days to ensure educa- of abuse policy and procedure and reporting requirements was completed upon hire. This audit was completed the facility Administrator, Director of Nursing and/or Director of Human resources. The audit revealed that al	d do ort hcy. ted ector g t in d 5 ent of dent ed in en for ires ation ed by	
	A record review of a r 10/4/17 at 1:40 am by resident had no signs	nursing note written on v Nurse #1 revealed the or symptoms of distress or y resting in bed with eyes			hires had been educated on abuse p and reporting procedures upon hire. audit was completed on 10/23/2017. Findings of this audit is documented "new hires abuse education audit too	olicy This on	

Facility ID: 050906

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		MEDICAID SERVICES				<u>OMB NC</u> T	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI		(X3) DATE SURVEY COMPLETED C		
			A. BUILDIN	1G			
		345549	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	12/2017
					070 OLD OCEAN HIGHWAY		
UNIVERS	AL HEALTH CARE / BRU	INSWICK			OLIVIA, NC 28422		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO
F 226	Continued From page	e 16	F 22	226			
	closed. The note stat				located in the facility compliance binde	r.	
		e undressing Resident #1 for					
		f 10/3/17, they noticed a			100% audit of all current residents' clin		
		ght upper arm. The note			documentation within the last 30 days	was	
	stated Nurse #1 was			completed by the Director of Nursing,			
	#1 measured the brui			Assistant Director of Nursing and/or Nu	ırse		
	motion and Resident the right lower arm.			Supervisor to determine if there is any injuries of unknown source documente	d in		
	bruise located on her			any resident's medical records, and if a			
	and purple and appro			determine whether a 24 hours and 5 da	-		
	(cm) length and 9 cm			investigation reports were completed a	-		
	Nurse #1 was not sur	e how the resident obtained			reported to the state agency and other		
	-	o going to bed she was			officials as required by regulation and/o		
	noted leaning in a cha	air on her right side.			Elder Justice Act. The audit revealed n		
					other incident of injury of unknown sou	rce	
		nursing note written on			documented in resident's medical records. This audit was completed on		
	-	y Nurse #1 revealed a call -call physician to explain the			10/23/17. Findings of this audit is		
		rge bruise on Resident #1.			documented on "clinical records audit		
		e resident was ambulatory			tool" located at the facility compliance		
		what could have caused the			binder.		
		orted the physician ordered					
		umerus and shoulder and			100% audit was completed by the Dire	ctor	
	that a call was placed	-			of Nursing of all incidents reports		
		ndicated the Director of			completed within the last 30 days to		
		ne Assistant Director of			identify any injuries of unknown source	•	
		e on site to examine the			and ensure that a proper investigation		
	bruise and the family	was notified.			was completed and a 24 hours as well 5 days reports are completed and	as	
	A record review of a r	nursing note written by Nurse			submitted to the state agency as requir	red	
		pm revealed one of the			by regulation and Elder Justice Act. Th		
		mber (FM) had arrived to			audit revealed no other incident of injur		
	-	The note stated upon			of unknown source noted. This audit w		
	-	s bruise, the FM requested			completed on 10/11/2017. Findings of		
		ated by the emergency			audit is documented on incident reports		
		e note indicated Resident #1			audit tool located at the facility complia	nce	
	-	Emergency Medical Service			binder.		
	(EMS) to the hospital	at 1:10 pm.			100% audit of akin apparaments		
					100% audit of skin assessments		

Event ID: K94Q11

Facility ID: 050906

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		MEDICAID SERVICES			OMB NO. 093	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		、 <i>'</i>		(X3) DATE SURVE COMPLETED		
		A. BUILDING	с			
		345549	B. WING		10/12/20)17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1070 OLD OCEAN HIGHWAY		
UNIVERS	AL HEALTH CARE / BRU	INSWICK		BOLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) IPLETIO DATE
F 226	Continued From page	e 17	F 22	16		
		nursing note written by Nurse		completed within the last 30 days	of all	
		6 pm indicated Resident #1		active residents completed by the		
		1:38 pm in stable condition		of Nursing, Assistant Director of N		
		he right shoulder with blue		and/or Nurse Supervisor to identi	•	
	bruising and swelling	noted to shoulder.		other resident with a documented	injury of	
				unknown source. The audit revea		
		arge summary from the ED		other incidents of injury of unknow		
		the resident had an x-ray of		source noted. This audit was com	pleted	
		he impression showed an		on 10/23/2017.		
		ght humeral fracture. The ated with the residents other		100% skin assessments of all act	ivo	
		vere osteoporosis, the		residents completed by the Direct	-	
		ed as closed fracture and a		Nursing, Assistant Director of Nur		
		would be appropriate.		and/or Nurse Supervisor to identi	•	
				other resident with an injury of un		
	A record review of a	physician ' s progress note		source. The audit revealed no oth		
	written on 10/6/17 for	r evaluation and		incidents of injury of unknown sou	urce	
		admission, revealed the		noted. This audit was completed	on	
		o having bruising on the right		10/23/2017.		
		0/4/17 per nursing staff. An				
		nerus and shoulder was		SYSTEMIC CHANGES		
		s was canceled per the FM		Effective 10/20/2017 the erstern	uraina	
		sident be sent for evaluation #1 was sent to the ED and		Effective 10/30/2017, the center r administrative team, which includ		
		ed fracture of the right		ADON, and/or SDC, initiated a pr		
		The resident was ordered to		reviewing clinical documentation		
	wear a shoulder imm			last 24 hours, completed skin		
	recommended for su			assessments, incident reports for	the last	
				24 hours, and Physician orders w	ritten in	
		nducted with Nurse #1 on		the last 24 hours to ensure any in	•	
		n. Nurse #1 reported that at		identified is thoroughly investigate		
		the aides reported to her		the source of injury is unknown th		
		rge bruise on the upper right		Director of Nursing will report suc		
		ed when she assessed the		Administrator to ensure a 24 hour		
		asurements and performed		five days reports are completed a		
	range of motion and	resident complained of pain		submitted to the State agency as by regulation. This systemic proc		
		se reported the resident had		take place daily (Monday through		
		onary chair for a couple of		Any identified issues will be addre		

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GENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	· · · ·	(X3) DATE SURVEY COMPLETED	
		345549	B. WING			10/12/2017
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				1070 OLD OCEAN HIGHWAY		
UNIVERS	AL HEALTH CARE / BRU	INSWICK		BOLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From page	<u>- 18</u>	F 22	26		
1 220			F 22		otiona will be	
		ea prior to going to bed on noted to be leaning to her		promptly and appropriate a implemented by the DON,		
		ndicated Resident #1 was		and/or Registered Nurse s		
		a fall or bumping her arm.		process will be incorporate		
	J			clinical rounds. Any negativ	•	
	An interview with the	DON on 10/12/17 at 4:45		be documented on the "da	-	
	pm revealed on 10/4/	17 at 7:30 am, Nurse #2		checklist form" and mainta	ined in the daily	
		nd made her aware of the		clinical meeting binder.		
	- · · ·	per arm on Resident #1.				
	-	at she and the ADON went		Effective 10/30/2017, week		
		m to evaluate the bruising.		Registered Nurse supervis		
		large bruise on the inside of		designated licensed nurse		
	÷	hat was blue in color with a		clinical documentation for t		
		I reported the resident was ot appear to be in any pain at		hours, completed skin asse incident reports for the last		
		reported she investigated the		Physician orders written in		
		gin. The DON stated she		hours to ensure any injurie		
		who identified the bruise at		thoroughly investigated an		
		the nurse who assessed the		of injury is unknown the su		
		10/3/17, and the nurse who		notify the Director of Nursi		
	assessed the bruise of	on day shift on 10/4/17, as		Administrator. The DON ar	nd/or the	
	well as the day shift r	nurses who worked on		Administrator will ensure a	24 hours and a	
	-	rovided evidence that she		five days reports are comp		
		ments, implemented audits		submitted to the State age		
	-	vices regarding notification		by regulation. This systemi	•	
		ed. The DON reported she		take place every Saturday		
	-	dent by completing the		Any negative findings will b		
		5-day report and submit		on the "week end supervise		
		ncy. The DON stated the for an injury of unknown		and maintained in the daily meeting binder.	Cillical	
		one of the criteria was that				
		ambulatory. The DON		Director of Nursing (DON),	Assistant	
		t #1 was ambulatory then		Director of Nursing (DON),		
	the criteria would not			Development Coordinator		
		t be necessary to complete		complete 100% re-education		
		y report nor report it to the		facility's abuse/neglect pol		
		. The DON confirmed that		notification protocols. This		
	she did not follow the			be provided for all employe		
	procedures regarding			full time, part time and as r		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/21/2017 MAPPROVED D. 0938-0391
				(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345549	B. WING				C 1 2/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10,	
UNIVERSA	AL HEALTH CARE / BRU	INSWICK		10	070 OLD OCEAN HIGHWAY		
				B	OLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	e 19	F.	226			
	unknown origin. An interview was con	ducted with the		220	This education will be completed by 10/31/2017. Any employee not educa by 10/31/2017 will not be allowed to v	vork	
	Administrator on 10/12/17 at 4:45 pm. The Administrator indicated that his expectation was if there was an injury of unknown origin that resulted in harm, the facility was responsible for following the facility 's Abuse policy and procedures.				until educated. This education will als added on new hires orientation proce for all new employees effective 10/31/2017, and will also be provided	SS	
					annually. MONITORING PROCESS		
					Effective 10/23/2017, the Administrator and/or DON will conduct random sele five staff interviews regarding the facil	cted	
					abuse policy and procedure as well as reporting requirements. Random interviews will be conducted daily 5x t a week (M-F) x 2 weeks, then 2x time	times es a	
					week (M-F) x 3 more weeks or until the pattern of compliance is maintained.	le	
					Effective 10/30/2017, Director of Nurs Assistant Director of Nursing, and/or Development Coordinator, will monito compliance with investigation and	Staff	
					reporting of injuries of unknown source by conducting clinical meeting daily (N This meeting will allow the team to re the daily clinical meeting checklist to ensure completion and proper follow	И-F).	
					through, incidents or accidents occurr from the prior clinical meeting to ensu any injury of unknown source was not	ire	
					investigated and reported per abuse policy. The nursing administrative tea will also review completion of skin assessments from prior day and ensu		
					any documented injury of unknown so was followed through per policy. Any		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
345549		B. WING				C 12/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	10/	12/2017
	AL HEALTH CARE / BRU	NSWICK		107	0 OLD OCEAN HIGHWAY		
		Nowiek		BO	LIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page	≥ 20	F 2		issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report f and filed in clinical meeting binder afte proper follow ups are done. This monitoring process will take place daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or un the pattern of compliance is maintaine Effective 10/31/2017, Director of Nursi will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitorir or modification of this plan monthly X3 months, or until the pattern of compliant is maintained. The QAPI committee ca modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 10/31/17, the center Executiv Director and the Director of Nursing wi be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensu- the facility remains in substantial compliance.	orm r V til d. ng ce ng nce n re ll	

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