STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted from 5/23/23 through 5/24/23. Additional information was obtained on 6/01/23 and 6/02/23. A partial extened survey was completed on 6/02/23. Therefore, the exit date was changed to 6/02/23. The following intakes were investigated NC00202133. Intake NC00202133 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) Tag F689 constituted Substandard Quality of Care. Noncompliance began on 5/08/23. The facility came back in compliance effective 5/11/23. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, Resident, Medical Director interviews, the facility failed to provide care in a safe manner for 1 of 3 residents (Resident #1) reviewed for accidents. On 5/8/23 the Nurse Aide raised the level of the	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/09/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 bed to provide incontinence care and change bed linens for Resident #1. Resident #1 was positioned on her right side while the bed linens were being changed and fell out of bed landing face down on the floor. The resident was sent to the Emergency Department (ED) for evaluation and diagnosed with a subdural hematoma (blood collection between the skull and surface of the brain), scattered skin tears, skin lacerations to the left forearm and right knee that required sutures, forehead abrasion, closed fracture of the right orbit (eye) with right periorbital hematoma (black eye) and premaxillary hemorrhage (bleeding) and a minimally displaced right nasal bone fracture. Resident #1 was admitted to the trauma service step down unit for wound care, antibiotics, and post operative pain control. Findings included: Resident #1 was admitted on 1/17/22 with diagnoses that included vascular dementia without behaviors, atrial fibrillation, chronic obstructive pulmonary disease (COPD), debility, bowel and bladder incontinence and bed bound. Review of physician orders revealed Resident #1 was prescribed Xarelto 2.5 milligrams (mg) daily for atrial fibrillation on 4/21/22 and scheduled oxycodone IR (immediate release) 5 mg 1 tablet every 8 hours for generalized osteoarthritis pain and was also prescribed oxycodone IR 5 mg 1 tablet every 4 hours as needed for generalized osteoarthritis pain on 3/29/23. Resident #1 was admitted into hospice on 10/14/22 with diagnoses that included moderate vascular dementia without behaviors, atrial fibrillation, chronic obstructive pulmonary disease	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 (COPD), debility, bowel and bladder incontinence, and bedbound. Review of the quarterly Minimum Data Set (MDS) dated 4/21/23 revealed moderately impaired cognition and required 2-person assistance with bed mobility and transfers. Resident #1 was always incontinent of bowel and bladder. Resident #1 had bilateral lower extremity impairment in range of motion and was receiving opioid pain medication daily. The MDS indicated no falls since admission/reentry/prior assessment. Review of Care Plan dated 4/26/23 identified a focus of at risk for falls related to history of falls with impaired mobility contributing of vascular dementia, insomnia, and muscle spasm. The goal was for the resident to not sustain falls that will create injury over the next review period and the interventions were to refer to physical therapy for evaluation, monitor for changes in condition that may warrant increased supervision/assistance and notify the physician, and floor mat next to bed when resident was in bed. The Nurse Aide care guide (Kardex) updated 10/06/22 revealed Resident #1 required extensive assistance of 2 with positioning and mobility. The care guide revealed that the resident required 1 assist with dressing, 2 assist with positioning, and 2 assist with mechanical lift. Interview with NA #1 on 5/24/23 at 8:30 am revealed incontinence care was being provided to Resident #1 on 5/8/23 when Resident #1 fell out of the bed. NA #1 stated he typically provided incontinence care and bed linen changes for this	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

resident without assistance and the fall was not expected. NA #1 explained Resident #1 was heavily soiled requiring a full bed change and after incontinence care had been provided Resident #1 was rolled onto her right side while the dirty sheets were being removed. Resident #1 changed the position of her top leg by sticking it out and rolled off the side of the bed onto the floor. The interview further revealed NA #1 had raised the level of the bed to provide care and the fall mat was in place at the time of the fall, but the resident fell off the opposite side of the bed. NA #1 observed Resident #1 lying on the floor face down with her right arm underneath her body after the fall. NA #1 notified Nurse # 3 who came and assessed Resident #1.

Phone interview with NA#1 on 6/2/23 at 9:42 am revealed when Resident #1 fell out of bed she yelled out "Oh, oh" and initially did not express pain but when she was being assessed by Nurse #3, she would say "oh, that hurts" when being moved. Skin tears were noted to both arms and legs, and she had bleeding on her face, but NA#1 did not know where the bleeding was coming from but stated there was a considerable amount of blood. Resident #1 was alert and oriented the entire time and seemed fully aware that she had fallen out of bed.

Resident Incident Report dated 5/8/23 at 3:15 pm revealed that Resident #1 went over the side of the bed toward the window during incontinence care with a bed change. The fall resulted in injuries including right lip small laceration, bump to the left side of forehead, nose fracture with black right eye, large skin tear to left forearm, large skin tear to right lower leg, skin tear to left knee and right forearm. Resident #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

transported to the Hospital by Emergency Medical Services (EMS). It further revealed that at the time of the incident the resident had received analgesics/narcotics in the past 8 hours. This report was documented by Nurse #3.

A nurse's notes written by Nurse #3 dated 5/8/23 at 6:46 pm revealed that the Resident #1 fell from the bed during a full bed linen change and was face down next to the bed after the fall. Bleeding was noted from the head, leg, and nose. It further revealed that the resident reported pain everywhere. Resident was alert. Emergency Medical Services (EMS) was notified and due to resident injuries and being on blood thinners. Resident #1 was transported to hospital emergency department (ED) where she was admitted for subdural hematoma.

A telephone interview with Nurse #3 on 5/23/23 at 2:50 pm revealed she was on duty on 5/08/23 when Resident #1 fell and was called to the room by Nurse Aide (NA) #1. Resident #1 was found on the floor next to her bed in the prone position. She indicated that NA #1 had been changing Resident #1 to include a full bed change and Resident #1 was a "fairly big" person for one aide to do but, only one aide would typically be assigned. Nurse #3 revealed that the resident was "sent out" with Emergency Medical Services. Nurse #3 stated that the resident could stabilize herself a little, but you had to always keep a hand on her. The interview further revealed the fall mat was in place at the time of the fall but was on the other side of the bed.

A follow up phone interview with Nurse #3 on 6/2/23 at 9:55 am revealed she was on duty on 5/8/23 when Resident #1 had a fall from the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 and was called to the room by NA #1. She observed Resident #1 on the side of the bed closest to the window face down on the floor, she described seeing a large amount of blood in her mouth, and bleeding noted from the nose. She added that she had injuries to her head, face and that her nose looked broken, and she could observe that blood was going to the back her throat, so she kept her on her side while awaiting Emergency Medical Services (EMS) to arrive. Nurse #3 revealed there was a lot of blood mostly from the face and Resident #1 had 2 deep skin tears, one on the left forearm and one on the right knee, and an abrasion to the forehead. Nurse #3 added that Resident #1's left arm may have come into contact with hardware from the a nearby chest of drawers when she fell causing the deep skin tear. When asked about pain Resident #1 indicated she had pain everywhere. Nurse #3 revealed that she worked with the resident after she was readmitted from the hospital after the fall. On return to the facility Nurse #3 described Resident #1 as bruised on her face and was in more pain than before the fall and when staff moved her to change her, she was vocal about the discomfort and pain and would grimace. Resident #1 would tell them it hurt. Nurse #1 stated that Resident #1 returned to the facility with a PRN (as needed) pain medication ordered but the pain medicine was changed to scheduled after the first few days after admission because of the pain. She described Resident #1's pain prior to the fall as more general discomfort and after the fall as being more related to the injuries from the fall. She added Resident #1 would not give you a number on a pain scale but would just say "real bad" so that is how they knew she was in a lot of pain. On return Resident #1 was described as having more "real bad" pain, especially in the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

first few days after return, and more lethargic and tired and it took about 10 days to get back to her baseline. Nurse #3 indicated that Resident #1 had anxiety and after the fall had to be reassured when she was changed because she was afraid she would fall again, but that was getting better now.

Resident Incident Report dated 5/8/23 at 3:45 pm revealed that Resident #1 fell out of bed while incontinence care was provided. The fall resulted in injuries including upper right lip laceration, raised bump to left forehead, possible nose fracture, bruise to right eye, multiple skin tears - left upper arm, left forearm, right upper arm, right forearm, and bilateral knees. Resident #1 was transported to the Hospital by Emergency Medical Services (EMS). It further revealed that at the time of the incident the resident had received analgesics/narcotics in the past 8 hours. This report was documented by Nurse # 2.

Phone interview with Nurse #2 on 6/1/23 at 3:55 pm revealed that she was the wound nurse and had assessed Resident #1's skin tears, bruises, and lacerations that she received from the fall on 5/8/23 and provided wound care to the Resident #1 after her readmission from the hospital after the fall. She added that Resident #1 was like her normal self even though she was all cut up, happy and talking to staff and no different from before the fall, other than her injuries. Nurse # 2 reported that Resident #1 denied pain and did not have non-verbal expressions during wound care. The interview further revealed that Nurse #2 would at times assist the NAs with brief changes and Resident #1 would say "ow, that hurts" or "don't touch me there" when they were rolling her over and added that Resident #1 had bruises on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

the backs of her arms and if touched there would say "ouch" and that Resident #1 did not do that prior to the fall and didn't complain of pain prior to the fall during care. Nurse #2 described Resident #1's skin condition after the fall and stated that she had multiple skin tears on both upper and lower extremities on both sides and bruising on the face, arms and legs with sutures in her right knee.

Review of hospital records dated 5/8/23 revealed Resident #1 presented to the emergency department (ED) after a fall from bed during a transfer that impacted her face. No report of loss of consciousness. The ED Provider's review of systems noted numerous skin avulsions, right periorbital ecchymosis and the resident reported a headache. The CT scan of the face noted closed fracture of the right orbit (eye) with right periorbital hematoma and premaxillary hemorrhage, a minimally displaced right nasal bone fracture. The CAT scan of the head noted a right frontal subdural hematoma. The history and physical completed by a Trauma Surgeon on 5/8/23 revealed the resident reported pain in her left shoulder, extremities and skin tears and rated the pain level as a 4 out of 10. History and physical further noted right periorbital ecchymosis and the lacerations to the left forearm and right knee were repaired with dissolvable sutures. The x-ray of the left shoulder was negative for fracture. Resident #1 was admitted to the trauma service step down unit for wound care, antibiotics and post operative pain control. It was determined that the subdural hematoma did not require surgical intervention. Resident #1 was discharged from the hospital back to the facility on 5/10/23 with orders that included Oxycodone 5 mg every six hours as needed for pain and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 stop Xarelto 2.5 mg. Review of a progress note dated 5/11/23 written by the Family Nurse Practitioner revealed Resident #1 was readmitted to the facility with a diagnosis of fall resulting in nasal bone fracture, fracture of right orbital floor, subdural hematoma and multiple skin tears. The progress note review revealed Resident #1 was readmitted with orders for Oxycodone 5 mg every four hours as needed for pain and an order for alprazolam 0.5 mg 1 tablet every eight hours and 1 tablet every 4 hours as needed for anxiety for 4 months. The physical exam revealed Resident #1 had bruising to the forehead, nasal and orbital area, and neck and bruising and multiple skin tears to upper and lower extremities. Resident #1 was oriented to person, not place and time. The review further revealed that anticoagulants were being held. Review of nurses note dated 5/10/23 7:15 pm Nurse # 1 revealed that Resident #1 returned from the hospital to the facility alert and oriented and noted to have numerous facial bruises (eye area) color observed to be reddish purplish. Resident #1 was noted to have dressings to bilateral arms and bilateral lower extremities and returned with a prescription for a narcotic pain pill that was faxed to a pharmacy. On 6/1/23 at 4:06 pm phone interview with Nurse #1 revealed that she was the nurse on duty when the resident was readmitted from hospital on 5/10/23. Nurse #1 indicated that she worked with Resident #1 on a routine basis and was familiar with her. She did not recall complaints or signs of pain on readmission. Nurse #1 described her condition as being bruised, to include on her face with dressings on the injuries from the fall. She	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

was described as happy to be back "home" and was laughing and smiling.

Review of a progress note dated 5/11/23 written by the Family Nurse Practitioner revealed Resident #1 was readmitted to the facility with a diagnosis of fall resulting in nasal bone fracture, fracture of right orbital floor, subdural hematoma and multiple skin tears. The progress note review revealed Resident #1 was readmitted with orders for Oxycodone 5 mg every four hours as needed for pain and an order for alprazolam 0.5 mg 1 tablet every eight hours and 1 tablet every 4 hours as needed for anxiety for 4 months. The physical exam revealed Resident #1 had bruising to the forehead, nasal and orbital area, and neck and bruising and multiple skin tears to upper and lower extremities. Resident #1 was oriented to person, not place and time. The review further revealed that anticoagulants were being held.

After the fall Resident #1 was initially prescribed oxycodone 5 mg 1 tablet every 6 hours as needed for pain. This regime was ordered on 5/10/23 and discontinued on 5/11/23.

Review of nurse's notes dated 5/11/23 12:24 pm Nurse #5, unit manager, revealed that she received a new physician order for Resident #1 to discontinue oxycodone 5 mg as needed (PRN) every 6 hours and to start Oxycodone 5 mg every 4 hours as needed for pain.

Review of the Medication Administration Record (MAR) on 5/11/23 oxycodone 5 mg 1 tablet every 4 hours as needed for pain was started. This order was discontinued on 5/12/23 after receiving 3 doses with a pain scale of 8 reported on a scale of 1 to 10 with 10 being the worst pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

Review of a progress note dated 5/12/23 written by Adult-Gerontology Nurse Practitioner revealed nursing staff reported Resident #1 moaned when repositioned and the family requested oxycodone 5 mg be scheduled. An order for oxycodone 5 mg every 4 hours written and an order for oxycodone 5 mg every 6 hours as needed for pain written.

Review of nurses note dated 5/12/23 at 6:40 pm revealed that Nurse #4 received new pain medication orders for Resident #1. The new order was to discontinue Oxycodone 5 mg every 6 hours and to start Oxycodone 5 mg every 4 hours.

A phone interview with Nurse #4 on 6/1/23 at 5:15 pm revealed that after Resident #1 was readmitted to the facility from the hospital that she was very bruised with skin tears on each extremity, bruising to her face and in a lot of pain. Nurse #4 further revealed that she did a pain assessment on Resident #1 the day after she returned (5/11/23) and she couldn't give a number on a pain scale but was moaning and grimacing. Resident #1's pain medication was prescribed as PRN (as needed) at that time and her son wanted it scheduled and the order was changed to scheduled every 4 hours since she was in pain but would not ask for anything. Nurse #4 further revealed that you could tell that she was hurting, and Resident #1 told her that her left arm was hurting but would not ask for pain medication. The interview further revealed that Resident #1's pain was worse after the fall, and she had non-verbal signs of pain. Nurse #4 described Resident #1 as more confused after the fall and that she could not insert a urinary catheter because Resident #1 was in too much pain and if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 you tried to open her legs it was too painful for her because of her injuries to her legs. On 5/12/23 a physician order for oxycodone 5 mg 1 tablet every 6 hours as needed for pain was started in addition to the scheduled every 4-hour dose. She received this as needed dose 3 times between 5/19/23 and 5/26/23. Review of the May MAR further revealed that Resident #1 reported pain (on a pain scale of 0-10) consistently as a 1-7 prior to the fall. After the fall Resident #1 reported pain (on a pain scale of 0-10) consistently as a 3-8. On 5/11/23 and 5/12/23 Resident #1 reported pain as an 8 (on a pain scale of 0-10). Review of Resident #1's MAR from 5/10/23 through 5/31/23 revealed that Resident #1 continued to receive scheduled oxycodone 5 mg every four hours and oxycodone 5 mg every 6 hours as needed for pain. MAR review further revealed that between the dates of 5/11/23 and 5/31/23 the resident had a total of 5 days where pain was documented as a 0 (on a pain scale of 0-10) all other dates had pain scale ratings ranging from a 3 to 8 (on a pain scale of 0-10). Interview with NA #2 on 5/23/23 at 12:30 pm revealed Resident #1 could communicate needs and was a 2 person assist. NA #2 stated she would always get help when providing incontinence care and linen changes for Resident #1. NA #2 indicated that she followed a care guide that was in a book on the unit and the care guide listed the resident as a 2 assist with positioning and mobility with a mechanical lift, and a 1 assist with dressing.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

Interview and observation of Resident #1 on 5/23/23 at 10:45 am revealed the resident did not report concerns of pain. Resident #1 was noted to have bandages to her left lower forearm and right upper arm and an abrasion to the left side of the forehead. Yellowing bruising was noted below the left eye and to the left side of the forehead. When asked Resident #1 describes her injuries and bruising as occurring from being in a "wreck" and did not respond when asked if she had pain.

Review of Medical Director progress notes dates 5/16/23 revealed Resident #1 was diagnosed with a nasal bone fracture, fracture of the right orbital floor, subdural hematoma, multiple skin tears, laceration of the left forearm and laceration of the knee. She was evaluated by neurosurgery and after a follow-up CT it was determined that she did not require surgical intervention for the subdural hematoma. Once stable Resident #1 was discharged back to the facility to continue long-term care with the help of hospice. The review revealed that upon physical examination by the facility Medical Director that Resident #1 had decreased range of motion in both lower extremities, a decrease of range of motion of both hands, but she was able to feed herself, and Resident #1 had hematomas all over her face. The review indicated that Resident #1 was back to her baseline and required total care. The Medical Director noted a concern that since the subdural hematoma Resident #1 would most probably have more cognitive impairment and would not be able to do the inhaler prescribed for her chronic obstructive pulmonary disease. Additionally, the report revealed that after several skin tears and nasal-orbital floor fracture that Resident #1 would continue on Tylenol (acetaminophen) 650mg three times a day and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 oxycodone every 6 hours as needed for pain. The review further revealed that Resident #1 was at significant risk of worsening medical and neurobehavioral status. An interview on 5/24/23 at 9:55 am the Medical Director indicated she was aware of Resident #1's fall from the bed on 5/08/23 and participated in the post incident care plan review. She was aware of the injuries sustained by the resident from the fall. She indicated that the resident was large, and the amount of assistance required during care would be determined by the facility. The interview revealed that Resident #1 would easily bruise and always had skin issues related to blood thinners. The Medical Director stated that the resident had returned to her baseline. Interview with the Director of Nursing (DON) on 5/23/23 at 5:30 pm revealed that the DON was aware of the injuries of Resident #1 from the fall. He stated that on the Kardex she was a 2 person assist with positioning, but based on her condition it was appropriate for a 1 person assist at the time of the fall. He further indicated that the fall was caused by the resident unexpectedly changing position. He stated the fall was unexpected for her. Interview with Administrator on 5/24/23 at 11:00 am revealed that a Plan of Correction (POC) had been done for the incident that involved Resident #1. 5/24/23 at 11:30 am interview with the DON and Administrator revealed both indicated that they would not expect a resident to fall from the bed during an occupied full bed linen change. The DON stated the fall and injuries obtained by	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 Resident #1 were determined as caused by the resident changing position unexpectedly and the Administrator agreed. The Administrator was notified of Immediate Jeopardy on 5/31/23 at 5:27 pm. The Administrator provided the following corrective action plan with a compliance date of 5/11/23. Address how corrective action will be accomplished for resident(s) found to have been affected: Resident #1 is a 92-year-old female, who has been a resident at the facility since 7/25/2016 and admitted to Hospice services 10/14/2022. She was admitted to the facility with the following diagnosis: GERD, Dysphasia, COPD, Candidiasis (skin, nail, vulva, and vagina), Allergic Rhinitis, Insomnia, Hypertension, Heart Failure, A. Fibrillation, Anxiety D/O, Hypothyroidism, Diabetes Mellitus, Vascular Dementia w/o behaviors, Depression D/O, Obstructive Sleep Apnea, Dyspnea and Obesity. Resident #1 is currently on Eliquis twice a day for the diagnosis of Arial Fibrillation. Nurse Aide #1 was providing ADL/Incontinent care to the resident. While positioned on her side Resident #1 kicked out her leg from the bed causing her to roll off the bed onto the floor between the bed and the window. Nurse Aide #1 immediately notified the residents' assigned nurse. Licensed Nurse #3 came to the room and completed a head-to-toe evaluation of the resident. Licensed Nurse #3 identified injuries to the residents' upper lip, left side of her forehead, nose, bilateral arms/legs and her right eye. First aid was initiated immediately, the Director of	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

Nursing was informed, who immediately came to assist, and 911 emergency services were contacted. Licensed Nurse #3 and the Director of Nursing provided first aid while awaiting 911 emergency services. Resident #1 was transported to New Hanover Regional Medical Center where she was admitted with a diagnosed of subdural hematoma.
Nurse Aide #1 received retraining on bed mobility to include appropriate positioning of resident during care and safe bed mobility practices with return demonstrations on 5/11/23 by the Asst. Director of Nursing. Resident #1 returned to the facility on 5/10/23 and has been changed to requiring 2 persons to assist her with bed mobility and positioning. A care plan meeting was held with resident #1 representatives, resident #1, Administrator, Director of Nursing, and hospice services on 5/12/23.

Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed:
All residents in the facility have the potential to be affected. An audit was completed of all current resident's positioning/bed mobility status by the Director of Nursing, Asst. Director of Nursing and Director of Rehabilitation Services to determine their current functional status and care needs. Current residents care plans have been reviewed and updated with any changes in functional mobility status by the MDS coordinator. Completed 5/11/23.

Address what measures will be put in place and systemic changes made to ensure that the identified issue does not occur in the future. Current licenses nurses and CNA's including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 agency nurses received retraining on appropriate positioning/bed mobility status with a return demonstration. This included reviewing the 24-hour report daily in the morning clinical meeting to identify changes in condition. All newly hired licensed nursing staff and CNA's will be educated on the functional mobility evaluation by the Director of Nursing or designee during orientation. Any nurse or CNA including agency personnel not in-serviced by 5/11/23 will not be able to work until completion of education. Resident #1 has been changed to requiring 2 persons to assist her with bed mobility and positioning. Indicate how the facility plan to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The Director of Nursing and Assistant Director of Nursing conduct a random observation audit of 5 residents per week for 12 weeks to ensure appropriate positioning/bed mobility status. Also, the Director of Nursing and Asst. Director of Nursing will review the 24-hour report daily in the morning clinical meeting to identify changes in condition, 5 days a week for 12 weeks. The results of all observations and audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for 3 months to determine the effectiveness of this plan. Negative findings will be addressed by the committee. Additional interventions will be developed, implemented, and monitored by the Committee to ensure sustained compliance.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 06/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17 Date of Compliance 5/11/2023 *This QAPI Action Plan must be discussed at your next QAPI meeting and Medical Director should review and sign. The QAPI Action Plan was signed and dated 5/12/23 by the Administrator and Department Managers On 5/24/23 at 12 pm, the corrective action plan with a compliance date of 5/11/23 was validated. The survey team confirmed the facility addressed the resident involved and acted to mitigate the risk of the other residents. The facility re-educated all staff on safety transfers and repositioning. The facility implemented an audit to update all care guides. The facility initiated a process to review resident's transfer capabilities and updated the care guides of all residents including new admissions. The facility also implemented the monitoring process, and it was to be included in the Quality Assurance and Performance Improvement Committee meeting. The facility's compliance date of 5/11/23 was validated.	F 689		