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 _____	R-C 01/25/2024

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

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F 000	INITIAL COMMENTS An onsite revisit was conducted on 01/23/24 through 01/25/24. Tags F600 and F607 were corrected as of 01/25/24. A repeat tag was cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		

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

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including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;

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consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

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(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint investigation survey of 3/8/21, the recertification survey of 10/26/21, and the recertification and complaint investigation survey of 12/16/22. This was for two deficiencies in the areas of Activities of Daily Living (ADL) Care Provided to Dependent Residents (F677) and Nutrition and Hydration Status Maintenance (F692). These areas were subsequently recited during the current revisit and complaint investigation survey of 01/25/24. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program.

Findings included.

This tag is cross-referenced to:

F677: Based on observations, record review, and staff interviews the facility failed to provide incontinence care to 4 of 4 residents (Resident #5, #10, #11, and #12) who were unable to carry out activities of daily living (ADL's) without staff assistance and were reviewed for needing assistance with ADLs.

During the recertification and complaint

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investigation survey completed on 12/16/22 the facility was cited for failure to provide ADL care to a dependent resident by not cleaning and trimming fingernails that were long and dirty.

F692: Based on observations, record review and staff, Registered Dietician and Physician interviews, the facility failed to: a) follow the physician orders to administer a nutritional supplement twice daily with lunch and dinner for weight loss; and b) obtain weekly weights as ordered for a resident (Resident #2) who had a weight loss. This was for 1 of 1 residents reviewed for weight loss.

During the complaint investigation on 03/08/21 the facility failed to implement dietary recommendations for ice cream to be served with lunch and dinner meals.

During the recertification survey completed on 10/26/21 the facility was cited for failure to obtain a physician ordered weight for a resident with weight loss.

During the recertification and complaint investigation survey completed on 12/16/22 the facility was cited for failure to obtain physician ordered weekly weights, obtain, and record accurate weights, and identify and verify the accuracy of weights.

During an interview on 01/25/24 at 6:00 PM the Administrator stated the key factor involving the repeat deficiencies was due to having a large turnover in clinical staff over the last several months. He stated they had staffing changes

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F 867	Continued From page 5 within the dietary department including the Registered Dietician and the Dietary Manager. Also, repeat deficiencies were due to nursing staff turnover and they recently hired a new Director of Nursing. He stated ad hoc meetings were held along with the monthly QAPI meetings. The next QA ad hoc would be held the following day on 01/26/24 or early the following week. He indicated education would be provided and these areas would be reviewed in QAPI until improvements occurred.	F 867		