| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345549 | A. BUILDING _____ B. WING _____ | C 06/27/2019 |

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

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| E 000 | Initial Comments<br><br>An unannounced Recertification/Complaint Survey was conducted on 06/24/19 through 06/27/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Prepareness. Event ID # 57ZY11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation. Event ID #57ZY11. | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, | F 561 | | 7/17/19 |

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

Electronically Signed | 07/14/2019

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religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on resident interviews, staff interviews and record review, the facility failed to provide scheduled showers twice per week for 2 of 4 residents (Resident #41 and Resident #80) interviewed during a Resident Council Meeting which was conducted as required during the annual recertification survey. Findings included:

1. Resident #41 was admitted to the facility on 12/05/18. Diagnoses included, in part, metabolic encephalopathy, difficulty walking and need for assistance with personal care. The Minimum Data Set (MDS) quarterly assessment dated 05/16/19 revealed the resident was cognitively aware and required extensive assistance with one staff physical assistance with all activities of daily living (ADLs).

A review of the weekly shower schedule revealed Resident #41's room was assigned to have a shower every Wednesday and Saturday.

A review of the bath/shower form for the months of April, May and June, 2019, revealed Resident #41 received a shower on the following days:

Wednesday 04/03/19
Saturday 04/06/19
Wednesday 04/10/19
Saturday No Shower 04/12/19
Wednesday 04/17/19
Saturday 04/20/19
Wednesday 04/24/19
Saturday No Shower 04/27/19

F561 Self Determination

Root Cause Analysis
Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that the facility did not follow policy and procedure for providing showers per resident preference.
Immediate Action
Residents #80 and #41 shower schedule and care plan were updated per resident preference on 6/20/2019 by the Director of Nursing (DON)

Identification of Others
By 7/17/2019 the Social Worker will interview alert and oriented residents to determine their preference with their shower schedule. All changes will be made by 7/17/19 to the shower schedule and their individual care plan by MDS Nurse.

Systemic Changes
Effective 7/17/19, 100% of certified nursing assistants will be educated by the Director of Nursing and/or the Executive Director on Resident's Rights and Resident's Choice. On a resident's scheduled shower day the CNA will provided a shower or bed bath per resident's preference. The bath team was dissolved and will have an assignment on

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| F 561 | Continued From page 2<br>Wednesday 05/01/19<br>Friday 05/03/19<br>Wednesday No shower 05/08/19<br>Saturday No shower 05/11/19<br>Wednesday No Shower 05/15/19<br>Saturday No Shower 05/18/19<br>Tuesday 05/21/19<br>Saturday No Shower 05/25/19<br>Wednesday 05/29/19<br>Saturday No Shower 06/01/19<br>Wednesday No Shower 06/05/19<br>Saturday No Shower 06/08/19<br>Monday 06/10/19<br>Wednesday 06/12/19<br>Wednesday 06/19/19<br>Saturday No Shower 06/22/19<br>Wednesday 06/26/19<br><br>An interview was conducted with residents who attended the Resident Council Meeting (RCM) on 06/25/19 at 11:00 AM. Resident #41 was in attendance at the RCM and was also the RC President. Resident #41 attended RCMs frequently. Resident #41 voiced that she did not get her scheduled showers each week and that she would only get one shower per week some weeks. Resident #41 stated she would get bathed and assistance would be provided with ADL care on the days she did not receive her shower, but she stated, "There was nothing like a nice hot shower" and her choice was to have a shower twice per week.<br><br>An interview was conducted with the bath aide (BA) on 06/26/19 at 11:00 AM. BA stated her primary responsibility was the BA and she was assigned to give showers full time on the 100/200/300/and 400 halls daily when she was on the schedule. BA stated she worked every other | F 561 | the hall allowing the CNA's to give their own showers. A new assignment sheet was created to divide the showers into two shifts Monday through Saturdays in order to accommodate preferences. Any staff not educated will not be allowed to work until educated. This education will be added to the new hire process.<br><br>Monitoring<br>The Director of Nursing/Unit Manager will monitor during clinical meeting 5 days per week (Monday-Friday) that all new admissions and any residents voicing a change in their shower schedule to ensure preferences are met. This monitoring will be conducted daily for 4weeks, then weekly x 4 weeks. Findings will be reported to monthly to the QAPI committee for recommendations or modification until a pattern of compliance is achieved.<br><br>RESPONSIBLE PARTY<br>Effective 7/17/2019, the Executive Director will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance | |

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weekend as part of her full time schedule. BA stated she had approximately 24 showers to complete in the course of her shift and she was usually able to get them all completed unless she was pulled from being a BA and had to work on the floor as a nursing assistant (NA). The BA stated she would get help from other staff members if she fell behind. BA stated that some residents have complained that they have missed their showers because she would have to work on the floor as a NA. BA reported she had been getting pulled from her position as BA to NA at least 2-3 times per week. The BA stated when that happened, not all showers would get done, but NA's would complete bed baths. The BA stated when she worked as a NA and had a specific assignment, she would do the showers for all the residents that were on her assignment for that day, but the others may go without their scheduled showers. The BA stated when she was hired as a NA she was oriented to the facility to perform ADL care which included bathing and showers.

An interview was conducted with Director of Nursing (DON) on 06/26/19 at 11:30 AM. The DON reported the BA handled all the showers in the facility and there was a second BA who worked as needed to help with bathing and showering. The DON reported the NAs did not do the showers because there was a BA performing that task. The DON reported when the BA was not on the schedule, the residents received bed baths. The DON reported the NA's were capable of completing showers and it was part of their job description.

An interview was conducted with Resident #41 on 06/27/18 at 9:00 AM. Resident #41 reported she

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received her shower on Wednesday, 06/26/19. Resident #41 stated she almost always had a shower on Wednesdays but she had missed several Saturday showers. Resident #41 stated she would prefer a shower twice per week and would like to get her Saturday shower as scheduled.

An interview was conducted with NA #1 on 06/27/19 at 12:30 PM. NA #1 stated the facility had a BA and she handled all the showers. NA #1 stated if the BA was not working, the NAs would give bed baths. NA #1 stated she knew how to give showers to residents and stated it was easier to shower the residents than it was to do bed baths.

2. Resident #80 was admitted to the facility on 10/15/16 with a readmission on 07/14/17. Diagnoses included, in part, chronic obstructive pulmonary disease (COPD), seizures, and difficulty walking. The MDS quarterly assessment dated 06/13/19 revealed Resident #80 was cognitively aware and required limited assistance with one staff physical assistance with all ADLs.

A review of the weekly shower schedule revealed Resident #80's room was assigned to have a shower every Monday and Thursday.

A review of the Resident Council Minutes (RCM) for April, 2019 revealed Resident #80 had expressed concerns regarding missing showers and she was only receiving one per week.

A review of the bath/shower form for the months of April, May and June, 2019, revealed Resident #80 received a shower on the following days:

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Monday No Shower 04/01/19
Thursday No Shower 04/04/19
Monday 04/08/19
Wednesday 04/10/19
Monday 04/15/19
Friday 04/19/19
Monday 04/22/19
Thursday No Shower 04/25/19
Monday No Shower 04/29/19
Thursday 05/03/19
Monday 05/06/19
Thursday No Shower 05/09/19
Monday No Shower 05/13/19
Thursday No Shower 05/16/19
Monday 05/20/19
Thursday No Shower 05/23/19
Monday No Shower 05/27/19
Thursday No Shower 05/30/19
Monday 06/03/19
Thursday No Shower 06/06/19
Monday 06/10/19
Wednesday 06/12/19
Friday 06/14/19
Monday 06/17/19
Thursday No Shower 06/20/19

An interview was conducted with residents who attended the Resident Council Meeting (RCM) on 06/25/19 at 11:00 AM. Resident #80 was in attendance at the RCM. Resident #80 attended the RCMs frequently. Resident #80 voiced that she did not get her scheduled showers each week and that she would only get one shower per week some weeks. Resident #80 stated she would get bathed and assistance would be provided with her ADL care on the days she did not receive her shower, but she stated, "I enjoy my showers and prefer to have a shower twice per week." Resident #80 stated she did not

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refuse to take her showers.

An interview was conducted with the bath aide (BA) on 06/26/19 at 11:00 AM. BA stated her primary responsibility was the BA and she was assigned to give showers full time on the 100/200/300/and 400 halls daily when she was on the schedule. BA stated she worked every other weekend as part of her full time schedule. BA stated she had approximately 24 showers to complete in the course of her shift and she was usually able to get them all completed unless she was pulled from being a BA to having to work on the floor as a nursing assistant (NA). The BA stated she would get help from other staff members if she fell behind. BA stated that some residents have complained that they have missed their showers because the BA would have to work on the floor as a NA. BA reported she had been getting pulled from her position as BA to NA at least 2-3 times per week. The BA stated when that happened, not all showers would get done, but NA ' s would complete bed baths. The BA stated when she was working as a NA and had a specific assignment, she would do the showers for all the residents that were on her assignment for that day, but the others may go without their scheduled showers. The BA stated when she was hired as a NA she was oriented to the facility to perform ADL care which included bathing and showers.

An interview was conducted with the Director of Nursing (DON) on 06/26/19 at 11:30 AM. The DON reported the BA handles all the showers in the facility and there was a second BA who worked as needed to help with bathing and showering. The DON reported the NAs did not do the showers because there was a BA

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| F 561 | Continued From page 7<br>performing that task. The DON reported when the BA was not on the schedule, the residents received bed baths. The DON reported the NAs were capable of completing showers and it was part of their job description.<br><br>An interview was conducted with Resident #80 on 06/27/18 at 9:30 AM. Resident #80 reported she received her shower today, Thursday. Resident #80 stated she would like to a get a shower three times per week but she knew it may be difficult at times and wanted them at least twice per week every week.<br><br>An interview was conducted with NA #1 on 06/27/19 at 12:30 PM. NA #1 stated the facility had a BA and she handled all the showers. NA #1 stated if the BA was not working, the NAs would give bed baths. NA #1 stated she knew how to give showers to residents and stated it was easier to shower the residents than it was to do bed baths.<br><br>An interview was conducted with the DON on 06/27/19 at 2:15 PM. The DON reported her expectation was for all nursing assistants to give showers as per the shower schedule. The DON reported although the BA was performing the task of showers primarily, it was the responsibility of the nursing aids if the BA was not available to perform the task of giving showers. | F 561 | | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or | F 585 | | 7/17/19 |

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reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,

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Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility

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| F 585 | Continued From page 10<br>or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, resident interviews, and record review the facility failed to provide a written grievance summary for 1 of 1 residents (Resident #10).<br><br>Findings included:<br><br>Resident #10 was admitted to the facility on 08/13/18 with a cumulative diagnoses including: dysphagia, adult failure to thrive, gastrostomy, severe protein malnutrition, and repeated falls.<br><br>Resident #10's quarterly Minimum Data Set (MDS) dated 04/05/19 indicated that resident had no cognitive impairments. The resident needed limited assistance for all activities for daily living (ADL).<br><br>A review of the facility's grievance log on 06/25/19 revealed two grievances from Resident #10, for not deep cleaning or waxing her room. On the bottom page of the first grievance dated 01/04/19 read, "Spoke with resident in person about deep clean and up-coming wax schedule." On the bottom page of the second grievance dated 01/17/19 read, "Spoke with resident's responsible party (RP) and roommates family that floors were waxed." Neither of the two grievance/concern | F 585 | F585 Grievances<br>Root Cause Analysis<br>Based on the root cause analysis by the facility administrative staff and the facility Executive Director, it was determined that the facility did not follow policy and procedure for providing a written response to a grievance for resident #10.<br>Immediate Action<br>On 6-26-19 a written response to the grievance for resident #10 was given to the resident.<br>Identification of others<br>On 6/26/19 the Regional Director of Operations review the last 90 days of grievances to identify any other grievances not given a written response. It was found that all grievances were handle incorrectly and starting on 6/26/19 all grievances would be handled per facility policy including providing written responses.<br>Systemic Changes<br>Effective 6/26/19, Department Heads were in-serviced on the grievance process. This education was provided by The Regional Director of Operations. Grievances will be addressed in daily | |

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| F 585 | Continued From page 11<br>forms reviewed had the back page summary or findings filled out.<br><br>An interview on 06/26/19 at 11:35 AM with the Housekeeping/Laundry Manager stated he did receive a grievance from Resident #10, per her request, to deep clean her room and waxed it. He said he cleaned and waxed Resident #10's room, even though it was not scheduled to be deep cleaned.<br><br>An interview on 06/26/19 at 3:00 PM with the Corporate Director of Operations (CDO) revealed Resident #10 did not receive a written grievance summary for her two grievances about her room needing to be deep cleaned and waxed, and should have.<br><br>An interview on 06/26/19 at 3:40 PM with Resident #10 revealed she put in grievances that her room needed to be deep cleaned and floors waxed. She said she did not receive a written grievance summary from the facility for any of her grievances.<br><br>An interview on 06/27/19 at 9:30 AM with the Administrator and the Corporate Director of Operations revealed Resident #10 did not receive a written grievance summary of the 2 grievances she reported, and should have.<br><br>An interview on 06/27/19 at 11:35 AM with the facility's Administrator and Director of Nursing (DON) revealed they did not know a grievance/concern complainant needed to receive a written summary of their grievance findings.<br><br>An interview on 06/27/19 at 11:45 AM with the Social Worker (SW) revealed that she did not | F 585 | stand up meeting Monday through Friday to ensure department heads are aware of grievances filed and to ensure follow up with written responses. This education will also be added to the new hire process.<br>Monitoring<br>Effective 6/26/19, the Executive Director will discuss grievances in daily stand up meeting Monday through Friday. Grievances will be monitored by the Executive Director daily Monday through Friday for written responses. This monitoring will be conducted daily x4 weeks, then weeklyx4. Findings will be reported in the monthly QAPI committee for recommendations and modifications until a pattern of compliance is achieved.<br>RESPONSIBLE PARTY<br>Effective 7/17/2019, the Executive Director will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance | |

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| F 585 | Continued From page 12<br>know until yesterday that she needed to provide a written grievance summary to a grievance/concern complainant. She said, she thought a verbal summary was okay. She said before today, she had only called or spoke to the complainant in person and verbally summarized the grievance, with nothing given to them in writing. She said, now she knows to provide a written grievance summary to every complainant. | F 585 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions. | F 636 | | 7/17/19 |

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| F 636 | Continued From page 13<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to complete a discharge minimum data set (MDS) assessment for 1 of 3 sampled residents (Resident #3) who were discharged from the facility. Findings included: | F 636 | F636<br>Root Cause Analysis<br>Based on the root cause analysis by the facility administrative staff and the facility Executive Director, it was determined that the facility did not follow RAI guidelines in | |

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| F 636 | Continued From page 14<br>Record review revealed Resident #3 was admitted to the facility on 02/01/19. The resident's documented diagnoses included hypertension, history of sepsis, and depression.<br><br>A 02/21/19 3:48 PM nurse's note documented, "Resident is dressed and ready for discharge, belongings are packed and ready to go. (Family member) to be in (at) 10:00 AM for discharge, orders reviewed and resident and (family member) both state understanding and no questions asked at this time. All meds...given to resident."<br><br>A 02/22/19 9:47 AM nurse's note documented, "On Thursday (02/21/19) Resident discharged home with her (family member). Resident will have (home health) providing (physical therapy, occupational therapy, and nursing services)."<br><br>Review of Resident #3's minimum data set (MDS) assessments revealed a discharge MDS was never completed after the resident's 02/21/19 discharge to the community (home).<br><br>During an interview with MDS Nurse #1 and #2 on 06/27/19 at 12:50 PM they stated they received discharge lists from the facility's social worker and business office, had discussions with the social worker and therapy departments about discharging residents, and they received reports from the Centers for Medicare and Medicaid Services documenting missed assessments. MDS Nurse #2 reported she could not explain how she missed completing a discharge MDS assessment for Resident #3, other than stating it was due to human error. She commented that the discharge assessment should have been completed, and without it, in the MDS system | F 636 | transmitting a discharge assessment for resident #3.<br>Immediate Action:<br>The discharge assessment for resident #3 was transmitted on 6/28/2019 by the MDS nurse.<br>Identification of others affected:<br>The Executive Director reviewed discharges for the last 60 days to ensure all discharges have a transmitted assessment. No other assessments were identified to be late in transmission<br>Systemic changes:<br>Education will be provided to the MDS Nurses on the RAI guidelines for transmission by the Executive Director by 7/15/19<br>Monitoring:<br>Effective 7/17/19, The Regional MDS Consultant will monitor discharge residents to ensure a discharge assessment has been completed and transmitted. This monitoring will be conducted weekly 8 weeks. Findings will be reported in the monthly QAPI committee for recommendations and modifications until a pattern of compliance is achieved.<br>RESPONSIBLE PARTY<br>Effective 7/17/2019, the Executive Director will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance | |

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| F 636 | Continued From page 15<br>Resident #3 appeared to still be an active resident who had not had a timely quarterly MDS assessment completed.<br><br>During an interview with the facility's Director of Nursing (DON) on 06/27/19 at 1:58 PM she stated she expected all required MDS assessments to be completed, a discharge MDS being one of those. She reported Resident #3's discharge should have been discussed in the daily stand up and clinical meetings attended by MDS nursing. She also remarked the social worker provided a list of discharging residents, and there was a discharge board upon which discharges were tracked. | F 636 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to: 1) accurately code the Minimum Data Set (MDS) for 1 of 1 residents (Resident #39) who was receiving hospice services and: 2) failed to accurately code the discharge destination on the MDS for 1 of 3 residents sampled for closed record review (Resident #86).<br><br>Findings included:<br><br>1. Resident #39 was admitted to the facility on 05/08/19. Diagnoses included Alzheimer's, dementia without behaviors, and incontinence.<br><br>A review of the admission history and physical on | F 641 | F641 Accuracy of Assessments<br>Root cause analysis<br>Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director the MDS Coordinator did not accurately portray resident condition on the MDS assessment for hospice for resident #39 and the discharge location for resident # 86 due to incomplete record reviews.<br>Immediate actions<br>Assessment for resident #39 dated 5/15/2019 was modified/corrected by the MDS Coordinator on 6/27/2019 to indicate hospice. | 7/17/19 |

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| F 641 | Continued From page 16<br>05/08/19 revealed the resident was being admitted to the facility on hospice care.<br><br>A review of a progress notes written on 05/08/19 admission note indicated, in part, resident was of lower cape fear hospice and was being admitted to the facility for long term care.<br><br>A review of the facility matrix revealed the resident was on hospice care.<br><br>The MDS 5-day assessment dated 05/15/19 revealed the resident was cognitively impaired. Resident #39 was coded under Section "J" for Health Conditions under J1400 Prognosis, as having a life expectancy of less than 6 months. Resident #39 was not accurately coded under Section "O" for Special Treatment and Programs under O0100 Other, for hospice care for; 1) while NOT a resident, and for; 2) while a resident.<br><br>A review of the care plan initiated on 05/08/19 and updated on 05/15/19 revealed there was no care plan in place for Resident #39 for comfort measures and or hospice.<br><br>An interview was conducted with Nurse #3 on 06/26/19 at 10:55 AM. Nurse #3 confirmed Resident #39 was on hospice and he stated she was admitted to the facility on hospice.<br><br>An interview was conducted with the MDS Nurse #2 on 06/27/19 at 11:50 AM. MDS Nurse #2 stated she coded the resident has having a life expectancy of less than 6 months under section "J" but she forgot to code the resident has receiving hospice care under section "O" for other services for Resident #39. The MDS Nurse #2 stated it was "missed." | F 641 | Assessment for resident #86 dated 5/8/2019 was modified/corrected by the MDS Coordinator on 6/27/2019 to indicate correct discharge location.<br>Identification of others<br>An audit of MDS assessments for the last recent assessment will be completed by the Executive Director on 7/14/19 validating accuracy of resident receiving hospice and the discharge location. Any assessments found to be incorrect will be corrected and resubmitted at this time by 7/17/19.<br>Systematic changes<br>Education will be provided to the MDS Coordinators by 7/15/2019 by the facility Executive Director pertaining to accuracy of assessments.<br>Monitoring process<br>Effective 7/15/2019, the facility Regional MDS Consultant audit a sample of completed MDS assessments weekly x4 weeks then a sample of assessment monthly x2 months to ensure coding accuracy. These audits will be recorded and kept by the ED for review.<br>Facility Executive Director will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br>RESPONSIBLE PARTY<br>Effective 7/172019, the Executive Director will be ultimately responsible to ensure implementation of the plan of correction | |

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| F 641 | Continued From page 17<br><br>An interview was conducted with the Director of Nursing (DON) at 2:15 PM. The DON reported her expectation of the MDS nurses was to ensure the information relating to any and all residents should be accurately coded and that it was an important function of their responsibility to maintain accuracy.<br><br>2. Record review revealed Resident #86 was admitted to the facility on 04/18/19. The resident's documented diagnoses included femur (hip) fracture, hypertension, and diabetes.<br><br>A 05/08/19 2:23 PM nurse's note documented, "Resident discharged from facility at 11:30 AM with her (family member). Discharge instructions explained to resident until understanding was stated. All of the appropriate paperwork was discussed, signed, copied and filed in resident's chart. Available medications were sent home with resident for her use."<br><br>A 05/08/19 4:37 PM nurse's note documented, "Resident discharged home with her (family member). She will have (home health) providing (physical therapy, occupational therapy, and nursing services)."<br><br>Review of Resident #86's 05/08/19 discharge minimum data set (MDS) assessment documented the resident had a planned discharge to an acute care hospital on 05/08/19 with return not anticipated.<br><br>During an interview with MDS Nurse #1 and #2 on 06/27/19 at 12:50 PM they stated they received discharge lists with destinations from the | F 641 | for this alleged noncompliance to ensure the facility remains in substantial compliance | |

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| F 641 | Continued From page 18<br>facility's social worker and business office, they reviewed discharge orders which documented destinations, and they had discussions with the social worker and therapy departments about discharging residents. After reviewing Resident #86's 05/08/19 discharge MDS assessment, MDS Nurse #2 reported the discharge destination was incorrectly coded. She explained Resident #86 was discharged to the community (home), and was not discharged to a hospital. She commented she could not explain this MDS inaccuracy other than stating that it was due to human error.<br><br>During an interview with the facility's Director of Nursing (DON) on 06/27/19 at 1:58 PM she stated she expected all the information on MDS assessments to be coded correctly. She reported Resident #86's discharge and discharge destination should have been discussed in the daily stand up and clinical meetings attended by MDS nursing. She also remarked the social worker provided a list of discharging residents with destinations, and there was a discharge board upon which discharges with destinations were tracked. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive | F 656 | | 7/17/19 |

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| F 656 | Continued From page 19<br>assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to develop a comprehensive care plan for 1 of 1 residents (Resident #39) who was receiving hospice services.<br><br>Findings included: | F 656 | F656<br>Root cause analysis<br>Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director the MDS Coordinator did not accurately portray | |

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| F 656 | Continued From page 20<br><br>Resident #39 was admitted to the facility on 05/08/19. Diagnoses included Alzheimer's, dementia without behaviors, and incontinence.<br><br>A review of the admission history and physical on 05/08/19 revealed the resident was being admitted to the facility on hospice care.<br><br>A review of a progress note written on 05/08/19 admission note indicated, in part, resident was of lower cape fear hospice and was being admitted to the facility for long term care.<br><br>A review of the facility matrix revealed the resident was on hospice care.<br><br>The Minimum Data Set (MDS) 5-day assessment dated 05/15/19 revealed the resident was cognitively impaired. The resident was coded under Section "J" for Health Conditions under J1400 Prognosis, as having a life expectancy of less than 6 months. Resident #39 was not coded under Section "O" for Special Treatment and Programs under O0100 Other, for hospice care for 1) while NOT a resident; and for 2) while a resident.<br><br>A review of the care plan initiated on 05/08/19 and updated on 05/15/19 revealed there was no care plan in place for Resident #39 for comfort measures and or hospice.<br><br>An interview was conducted with Nurse #3 on 06/26/19 at 10:55 AM. Nurse #3 reported the resident was on hospice and he stated she was admitted to the facility on hospice. Nurse #3 was unable to provide a care plan developed by the facility for Resident #39. | F 656 | resident condition on the Careplan for hospice for resident #39.<br>Immediate Action:<br>The Care Plan for resident #39 was reviewed and updated to include issues related to pain management on 6/26/19 by the MDS Nurse.<br>Identification of others affected:<br>The care plan team will complete a review and will update all resident care plans for residents currently receiving hospice services, utilizing most recent Comprehensive Assessment and other chart information by 7/17/19.<br>Systemic changes:<br>Education was provided to the Care Plan Team by the Executive Director on 7/15/2019, which included development of comprehensive, person centered care plans consistent with resident rights, measurable objectives and time frames to meet a residents medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment, plan to provide all needed services, goals and desired outcomes, preferences and potential for future discharge.<br>Newly updated care plans were placed in each resident's chart. Care Plan review will be reviewed and updated following the MDS schedule going forward and updates will be documented on care plans as issues occur.<br>Monitoring:<br>Effective 7/15/2019, the facility Regional MDS Consultant audit a sample of completed careplans weekly x4 weeks then a sample of assessment monthly x2 | |

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| F 656 | Continued From page 21<br><br>An interview was conducted with the MDS Nurse #2 on 06/27/19 at 11:50 AM. MDS Nurse #2 stated Resident #39 should have had a care plan in place if she was receiving hospice services.<br><br>An interview was conducted with the Director of Nursing (DON) at 2:15 PM. The DON reported Resident #39 should have had a hospice care plan in place and her expectation of the MDS nurses was to ensure they implemented care plans for a resident receiving hospice services. | F 656 | months. These audits will be recorded and kept by the ED for review.<br>Facility Executive Director will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br>RESPONSIBLE PARTY<br>Effective 7/17/2019, the Executive Director will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and | F 812 | | 7/17/19 |

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| | 345549 | A. BUILDING _____ B. WING _____ | C 06/27/2019 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 812 | Continued From page 22<br>serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer. Findings included:<br><br>During kitchen observations on 06/26/19 food carts emptied of breakfast trays were wiped down using a cloth kept in a red sanitizing bucket at the dish machine. Three carts were emptied and wiped down at 9:18 AM, 9:29 AM, and 9:37 AM on 06/26/19. Two other red sanitizing buckets were observed at the two food preparation counters in the kitchen.<br><br>At 9:48 AM on 06/26/19 strips were used to check the sanitizing solutions in all three red buckets. The solution in all buckets registered 50 parts per million (PPM) of quaternary sanitizer.<br><br>At 9:52 AM on 06/26/19 Dietary Employee #1 stated she made up the sanitizing solution in the three red buckets at about 8:45 AM on 06/26/19. She explained she obtained the quaternary sanitizing solution from the three-compartment sink dispensing system. She reported she did not check the strength of the sanitizing solution in the buckets when she prepared them or thereafter because she had checked the sanitizing solution in the three-compartment sink earlier, and it registered the 150- 200 PPM required by the manufacturer.<br><br>At 11:40 AM on 06/26/19 Dietary Employee #2, a cook, stated between food preparation tasks she wiped down her food preparation tables with a | F 812 | F812<br>Root cause analysis<br>Based on the root cause analysis by the Facility Executive Director the kitchen staff incorrectly prepared the sanitizing solution for the red buckets.<br>Immediate Action:<br>On 6/26/2019 the dietary employee discarded the sanitizing solution immediately. The Sanitizing solution was remade and tested at 200 ppm required by the manufacture.<br>Systemic Changes<br>Moving forward, effective 7/15/2019, the dietary staff will check the red sanitizing buckets everyday with testing strips to ensure reading are per manufacture recommendations. Moving forward, effective 7/15/2019, the dietary manager will designate staff to use and document the sanitizer test strips.<br>By 7/15/2019 the Registered Dietician completed an education with the Assistant Manager regarding preparation and testing of the red sanitation buckets. By 7/15/2019, the Registered Dietician will complete 100% education with dietary staff to include full time, part time and as needed staff. This education Included preparation and testing of the red sanitation buckets. This education will be completed by 7/17/2019, any dietary staff not educated by 7/17/2019 will not be allowed to work until educated. This education will be added on new hire | |

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| F 812 | Continued From page 23<br>cloth from the red buckets which contained quaternary sanitizing solution. She reported she was informed that this sanitizing solution was supposed to register 150 - 200 PPM in order to be effective.<br><br>The facility was temporarily without a dietary manager so on 06/27/19 at 12:39 PM the Regional Director of Operations was interviewed. She stated she preferred the quaternary solution in the red sanitizer buckets to register 200 PPM when checked with the appropriate strips. She reported when the strength was less than this there was a chance that the surfaces being wiped down were not properly disinfected. She commented the strength of the solution in the buckets should be checked when the buckets were made up and every two hours thereafter as the solutions were changed out/remade.<br><br>At 1:55 PM on 06/27/19 Dietary Employee #3 stated the red buckets in the kitchen were filled with the sanitizer dispensed at the three-compartment sink. She reported the strength of the sanitizing solutions in the red buckets should be checked when the buckets were made up and every two hours afterward. She commented strips used to measure the strength of the sanitizing solutions turned different shades of green, and the strips should register at least 150 PPM. According to the employee, if the strips registered less than 150 PPM there was an increased chance that germs and bacteria would not be killed. | F 812 | orientation process for all dietary staff effective 7/15/2019.<br>MONITORING PROCESS<br>Effective 06/26/2019, the Certified Dietary Assistant Manager and/or Administrator will monitor compliance of red sanitation buckets daily (Monday - Friday) for 4 weeks, weekly for 4 weeks, then monthly until substantial compliance is maintained for three consecutive months. Effective 7/17/2019, the Dietary Manager/Asst. Dietary Manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br>RESPONSIBLE PARTY<br>Effective 7/172019, the Executive Director and Dietary Manager will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance | |
| F 867<br>SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance. | F 867 | | 7/17/19 |

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| F 867 | Continued From page 24<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility's quality assurance (QA) program failed to prevent the reoccurrence of deficient practice related to inaccurate coding of minimum data set (MDS) assessments which resulted in a repeat deficiency at F641. The re-citing of F641 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included:<br><br>This tag is cross-referenced to:<br><br>F641: Accuracy of Assessments: Based on staff interviews and record review the facility failed to: 1) accurately code the Minimum Data Set (MDS) for 1 of 1 residents (Resident #39) who was receiving hospice services and: 2) failed to accurately code the discharge destination on the MDS for 1 of 3 residents sampled for closed record review (Resident #86).<br><br>Review of the facility's survey history revealed F641 was cited during the facility's 06/21/18 annual recertification survey for inaccurate coding on MDS assessments. The facility was re-cited during the current 06/27/19 annual recertification/complaint investigation survey for the same issue of inaccurate coding on MDS assessments.<br><br>During an interview with MDS Nurse #1 and MDS Nurse #2 on 06/27/19 at 12:50 PM they were | F 867 | F867 QAPI<br><br>Root cause analysis<br>Based on the root cause analysis by the Facility Director of Nursing Services and the Facility Executive Director the MDS Coordinator did not continually code accurately residents' condition on the MDS assessment.<br><br>Immediate actions<br>Assessment for resident #39 dated 5/15/2019 was modified/corrected by the MDS Coordinator on 6/27/2019 to indicate hospice.<br>Assessment for resident #86 dated 5/8/2019 was modified/corrected by the MDS Coordinator on 6/27/2019 to indicate correct discharge location.<br><br>Identification of others<br>An audit of MDS assessments for the last recent assessment will be completed by the Executive Director on 7/14/19 validating accuracy of resident receiving hospice and the discharge location. Any assessments found to be incorrect will be corrected and resubmitted at this time by 7/17/19.<br><br>Systematic changes<br>Education will be provided to the MDS | |

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| F 867 | Continued From page 25<br>unable to explain how data on the MDS assessments was coded incorrectly, other than stating it was due to human error. MDS Nurse #2 stated there was a lot of data to look at when deciding how to code the information required on the MDS assessments.<br><br>During an interview with the Director of Nursing (DON) on 06/27/19 at 1:58 PM she stated she thought the repeat deficiency at F641 occurred because after the complete date in the plan of correction designed as a result of the 06/21/18 survey old habits were resumed on the part of the MDS nurses which were not beneficial to the facility. | F 867 | Coordinators by 7/15/2019 by the facility Executive Director pertaining to accuracy of assessments.<br><br>Monitoring process<br>Effective 7/15/2019, the facility Regional MDS Consultant audit 10 of completed MDS assessments weekly x6 weeks then a sample of assessment monthly x4 months to ensure coding accuracy. These audits will be recorded and kept by the ED for review.<br>Facility Executive Director will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The Regional MDS and Nurse Consultant will attend the next two Monthly QA Meeting and will continue at least quarterly thereafter to ensure all corrective measures continue to be carried out. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.<br><br>RESPONSIBLE PARTY<br>Effective 7/17/2019, the Executive Director will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. | |