STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		7/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2024

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
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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
E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan, update for current contacts, address EP collaboration, collaborate with local stakeholders, update, or review for arrangements with other facilities, review and update the communication plan, update names and contact information, share information with residents or family members, put into place EP training, and document information in the EP regarding the emergency generator. This failure had the potential to affect all residents. The findings included: A review of the facility's Emergency Preparedness (EP) Plan occurred on 7/3/24 at 2:53 PM with the Maintenance Director. During the review, it was discovered the plan had not been updated in the last 12 months and was last updated on 10/28/22. Emergency contact information was not updated. The resident risk assessment was not updated. The Maintenance Director indicated he was not properly trained on how to train employees on EP and the required tabletop drills. He confirmed there was no documentation of the annual training or required exercises for staff on the EP plan at this facility.	E 004	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. E004 1.No residents were affected by deficient practice. The Maintenance Director was educated on EP policy and procedure by Administrator on 7/3/24. 2. Any resident could have been affected by this deficit practice. The resident risk assessment was completed by the administrator on 7/8/24. The new EP plan/policies were reviewed for the current year with Maintenance Director and Administrator on 7/8/24 by Regional Maintenance Director. Facility rounds were conducted by the regional director, maintenance director and administrator to review systems in the facility on 7/8/24. All drills, audits, trainings, current contacts, staff, resources as well as facility collaboration with local and state offices were updated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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
E 004	Continued From page 2 A review of the facility's Emergency Preparedness (EP) Plan occurred on 7/3/24/ at 3:05 PM, with the Maintenance Director and the Administrator. During the review, it was discovered the emergency plan had several sections that were not updated to include emergency contact information, communication systems, annual training or required exercised for staff on the EP plan at this facility had not been updated since 10/28/22. The Administrator stated some sections of the EP plan had been updated but not all and all staff , including new hire training had not been trained on the emergency plan. Review of the EP book revealed there was no system in place to ensure all staff and new hires were trained upon hire or annually.	E 004	by the maintenance director, administrator and assistant administrator and will be completed on 7/31/24. 3. Effective 7/31/24, the EP plan will be reviewed, updated annually and as needed with current staff, staff changes, community partners and suppliers. EP drills and training will be conducted monthly by the Maintenance Director or designee with staff, residents and/or community partners to ensure staff and residents are prepared for any emergency that they may be affected by. Facility will partner with state liaison at least quarterly and monthly to ensure compliance and needed information is obtained for EP plan. Effective 7/31/24, all new hires will be educated on EP plan by the maintenance director or designee as well as all staff at least yearly and PRN. 4. Effective 7/31/24, EP drills and training documents will be reviewed in the monthly QAPI meeting for review, trends and opportunities for improvement by the maintenance director with the IDT team. All new contacts, vendors and community contacts will be reviewed in QAPI for updates as needed. All new training will be reviewed in monthly QAPI for staff education. 5. Compliance date 7/31/24-the Administrator and Maintenance Director are ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains compliance.	
F 000	INITIAL COMMENTS	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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	Continued From page 3 A recertification survey and complaint investigation was conducted on 6/30/24-7/3/24. Event ID #BC1611. The following intakes were investigated NC00214413 and NC00214261. One of four allegations resulted in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 550	Continued From page 4 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and resident, the facility failed to maintain a resident's dignity when Housekeeper #1 spoke to Resident #13 in a demeaning manner regarding the cleanliness of his room and cursed at the resident. This deficient practice affected 1 of 3 residents reviewed for dignity. Findings included: Resident #13 was admitted on 9/27/19. A witness statement written by Housekeeper #2 indicated on 3/03/24 at 2:20 PM she had been making rounds on the hall when she heard and saw Housekeeper #1 in Resident #13's room, cursing him. On 07/03/24 at 8:51 AM an interview with Housekeeper #2 was conducted. She stated on 3/03/24 she had been in the hallway talking with Housekeeper #1 who was talking directly to Resident #13 who was in his room. Housekeeper #1 cursed at Resident #13 and said things about his lack of cleanliness. She explained after Housekeeper #1 had said curse words, he	F 550	F550- 1. Resident #13 was affected by deficient practice. Dignity and safety provided by assigned staff immediately to affected resident. Charge nurse assessed resident #13 for mental or physical trauma- none noted. The accused staff was immediately removed from the building by the charge nurse with notification to supervisors. State reportable filed by MDS nurse on 3/3/24 following incident. All measures put in place at the time by facility to provide safety, dignity and respect. 2. Any resident could have been affected by this deficient practice. Resident # 14 roommate and residents on the 300-hall wing were interviewed by Charge nurse on 3/3/24 with follow up interviews by SW and Administrator on 3/4/24. No other residents affected by incident or staff member. Staff interviews were conducted for witness statements by MDS nurse, AIT and Administrator. All staff re-educated by writer on all types of abuse, neglect, dignity, respect, resident rights and reporting any unusual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 550	Continued From page 5 (Housekeeper #1) left the hall, and she did not see him again and thought he had may have been sent home. She stated she immediately reported the incident to Minimum Data Set (MDS) Nurse #1 and wrote up a statement about what happened. She stated the incident happened quickly and she did not understand what had triggered Housekeeper #1. Housekeeper #1 was unable to be contacted for an interview. On 7/03/24 at 9:44 AM an interview with MDS Nurse #1 was conducted. She stated on 3/03/24 when she arrived at the facility, Resident #13 was sitting in the dining room, and he told her the housekeeper (Housekeeper #1) just cursed at him. After talking with Resident #13, he went back to his room. MDS Nurse #1 stated she verified Housekeeper #1 had left the building before she arrived. She stated Housekeeper #2 reported to her she had witnessed the event and wrote a statement. Resident #13's most recent quarterly Minimum Data Set (MDS) dated 6/06/24 indicated he was cognitively intact. An interview with Resident #13 was conducted on 06/30/24 at 11:32 AM. Resident #13 explained a while ago a staff member had cursed at him. He stated he had no idea what the staff member had been upset about and had not experienced anything like that before or since. He stated the Administrator had spoken with him about what happened, and he had no further concerns regarding this incident. He stated he had not seen that staff member since then and was not afraid of anyone. Resident #13 stated his roommate	F 550	occurrences with staff/residents on 3/4/24 and was completed on 3/8/24 by Administrator and designee. 3. Effective 3/4/24, all new hires will be educated at orientation on abuse, neglect, dignity, respect, resident rights and reporting process. All staff will be re-educated at least yearly and PRN by SDC or designees on these topics. All incidents will be reported timely, to supervisors daily and managers on duty or immediate supervisors on the weekends for appropriate follow-up and/or referral to state agency if deemed necessary. Events will be reviewed in standup meetings with IDT daily to ensure compliance with POC, and appropriate referrals are forwarded. 4. Effective 3/4/24, hall ambassadors and /or designee will make rounds daily to ensure safety, dignity and overall well-being of the residents in the facility. All findings and trends will be reviewed in monthly QAPI for corrective actions and training as needed. (Most recent training was 7/8/24-7/12/24 and 7/25/24.) 5.Compliance date: 7/31/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 550	Continued From page 6 (Resident #43) had been present when the incident occurred. An interview with Resident #43 was conducted on 06/30/24 at 11:42 AM. He stated he did not recall anyone cursing at his roommate and had not had anyone speak inappropriately to him. An interview with the Administrator was conducted on 7/03/24 at 4:31 PM. She stated on 3/03/24 staff had ensured Housekeeper #1 had left the facility and Resident #13 was safe.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 584	Continued From page 7 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to maintain clean and sanitary resident rooms for 2 of 13 rooms on the 500 hall (Rooms 501 and 513) observed for clean and homelike environment. The findings included: a. An observation on 6/30/24 at 10:40 AM, revealed the floor in Room 501 was noted to be sticky with spilled food particles and multiple pieces of paper lying on it. On 6/30/24 at 11:06 AM, an observation and interview was conducted with the resident who resided in Room 501. The resident stated he had accidentally dropped candy and snacks on the floor last night. He further stated he left his room after breakfast with the hope that housekeeping staff would clean his room. He stated the housekeeping staff were supposed to clean his	F 584	F584- 1. Affected rooms, 501 and 513 were cleaned and trash disposed of properly by HSK staff on 6/30/24. Additional staff were called by housekeeping supervisor to help clean all halls per protocol. 2. All residents have the potential to be affected by this deficient practice. Maintenance staff were re-educated on maintaining a safe home like environment for the residents as well as placement of furniture in the resident□s room by the administrator on 7/3/24. Maintenance Director and staff made rounds on 7/3/24 to check for safety and proper placement of furniture in the facility/rooms to maintain homelike environment. 3. All staff were educated on 7/5/24-7/12/24 on proper handling of waste, trash, proper placement of furniture, keeping the resident□s rooms tidy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 584	Continued From page 8	F 584		

room in the morning, however, it had not yet been cleaned.

b. An observation of Room 513 was conducted on 6/30/24 at 11:20 AM. The floor was observed to be sticky. There were 2 empty, crumbled wipes packets (one near the side of the bed and one near the foot of the bed) and pieces of paper on the floor. The packets appeared crumbled and the trash can beside the bed was overflowing with trash. There was a biohazard bin (red color container) near the entrance of the door, which was overfilled with personal protection equipment (Gowns and gloves), which were visible coming out of the container. The couch in room was placed upside down on one side of the room. The side table appeared dusty with visible stains and sticky patches on the surface.

An observation of Room 513 was conducted on 6/30/24 at 1:00 PM. The floor did not appeared to be swept and mopped. The floor appeared sticky and dirty. The 2 crumpled wipes packets were still on the floor. The trash can beside the bed was emptied, but there was an empty trash bag and dirty bed linens on the floor, beside the bed. The couch was still inverted. The biohazard bin was not yet emptied.

During an interview on 7/3/24 at 11:30 AM, Housekeeper #3 indicated she was usually assigned on the 500 hallway. She further indicated that she was on the schedule to work the weekend of 6/29/24 and 6/30/24 but had to call out as she had pneumonia. Housekeeper #3 stated she cleaned the resident's rooms daily and this included emptying the trash cans. She added nurse aides were responsible to remove the biohazard waste and place any soiled clothes in

clutter -free. The housekeeping supervisor also did reeducation with her staff on proper protocol for cleaning a room on 7/5/24
Effective 7/11/24, Housekeeping staff to make daily rounds ensuring that all residents areas are clean, mopped and trash is disposed properly/timely. HKG team and regional in with team performing cleaning tasks, deep cleans throughout building to have building in compliance by 7/31/24.
4. Effective 7/11/24, Housekeeping staffing and cleaning detail and/or obstacles will be reviewed daily in stand-up meeting to ensure adequate staff to perform duties in the facility daily as well as tasks are being done timely. HSK supervisor will onboard PRN staff on a continuous basis to fill vacant spots and call outs in the facility.
Effective 7/11/24, All new hires in Housekeeping will be educated by the housekeeping supervisor or designee on proper cleaning of the facility and maintenance of the resident□s rooms and will be re-educated at least yearly and PRN.
Effective 7/11/24, The housekeeping supervisor or designee will make rounds daily for compliance in cleaning schedules.
Effective 7/11/24, All facility staff will be educated at hire, yearly and PRN on maintaining a clean, safe homelike environment in the facility.
5. Effective 7/11/24, Angel facility rounds will be done daily by IDT team, which includes maintenance or designees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 584	Continued From page 9 the plastic bag for laundry staff to pick them up. During an interview on 7/3/24 at 11:40 AM, Housekeeper #4 indicated that he was a floor tech, but was working as a housekeeping staff for 400 and 500 hallway over the weekend (6/29/24 - 6/30/24) as the assigned staff had called out sick. He further indicated he had started cleaning rooms from 400 hallway and was unable to clean the rooms on the 500 hallway till later that morning. Housekeeper #4 stated he had cleaned the Room 501, as it had a lot of food on the floor. Regarding room 513, he indicated he had observed the overflowing thrash can, and the overflowing biohazard waste bin. He indicated that both were emptied, and clean bags were placed in them. Housekeeper #4 stated he did observe the furniture was inverted and not properly placed in the room. Housekeeper #4 further stated he thought that the maintenance staff were working in the room hence did not report or rearrange the furniture. Housekeeper #4 indicated he thought he had thoroughly cleaned the floor, dusted and disinfected the other furniture in the room. He indicated he did not notice any clothes on the floor. During an interview on 7/3/24 at 11:50 AM, the Maintenance Director indicated the entire 500 hallway and rooms were disinfected last week (6/27/24) as one of the Nurse aides had seen a bedbug on her shoe. The exterminator was called, and the rooms were sprayed. It was during that time that furniture was turned over. The Maintenance Director stated he had forgotten to put the furniture back properly and it was only on Monday (7/1/24) when he noticed that the resident room furniture was not arranged. He set up the furniture on Monday.	F 584	in am/ pm to ensure a clean, safe, comfortable homelike environment. MOD/UM to make rounds on the weekend to ensure this process continues. HK regional or designees, to make rounds q week to include walk thru compliance rounds and trainings in housekeeping every week for four weeks then monthly thereafter if substantial compliance is maintained. A monthly summary done by HSK or designee will be reviewed at monthly QAPI to ensure continued compliance. 6. Compliance date: 7/31/24- HKG director and Administrator are responsible for the implementation of this plan of correction and to ensure that the facility attains and maintains substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 584	Continued From page 10	F 584		

During an interview on 7/03/24 at 12:23 PM, the Housekeeping Manager stated during the week there were 5 housekeeping staff (1 housekeeping staff for each hallway) and during the weekends there were only 4 housekeeping staff available to clean the resident's rooms. There was only one housekeeping staff assigned to 400 and 500 hallway over the weekend. The Housekeeping Manager further stated that the Assistant Manager was available on the weekends and did an audit over the weekend. She indicated she did not receive any report from the Assistant Manager regarding the rooms not been cleaned on Monday (7/1/24). The Housekeeping Manager stated the biohazard bin was emptied by the Maintenance Director. The housekeeping staff were responsible for emptying the trash can and removing linen on the floor.

The Housekeeping Assistant Manager was unavailable to be interviewed.

During an interview on 7/3/24 at 3:07 PM, the Administrator stated the 500 hallway was a rehab hallway and the residents in the hallway had different acuity levels and the rooms and hallway required more frequent cleaning. She further stated all resident rooms should be cleaned daily and trash should be disposed of as needed by the housekeeping staff. The biohazard bin should be emptied as needed. The Administrator stated there should be the same number of housekeeping staff on the weekends as there were on the weekdays. All efforts should be made to ensure all resident's rooms were clean and sanitary. The Administrator stated the pest control company had disinfected all the rooms on the 500 hallway on Thursday (6/27/24) due to a single

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 584	Continued From page 11 occurrence of bed bug in a newly admitted resident's room. The entire hallway was sprayed, and all protocol followed due to this incident. The Administrator stated the furniture should have been placed back appropriately in all resident's rooms. The Administrator stated the facility Housekeeping Manager and Maintenance Director were responsible for ensuring the facility was clean and furniture properly placed for the safety of all the residents.	F 584		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 732	Continued From page 12 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the daily nurse staffing information to residents and visitors for 1 of the 4 days (6/30/24) of the survey period. Finding included: On 6/30/24 during facility initial tour and multiple observations throughout the day including at 9:20 AM and at 1:30 PM, the daily nurse staffing sheet posted near the facility lobby was dated 6/28/24. The posting was not updated to reflect the current date, census, and staffing information. During an interview on 7/3/24 at 2:17 PM, the Scheduler stated she was responsible for completing the staffing information for the week. On Friday, she completed the staff postings from Friday to Monday. These forms were given to the Administrator. The Administrator was responsible for posting the information in the front lobby daily. During an interview on 7/3/24 at 4:00 PM, the Administrator stated the nurse staff posting should be posted daily. The Administrator indicated the Staff Development Coordinator was	F 732	F732-Posted Nursing Hours SS-C. 1. There was no resident identified to be affected by this alleged practice. Posting reflective of current census/staffing with was posted by staffing coordinator on 6/30/24. 2. Any resident could have been affected by the alleged deficient practice. On 7/3/24, the facility staffing coordinator, ED and DON completed an audit of current facility staffing sheets for the last 30 days to identify any other day that nursing staffing data were not posted at the beginning of each shift. No other day identified with missing posting of nursing staffing information. Findings of this audit is documented on a nursing staffing data audit tool. 3. Effective 7/3/24, the staffing coordinator will post nursing information for three consecutive days at a time on the posting board located in the facility□s front lobby. The posting will be reflective of the current day staffing/census and the next two days and will be update as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 732	Continued From page 13 responsible for ensuring that the daily nurse staffing sheet was accurately completed and was posted in the lobby during the weekend. The Administrator indicated she oversaw the process and ensured the daily nurse staffing sheet was posted and was clearly visible for residents and visitors. The Staff Development Coordinator was unavailable to be interviewed.	F 732	needed by nurse mangers, receptionist, staffing coordinator, administrative staff and/or administrator. All administrative staff which includes the staffing coordinator, receptionist, nurse mangers and mangers on duty were educated on 7/3/24- 7/8/24 on posting accurate daily nursing hours reflective of current schedule by the administrator. The emphasis of the education included but was not limited to timely posting, accurate census and updating the census/staffing when it changes throughout the day. This education was added to orientation process for new staffing coordinators, receptionist, nurse managers and mangers on duty effective 7/3/24 4. Effective 7/3/24 the Administrator and/or Director of nursing will inspect the nursing posting hours located in the front lobby to ensure nursing information is posted at least two consecutive days and contain accurate information based on the staffing numbers and census at the beginning of each shift. This monitoring process will be completed Monday-Friday daily by ED or designee and completed Saturday and Sunday by mangers on duty for two weeks, then monthly for three months or until a pattern of compliance is maintained. Findings of this monitoring process will be documented in staffing nursing monitoring tool located in the facility compliance binder. Effective 7/31/24, the staffing coordinator will report findings of the monitoring tool in QAPI meeting for recommendations, and/or modifications monthly for three months or until the pattern of compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 732	Continued From page 14	F 732	is achieved. 5. Compliance date: 7/31/24	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to secure medications, date opened multi dose medications, and discard expired medications for 3 of 7 medication observations (400 hall medication cart, 500 hall medication storage/prep	F 761	F761- 1. No residents were affected by deficient practice. All expired, illegible or undated medications were discarded appropriately by the assigned charge nurse on each	7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 761	Continued From page 15 room, and the100 hall medication cart). Findings included: 1. On 7/03/24 at 10:43 AM the 400 hall medication cart was reviewed with Medication Aide #1. The following were discovered during the review: a. Thirty-two loose unidentifiable tablets in the bottom of the right side second and third drawers. b. One lidocaine 1% 20 milliliter (ml) multidose vial without its security cap with and no opened-on date noted. c. Two lidocaine 1% 10 ml multidose vials without security caps and with no opened-on dates noted. d. One Latanoprost 0.005% eye drops with a prescription filled on date of 4/15/24. Observed with "date opened 4/12/24" and an "expires 6 weeks after opening 5/22/24" notation. On 7/03/24 at 11:20 AM an interview with Nurse #2 was conducted. She stated the multidose injectable lidocaine vials should have been marked when they were opened and the eyedrops should have been discarded 6 weeks after opening according to the instructions on the prescription package. On 7/03/24 at 11:56 AM an interview with the interim Director of Nursing (DON) was conducted. She stated she expected all medications to be marked when opened and discarded when expired. 2. On 7/03/24 at 11:30 AM the 500 hall medication room was reviewed with Nurse #3. The following were discovered during the review: a. One acetaminophen 650 milligram (mg) rectal suppository with an expiration date of 12/2020 was discovered in the drawer under the	F 761	cart on 7/3/24. All medications on each cart, refrigerator and med room were checked and stored per pharmacy/manufacturer protocol by SDC/supervisors and designees on 7/3/24. Med aide #1, Nurse #2, Nurse #3 and Nurse #4 were re-educated by Administrator on proper storage, labeling and securing the med carts. 2. All residents have the potential to be affected. DON/SDC and designees did an 100% audit on all carts and med rooms on 7/3/24 and 7/4/24 for proper storage, labeling and ensuring carts were locked. In service was held by DON/SDC and designees on 7/3/24-7/8/24 with all licensed nurses and medication aides including agency on med storage, labeling, securing the cart and privacy. 3. Effective 7/31/24, all new hires nurses, med aides, agency if applicable will be educated during orientation on expectations on labeling, storage and securing drugs on the carts. Licensed nurses, med aides and agency will not be allowed to work the cart if they have not had this training by 7/31/24. 4. Effective 7/8/24, the DON/SDC or designee will complete an audit of med carts and med rooms daily 5 days a weekly for 4 weeks to ensure proper labeling, secure carts and storage of meds and biologicals. Pharmacy consultant/tech will do monthly review of carts and med rooms for compliance with storage and labeling of meds and biologicals. DON/administrative and/or designee will complete monthly summary of audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 761	Continued From page 16 medication refrigerator. b. One COVID19 mRNA vaccine with an expiration date of 4/24/2024 was discovered in the refrigerator. An interview was conducted on 7/03/24 at 11:35 AM with Nurse #3. She stated expired medications should be discarded. On 7/03/24 at 11:56 AM an interview with the interim Director of Nursing (DON) was conducted. She stated she expected all medications to be marked when opened and discarded when expired. 3. An observation was conducted on 7/3/24 at 9:00 AM-9:10 AM, the medication cart on the 100 hall was left unattended with the medication (2) tablets of Renvela 800 milligrams- Sevelamer carbonate in the medication bubble card in the right corner on top of the medication cart . Nurse #4 left the medication cart to administer medication to another resident at 9:00 AM and did not return to cart until 9:10 AM. An interview was conducted on 7/3/24/24 at 9:10 AM, with Nurse #4 who stated her intentions was to discard the medication card because it was empty, and she did not see the leftover medication in the card. She further stated the medication should not have been left unsecured and she should have checked to make sure the medication card was finished. An interview was conducted on 7/3/24 at 9: 55 AM, with the Administrator who stated all medications should be secured in the medication cart or discarded properly when they are finished. The nursing staff should not leave any	F 761	results and present to monthly QAPI meeting to ensure continued compliance. 5. Compliance date 7/31/24- the ED, DON and UM are responsible for the implementation of this plan of correction and ensure that the facility attain and maintains substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 761	Continued From page 17 medication unattended at any point in time.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep food preparation areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the floor and ceiling vents located over the food prep and food service area. This practice had the potential to affect food served to residents. The findings: During a kitchen tour on 6/30/24 at 9:34 AM, the following observations were made with the	F 812	F812 1. No residents were affected by deficient practice. The 6 burner stove, 2 compartment oven, fryer, steam table and warmers were broken down, cleaned and degreased on 6/30/24-7/1/24 by dietary team. Maintenance team cleaned ceiling vents and air conditioning vents on 7/1/24. 2. All residents have the potential to be affected by this deficient practice. All kitchen staff and maintenance staff re-educated on cleaning schedules and	7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 812	Continued From page 18 kitchen Cook/Dietary Aide: a. The 6- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills. b. The 2-compartment ovens had a heavy grease build-up, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where food was being cooked. There was a dried grease buildup observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven. c. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. The fryer had heavy grease and food build-up inside and outside, food products behind the fryer. d. The floor underneath the stove, fryer, steamer, and ovens had large amounts of dried food, grease puddles and trash. e. The 3 plate warmers had 2 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around. f. The 5-compartment steam table had floating food particles in standing water, the lids of the steam table had large volumes of dried food and greasy build up around edges.	F 812	proper cleaning of the kitchen/equipment 6/30/24-7/8/24. Fryer and 2 compartment oven replaced on 7/8/24-7/10/24 with new equipment. All new dietary staff and maintenance personnel will be educated in orientation on cleaning of the kitchen and equipment, maintenance of equipment, safety and food/equipment storage by CDM or designee. 3. Effective 7/8/24, dietary aides and/or designees, have daily cleaning schedules pre/post each meal daily. CDM or designee, perform weekly audits of maintenance/cleaning of kitchen and equipment. The Maintenance team performs daily environmental rounds which includes, checking the vents in the kitchen. Kitchen concerns, repairs and changes are reviewed daily in stand up with IDT team for immediate interventions and work orders. 4. Effective 7/8/24, the RD, CDM and/or Administrator will perform monthly kitchen sanitation inspection. Audit results are reviewed in monthly QAPI meeting for compliance, and training opportunities. 5. Compliance date 7/31/24-Administrator and CDM are ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 812	Continued From page 19	F 812		

g. The 2 ceiling vents and 2 air conditioning units had large volumes of black dust/debris blowing over food service and prep surfaces.

An observation was conducted on 6/30/24 at 10:04 AM, the Cook/ Dietary Aide confirmed the 2 rows of clean plates in the plate warmer and 3 rows of clean plate bases into the base warmer. When asked when the last time was the plate and base warmer had been cleaned the response was "I don't know, and I am not sure if there was a cleaning checklist." Dietary Aide stated there were not enough staff to clean and cook and they were doing the best they could to get things done and the meal served.

An interview was conducted on 6/30/24 at 10:50 AM, the Dietary Manager and Kitchen Supervisor stated the kitchen staff were required to wipe down kitchen equipment after each meal and deep cleaned weekly in accordance with the kitchen cleaning checklist. The DM and Kitchen Supervisor further stated they were responsible for ensuring the kitchen staff kept the equipment clean and orderly. The Dietary Manager (DM) and Kitchen Supervisor acknowledged the identified kitchen equipment, the floors, ceiling fan and air condition units had not been cleaned in accordance with the checklist. The DM stated all cleaning checklists and responsibilities would be updated and available for all kitchen staff.

An interview was conducted on 7/2/24 at 12:10 PM, the Administrator who stated the dietary manager and kitchen supervisor was responsible for ensuring the kitchen was cleaned and maintained. The Administrator stated the expectation would be for the Dietary Manager to ensure all kitchen cleaning protocols were in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 812	Continued From page 20 place and followed in accordance with kitchen sanitation guidelines. She further stated the Maintenance Director was responsible for ensuring the kitchen ceiling vents/fans were cleaned monthly. She indicated a kitchen and maintenance audit would be conducted to assess the environmental and dietary needs of the facility. An interview and observation were conducted 7/2/24 at 3:44 PM, the Maintenance Director who stated the fans and kitchen vents had not been cleaned in several months and confirmed that they needed to be done it was an oversight on his part.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to ensure the garbage and refuse was disposed of and keep 4 of 4 dumpsters and surrounding area clean and free from debris. The findings included: During an initial tour observation on 6/30/24, at 9:54 AM, revealed 4 dumpsters located near a wooded area at the back of the facility had large amounts trash bags of garbage and refuse overflowing from the tops and loose paper products, boxes and loose food products outside of containers on the ground and surrounding areas. A follow-up observation and interview were	F 814	F814 1. No residents were affected by this deficient practice. Facility dumpster area was cleaned with removal of paper and food products by dietary staff on 7/2/24. Area around rental bin was cleaned properly by HSK and Maintenance staff on 7/1/24-7/2/24. 2. Residents have the potential to be affected. Dietary staff were re-educated by CDM, HSK staff by supervisor and all facility staff by administrator proper way to dispose of garbage and refuse as well as maintenance of grounds from 6/30/24-7/8/24. Bin removal company	7/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 814	Continued From page 21 conducted on 7/2/24 at 12:00 PM, with the Dietary Manager revealed the trash bags filled with garbage left on the ground had been removed, however the surrounding area had not been thoroughly cleaned evidence by the remaining paper and food products was still on the ground around the sides and backs of the dumpsters. The Dietary Manager stated the dietary staff were responsible for cleaning the 3 smaller dumpsters daily and the larger rental dumpster should have been emptied on 6/28/24. The rental company did not come to empty the larger rental dumpster after several calls had been made by administrator and maintenance director. An interview was conducted on 7/2/24 at 12:10 PM, the Administrator who stated the dietary manager and kitchen supervisor were responsible for ensuring the dumpsters and surrounding area were clean and maintained. She was aware the company for the rental dumpster had not emptied the dumpster by the 6/28/27 as scheduled. She had contacted the company for removal and the dumpster would be emptied immediately.	F 814	called- bin removed 7/12/24. 3. Effective, 7/8/24, All new hires, and agency if applicable will be educated at orientation and at least yearly /PRN on disposing of garbage and refuse properly to maintain a clean safe environment by SDC or designee. 4. Effective 7/8/24, Environmental rounds to be made daily by dietary supervisor, housekeeping supervisor and administrator to ensure compliance with disposal of garbage and refuse. 5. Compliance Date: 7/31/24	