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	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care / Brunswick	1070 Old Ocean Highway Bolivia, NC 28422

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37673 Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage on 28 of 45 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 1, 2024 (October 1-December 31, 2023) revealed the facility had no Registered Nurse (RN) coverage on 10/08/23, 11/19/23, 12/03/23 and 12/31/23. Review of the daily assignment schedules from October 1, 2023 through March 19, 2024 revealed the facility failed to provide 8 hours of RN coverage on the following dates: 10/08/23, 11/13/23, 11/14/23, 11/18/23, 11/29/23, 11/23/23, 12/03/23, 12/16/23, 12/20/23, 12/21/23, 12/22/23, 12/26/23, 12/30/23, 12/31/23, 01/13/24, 01/14/24, 01/27/24, 01/28/24, 02/10/24, 02/11/24, 02/14/24, 02/16/24, 02/15/24, 02/28/24, 03/04/24, 03/07/24, 03/29/24, and 03/10/24. In an interview with the facility Scheduler on 03/19/24 at 4:30 PM she reported the facility had been short RN coverage every other weekend for several months but could not remember how long it had been since the last RN Weekend Supervisor had resigned. She noted the facility did not use Agency staffing. She stated the facility had recently hired 2 RN's, one had started, and one was waiting to start work. In a meeting on 03/20/23 at 1:00 PM with the Payroll and Human Resources Coordinator she verified by reviewing the daily assignment sheets and payroll punches that there was no RN coverage on the 28 dates reviewed. In an interview with the Administrator on 03/20/24 at 3:30 PM he stated that the facility did not have adequate RN coverage because of staff resigning. He reported that 2 RNs had changed to PRN (as needed) and a few RNs had quit. He noted that a new RN had started the previous day and was orienting. He stated a weekend RN supervisor was supposed to start the previous weekend but did not show up for work and was not returning the facility phone calls. He noted the facility was advertising on social media, had flyers in the community, was using a State based recruiting site, and was attending job fairs in the community in an effort to recruit Registered Nurses.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37673 Based on record review and staff interviews the facility failed to accurately document the Daily Nursing Hours postings for 2 of 45 Daily Nursing Hours reports reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 1, 2024 (October 1-December 31, 2023) revealed the facility had no Registered Nurse (RN) coverage on 10/08/23, 11/19/23, 12/03/23 and 12/31/23. Review of the facility Daily Nursing Hours postings revealed on 10/08/23 and on 12/03/23 the facility counted 8 RN hours for both dates. Review of the daily assignment sheets revealed there was no RN coverage in the building on 10/08/23 and 12/03/23 as posted. In an interview with the Payroll/Human Resources Coordinator on 3/20/24 at 1:00 PM she stated that no RN was scheduled or paid on 10/08/23 or 12/03/23 showing there had been no RN in the building on those dates. In an interview with the Administrator on 03/20/24 at 3:30 PM he stated he did not know why the staff postings were wrong. He noted on one of the days an RN had been scheduled but did not show up for work. He stated he verified with the Payroll Coordinator that no RN worked on10/08/23 and 12/03/23 but hours were documented on the staff postings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the physician order and provide sliding scale insulin to 2 residents (Resident #60 and Resident #2) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in Resident #60 not receiving a total of 21 doses of sliding scale insulin from 03/08/24 through 03/17/24 and Resident #2 not receiving a total of 6 doses of sliding scale insulin from 03/01/24-03/17/24. This was for 2 of 2 residents reviewed for insulin administration. There was no significant outcome to either resident. Findings included: 1. Resident #60 was readmitted to the facility on [DATE] with diagnosis including diabetes with diabetic polyneuropathy. Review of Resident #60's care plan revealed a 2/28/24 focus of at risk for hypo or hyperglycemia due to diabetes. The goal indicated Resident #60 would not exhibit signs of hypo or hyperglycemia. Interventions indicated to administer medications as ordered and observe for signs and symptoms of hypo or hyperglycemia (sweating, tremor pallor, nervousness, headache, double vision, confusion, lack of coordination, and refer to MD. A physician order dated 02/28/24 revealed Resident #60 received Januvia, an oral medication used to lower blood sugar levels, 100 milligrams (mg.) once daily for hyperglycemia, elevated blood sugar levels. A 02/28/24 physician order also indicated Resident #60 received glyburide 5mg. twice daily for diabetes. The 3/2/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #60 was cognitively intact with no behaviors and received insulin. A progress note dated 3/4/24 documented by the Nurse Practitioner (NP) revealed Resident #60 was examined due to a chief complaint of diabetes. The NP noted Resident #60's blood glucose readings were elevated, likely due to a steroid taper. The plan indicated the NP would order more aggressive sliding scale insulin coverage and continue glyburide and Januvia as ordered. A physician order dated 3/8/24 indicated Novolog Flex pen 100 units per milliliter subcutaneous PRN (as needed) using facility sliding scale protocol for blood glucose 0-60=0 units insulin and call the physician, 61-350=0 units, 351-400=4 units, greater than 400 =8 units and recheck in 4 hours and if remains greater than 400 notify the physician. The order further indicated Accu-Chek blood sugar test with sliding scale. Use Novolog insulin for blood sugar greater than 200. 201-250=2 units, 251-300 =4 units, 301-350=6 units, 351-400=8 units, greater than 400=10 units for diabetes. The March 2024 Medication Administration Record (MAR) for Resident #60 indicated blood glucose readings were recorded at 6:00 AM, 11:30 AM, 4:30 PM and 9:00 PM. Review of the March 2024 MAR for Resident #60 revealed the sliding scale insulin was not administered as needed for blood glucose greater than 200 mg/dl for the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/0924 at 11:30 AM blood glucose reading was 248 no insulin administered 03/09/24 at 4:30 PM blood glucose reading was 265 no insulin administered 03/09/24 at 9:00 PM blood glucose reading was 327 no insulin administered 03/10/24 at 6:00 AM blood glucose reading was 209 no insulin administered 03/10/24 at 11:30 AM blood glucose reading was 247 no insulin administered 03/10/24 at 4:30 PM blood glucose reading was 247 no insulin administered 03/10/24 at 9:00 PM blood glucose reading was 301 no insulin administered 03/11/24 at 11:30 AM blood glucose reading was 238 no insulin administered 03/11/24 at 4:30 PM blood glucose reading was 210 no insulin administered 03/11/24 at 9:00 PM blood glucose reading was 231 no insulin administered 03/12/24 at 6:00 Am blood glucose reading was 202 no insulin administered 03/12/24 at 11:30 AM blood glucose reading was 268 no insulin administered 03/12/24 at 4:30 PM blood glucose reading was 287 no insulin administered 03/12/24 at 9:00 PM blood glucose reading was 313 no insulin administered 03/13/24 at 4:30 PM blood glucose reading was 305 no insulin administered 03/13/24 at 9:00 PM blood glucose reading was 215 no insulin administered 03/14/24 at 4:30 PM blood glucose reading was 258 no insulin administered 03/14/24 at 9:00 PM blood glucose reading was 228 no insulin administered 03/15/24 at 11:30 AM blood glucose reading was 205 no insulin administered 03/15/24 at 4:30 PM blood glucose reading was 255 no insulin administered 03/15/24 at 9:00 PM blood glucose reading was 309 no insulin administered (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/21/24 at 9:15 AM with Unit Manager #1. Unit Manager #1 stated she had routinely provided care for Resident #60 and checked her blood sugar as scheduled. She stated she was not aware of the more specific sliding scale order that was added but if she had she would have administered it as ordered. Unit Manager #1 stated the order entered in Resident #60's electronic medical record on 3/8/24 was confusing and required clarification. Unit Manager #1 reviewed the MAR and stated Resident #60 had not received the sliding scale insulin according to the physician order. The Unit Manager stated the order for Novolog Flexpen as needed for blood sugar greater than 350 is the standard protocol and should have been discontinued when the other order for sliding scale insulin was received on 3/8/24. She indicated this was likely the cause of the new more specific sliding scale order not being followed. An interview was conducted on 3/21/24 at 9:25 AM with the Nurse Practitioner (NP). The NP stated on 3/4/24 she reviewed Resident #60's blood glucose readings and observed elevations in the readings likely caused by a steroid taper. The NP revealed on 3/8/24 she changed the sliding scale to provide increased coverage. The NP stated Resident #60 should have received the more aggressive sliding scale insulin coverage. The NP reviewed the MAR and indicated the facility failed to discontinue the standard protocol when the new sliding scale was entered. The NP stated the transcription error resulted in the omission of doses of sliding scale insulin according to the new order. The NP stated she expected the standard protocol for sliding scale to be discontinued when the new order was written. The NP stated Resident #60 did not experience serious outcome from the omission however it was a significant error with the potential for adverse effects. An interview was conducted with the Director of Nursing (DON) on 3/21/24 at 9:35 AM. The DON stated Resident #60's sliding scale insulin coverage order was confusing and was entered incorrectly. The DON stated the new sliding scale order that was received on 3/8/24 should have superseded the previous order. The DON stated her expectation was for staff to follow the physician orders and indicated the sliding scale insulin was an order that should have been transcribed correctly and followed. The DON stated it was an error that the insulin was not administered per the current sliding scale order and the standard protocol should have been discontinued. An interview was conducted with Unit Manager #2 on 3/21/24 at 10:06 AM. Unit Manager #2 stated she frequently entered physician orders in the electronic medical record, and she routinely provided care for Resident #60. Unit Manager #2 indicated the orders for sliding scale for Resident # 60 were confusing. When the NP gave the order for the more specific sliding scale, the prior standard as needed sliding scale protocol should have been discontinued but that was not how it was entered. 2.Resident #2 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus. A physician order dated 1/15/24 indicated blood sugar checks for diabetes use facility protocol sliding scale as needed. Resident #2's 1/16/24 quarterly MDS assessment indicated resident was cognitively intact, received an injection once in the look back period and did not receive insulin or have changes to insulin orders. A care plan dated 1/31/24 indicated a focus of diabetes with a goal of blood sugars will stabilize. Interventions included: Observe for signs of hypo and hyperglycemia and obtain blood sugars as ordered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated 2/21/24 indicated Novolog Flex pen injection solution 100 unit per milliliter. Inject subcutaneously every 4 hours as needed. Accu-Chek with sliding scale. Use Novolog Insulin. Inject per sliding scale for diabetes for blood glucose readings as follows 201-250=2U, 251-300=4U, 301-350=6U, 351-400=8U, BS>400 OR <70 CALL MD Review of the March 2024 MAR for Resident #2 revealed blood glucose readings were recorded at 06:00 AM and 4:30 PM. The sliding scale insulin was not administered as needed for blood glucose readings greater than 200 mg/dl on the following dates: 03/04/24 at 6:00 AM blood glucose reading was 237 no insulin administered 03/05/24 at 6:00 AM blood glucose reading was 239 no insulin administered 03/08/24 at 6:00 AM blood glucose reading was 233 no insulin administered 03/09/24 at 6:00 AM blood glucose reading was 225 no insulin administered 03/11/24 at 4:30 PM blood glucose reading was 202 no insulin administered 03/16/24 at 6:00 AM blood glucose reading was 203 no insulin administered. An interview was conducted with Unit Manager #1 on 3/21/24 at 1:15 PM. Unit Manager #1 revealed she routinely provided care to Resident #2 and entered physician orders. Unit Manager #1 indicated Resident #2 had a sliding scale insulin order as needed every four hours to be administered according to the blood glucose reading. The blood glucose readings were obtained twice per day and the order indicated to use the facility protocol which required insulin administration for a blood glucose reading of 351 or greater however the other sliding scale order indicated to administer insulin starting with a reading above 201. Unit Manager #1 stated the MAR was confusing and it was human error that doses of insulin were omitted. An interview was conducted with the Director of Nursing on 3/21/24 at 1:20 PM. The DON revealed the omission of the insulin according to the sliding scale was a medication error. The DON stated the order was confusing and required clarification in the electronic medical record. The DON stated she expected orders to be transcribed correctly and medication to be administered per physician order. An interview was conducted with Unit Manager #2 on 3/21/24 at 1:45 PM. Unit Manager #2 indicated she frequently entered physician orders in the computer and routinely provided care for Resident #2. Unit Manager #2 stated Resident #2's MAR was confusing, and it was human error that the order was not entered correctly. She indicated what should have occurred when the order for the Novolog sliding scale was entered it should have been entered with the order for the blood glucose checks and that was not how it was entered. She indicated this was likely the cause of the sliding scale insulin order not being followed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Nurse Practitioner (NP) on 3/21/24 at 3:20 PM. The NP indicated she expected the orders to be followed as ordered and expected the orders to be entered in the computer accurately and correctly. The NP stated it was imperative for the medications to be administered as ordered, especially insulin, for the evaluation of the resident and their medical condition. The NP stated Resident #2 did not experience a negative outcome due to the omission of the sliding scale insulin doses. An interview was conducted with the Administrator on 3/21/24 at 3:45 PM. The Administrator stated he expected that physician orders would be transcribed and followed accurately and correctly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32968 Based on observations and staff interviews the facility failed to ensure refrigerated meat items stored for use in the walk-in refrigerator for resident sandwiches were dated and sealed. This practice had the potential to affect food quality. The findings include: An observation on 03/18/24 at 12:00 PM of the kitchen's walk-in refrigerator, with the Dietary Manager (DM) revealed; two clear plastic bags of sliced sandwich ham (16 & 8 once), not sealed or dated and were open to air. The DM was unable to explain why food stored in the kitchen's walk-in refrigerator was not dated and open to air. During an interview with the DM on 03/18/24 at 12:30 PM she said she monitored the items in the refrigerators and freezers weekly when conducting inventory. She stated the two bags of sliced ham should have been dated and sealed and not opened to air. During an interview with the Administrator on 03/21/24 at 2:45 PM, he reported it was his expectation the facility's kitchen staff follow all regulatory guidelines for food and kitchen sanitation safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37673 Based on record review and staff interviews, the facility failed to accurately document the time and date in the electronic Medication Administration Record (eMAR) 5 out of 28 times when prescribed as needed narcotic pain medications were removed from the narcotic dispensing cards for 2 of 2 residents reviewed (Residents #46 and #177). Findings included: A. Review of the physician orders for Resident #46 included the following order: Percocet 10 mg-325 mg tablet: Administer 1 tablet by mouth every 24 hours as needed for pain (Oxycodone HCL/Acetaminophen). Start date 02/07/24. Review of the Controlled Drug Receipt/Record/Disposition Form for Resident #46 revealed Nurse #1 had removed one dose of Percocet 10-325 mg from the locked narcotic drawer on 03/19/24 at 6:49 PM. Review of the electronic Medication Administration Record (eMAR) for Resident #46 did not document that Oxycodone-APAP 10-325 had been administered to the resident on 03/19/24 at 6:49 PM. In an interview with Nurse #1 on 03/21/24 at 2:18 PM via phone she stated she had given Resident #46 Percocet 10-325 mg on 03/19/24 but had forgotten to sign it off in the eMAR because she had been on another hall passing medications and when she returned to this hall, she was immediately asked to medicate two residents for pain. She explained because the residents were in rooms near each other she pulled the medications for both residents at the same time and forgot to sign them out in the eMARs. B. Review of the physician orders for Resident #177 included the following order: Hydrocodone 10 mg-acetaminophen 325 mg tablet: administer 1 tablet orally every 8 hours as needed. Record the residents pain level (0-10), for pain level 1-6. Start date 03/15/24. Review of the Controlled Drug Receipt/Record/Disposition Form for Resident #177 documented Nurse #5 had removed one dose of Hydrocodone 10 mg-Acetaminophen 325 mg from the locked narcotic drawer on 03/19/24 at 9:00 AM and Nurse #1 had removed 3 doses from the drawer at on 03/19/24 at 6:49 PM and 10:00 PM and again on 03/20/24 at 6:30 AM. Review of the electronic Medication Administration Record (eMAR) for Resident #177 did not document that Hydrocodone 10 mg-Acetaminophen 325 mg had been administered to the resident on 03/19/24 at 9:00 AM, 6:49 PM or 10:00 PM or on 03/20/24 at 6:30 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #1 on 03/21/24 at 2:18 PM via phone. She stated that she had administered the pain medications to Resident #177 on 03/19/24 at 6:49 PM, 10:00 PM and again on 03/20/24 at 6:30 AM. She explained she signed the medication out of the locked narcotic drawer each time she gave the medication to him but was unable to sign off the medication in the eMAR as administered because the medication on the eMAR was locked. She stated she did not know how to unlock a medication in the eMAR and since the Director of Nursing had changed, she did not know who had the authority to unlock it. An interview was conducted with Nurse #5 on 03/27/24 at 5:39 PM via phone. She stated she recalled Resident #177 and was positive she had administered Hydrocodone to him on 03/19/24 at 9:00 AM because it was the only time she had given him any pain medication. She explained she signed the medication out of the locked narcotic drawer but had forgotten to document it on the eMAR. In an interview with Unit Manager #1 on 3/21/24 at 2:50 PM she stated she expected all medications to be documented accurately on the narcotic reconciliation sheet and in the eMAR. She stated if a nurse marked a medication in the eMAR as prepared but did not return to mark it as administered, the medication would lock, and no further documentation could be added until the nurse who originally marked it as prepared returned and documented that dose as administered. She was not sure which staff member could unlock a medication in an eMar since the last DON had left but noted that she could not. In an interview with the Administrator on 3/21/24 @ 4:19 PM he stated he expected the nurses to document in the narcotic record and the eMAR each time a medication was administered.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37673 Based on record review, Nurse Practitioner interview and staff interviews, the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification survey completed on 10/26/21 and an on-site revisit survey and complaint investigation survey completed on 02/04/23. This was for three repeat deficiencies originally cited in the areas of Posted Nurse Staffing Information (F732), Residents Are Free of Significant Med Errors (F760) and Resident Records - Identifiable Information (F842). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross-referenced to: F732: Based on record review and staff interviews, the facility failed to accurately document the Daily Nursing Hours postings for 2 of 45 Daily Nursing Hours reports reviewed. During the recertification survey of 10/26/21 the facility failed to post accurate nurse staffing information. F760: Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the physician order and provide sliding scale insulin to 2 residents (Resident #60 and Resident #2) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in Resident #60 not receiving a total of 21 doses of sliding scale insulin from 03/08/24 through 03/17/24 and Resident #2 not receiving a total of 6 doses of sliding scale insulin from 03/01/24-03/17/24. This was for 2 of 2 residents reviewed for insulin administration. There was no significant outcome to either resident. During the recertification survey of 10/26/21 the facility failed to prevent significant medication errors by 1) not following the physicians order to increase Zoloft (used in treatment of major depressive disorder) from 50 mgs (milligrams) to 75 mgs daily resulting in failure to administer 41 doses of Zoloft 75mgs and 2) not following the physicians order to hold 10 units of Novolog insulin 100 units/ml (milliliter) for blood glucose less than 300 mg/dl (deciliters) resulting in 4 doses of Novolog insulin 10 units administered when blood glucose was less than 300 mg/dl for 3 of 24 residents whose Medication Administration Record (MAR) was reviewed. F842: Based on record review and staff interviews, the facility failed to accurately document the time and date in the electronic Medication Administration Record (eMAR) 5 out of 28 times when prescribed scheduled and as needed narcotic pain medications were removed from the narcotic dispensing cards for 2 of 2 residents reviewed (Residents #46 and #177). During the recertification survey of 10/26/21 the facility failed to accurately document the administration of a medication, Clonazepam 0.25 milligrams (mg), on the Medication Administration Record (MAR). (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the on-site revisit and complaint investigation survey of 02/04/23 the facility failed to maintain an accurate medical record that included an unwitnessed fall. In an interview with the facility Administrator on 03/21/24 at 4:19 PM he stated he was not sure why deficiencies had repeated. He felt staff turnover had contributed. He did note he had failed to monitor the daily staff posting to ensure accuracy and planned to review the posting daily going forward.