		ID HUMAN SERVICES				FC	DRM APPROVED	
		MEDICAID SERVICES					NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345549	B. WING _			C 02/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE / BRU	Newlor		107	0 OLD OCEAN HIGHWAY			
UNIVERSI	AL HEALTH CARE / BRU	NSWICK		во	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		FC	000				
	investigation was con through 02/04/23. Eve following intakes were and NC00196622. 2 of the 5 complaint a defiicency.	e investigated NC00196625 Illegations resulted in						
F 584 SS=E		ble/Homelike Environment (7)	F 5	584			3/1/23	
	§483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir	ght to a safe, clean, elike environment, including siving treatment and						
	homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall e	ride- clean, comfortable, and it, allowing the resident to al belongings to the extent ring that the resident can vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for resident's property from loss						
		eeping and maintenance maintain a sanitary, orderly, ior;						
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are						
	§483.10(i)(4) Private	closet space in each						
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE 02/24/2023	

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/28/2023 MAPPROVED D: 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345549		B. WING					C /04/2023	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	<u> </u>	•	
UNIVERSAL HEALTH CARE / BRUNSWICK					070 OLD OCEAN HIGHWAY SOLIVIA, NC 28422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE	
F 584	<ul> <li>§483.10(i)(5) Adequative levels in all areas;</li> <li>§483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and</li> <li>§483.10(i)(7) For the sound levels.</li> <li>This REQUIREMENT by:</li> <li>Based on record reviperature (300-hall shower room clean, comfortable, how the temperature (300-hall shower room clean, comfortable, how the findings included</li> <li>An observation of the completed on 02/01/2</li> <li>Maintenance Director temperature was 105 he began to monitor to 100 degrees F after 3 water monitoring.</li> <li>An interview with the occurred on 02/01/23</li> <li>Maintenance Director</li> </ul>	ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced ew, observations, staff, and e facility failed to maintain es in 1 of 2 shower rooms in #1) reviewed for safe, omelike environment. 500-hall shower room was 3 at 1:30 P.M. with the The shower water degrees Fahrenheit when he water and dropped to minutes of continuous hot Maintenance Director	F	584	<ol> <li>No resident was name deficient practice.</li> <li>A certified plumber was en assess the facility boiler on report confirmed that water boiler room and water retur circulating the facility was f compliance with water tem regulations. He also confirr monitoring of water temper faucets and whirlpool tubs compliance with temperatur Point testing at showerhea that water temperature fluc acceptable levels. The issi water temperature was trace showerheads on 2/3/23. Re shower cores were obtained on 2/6/23.</li> <li>All residents had the p</li> </ol>	ed in this alle gaged to 2/1/23. The exiting the ning after ound to be i perature ned, point atures at were, to be re regulation ds revealed tuated belov ue with the ced to the eplacement ed and instal	n in ns. v		
	the residents. He furth Assistants were not a showers all day becau	egrees F to prevent burning ner stated that the Nurse ble to give back-to-back use the water temperatures ited that when a nurse			affected by, this alleged de 3. All 3 of the facility sho replaced on 2/6/23, by Ma Director to ensure water te showers remain with guide	ower cores v intenance mperatures	vere		

Facility ID: 050906

	S FOR MEDICARE &					8 NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	DATE SURVEY
	345549					С
			B. WING			02/04/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
UNIVERSAL HEALTH CARE / BRUNSWICK			1070 OLD OCEAN HIGHWAY			
	CAL HEALTH CARE / BRONOWICK			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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 584	Continued From page	- 2	F 58	34		
		complained of the water	1.50	4. Maintenance Staff	was educated by	
		wers that he or the Assistant		the facility Administrator		
	Director of Maintenar			water temperature levels		
		biler. The Maintenance		areas per regulations		
	Director stated that th			The Maintenance Direct	or/ designee will	
		ater temperatures since		audit water temperature		
	December when a re-	sident's family member had		showerheads 5 times pe	er week for 2	
	filed complaints with	the Health Department,		weeks then 3 times per v	week for 2 weeks,	
		the State. He further stated		then monthly for 2 month		
		rtment had followed up on		proper water temperatur	es are present at	
		30/22 and the temperature		showerheads.		
	-	gistered 105 degrees F. The		Administrator will comp	-	
		r indicated that the Health		the audit results and pre monthly QAPI meeting, t		
	Department had not t temperatures in the s			continued compliance.	lo ensure	
	An interview occurred	d with the Administrator,				
		r, and the Director of Nursing				
	(DON) on 02/01/23 a					
		that the facility was going to				
		e check the hot water				
	temperature.					
	A telephone interview	was conducted with the				
	Plumber on 02/03/23	at 08:48 A.M. The Plumber				
	stated that he had ch					
		at the boiler on 02/02/23.				
		hot water temperature was				
		ees F leaving the boiler and				
		grees F on the return. He was not aware the water				
		ropping in the showers. The				
	-	at there could be several				
		de the building that could be				
		nperatures to drop in the				
		at he would need to come				
	back to the facility an	d check the hot water				
	-	hower rooms and run more				
	tests to determine the					

If continuation sheet Page 3 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:				E CONSTRUCTION	(X3) DATE SUR COMPLETE		
		345549	B. WING				C 04/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / BRU	NSWICK			070 OLD OCEAN HIGHWAY 3OLIVIA, NC 28422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584 F 842 SS=D	completed on 02/03/2 Maintenance Director temperature was 106 to monitor the water a after 9 minutes of cor monitoring. An interview with the completed on 02/03/2 Maintenance Director temperature should n showers. He further s 2022 the facility had r water temperatures. An interview was con Administrator and the Regional Clinical Con P.M. The Administrator the shower hot water 100 degrees F and 12 stated that a plumber the hot water in the sl Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (ii) The facility may not re resident-identifiable to accordance with a co agrees not to use or co	300-hall shower room was 3 at 12:25 P.M. with the The shower hot water degrees F when he began and dropped to 96.6 degrees itinuous hot water Maintenance Director was 3 at 12:35 P.M. The stated that the water ot be below 100 degrees for tated that prior to December hever had an issue with hot ducted with the Director of Nursing and the sultant on 02/03/23 at 2:15 or stated that he expected temperatures to be between 16 degrees F. He further was going to come and fix hower rooms on 02/06/23. dentifiable Information 483.70(i)(1)-(5) ht-identifiable information. lease information that is o an agent only in ntract under which the agent disclose the information he facility itself is permitted		842			3/1/23

Facility ID: 050906

If continuation sheet Page 4 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
345549		345549	B. WING				04/2023	
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			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JLD BE COMPLET		
F 842	§483.70(i)(1) In accor professional standard must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faci all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme	dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential ned in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, <i>v</i> iolence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when	F	842				

Facility ID: 050906

If continuation sheet Page 5 of 9

	-	ID HUMAN SERVICES				FORM	M APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:			· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			D. 0938-0391 SURVEY PLETED	
			A. BUILDI	ING _		C		
345549			B. WING				04/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE / BRU	NSWICK		1	070 OLD OCEAN HIGHWAY			
ONIVERO				B	30LIVIA, NC 28422			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLETION		
F 842	Continued From page	5		842				
1 042				84Z				
	legal age under State	aw.						
	§483.70(i)(5) The me	dical record must contain-						
		on to identify the resident;						
		sident's assessments;						
	(III) The comprehensi provided;	ve plan of care and services						
		/ preadmission screening						
	and resident review e							
	determinations condu	-						
		's, and other licensed						
	professional's progres	logy and other diagnostic						
		equired under §483.50.						
		is not met as evidenced						
	by:							
		iew and Responsible Party,			1. Resident #3 is no longer a resider	nt at		
		ne facility failed to maintain record that included an			<ul><li>the facility as of 1/8/2023.</li><li>2. On 2/20/23, The Director of Nursin</li></ul>	na		
		of 1 resident (Resident #3)			and Unit Manager completed a review			
	reviewed for resident	. ,			the medical records & incident reports	of		
	information.				current residents to determine if there			
	The findings included				were any other residents who had a fa that did not have follow up, including	11		
					notification of the resident family. No			
	Resident #3 was adm	nitted to the facility on			other residents were identified.			
	10/27/22.				3. On 2/17/23, the Director of Nursir	ng		
	Deview of Desident #				and Administrative Nurses began			
		3's electronic medical reveal any notes or nursing			education with the licensed nurses on documentation of falls and completing	an		
	. ,	sident #3's fall on $01/03/23$ .			incident report with each fall via in pers			
					or by phone. Any nurse who has not b			
		ducted with the Director of			educated by 3/1/23 will not be allowed	to		
		/03/23 at 12:30 P.M. The			work until they have been educated or	the		
		as made aware on 01/04/23			required falls documentation. This	.1		
		ls with the nurses, that nd on the floor the night			education will be included in the clinical orientation process for new nurses.	1		
		her stated that he had asked			Director of Nursing or designee will			
		ne on 01/04/23 to document			complete clinical orientation process.			

Facility ID: 050906

If continuation sheet Page 6 of 9

STATEMENT OF DEFICIENCIES AND PLAY OF CORRECTION       (21) DEFINITION NUMBER       (22) MUTURE CONSTRUCTION A BUILINAG       (22) MUTURE A BUILINAG       (22) MUTURE CONSTRUCTION A BUILINAG       (22) MUTURE CONSTRUCTION A BUILINAG       (22) MUTURE CONSTRUCTION A BUILINAG       (22) MUTURE CONSTRUCTION A BUILINAG       (22) MUTURE CONSTRUCTION (22) MUTURE CONSTRUCTION (23) MUTURE CONSTRUCTION (24) MUTURE CONSTRUC			ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/28/2023 RM APPROVED O. 0938-0391
345549         B. WHS         02/04/2           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STRE, ZIP CODE         107 OLD OCEAN HIGHWAY         5000000000000000000000000000000000000			(X1) PROVIDER/SUPPLIER/CLIA	` '				IPLETED
NMME OF PROVIDER OR SUPPLER         STREET ADDRESS, CITY STRE, 21P CODE           UNIVERSAL HEALTH CARE / BRUNSWICK         100 CL DCEAN HIGHWAY           OWING         SUMMARY STATEMENT OF DEFICIENCIES         100 PROVIDER OR SUPPLER         10	345549		B. WING			02	C 2/04/2023	
UNIVERSAL HEALTH CARE / BRUNSWICK         BOLIVIA, NC 28422           (Xi) [D] PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BY EAR)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BE INFORMATION)         D PREFIX TAG         PREFIX (EACH DEFICIENCY MIST BY EAR)         D PREFIX TAG         PREFIX TAG         PREFIX TAG        PREFIX T	NAME OF P	ROVIDER OR SUPPLIER	-	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHUD         SUMMARY STATEMENT OF DEFICIENCIES RESULTORY OR LSC IDENTIFYING INFORMATION)         D PROTEX TAG         PRODERS FLAN OF CORRECTION (ECA) DEFICIENCY MUST BE PRECEDED BY FULL RESULTORY OR LSC IDENTIFYING INFORMATION)         D PROTEX           F 842         Continued From page 6 a note in the chart about the fall and to fill out an incident report when she returned to work. The DON indicated that when he was reviewing Resident #3's chart on 01/09/23 that he noted that Nurse #1 had not documented in the nurses' notes or completed an incident report regarding Resident #3's chart on 01/09/23. The the noted that Nurse #1 had not documented in the nurses' notes or completed an incident report regarding Resident #3's being found on the floor on 01/03/23. The DON stated that he had again asked Nurse #1 to document in the chart and an incident report regarding Resident #3's being found on the floor on 01/03/23. A telephone interview was conducted with Nurse #1 on 02/03/23 at 3:37 P.M. Nurse #1 stated that Resident #3 was found on the floor on 01/03/23 at 09:10 PM by a nurse aid (NA). She further stated that Resident #3, and they were within normal limits. Nurse #1 stated that Resident #3, and they were within normal limits. Nurse #1 stated that Resident #3, and they were within normal limits. Nurse #1 stated that Resident #3, and they were within normal limits. Nurse #1 further stated that Resident #4 was assisted back to bed by the NA's. She further stated that the adout file do ta incident report. Nurse #1 further stated that ne susces' notes, and she had not file do ut an incident report. Nurse #1 further stated that he had not file do ut an incident report. Nurse #1 further stated that he had not file do ut an incident report. Nurse #1 further stated that he had not file do ut an incident report. Nurse #1 further stated that he had not file do ut an incident report. Nurse #1 furthere stated that he had not file					10	070 OLD OCEAN HIGHWAY		
PREFIX TVG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION)       PREFIX TVG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION)       COMMANDEL	UNIVERS	AL HEALTH CARE / BRU	INSWICK		В	OLIVIA, NC 28422		
<ul> <li>a note in the chart about the fall and to fill out an incident report when she returned to work. The DON indicated that when he was reviewing Resident #3's chart on 01/09/23 that he noted that Nurse #1 had not documented in the nurses' notes or completed an incident report regarding Resident #3 being found on the floor on 01/03/23. The DON stated that he had again asked Nurse #1 to document in the nurses' notes and to fill out an incident report regarding Resident #3 being found on the floor on 01/03/23. He stated that he should have followed up with Nurse #1 to ensure that a note was documented in the chart and an incident report nearly indicated that she had obtained a set of vital signs for Resident #3 was found on the floor on 01/03/23 at 09:10 PM by a nurse ati (NA). She further stated that Resident #3 was found on the floor on 01/03/23 at 09:10 PM by a nurse ati (NA). She further stated that she had obtained a set of vital signs for Resident #3 was found with her upper body on the floor mat and did not appear to have any injuries or mental status changes. Nurse #1 indicated that she had obtained a set of vital signs for Resident #3 and they were within normal limits. Nurse #1 stated that the Resident #3 was assisted back to bed by the NA's. She further stated that it had been a very busy night and she forgot to document the assessment in the nurses' notes, and she had not filled out an incident report and to document an ote regarding the fall in the chart when she came back to work. Nurse #1 indicated that she had forgotten to document in the nurses' notes, and she had not filled out an incident report and to document an back to work. Nurse #1 indicated that she had forgotten to document in the nurses' notes, and she had not filled out an incident report and to document an back to work. Nurse #1 indicated that she had forgotten to document in the nurses' notes, and she had not filled out an incident report and to document an back to work. Nurse #1 indicated that she had forgotten to document in t</li></ul>	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
the chart and to fill out an incident report regarding Resident #3 being found on the floor on	F 842	a note in the chart ab incident report when DON indicated that w Resident #3's chart of that Nurse #1 had no notes or completed a Resident #3 being for The DON stated that #1 to document in the an incident report reg found on the floor on should have followed that a note was docu incident report had be A telephone interview #1 on 02/03/23 at 3:3 Resident #3 was four at 09:10 PM by a nur stated that Resident is body on the floor mat any injuries or menta indicated that she ha signs for Resident #3 normal limits. Nurse is was assisted back to stated that it had bee forgot to document the notes, and she had no report. Nurse #1 furth told her on 01/04/23 is and to document a no chart when she came indicated that she has the chart and to fill out	bout the fall and to fill out an she returned to work. The when he was reviewing on 01/09/23 that he noted of documented in the nurses' in incident report regarding und on the floor on 01/03/23. he had again asked Nurse e nurses' notes and to fill out garding Resident #3 being 01/03/23. He stated that he I up with Nurse #1 to ensure mented in the chart and an een completed. was conducted with Nurse 7 P.M. Nurse #1 stated that nd on the floor on 01/03/23 se aid (NA). She further #3 was found with her upper t and did not appear to have I status changes. Nurse #1 d obtained a set of vital 8, and they were within #1 stated that Resident #3 bed by the NA's. She further en a very busy night and she ne assessment in the nurses' not filled out an incident ner stated that the DON had to fill out an incident report ote regarding the fall in the e back to work. Nurse #1 d forgotten to document in ut an incident report	F	842	Administrative Nurses will review the 24-hour reports, 5 days/week in the morning clinical meeting to identify fa that have occurred. The residents' medical record will be reviewed statu post a fall during the clinical meeting ensure there is a nursing note and incident report completed. 4. The Director of Nursing or design will audit the documentation of falls a the completion of incident reports pro 5 (five) times per week for 4 (four) we then 3 (three) times per week for 4 (four) we then 3 (three) times per week for 4 week The Director of Nursing or designee present the results of these audits, monthly in the Quality Assurance Performance Improvement (QAPI) meeting to the interdisciplinary team ensure continued compliance. The O committee can modify this plan to en-	s to nee nd cess eeks, our) eks. vill to QAPI	
01/03/23.	F 885	01/03/23.	-	F	885			3/1/23
SS=D					550			0, 1/20

Facility ID: 050906

If continuation sheet Page 7 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/04/2023		
345549			B. WING				
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE / BRUNSWICK					070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422		
(X4) ID PREFIX TAG				X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 885	CFR(s): 483.80(g)(3)( §483.80(g) COVID-19 must— §483.80(g)(3) Inform representatives, and facilities by 5 p.m. the the occurrence of eith infection of COVID-19 or staff with new-onse occurring within 72 ho information must— (i) Not include person (ii) Include information implemented to preve- transmission, includin facility will be altered; (iii) Include any cumu their representatives, or by 5 p.m. the next subsequent occurrence confirmed infection of whenever three or more new onset of respirate 72 hours of each other This REQUIREMENT by: Based on record revisi interviews, the facility representatives and facility	(i)-(iii) P reporting. The facility residents, their families of those residing in a next calendar day following ter a single confirmed P, or three or more residents et of respiratory symptoms burs of each other. This ally identifiable information; n on mitigating actions ent or reduce the risk of g if normal operations of the and lative updates for residents, and families at least weekly calendar day following the ce of either: each time a 1 COVID-19 is identified, or or residents or staff with ory symptoms occur within er. i is not met as evidenced ew, and staff and family failed to notify residents amily members by 5:00 P.M. when a confirmed case of ed for 1 of 3 residents	F	885		o ⊃ eir	
	Findings included:	ngs included: dent #3 was admitted to the facility on			residents were identified. 3. On 2/17/23, the Director of Nursing and Administrative Nurses began		
	Resident #3 was adm				and Authinistrative Nurses began		

Event ID: AFPH11

Facility ID: 050906

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345549	B. WING				04/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / BRU	NSWICK			70 OLD OCEAN HIGHWAY DLIVIA, NC 28422		
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 885	not reveal any entries Resident #3's positive Review of the EMR for progress note written dated 01/02/23. The p "Patient seen today for Review of the EMR for progress note written 01/03/23, which read diagnosed with Covid very high risk of comp An interview was com Preventionist on 02/0 Infection Preventionis tested positive for Co further stated that it d positive test result was progress notes. The I indicated that Resides (RP) was not notified results.	progress notes for 01/23 through 01/03/23 did by nursing staff regarding c Covid-19 test. or Resident #3 revealed a by the Nurse Practitioner progress note read in part, or positive COVID test." or Resident #3 revealed a by the Physician dated in part, "Resident #3 was -19 on 01/01/23. She is at olications from Covid." npleted with the Infection 2/23 at 1:05 P.M. The t stated that Resident #3 vid-19 on 01/01/23. She id not appear that the s documented in the nurses' infection Preventionist at #3's Responsible Party of the positive Covid-19 ducted with the Director of /02/23 at 2:17 P.M. The dent #3's RP was not	F	385	education with the licensed nurses on notifying the family member/Responsik Party of their residents' positive COVIE test results. This education is being conducted either in person or by phone Any nurse who has not been educated 3/1/23 will not be allowed to work until they have been educated on the requir COVID positive test result notification process. This education will be include in the clinical orientation process for ne nurses. 4. The Director of Nursing or designe will audit the notification and documentation of responsible party/far members being notified of their resider COVID positive result. This audit will be done weekly for 4 weeks, then monthly 2 months to ensure that at the time of a resident covid + result that notification completed. The Director of Nursing or designee will present the results of this audit, month the Quality Assurance Performance Improvement (QAPI) meeting to the interdisciplinary team to ensure continue compliance. The QAPI committee can modify this plan to ensure the facility remains in compliance.	) by ed ed ed ew ee nily nts' be y for a is ll ly in	

Facility ID: 050906

If continuation sheet Page 9 of 9