DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
AND I LAN OI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG			
		345291	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 10	)/18/2018
					00 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		0	XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	A complaint survey v through 10/7/18 and	vas conducted from 10/5/18 10/18/18.					
	Immediate Jeopardy	(IJ) was identified at:					
	CFR 483.25 at Tag F J.	689 at a Scope and Severity					
	The tag F689 constitu Care.	ued Substandard Quality of					
		began on 5/19/18 and was An extended survey was					
F 600 SS=J	-	ested addition of F600 at IJ Neglect	F6	600			10/20/18
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					
	§483.12(a) The facilit	y must-					
	physical abuse, corpo involuntary seclusion This REQUIREMENT by:	is not met as evidenced					
	Based on record rev	iew, observation, staff, and			Date: 10/06/2018		
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						10/16/2018

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.

		MEDICAID SERVICES				OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	` '	SURVEY PLETED
							С
		345291	B. WING			10	/18/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				500 F	PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		OXF	ORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 1	F 60	0			
		e facility failed to prevent	1 00		Corrective action accomplished for th	080	
		t's #2 and #3) of 3 sampled			esidents found to have been affected		
	-	or abuse. Resident #1, a			he deficient practice.	~ ~ ,	
		resident, made an unwanted			On 5/19/2018 at 10:00 pm, Resident :	#1	
		e personal space of Resident			vas observed in the room by the licer		
		ually aggressive behavior			nurse #1. Resident #1 was attempting		
		a cognitively impaired		p	out his hands under resident #2 s co	ver	
	resident. Residents #	2 specified the unwanted		v	vhile resident #2 was in bed. Resider	nt #1	
		setting to her and Resident		v	vas removed from the room by licens	ed	
	-	facility staff and found to			nurse #1. Head to toe skin assessme		
	have no physical inju	ries.			or resident #2 completed by licensed		
					nurse #1 on 5/19/2018 no injuries not	ed.	
		began on 5/19/18 when			Resident #1 was placed on every 15		
		n unwanted advancement			ninutes watch check for 3 days and w		
	into the personal spa				discontinued as resident was noted to	)	
		was removed on 10/6/18 rided an acceptable credible			show no behaviors of wondering, or sexual inappropriate abusive behavio	re	
		ate jeopardy removal. The			Resident #1 & #2 attending physician		
		t of compliance at a scope			esponsible party notified.	anu	
		d position "D" (not actual			On 9/19/18 at 10:15 pm, Resident # 1		
		or more than minimal harm			vas observed in the room of resident		
	that is not immediate				Resident # 1 was leaning over reside		
		aff have been in-serviced.			#3and was observed kissing resident		
	-			c	on her mouth by certified nursing		
	Findings included:			a	assistant #1. Resident #1 right hand v	vas	
					observed in resident #3 brief and left		
		nitted to the facility on			vas observed putting his P& back in I		
		noses of traumatic brain			pants. Two Nurse Aides, #1 and #2, s		
		arthria (slowed or slurred			esident # 1 and immediately remove		
		ia (the inability to produce			him from the room. The CNAs reported		
	clear speech).	on the most recent substants			o licensed nurse #1 who completed h		
		on the most recent quarterly			o toe skin assessment resident # 3 a ound no signs of injury. Charge nurse		
	7/27/18 coded Reside	IDS) assessment dated			called the administrator at @11:30pm		
		with trouble concentrating			nform of the incident. He advised the		
	two to six days of the	-			nurse to move patient #1 to the 100 h		
		assessed as having no			which is away from Resident #3. Resi		
		atory with no assistance.			# 1 was immediately moved to another		
		,			oom and placed on 15 minute check		1

Facility ID: 943387

If continuation sheet Page 2 of 50

					CONSTRUCTION		0. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDING	<u> </u>			C
		345291	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2010
				50	00 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		0	XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
F 600	Continued From page	a 2	F 60	00			
1 000			FUL	00	licenced purse #1 to ensure he did not	<b>a</b> 0	
		n the care plan initiated on #1 had problem areas for his			licensed nurse #1 to ensure he did not in any room other than his own, effecti	-	
		motion, listen and share			9/19/18 at 10:45 pm for 3 days until		
		ditory and verbal deficits.			9/22/18 at 7:00am then was reduced to	o 30	
		sident #1 was updated on			minutes check as resident exhibited no		
	-	lem area that stated, "I			wandering behavior for 3 days. 30		
	demonstrate inapprop	priate behavior towards a			minutes check was continued for 5 day	/S	
	female resident." The	e documentation of the			until 9/26/2018 at 3pm when it was		
		e plan stated, "Place resident			reduced to hourly as resident exhibited	l no	
	in area where consta	nt observation is possible."			wandering behavior for 5 days. On		
	<b>-</b>				9/28/18 Resident was observed walkin	g	
		n in a nursing note, written			up and down the hall more often than	_	
		/19/18 at 10:25 PM for			usual. Licensed nurse #2 increased the		
	Resident #1 stated, "I	ent's room on 300 hall. He			monitoring to every 30 minutes comple by certified nurse aides on duty continu		
		s room and was sitting in her			until 10/1/18 at 7am when resident was		
	-	the wheel chair, had his			noted ambulating more on hallways.	5	
		ers and was attempting to			Every 15 minutes checks continue unti	I	
		tely without [her] consent.			today. Every 15 minute checks will		
	Resident (#2) had yel	lled out and had turned her			continue until resident #1 is noted to		
		help. Resident (#1) was			wander safely on the hallway and		
		om and returned to his room			exhibited no signs of wandering to othe		
	and asked to go to be	ed for the night."			resident s room. Licensed nurse on d	•	
					will monitor to ensure the completion o		
	-	noses of heart failure,			minutes check. Resident #1 & #3 famil	У	
		iety and depression. The emost recent quarterly MDS			members were notified at the time by nurse #1. Both resident s physicians		
		31/18 coded Resident #2 as			were notified at the time and no new		
	having moderately im				orders by licensed nurse #1.		
		ssistance of one person with			Address how corrective action will be		
	bed mobility.				accomplished for those residents havin	ng	
					the potential to be affected by the same	-	
	Resident #2 was inter	rviewed on 10/5/18 at 11:13			deficient practice.		
		ealed Resident #1 came in			On 10/06/2018, 100% interviews was		
		I put his hand under her bed			completed by Assistant Director of		
		he hollered and rang the call			Nursing, Director of Social services,		
	· · ·	came and got Resident #1			Registered nurse supervisor and/or		
		n asked how this made her			Central Supplies supervisor for all current		
		revealed it was "upsetting."			alert and oriented residents in the facili		

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If continuation sheet Page 3 of 50

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/16/201 MAPPROVE D. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345291	B. WING		C 10/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE / OXF	ORD				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Continued From page 3 She indicated she still saw Resident #1 walking in the halls but he had not come into her room after that incident. Nurse #1, a nursing supervisor, was interviewed on 10/5/18 at 4:12 PM. Nurse #1 revealed that she was the nurse on the hall where Resident #1 resided on the evening of 5/19/18 but she usually worked on the first shift (7:00 AM to 3:00 PM). She indicated Resident #1 was removed from the room of Resident #2, redirected to his own room, and went to sleep on the evening of 5/19/18. She stated she called the facility Administrator to notify him of the incident with Resident #1 and Resident #2. Nurse #1 indicated she was directed by the Administrator to "keep an eye on him (Resident #1)." Nurse #1 revealed Resident #1 was checked on every 15 minutes by the nursing staff for "a couple of days" after the 5/19/18 incident.		F 60	<ul> <li>to identify any other resident with allegation of Abuse and/or Negle other resident, voiced allegation and/or neglect, or sexual inappro- behaviors.</li> <li>On 10/06/2018 100% interviews completed by the Director of Nur- Assistant Director of Nursing, Sta Development Coordinator, and/o Manager for all employees on sit 10/6/2018 to identify any awaren any resident with an allegation of and/or Neglect. No concerns rela abuse, neglect or sexual misappi behavior were voiced. This intervices completed for all staff, to include part time and as needed staff. Ar employee not interviewed by 10/0 will not be allowed to work until interviewed.</li> </ul>	ct. No of abuse opriate was sing, aff r Nurse e on ess of f Abuse ated to ropriate view was full time, ny	
	on 10/6/18 at 8:41 Al worked on the secon PM) and sometimes AM) for the hallway w May 2018. Nurse #2 Resident #1 demons behavior of going into on 5/19/18. She said wander but was easi revealed the nursing for a few days after the a while the staff "felt revealed she did not so the nursing staff w Documentation in a r 10:39 PM, written by	Supervisor, was interviewed M. Nurse #2 indicated she d shift (3:00 PM to 11:00 third shift (11:00 PM to 7:00 where Resident #1 resided in indicated that the first time trated the concerning of female resident rooms was he did have a tendency to ly redirected. Nurse #2 staff kept an "eye on him" he 5/19/18 incident but after like he was okay." Nurse #2 think he would hurt anybody vere watching him. hursing note dated 5/27/18 at Nurse #3, stated in part, wandering in and out of		100% interview of all current aler oriented residents was completed 10/6/2018 by Assistant Director of Nursing, Director of Social service Registered nurse supervisor and Central Supplies supervisor to id resident which includes Resident has wandered into their room uni and exhibited any inappropriate to No other resident voiced any com regarding resident #1 or any other resident related to wandering bel 100% of all current employees of was interviewed by the Executive Director of Nursing, Director of S Services and Nursing Supervisor 10/5/2018 and 10/6/2018 to idem	d on of res, /or entify any t #1 who invited oehavior. ncern er haviors n duty e Director, ocial	

Facility ID: 943387

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/16/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		345291	B. WING				C / <b>18/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, C	CITY, STATE, ZIP CODE		
				500 PROSPECT AVE	ENUE		
UNIVERSA	AL HEALTH CARE / OXF	ORD		OXFORD, NC 275	565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL EFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 600	Continued From page	<i>م</i>	F 60	0			
1 000					ahay iana fan naaidant 444		
	residents rooms. Res	ident has been easily			ehaviors for resident #1 resident to include resi		
					e deficit. No other staff	uents	
	Documentation in a n	oursing note dated 5/28/18 at			ed concerns for any		
		Jurse #3, stated in part,			sidents beside, resident	t #2,	
	"Resident did have be	ehaviors noted this shift 11		and #3. Any	staff member not interv	iewed	
	PM -7 AM. Patient wa	as combative with writer and		by 10/6/2018	at 11:59pm will be not	be	
		m out of ladies bedrooms		allowed to wo	ork until interviewed.		
		ally able to redirect resident		_       .	• •• • • •		
	to his room and conti			-	pers for residents that a		
	made aware."	Supervisor and management			ented were interviewed	•	
	made aware.				ON on 10/06/18 to ider s which includes Reside	-	
	Nurse #3 the nurse v	who wrote the nursing notes			dered into their family		
		9 PM and 5/28/18 at 8:52			oom uninvited and exhi	bited	
	AM, did not respond	to requests for an interview.			riate behavior. No fami iced any concern regard	-	
	An interview was con	ducted Nurse #2 (second		resident #1 o	or any other resident rel	ated	
		0/6/18 at 8:41 AM. Nurse #2		to wandering			
		t aware of the combative			n interviewable resident		
		ts to get into the female			issessments completed		
	residents rooms of R	esident #1 on 5/28/18.			rvisor, SDC and hall nu		
	An interview was can	ducted with Nurse #1 (first			and 10/6/2018 to look t se or signs of sexual ab	-	
		0/6/18 at 9:32 AM. Nurse #1			abuse or sexual abuse v		
		t aware of the combative		noted.			
		ts to get into the female					
		esident #1 on 5/28/18.		Measures wil	Il be put into place or w	hat	
				systematic ch	hanges will be made to		
		f Nursing) was interviewed		ensure that the	he deficient practice wil	l not	
		M. The DON indicated she		occur.			
		of the 5/28/18 behavior of		<b>F##</b> 40%			
	Resident #1.				06/2018 the ADON, Nu	ise	
	An interview was con	ducted with the DON on			and/or SDC, initiated a eviewing clinical		
		She indicated that after the		· · ·	on for the last 24 hours.	This	
		ehavior of Resident #1 the			clude completed skin		
	-	ed with the intervention of 15			s, incident reports for the	e last	
		eded. She indicated that			d Physician orders writt		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE S	0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLI	
					c c	
		345291	B. WING		10/1	8/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
	AL HEALTH CARE / OXF	ORD		500 PROSPECT AVENUE		
				OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 600	Continued From page	e 5	F 60	00		
	after the 5/28/18 beh		1 00	the last 24 hours to ens	ure that	
		ursing notes the resident's		inappropriate behaviors		
		ed with the interventions of		may indicate possible a		
		is needed and redirection		misappropriation of resi		
	with rest as needed.			and/or injuries of unknow		
				identified and investigat		
		n in an incident report		ensure measures are pu	-	
		1 dated 9/19/18 at 10:15 PM		prevent resident⊡s abu		
		) was observed in another		happened. This systemi		
		ale Resident #3) by 2 staff r resident kissing her on the		place daily (Monday thro identified issues will be		
	mouth and had his rig			promptly, and appropria		
	-	nd his left hand on his penis.		implemented by the DO		
		pom, he was removed from		and/or Registered Nurse		
		another hall and 15 minute		negative findings will be		
	checks were started of	on resident." The		the daily clinical meeting	g form and	
		e incident report indicated		maintained in the daily of	clinical meeting	
	-	t #1 was notified at 11:30		binder.		
		noted as well as notification				
	of the physician, DON	N, and Administrator.		Effective 10/06/2018, w		
	Dooidoot #2 bad dia	income of ophasis and		Registered Nurse super		
	history of cerebral va	noses of aphasia and		designated licensed nur reviewing clinical docum		
		annual MDS assessment		last 24 hours. Then this		
		Resident #3 as severely		include completed skin		
		with cognitive decision		incident reports for the I		
		e was totally dependent on		Physician orders written		
	one or two people for	all activities of daily living.		hours to ensure that ina		
				behaviors documented	-	
		erved on 10/5/18 at 11:28		possible abuse, neglect		
		back in a low bed. The		of resident s properties	2	
		ng sounds but did not		unknown sources is ide		
	communicate verbally	у.		investigated thoroughly		
	The documentation in	n an incident report, written		measures are put in pla resident⊡s abuse before	-	
	by Nurse #1, regardir	-		This systemic process v		
		stated, "Resident (#3) was		every Saturday and Sur		
		bed, another resident was		findings will be docume		
		sing her in the mouth and		end supervisor report fo		

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	3 FOR MEDICARE &	MEDICAID SERVICES				OME	NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	· · ·	DATE SURVEY
		345291	B. WING				C 10/18/2018
NAME OF PI	ROVIDER OR SUPPLIER	I		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				500 I	PROSPECT AVENUE		
JNIVERS	AL HEALTH CARE / OXF	ORD		OXF	ORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 600	Continued From page	2 6	F 60	00			
	had his hand in her b out for help, was lying	rief. Resident was not yelling		r	maintained in the daily clinical meetin binder.	ŋ	
	there were no injuries of the physician, DOM	noted as well as notification		i [	Effective 10/6/2018, the center nterdisciplinary team, which includes Director of Nursing, MDS nurse #1, N	NDS	
	on 10/5/18 at 4:12 PM was the nurse on the	A. Nurse #1 confirmed she hall when Resident #1 was Resident #3 on 9/19/18.		L L	number #2, Registered nurse, Social worker #1, and Activity Coordinator # Executive director initiated a process reviewing any resident who is noted	≠1, ₅ for	
	aides that Resident # touching Resident #3	. She said Resident #1 was		i	nappropriate wandering behaviors to dentify the root cause of the behavio exhibited and put forth an appropriat	or e	
	was assessed for any Administrator was no	to his room, Resident #3 / injuries, and the tified of the incident. Nurse nistrator instructed her to		k	ntervention to prevent escalation of behaviors and hence prevent abuse before it happened. Intervention to in but not limited to prompt psychiatric		
	move Resident #1 to hallway. Nurse #1 rev	another room on another vealed she moved the		e	evaluation, social service consultatio one on one care, and/or medication		
	minute checks were i Nurse #1 stated she a	allway immediately and 15 nitiated for Resident #1. asked the two nurse aides		i a	evaluation will be implemented when appropriate to prevent possibility of a Any identified issues will be address	ibuse. ed	
	incident. Nurse #1 sta	atements regarding the ated the facility social worker day of the events on the		i	promptly and plan of care developed ndicated. This review will take Mond hrough Friday effective 10/06/2018		
		f the incident from NA d, "At 10:15 PM call light		5	Effective 10/06/2018, week end RN supervisor and/or designated license nurse reviewing any resident who is		
	was on in Room [Nun a wheelchair by bed A	nber] and noticed there was A. As I entered the room [I]		\   i	with inappropriate wandering behavion dentify the root cause of the behavion	ors to or	
	in her mouth, his righ left hand was putting	nt over kissing [Resident #3] t hand was in her brief, his his private part back in his		i k	exhibited and put forth an appropriat ntervention to prevent escalation of pehaviors and hence prevent abuse	the	
		n what he was doing, I e then exited the room."		ł	before it happened. Intervention to in out not limited to prompt psychiatric evaluation, social service consultatio		
		f the incident from NA #2 /ay after CNA (certified		0	one on one care, and/or medication evaluation will be implemented when		

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		MEDICAID SERVICES					NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	<b>I Y Y</b>	ATE SURVEY OMPLETED
							С
		345291	B. WING				10/18/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
				50	0 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		0)	XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	<b>-</b> 7	F 60	20			
1 000			FUU		appropriate. Intervention to include by	it not	
		ked [Resident #3 what he over [Resident #3's] bed and			appropriate. Intervention to include bu limited to prompt psychiatric evaluatio		
		rt out and then he put [it]			social service consultation, one on on		
	back in his pants."	יי סמי מויט נויפוו וופ אמו וונן			care, and/or medication evaluation wil		
					implemented when appropriate to pre-		
	An interview was con	ducted with the social			possibility of abuse. Any identified issu		
		4:56 PM. The social worker			will be addressed promptly and plan of		
		s notified of the behavior of			care developed as indicated. This revi		
		iorning of 9/20/18. The			will take Saturday and Sunday through		
		ed the nursing staff were			Friday effective 10/06/18.		
		eing of Resident #3 and that					
	•	esident #3 on 9/20/18.			Executive Director, Director of Nursing	<b>q</b> ,	
					Certified Dietary Manager, Director of	-	
	Nurse #2, the second	I shift nursing supervisor,			Social Services and/or Staff Developn	nent	
	was interviewed on 1	0/6/18 at 8:41 AM. She			Coordinator conducted re-education for	or	
	stated the behavior o	n the evening of 9/19/18 was			current scheduled staff, full time, part	time	
		or for Resident #1. She			and as needed employee for all		
		isually have problematic			departments started on 10/5/2016. Th		
	behavior but would w	ander in the hallways.			education included identifying wander		
		awad an 10/5/10 at 1:15 DM			residents, the facility s abuse and ne		
		ewed on 10/5/18 at 4:15 PM.			prohibition policy including prevention		
	The DON indicated sl				protection, investigation, and notificati as well as, appropriate actions to be	ΟΠ,	
	behavior of Resident	hat the intervention put in			taken to prevent abuse from happenin	na hv	
		nt was the removal of the			early identification of warning signs fro		
		allway, every 15 minutes a			wandering residents. This education v		
		f the resident, a mental			be completed by 10/6/2018, any empl		
		ing of the urine for possible			not educated by 10/06/2018 will not be	-	
		s as needed, redirection,			allowed to work until educated on this		
		ent of facility activities. The			requirement. Effective 10/6/2018, this		
	-	nentation of the 15 minute			education will be added on new hires		
	-	dent initiated on 9/19/18 and			orientation for all new facility employed	es.	
		nitoring time interval varied			This education will also be provided		
		e behavior of Resident #1			annually for all staff effective 10/06/20	)18.	
		cated the nurses staff varied					
	the monitoring interva	al for the resident based on			The facility plans to monitor its		
	-	ring he was doing. The DON			performance to make sure that solution	ns	
		was walking around more			are sustained.		
	the interval was even	y 15 minutes to check on			Effective 10/07/2018 the Administrator	r	

Facility ID: 943387

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/16/2018 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345291	B. WING				C 18/2018
NAME OF PI	ROVIDER OR SUPPLIER			SI	IREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD		50 O			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	and behavior monitor that various time inter the resident. The doc 9/19/18 beginning at monitored every 15 m 9/20/18. There was no location documentation for 9/2 9/21/18 at 2:30 PM. An interview was con 10/6/18 at 8:04 AM. N -9/21/18 she was ass first shift and part of t indicated she monitor minutes or 30 minute written on the behavio 3 indicted the nursing determine the monitor NA #3 stated Resider every day since he an stated she was told F ladies room, had don and had to be moved that Resident #1 was not go into female res An interview was con 10/6/18 at 7:45 AM. N assigned to Resident second shift and mon minutes.	nentation on the location ing for Resident #1 indicated rvals were used to monitor umentation shows that on 10:15 PM Resident #1 was ninutes until 6:45 AM on n/behavior log 20/18 from 7:00 AM to ducted with NA #3 on NA #3 stated that on 9/20/18 igned to Resident #1 on the he second shift. NA #3 red the resident every 15 s depending what was on or log on the clip board. NA# a assistants did not ring interval for Resident #1. nt #1 has been monitored rived on the hallway. NA #3 Resident #1 had been in a e something inappropriate to another hall. NA#3 stated being monitored so he did sident rooms.	F	600	Director of Nursing, and/or Director of Social Services will review clinical documentation for the last 24 hours. review will include, completed skin assessments, incident reports for the 24 hours, and Physician orders written the last 24 hours to ensure that inappropriate behaviors documented for may indicate possible abuse, neglect, misappropriation of resident s proper and/or injuries of unknown sources is identified and investigated thoroughly ensure measures are put in place to prevent resident s abuse before it happened. Any issues identified durin this monitoring process will be address promptly by the DON, ADON, SDC ar Registered Nurse supervisor. Findings from this monitoring process will be documented on a daily clinical report for and filed in clinical meeting binder afte proper follow ups are done. This monitoring process will take place daii (Monday - Friday) for 2weeks, weekly more weeks, then monthly x 3 months until the pattern of compliance is maintained. Effective 10/7/2018, Executive Directo and/or Director of Nursing will report findings of this monitoring process to f facility Quality Assurance and Performance Improvement Committee any additional monitoring or modificat of this plan monthly for three months, until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility	This last in that ties and g sed id/or s form er y x 2 s or y x 2 s or or the e for or	
	second shift and mon minutes. NA #5 was interviewe				of this plan monthly for three months, until the pattern of compliance is	or	

Facility ID: 943387

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CENTERS FOR MEDICARE & M	IEDICAID SERVICES				M APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	345291	B. WING		10	C / <b>18/2018</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
UNIVERSAL HEALTH CARE / OXFO	RD		500 PROSPECT AVENUE OXFORD, NC 27565		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTION CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
<ul> <li>indicated she would me to 30 minutes based of monitoring sheet at the indicated she was assi 9/20/18-9/21/18 for the monitored the resident 9/20/18. NA #5 stated of got up to use the bathr time she went in to che sleeping.</li> <li>The documentation on monitoring for Residen indicated the resident of hour. The documentation behavior monitoring for 9/26/18-9/27/18 chang Documentation indicate was monitored every h documentation for mor 9/29/18-9/30/18. The d behavior monitoring re- minutes from 10/1/18 t</li> <li>Documentation in a ph dated 10/1/18 stated, " to 100 Hall because he molesting another reside communication with hill that the only way to he the hall he was on. The since then."</li> <li>The physician was inter 10:45 AM. The physicia can't communicate due which left him unable to</li> </ul>	r people's rooms. NA #5 onitor the resident every 15 n what was on the e nurses station. NA #5 igned to Resident #1 on e third shift. She stated she e every 15 or 30 minutes on once or twice Resident #1 room but the majority of the eck on him he was still the location and behavior at #1 for 9/21/18-9/25/18 was monitored every half ion for the location and r Resident #1 for yed to every hour. ed on 9/28/18 Resident #1 half hour. There was no hitoring of Resident #1 for documentation indicated the sumed for every 15 to 10/6/18. hysician's progress note '[Patient] has been moved e was caught sexually dent. Because adequate m is impossible, we felt elp was to remove him from ere have been no incidents	F	The title of the person implementing the acc correction Effective 10/06/2018 Director and the Direct be ultimately respons implementation of this to ensure the facility a substantial compliance	eptable plan of the facility executive ctor of Nursing will sible for the s plan of correction attains and maintains	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMF	E SURVEY PLETED		
		345291	B. WING			C 10/18/2018			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
UNIVERS	AL HEALTH CARE / OXF	ORD							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE		
F 600	Resident #1 had with #3. He stated Reside by Resident #1 comin touch her. He stated I other additional incide moved to another hal The Administrator wa 4:15 PM. The Adminis notified of the 9/19/18 from Nurse #1 late the not recall sending a re the 9/19/18 incident wa acknowledged it was The DON was intervie She indicated it was I safety of the residents been and was remove DON said the priority safe. She stated it was residents be assesse reporting, care planni needed, and incident allegation of sexual a On 10/15/18 at 6:00 F informed of the imme provided a credible all jeopardy removal on The credible allegatio removal indicated: The creation of this Le constitutes a written a	Resident #2 and Resident In #2 was scared a little bit ag in her room but he did not he was not aware of any ents since Resident #1 was lway. Is interviewed on 10/5/18 at strator confirmed he was B incident by a phone call at night. He stated he did eport to the state regarding with Resident #1 and the facility policy to do so. Evwed on 10/6/18 at 4:24 PM. her expectations that for the is Resident #1 should have ed from the situation. The was to keep the residents is her expectation that d, family notified, proper ng, staff in-services as reports filled out after an buse. PM the Administrator was diate jeopardy. The facility legation of immediate	F	600					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SL COMPLE C	
		345291	B. WING				
	ROVIDER OR SUPPLIER AL HEALTH CARE / OXF	ORD	1		STREET ADDRESS, CITY, STATE, ZIP CODE 500 PROSPECT AVENUE OXFORD, NC 27565	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       CIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE       Y OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 600	surveyor agency. This because of requirement law, and to demonstra- by the provider to impleach resident. Date: 10/06/2018 Corrective action accorresidents found to har deficient practice. On 5/19/2018 at 10:0 observed in the room Resident #1 was atter under resident #2's co- bed. Resident #1 was licensed nurse #1. He for resident #2 comple on 5/19/2018 no injur placed on every 15 m days and was discont to show no behaviors inappropriate abusive #2 attending physicia notified. On 9/19/18 at 10:15 p observed in the room 1 was leaning over re kissing resident #3 or nursing assistant #1. observed putting his F Nurse Aides, #1 and a	nclusions set forth by the s letter is solely prepared ent under state and federal ate the good faith attempts prove the quality of life of omplished for those we been affected by the 0 pm, Resident #1 was by the licensed nurse #1. mpting to put his hands over while resident #2 was in a removed from the room by ead to toe skin assessment eted by licensed nurse #1 ies noted. Resident #1 was inutes watch check for 3 tinued as resident was noted of wondering, or sexual behaviors. Resident #1 & n and responsible party om, Resident # 1, was of resident # 3. Resident # sident #3 and was observed n her mouth by certified Resident #1 right hand was #3 brief and left hand was	F	600			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345291	B. WING				C 18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	called the administrat the incident. He advis patient #1 to the 100 Resident #3. Resident moved to another roo checks by licensed nu go in any room other 9/19/18 at 10:45 pm f 7:00am then was redu- resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes che until 9/26/2018 at 3 P hourly as resident exhibited no days. 30 minutes at as often than usual. Lice the monitoring to ever certified nurse aides of 10/1/18 at 7 AM wher ambulating more on h checks will continue u wander safely on the signs of wandering to Licensed nurse on du completion of 15 minutes at the time and no ne #1. Address how corrective accomplished for thos potential to be affected practice. On 10/06/2018, 100%	as of injury. Charge nurse #1 or at @11:30pm to inform of sed the nurse to move hall which is away from t # 1 was immediately m and placed on 15 minute urse #1 to ensure he did not than his own, effective or 3 days until 9/22/18 at uced to 30 minutes check as wandering behavior for 3 ck was continued for 5 days M when it was reduced to hibited no wandering 0n 9/28/18 Resident was and down the hall more nsed nurse #2 increased ry 30 minutes completed by on duty continue until n resident was noted hallways. Every 15 minutes today. Every 15 minute until resident #1 is noted to hallway and exhibited no other resident's room. ty will monitor to ensure the utes check. Resident #1 & ere notified at the time by nt's physicians were notified w orders by licensed nurse	F	600			

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	D: 11/16/2018 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345291	B. WING		_		C 18/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD		00 PROSPECT AVENUE DXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	and/or Central Suppli- alert and oriented res- identify any other resi Abuse and/or Neglect allegation of abuse ar inappropriate behavior On 10/06/2018 100% by the Director of Nur Nursing, Staff Develo Nurse Manager for all 10/6/2018 to identify a resident with an alleg. Neglect. No concerns sexual misappropriate interview was comple full time, part time and employee not intervie be allowed to work ur 100% interview of all residents was comple Assistant Director of the services, Registered to Central Supplies support resident which include wandered into their ro- any inappropriate behavior other resident related 100% of all current er interviewed by the Ex Nursing, Director of S Supervisor on 10/5/20 if any wandering behavior noted to any resident	stered nurse supervisor es supervisor for all current idents in the facility to dent with an allegation of t. No other resident, voiced nd/or neglect, or sexual ors. interviews was completed sing, Assistant Director of pment Coordinator, and/or employees on site on any awareness of any ation of Abuse and/or related to abuse, neglect or behavior were voiced. This ted for all staff, to include d as needed staff. Any wed by 10/06/2018 will not still interviewed. current alert and oriented ted on 10/6/2018 by Nursing, Director of Social nurse supervisor and/or ervisor to identify any es Resident #1 who has bom uninvited and exhibited havior. No other resident egarding resident #1 or any to wandering behaviors	F 600				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>			(X3) DATE COMF	
		345291	B. WING				
	ROVIDER OR SUPPLIER	ORD			STREET ADDRESS, CITY, STATE, ZIP CODE 500 PROSPECT AVENUE	<u> </u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	I IX	OXFORD, NC 27565 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION DATE
F 600	Continued From page	9 14	F	600	DEFICIENCY)		
	resident #2, and #3. A	018 at 11:59 PM will be not					
	and oriented were into ADON on 10/06/18 to includes Resident #1 family member's room any inappropriate bervoiced any concern re other resident related 100% of non intervier toe assessments com	esidents that are not alert erviewed by the DON and b identify any residents which who has wandered into their in uninvited and exhibited havior. No family members egarding resident #1 or any to wandering behaviors. wable residents had head to impleted by the RN hall nurses on 10/5/2018					
	systematic changes v the deficient practice	vill be made to ensure that will not occur.					
	reviewing clinical doc hours. This review wil assessments, inciden hours, and Physician	DC, initiated a process for umentation for the last 24 Il include completed skin It reports for the last 24 orders written in the last 24					
	documented that may neglect, misappropria and/or injuries of unkn and investigated thore measures are put in p	place to prevent resident's					
	will take place daily (I	ened. This systemic process Monday through Friday). Any be addressed promptly, and					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/16/2018 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345291	B. WING		_		C 18/2018
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	00 PROSPECT AVENUE			
UNIVERSA	AL HEALTH CARE / OXF	ORD	c	DXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page appropriate actions w DON, ADON, SDC ar supervisor. Any negat documented on the "c and maintained in the binder. Effective 10/06/2018, supervisor and/or des review reviewing clinic last 24 hours. Then th completed skin assess the last 24 hours to er behaviors documente abuse, neglect, misap properties and/or injur identified and investig measures are put in abuse before it happe will take place every S negative findings will "week end supervisor maintained in the dail Effective 10/6/2018, th team, which includes nurse #1, MDS numb Social worker #1, and Executive director init reviewing any resider inappropriate wander root cause of the beha	<ul> <li>15</li> <li>ill be implemented by the d/or Registered Nurse ive findings will be laily clinical meeting form" daily clinical meeting</li> <li>week end Registered Nurse ignated licensed nurse will cal documentation for the nis review will include sments, incident reports for Physician orders written in sure that inappropriate d that may indicate possible propriation of resident's reso of unknown sources is ated thoroughly and ensure blace to prevent resident's ned. This systemic process Saturday and Sunday. Any be documented on the report form" and y clinical meeting binder.</li> <li>the center interdisciplinary Director of Nursing, MDS or #2, Registered nurse, Activity Coordinator #1, lated a process for</li> </ul>	F 600				
	to prompt psychiatric consultation, one on c	evaluation, social service one care, and/or medication lemented when appropriate					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345291	B. WING				C 18/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERS	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	issues will be address care developed as ind Monday through Frida Effective 10/06/2018, and/or designated lice resident who is noted wandering behaviors the behavior exhibited appropriate intervention the behaviors and here happened. Intervention to prompt psychiatric consultation, one on or evaluation will be imp Intervention to include psychiatric evaluation one on one care, and will be implemented w possibility of abuse. A addressed promptly a as indicated. This rev Sunday through Frida Executive Director, Di Dietary Manager, Dire and/or Staff Developm re-education for curre part time and as need departments started of education included id residents, the facility's prohibition policy incl investigation, and not appropriate actions to from happening by ea signs" from wandering	of abuse. Any identified sed promptly and plan of dicated. This review will take ay effective 10/06/2018 week end RN supervisor ensed nurse reviewing any with inappropriate to identify the root cause of d and put forth an on to prevent escalation of nee prevent abuse before it on to include but not limited evaluation, social service one care, and/or medication lemented when appropriate. e but not limited to prompt , social service consultation, /or medication evaluation when appropriate to prevent any identified issues will be and plan of care developed iew will take Saturday and by effective 10/06/18. irrector of Nursing, Certified ector of Social Services nent Coordinator conducted ant scheduled staff, full time, led employee for all on 10/5/2016. This entifying wandering is abuse and neglect uding prevention, protection,	F	600			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	
		345291	B. WING				U 18/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	work until educated o 10/6/2018, this educated hires orientation for al This education will als all staff effective 10/00 The facility plans to m make sure that solution Effective 10/07/2018 Nursing, and/or Direct review clinical docum hours. This review with assessments, inciden hours, and Physician hours to ensure that in documented that may neglect, misappropriate and/or injuries of unkn and investigated thorof measures are put in p abuse before it happed during this monitoring promptly by the DON, Registered Nurse sup monitoring process w clinical report form an binder after proper fol monitoring process w Friday) for 2 weeks, w monthly x 3 months o compliance is maintait Effective 10/7/2018, E	<ul> <li>118 will not be allowed to In this requirement. Effective tion will be added on new Il new facility employees. so be provided annually for 6/2018.</li> <li>anonitor its performance to ons are sustained.</li> <li>the Administrator, Director of tor of Social Services will entation for the last 24 ill include, completed skin t reports for the last 24 orders written in the last 24 orders written in the last 24 orders written in the last 24 nappropriate behaviors r indicate possible abuse, tion of resident's properties nown sources is identified pughly and ensure place to prevent resident's ened. Any issues identified process will be addressed pack to prevent resident's ened. Any issues identified process will be addressed process will be</li></ul>	F	60			

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DEPARTMENT OF HEA CENTERS FOR MEDIC						FORM	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE		
		345291	B. WING			C 10/18/2018		
NAME OF PROVIDER OR SUPP	LIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
					500 PROSPECT AVENUE			
UNIVERSAL HEALTH CAR	E / UXF	ORD			OXFORD, NC 27565			
PREFIX (EACH DI	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
<ul> <li>months, or un maintained. Triplan to ensure compliance.</li> <li>The title of the implementing Effective 10/0 and the Direct responsible for correction to e maintains sub</li> <li>Compliance D</li> <li>The credible at 5:30 PM as observation, since the fact of the provision of sample of stat assure the fact additional resist behavior of Reference and oriented responsible for correction to e maintains sub</li> </ul>	f this plating of this plating of this plating of this plating of the part of the part of the acc o	an monthly for three attern of compliance is I committee can modify this cility remains in substantial In responsible for eptable plan of correction the facility executive Director ursing will be ultimately uplementation of this plan of he facility attains and compliance. 06/2018 In was verified on 10/18/18 ced by record review, I resident interviews. Ucted with a sample of staff ee shifts to verify ducted for all employees wandering residents, abuse res, proper reporting, be taken for residents with wandering assessment ents per protocol and fall residents. The same ters were interviewed to erviewed them regarding ffected by the wandering	F	60				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	
		345291	B. WING				_ /18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE / OXF	ORD			00 PROSPECT AVENUE DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600 F 607 SS=D	and oriented were inter- contacted by the facil for abuse or inapprop- residents. Three residents that we wandering/behaviors care plans in place to behaviors and approp- Observations were me residents with no con- inappropriate behavior Documentation of wa in-service records, and behavior/wandering low assessments of non-i- audit tools, and clinicated reviewed. All of the evidence inter- completed the correct Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facilitit implement written pol §483.12(b)(1) Prohibitine neglect, and exploitated misappropriation of residual	esidents who were not alert erviewed to verify they were ity regarding any concerns riate behavior by wandering were at risk for were reviewed and all had address wandering oriate interventions in place. ade of the wandering cerns noted regarding or. ndering risk assessments, d the current og for Resident #1, skin nterviewable residents, al round checklists were dicated the facility had tive action by 10/6/18. buse/Neglect Policies -(3) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures		600			10/20/18

Event ID: GHQ711

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	ĆCC	MPLETED
						С
		345291	B. WING			0/18/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
				500 PROSPECT AVENUE		
UNIVERSI	AL HEALTH CARE / OXF	ORD		OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 607	Continued From page	e 20	F 60	17		
		e training as required at	1.00			
	paragraph §483.95,					
		Γ is not met as evidenced				
	by:					
	Based on record rev	iew and staff interview the		Date: 10/06/2018		
		t an alleged violation of		Corrective action accom	•	
		e behavior to the state		residents found to have	been affected by	
		irs and an investigative		the deficient practice.		
		ng days for 1 (Resident #3) of		On 5/19/2018 at 10:00 p		
	-	reviewed for potential		was observed in the roo	-	
	violations of abuse.			nurse #1. Resident #1 w put his hands under resi		
	Findings included:			while resident #2 was in		
	r maings meiddea.			was removed from the re		
	The documentation in	n the facility abuse		nurse #1. Head to toe sl	-	
	prevention, interventi	-		for resident #2 complete		
		and procedures revealed		nurse #1 on 5/19/2018 r		
	the following reportin	g and response steps were		Resident #1 was placed	on every 15	
		ity Executive Director was to		minutes watch check for	3 days and was	
		of suspected or alleged		discontinued as resident		
		tive Director, in conjunction		show no behaviors of wo	-	
		lursing, was to notify the		sexual inappropriate abu		
		cation agency. Notices to the		Resident #1 & #2 attend		
	state agency were to	•		responsible party notifie		
		e minimum notice of name of er, type of abuse, date and		On 9/19/18 at 10:15 pm, was observed in the roo		
		lent occurred, names of all		Resident # 1 was leanin		
	-	he incident, and immediate		#3. Resident #1 observe	-	
	•	leted copy of the Abuse		#3 on her mouth by cert	•	
	Report and written su			assistant #1. Resident #	-	
	interviews, if any, are	e provided to the Executive		observed in resident #3	brief and left hand	
		nd state guidelines. All		was observed putting his		
	-	d all sustained incidents were		pants. Two Nurse Aides		
		state agency and to all other		resident # 1 and immedi	-	
	-	d all necessary corrective		him from the room. The		
		ng on the results of the		to licensed nurse #1 who		
	investigation.			to toe skin assessment r		
	Resident #1 was adn			found no signs of injury.	Charge nurse #1	

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			()(0)		OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345291	B. WING		10/18/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				500 PROSPECT AVENUE	
UNIVERSA	AL HEALTH CARE / OXF	ORD		OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET
F 607	Continued From page	e 21	F 60	17	
		noses of traumatic brain	1.00	inform of the incident. He advis	ed the
		arthria, and anarthria.		nurse to move patient #1 to the	
	,,,, ujo			which is away from Resident #3	
	The documentation o	on the most recent quarterly		# 1 was immediately moved to a	
		MDS) assessment dated		room and placed on 15 minute	-
	7/27/18 coded Reside	5		licensed nurse #1 to ensure he	-
		with trouble concentrating		in any room other than his own,	
	two to six days of the	assessment period.		9/19/18 at 10:45 pm for 3 days 9/22/18 at 7:00am then was rec	
		atory with no assistance.		minutes check as resident exhit	
				wandering behavior for 3 days.	
	The documentation ir	n the care plan initiated on		minutes check was continued for	
		#1 had problem areas for his		until 9/26/2018 at 3pm when it v	-
		motion, listen and share		reduced to hourly as resident ex	whibited no
	information due to au	iditory and verbal deficits.		wandering behavior for 5 days. 9/28/18 Resident was observed	
		noses of aphasia and		up and down the hall more often	
	history of cerebral va			usual. Licensed nurse #2 increa	
		annual MDS assessment		monitoring to every 30 minutes	
		Resident #3 as severely		by certified nurse aides on duty until 10/1/18 at 7am when resid	
		with cognitive decision e was totally dependent on		noted ambulating more on hally	
		all activities of daily living.		Every 15 minutes checks contin	
				today. Every 15 minute checks	
	The documentation ir	n an incident report		continue until resident #1 is not	
		1 dated 9/19/18 at 10:15 PM		wander safely on the hallway ar	
		) was observed in another		exhibited no signs of wandering	
		ale Resident #3) by 2 staff		resident s room. Licensed nurs	3
		r resident kissing her on the		will monitor to ensure the comp	
	mouth and had his rig	and his left hand on his penis.		minutes check. Resident #1 & # members were notified at the tir	-
					-
		nother hall and 15 minute		were notified at the time and no	
	checks were started			orders by licensed nurse #1.	
		e incident report indicated		On 10/16/2018, the initial report	
	-	t #1 was notified at 11:30		report were sent to the Departm	
	-				
	of the physician, DOM	N, and Administrator.		-	-
	When staff entered ro her room, place on an checks were started of documentation on the the family of Residen	bom, her was removed from nother hall and 15 minute on resident." The e incident report indicated at #1 was notified at 11:30 noted as well as notification		nurse #1. Both resident⊡s phys were notified at the time and no orders by licensed nurse #1. On 10/16/2018, the initial report	icians new t and 5 day nent of r resident Ily

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
				·		С
		345291	B. WING			0/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				500 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED <sup>-</sup> DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 607	Continued From pag	e 22	F 60	7		
	The documentation in		1 00	9/19/2018, with resident	#1 named as an	
		3 dated 9/19/18 at 10:15 PM		alleged perpetrator. The		
		B) was observed lying in her		completed and submitte		
		t was standing over her		of Nursing, and reviewe		
	kissing her in the mo	uth and had his hand in her		Administrator. Local Lav	v enforcement,	
		not yelling out for help, was		area ombudsmen and A		
		he documentation in the		services were all notified	•	
		ted there were no injuries		incident on 10/16/2018 a		
	DON and Administra	fication of the physician,		Address how corrective		
		lor.		accomplished for those the potential to be affect		
	Nurse #1 a nursing a	supervisor, was interviewed		deficient practice.	led by the same	
	-	M. Nurse #1 confirmed she		On 10/06/2018, 100% ir	nterviews was	
		hall when Resident #1 was		completed by Assistant		
	found in the room of	Resident #3 on 9/19/18.		Nursing, Director of Soc		
	Nurse #1 indicated s	he was notified by two nurse		Registered nurse superv	visor and/or	
		#1 was inappropriately		Central Supplies superv		
		<ol> <li>She said Resident #1 was</li> </ol>		alert and oriented reside		
		I to his room, Resident #3		to identify any other resi		
	was assessed for an			allegation of Abuse and	-	
		tified of the incident. Nurse inistrator instructed her to		other resident, voiced al	-	
		another room on another		and/or neglect, or sexual behaviors.	a mappropriate	
	hallway.			On 10/06/2018 100% in	terviews was	
				completed by the Direct		
	The Director of Nursi	ng and the Administrator		Assistant Director of Nu		
		10/5/18 at 4:15 PM. The		Development Coordinat		
		ned he was notified of the		Manager for all employe		
		phone call from Nurse #1		10/6/2018 to identify any		
		ated he did not recall sending		any resident with an alle		
		egarding Resident #1's		and/or Neglect. No conc		
		e behavior toward Resident knowledged it was the		abuse, neglect or sexua behavior were voiced. T		
		b. The Director of Nursing		completed for all staff, to		
		otified of the 9/19/18 incident		part time and as needed		
		20/18 and did not send a		employee not interviewe		
	-	state agency. The Director of		will not be allowed to wo	-	
		at a report should have been		interviewed.		
	sent to the state age		1			1

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/16/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345291	B. WING				 18/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10,	10/2010
UNIVERS	AL HEALTH CARE / OXF	ORD			10 PROSPECT AVENUE XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 607	Continued From page	23	F	607	100% audit of all current residents clin documentation from 9/19/2018 to curr (10/16/2018) was completed by the Director of Social Services, Medical Record Supervisor and Activity Director determine if there is any documentation that indicate sexual inappropriate behaviors or any other indication of at or neglect in any resident smedical records, and if any, determine whethe initial report within two hours, and an investigative reports within 5 working of were completed and reported to the st agency and other officials as required regulation. The audit revealed no other incident of abuse, or sexual inappropri behaviors documented in residents medical records, without proper follow through. This audit was completed on 10/16/2018. Findings of this audit is documented on Abuse Reporting audit tool located at the facility compliance binder. 100% audit was completed by the Dire of Nursing, Assistant Director of Nursi and/or Staff Development Coordinator all incident reports completed within th last 30 days to identify any incident that may indicate abuse, neglect or injuries unknown source and ensure that a pro- investigation was completed and initial report within two hours, and an investigative reports within 5 working of were completed and reported to the st agency and other officials as required regulation. The audit revealed no other incident of abuse, neglect or injury of unknown source noted. This audit was completed on 10/16/2018. Findings of	ent or to on ouse r an days rate by r iate r iate r iate of ne at s of oper I days rate by r iate	

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STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		345291	B. WING		C 10/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE / OX	FORD		500 PROSPECT AVENUE OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETI
F 607	Continued From pag	je 24	F 60	<ul> <li>audit is documented on incidem audit tool located at the facility of binder.</li> <li>Measures will be put into place systematic changes will be made ensure that the deficient practic occur.</li> <li>Effective 10/16/2018, Facility with any allegation of abuse, neglect inappropriate behaviors and/or unknown source immediately be than two hours after the allegatim made or witnessed to the facility. Executive Director and to other officials including the State Sum in the accordance with State law. Chief Clinical officer completed education on facility abuse profipolicy and procedure to the facility. Executive Director and Director on 10/06/2018. The education in the seven components of abuse include, screening, prevention, identification, protection, investin notification and reporting. The emphasized on the methodolog prevent, identify and report abu or injury of unknown source perfacility abuse/neglect policy aprocedures.</li> <li>Effective 10/06/2018 the ADON Supervisors, and/or SDC, initiat process for reviewing clinical documentation for the last 24 hours, and Physician orders the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappropriate behaviors documentation for the last 24 hours to ensure that inappro</li></ul>	compliance or what de to se will not ill report t, sexual injury of ut not later ion is y state vey Agency w. an hibition ility of Nursing ncluded e to igation, education gies to se, neglect r the and l, Nurse ted a ours. This kin for the last written in

Event ID: GHQ711

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					С
		345291	B. WING		10/18/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE / OX	(FORD		500 PROSPECT AVENUE DXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 607	Continued From pa	ge 25	F 607		perties is hly and o ssure llowed and will friday). sed will be SDC r. Any ed on ting r ew 24 ent 24 dicate priation uries of ent ed. The

Event ID: GHQ711

Facility ID: 943387

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED C 10/18/2018	
		345291	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD		500 PROSPECT AVENUE		
				OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLET	
F 607	Continued From page	≥ 26	F 60	<ul> <li>systemic process will take place Saturday and Sunday. Any nega findings will be documented on t end supervisor report form and maintained in the daily clinical m binder.</li> <li>Executive Director, Director of N Certified Dietary Manager, Direct Social Services and/or Staff Dev Coordinator conducted re-educa current scheduled staff, full time time, and as needed employee f departments. This education inct facility is abuse and neglect propolicy, including prevention, prot investigation, and notification. Themphasis of this education will p proper notification and time frameducation will be completed by 10/16/2018, any employee not e by 10/16/2018 will not be allowe until educated on this requireme Effective 10/16/2018, this educa be added on new hires orientation new facility employees. This edu also be provided annually for all effective 10/16/2018.</li> <li>The facility plans to monitor its performance to make sure that sare sustained.</li> <li>Effective 10/16/2018, Director of Assistant Director of Nursing, an Development Coordinator, will m compliance with abuse policies a procedures, specifically in the arreporting through reviewing clinic documentation for the last 24 homes.</li> </ul>	ative he week he week heeting uursing, tor of velopment tition for , part for all luded the hibition tection, he blaced on he. This reducated d to work nt. tion will on for all ucation will staff solutions f Nursing, nd/or Staff honitor and rea of cal	

Event ID: GHQ711

Facility ID: 943387

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				
	CORRECTION	IDENTIFICATION NUMBER:	. ,		(X3) DATE SURV COMPLETE			
		345291	B WING		С			
NAME OF PE	OVIDER OR SUPPLIER	545251		TREET ADDRESS, CITY, STATE, ZIP CODE	10/18/2	J18		
				00 PROSPECT AVENUE				
UNIVERSA	L HEALTH CARE / OXF	ORD	c	DXFORD, NC 27565				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CON	(X5) MPLETIO DATE		
F 607	Continued From page	2 27 2 27	F 607	review will include, completed s assessments, incident reports f 24 hours, and Physician orders the last 24 hours to ensure that inappropriate behaviors docume may indicate possible abuse, ne misappropriation of resident s and/or injuries of unknown sour identified, and reported per faci policy and procedures. Any issu- identified during this monitoring will be addressed promptly by th ADON, SDC and/or Registered supervisor. Findings from this m process will be documented on clinical report form and filed in o meeting binder after proper follo done. This monitoring process of place daily (Monday - Friday) for weekly x 2 more weeks, then m months or until the pattern of co is maintained. Effective 10/16/2018, Facility Administrator and/or Director of will report findings of this monitor process to the facility Quality As and Performance Improvement Committee for any additional m or modification of this plan mon three months, or until the patter compliance is maintained. The committee can modify this plan the facility remains in substantia compliance.	or the last written in ented that eglect, properties ces is lity abuse ues process he DON, Nurse nonitoring a daily clinical ow ups are will take or 2weeks, ionthly x 3 ompliance			
				The title of the person responsi	ible for			

Event ID: GHQ711

Facility ID: 943387

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/16/2018 / APPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345291	B. WING				C 18/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	UNIVERSAL HEALTH CARE / OXFORD			5	00 PROSPECT AVENUE		
	UNIVERSAL MEALIN GARE / OXI ORD			С	DXFORD, NC 27565		
(X4) ID PREFIX TAG	X         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 607	Continued From page	28	F	607	correction Effective 10/16/2018 the facility executi Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and mainta substantial compliance.	n	
F 689 SS=J			F	689	Compliance Date 10/16/2018		10/20/18
	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on record revi resident interview the supervision of 1 (Resi residents reviewed for resulting in unwanted personal space of Re- aggressive behavior of #3. Immediate Jeopardy B removed on 10/6/18 v acceptable credible af facility will remain out and severity level grid with potential for more	re that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced ew, observation, staff, and facility failed to provide dent #1) of 3 sampled			Date: 10/06/2018 Corrective action accomplished for thos residents found to have been affected b the deficient practice. On 5/19/2018 at 10:00 pm, Resident #1 was observed in the room by the licens nurse #1. Resident #1 was attempting t put his hands under resident #2 s cove while resident #2 was in bed. Resident was removed from the room by licensed nurse #1. Head to toe skin assessment for resident #2 completed by licensed nurse #1 on 5/19/2018 no injuries noted Resident #1 was placed on every 15 minutes watch check for 3 days and wa discontinued as resident was noted to	by ed co er #1 d	

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/16/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345291	B. WING			C 10/18/2018	
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD			0 PROSPECT AVENUE XFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	e 29	F 6	89			
	all staff have been in				show no behaviors of wondering. Resident #1 & #2 attending physician	and	
	Findings included:	nitted to the facility on			responsible party notified. On 9/19/18 at 10:15 pm, Resident # 1 was observed in the room of resident		
	1/12/18 and had diag	noses of traumatic brain arthria (slowed or slurred			Resident #1 was leaning over resident #3. Resident #1 observed kissing resi	nt	
	speech), and anarthr clear speech).	ia (the inability to produce			#3 on her mouth by certified nursing assistant #1. Resident #1 right hand v observed in resident #3 brief and left		
		on the most recent quarterly /IDS) assessment dated			was observed putting his P& back in I pants. Two Nurse Aides, #1 and #2, s	nis	
		with trouble concentrating			resident # 1 and immediately remove him from the room. The CNAs reported	ed it	
		assessment period. assessed as having no atory with no assistance.			to licensed nurse #1 who completed h to toe skin assessment resident # 3 a found no signs of injury. Charge nurse	nd	
		coded as having wandering			called the administrator at @11:30pm inform of the incident. He advised the nurse to move patient #1 to the 100 h	i to e	
	1/31/18 for Resident	n the care plan initiated on #1 had problem areas for his			which is away from Resident #3. Res # 1 was immediately moved to another	ident er	
		motion, listen and share Iditory and verbal deficits.			room and placed on 15 minute check licensed nurse #1 to ensure he did no in any room other than his own, effec	ot go	
	5/19/18 at 10:25 PM	n a nursing note dated for Resident #1 stated, n another female resident's			9/19/18 at 10:45 pm for 3 days until 9/22/18 at 7:00am then was reduced minutes check as resident exhibited r		
	room on 300 hall. He and was sitting in her	had gotten in females room (Resident #2) room in the			wandering behavior for 3 days. 30 minutes check was continued for 5 da		
	was attempting to tou without [her] consent	hands under her covers and uch her inappropriately . Resident (#2) had yelled			until 9/26/2018 at 3pm when it was reduced to hourly as resident exhibite wandering behavior for 5 days. On	d no	
	Resident (#1) was re	er call bell on to call for help. moved from her room and and asked to go to bed for			9/28/18 Resident was observed walki up and down the hall more often than usual Licensed purse #2 increased th	•	
	the night."	and asked to go to bed for			usual. Licensed nurse #2 increased the monitoring to every 30 minutes comp by certified nurse aides on duty contin	eted	
	Resident #2 had diag	noses of heart failure,			until 10/1/18 at 7am when resident wa		

Facility ID: 943387

If continuation sheet Page 30 of 50

		MEDICAID SERVICES				<u>O. 0938-03</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
			A. DOILDING			С	
		345291	B. WING		1	10/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
		000		500 PROSPECT AVENUE			
UNIVERS	AL HEALTH CARE / OXF	ORD		OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 689	Continued From page	20	ГС	0			
1 009	-		F 68	-			
		iety and depression. The		noted ambulating more on hallw			
		e most recent quarterly MDS 31/18 coded Resident #2 as		Every 15 minutes checks continuted today. Every 15 minute checks v			
	having moderately im			continue until resident #1 is note			
		ssistance of one person with		wander safely on the hallway an			
	bed mobility.			exhibited no signs of wandering			
	j.			residents room. Licensed nurse			
	Resident #2 was inter	rviewed on 10/5/18 at 11:13		will monitor to ensure the comple	-		
	AM. Resident #2 reve	ealed Resident #1 came in		minutes check. Resident #1 & #3	3 family		
	her room at night and	l put his hand under her bed		members were notified at the tim	ne by		
		ne hollered and rang the call		nurse #1. Both resident⊡s physi			
		came and got Resident #1		were notified at the time and no	new		
		n asked how this made her		orders by licensed nurse #1.			
		revealed it was "upsetting."		Address how corrective action w			
		I saw Resident #1 walking in not come into her room after		accomplished for those residents	-		
	that incident.	ior come into her room alter		the potential to be affected by th deficient practice.	e same		
				100% of wandering risk assessn	ants for		
	The care plan for Res	sident #1 was updated on		all current residents with wander			
		lem area that stated, "I		behavior completed by the Direc	•		
		priate behavior towards a		Nursing on 10/6/18 to identify if a			
		documentation of the		resident exhibited wandering bel			
		plan stated, "Place resident		the past 7 days, no other resider			
	in area where consta	nt observation is possible."		identified with wandering attemp last 7 days.	t in the		
	Nurse #1, a nursing s	upervisor, was interviewed		100% interview of all current ale	rt and		
	-	A. Nurse #1 revealed that		oriented resident was completed	on		
	she was the nurse on	the hall where Resident #1		10/6/2018 by Assistant Director	of		
		ng of 5/19/18 but she usually		Nursing, Director of Social service			
		ift (7:00 AM to 3:00 PM).		Registered nurse supervisor and			
		nt #1 was removed from the		Central Supplies supervisor to id			
		redirected to his own room,		resident to include Resident #1 h			
		the evening of 5/19/18. She		wandered in their room uninvited			
		facility Administrator to notify the Resident #1 and Resident		exhibited any inappropriate beha other resident voiced any concer			
		d she was directed by the		regarding resident #1 or any oth			
		p an eye on him (Resident		resident related to wandering be			
	#1)." Nurse #1 reveal						
		minutes by the nursing staff		100% interview of all current em			

Facility ID: 943387

If continuation sheet Page 31 of 50

		MEDICAID SERVICES			OMB NO.	0300-00
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SI COMPLE	
					С	
		345291	B. WING		10/18	8/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP C	CODE	
	AL HEALTH CARE / OXF	ORD		500 PROSPECT AVENUE		
				OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	a 31	F 68	99		
	· · · · · · · · · · · · · · · · ·	after the 5/19/18 incident.	1 00	on duty interviewed by the	Executive	
				Director, Director of Nursin		
	Nurse #2, a nursing s	supervisor, was interviewed		Director of Social Services	-	
		M. Nurse #2 indicated she		and 10/6/2018 to identify if		
	worked on the second	d shift (3:00 PM to 11:00		behaviors for resident #1 w	vas noted to	
		third shift (11:00 PM to 7:00		any resident to include resi		
		/here Resident #1 resided in		cognitive deficit. No other		
		indicated that the first time		voiced concerns for any ac		
	Resident #1 demonst	•		residents beside, resident		
		female resident rooms was		staff member not interview	•	
		he did have a tendency to		10/6/2018 at 11:59pm will		
		y redirected. Nurse #2		allowed to work until interv	lewed.	
		staff kept an "eye on him" ne 5/19/18 incident but after		Measures will be put into p	lace or what	
		like he was okay." Nurse #2		systematic changes will be		
		think he would hurt anybody		ensure that the deficient pr		
	so the nursing staff w			occur.		
		ere watering inte		Effective 10/6/2018, and m	noving forward.	
	Documentation in the	nursing notes from 5/20/18		licensed nurses will comple		
		ne resident was not noted to		risk assessments for all res	sidents on	
	have any inappropria	te behaviors at night but did		admission/re-admission, qu	uarterly, with	
	ambulate in the hallw	ays of the facility. There was		any significant changes of	resident⊡s	
	no documentation in	the nursing notes to indicate		condition, and/or wheneve	r a resident is	
		dering into other resident's		noted to exhibit wandering		
	rooms between 5/20/	18 to 5/26/18.		behaviors/attempts. Any no		
		· · · · · · · · · · · · · · ·		will be addressed and corr		
		ursing note dated 5/27/18 at		licensed nurses immediate		
		art, "Resident has been		interventions will be impler		
	wandering in and out			resident⊡s care plan will b		
		asily redirected this shift." Jursing note dated 5/28/18 at		updated immediately by lic Direct care staff will be not		
	8:52 AM stated in par	•		interventions put forth by a		
		shift 11PM -7AM. Patient		through resident s care gu		
		vriter and staff trying to keep		located in each nursing sta		
	him out of ladies bed			Effective 10/6/2018, the ce		
		direct resident to his room		interdisciplinary team, which		
	-	nitor him throughout the shift.		Director of Nursing, MDS r		
		agement made aware."		number #2, Registered nur		
				worker #1, and Activity Co		

Event ID: GHQ711

Facility ID: 943387

If continuation sheet Page 32 of 50

				FOR	D: 11/16/2018 MAPPROVED D. 0938-0391
DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
	345291	B. WING		C 10/18/2018	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE / OXFORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE
<ul> <li>Continued From page 32</li> <li>Nurse #3, the nurse who wrote the nursing note dated 5/27/18 at 10:39 PM and 5/28/18 at 8:52</li> <li>AM, did not respond to requests for an interview.</li> <li>An interview was conducted Nurse #2 (second shift supervisor) on 10/6/18 at 8:41 AM. Nurse #2 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18.</li> <li>An interview was conducted with Nurse #1 (first shift supervisor) on 10/6/18 at 9:32 AM. Nurse #1 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18.</li> </ul>		F 68	Executive director initiated a pro- reviewing any resident who is ne- inappropriate wondering behavi- identify the root cause of the be- exhibited and put forth an appro- intervention to prevent the reoco- Intervention to include but not lin prompt psychiatric evaluation, s service consultation, one on one and/or medication evaluation wi implemented when appropriate. identified issues will be address promptly and plan of care devel indicated. This review will take M through Friday effective 10/6/18	oted with ors to havior priate currence. mited to occial e care, II be Any ed oped as Monday	
on 10/5/18 at 4:15 PM was not made aware Resident #1. An interview was con 10/6/18 at 11:31 AM. 5/19/18 wandering be care plan was update minute checks as nee after the 5/28/18 beha documented in the nu care plan was update frequent monitoring a with rest as needed. Review of the medica not reveal any docum behavior or wanderin August of 2018.	A. The DON indicated she of the 5/28/18 behavior of ducted with the DON on She indicated that after the ehavior of Resident #1 the d with the intervention of 15 eded. She indicated that avior of Resident #1 ursing notes the resident's d with the interventions of s needed and redirection al record for Resident #1 did intertation to indicate any g problems in June, July, or e care plan for Resident #1		<ul> <li>supervisor and/or designated lic nurse reviewing any resident wh with inappropriate wandering be identify the root cause of the be exhibited and put forth an appro- intervention to prevent the reoco- Intervention to include but not lin prompt psychiatric evaluation, s service consultation, one on one and/or medication evaluation wi implemented when appropriate. identified issues will be address promptly and plan of care devel indicated. This review will take S and Sunday through Friday effer 10/6/18.</li> <li>Executive Director, Director of N Certified Dietary Manager, Director Social Services and/or Staff Dev Coordinator conducted re-education</li> </ul>	ensed no is noted haviors to havior priate currence. mited to occial e care, II be Any ed oped as Saturday ctive	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER AL HEALTH CARE / OXF SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Nurse #3, the nurse w dated 5/27/18 at 10:3 AM, did not respond the An interview was conshift supervisor) on 10 revealed she was not behavior and attempt residents rooms of Ref An interview was conshift supervisor) on 10 revealed she was not behavior and attempt residents rooms of Ref An interview was conshift supervisor) on 10 revealed she was not behavior and attempt residents rooms of Ref The DON (Director of on 10/5/18 at 4:15 PM was not made aware Resident #1. An interview was conson 10/6/18 at 11:31 AM. 5/19/18 wandering be care plan was updated minute checks as need after the 5/28/18 behaved documented in the nu- care plan was updated minute checks as need after the 5/28/18 behaved documented in the nu- care plan was updated minute checks as need after the 5/28/18 behaved documented in the nu- care plan was updated minute checks as need after the 5/28/18 behaved documented in the nu- care plan was updated minute checks as need after the 5/28/18 behaved behavior or wandering a with rest as needed. Review of the medicar not reveal any docum behavior or wandering August of 2018. Documentation on the	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345291         ROVIDER OR SUPPLIER         AL HEALTH CARE / OXFORD         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 32         Nurse #3, the nurse who wrote the nursing note dated 5/27/18 at 10:39 PM and 5/28/18 at 8:52         AM, did not respond to requests for an interview.         An interview was conducted Nurse #2 (second shift supervisor) on 10/6/18 at 8:41 AM. Nurse #2 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18.         An interview was conducted with Nurse #1 (first shift supervisor) on 10/6/18 at 9:32 AM. Nurse #1 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18.         The DON (Director of Nursing) was interviewed on 10/5/18 at 4:15 PM. The DON indicated she was not made aware of the 5/28/18 behavior of Resident #1.         An interview was conducted with the DON on 10/6/18 at 11:31 AM. She indicated that after the 5/19/18 wandering behavior of Resident #1 the care plan was updated with the intervention of 15 minute checks as needed. She indicated that after the 5/28/18 behavior of Resident #1 documented in the nursing notes the resident's care plan was updated with the interventions of frequent monitoring as needed and redirection with rest as needed.         freq	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         AL HEALTH CARE / OXFORD         ROVIDER OR SUPPLIER         AL HEALTH CARE / OXFORD         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 32         Nurse #3, the nurse who wrote the nursing note dated 5/27/18 at 10:39 PM and 5/28/18 at 8:52 AM, did not respond to requests for an interview.         An interview was conducted Nurse #2 (second shift supervisor) on 10/6/18 at 8:41 AM. Nurse #2 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18.         An interview was conducted with Nurse #1 (first shift supervisor) on 10/6/18 at 9:32 AM. Nurse #1 revealed she was not aware of the combative behavior and attempts to get into the female residents rooms of Resident #1 on 5/28/18.         The DON (Director of Nursing) was interviewed on 10/5/18 at 4:15 PM. The DON indicated she was not made aware of the 5/28/18 behavior of Resident #1.         An interview was conducted with the DON on 10/6/18 at 11:31 AM. She indicated that after the 5/19/18 wandering behavior of Resident #1 documented in the nursing notes the resident's care plan was updated with the intervention of 15 minute checks as needed. She was not monitoring as needed and redirection with rest as needed.         Review of the medical record for Resident #1 did not reveal any documentation to indicate any behavior or wandering problems in June, July,	S FOR MEDICARE & MEDICAID SERVICES         CORRECTION       (X1) PROVIDER/SUPPLIERCLIA         IDENTIFICATION NUMBER:       A BUILDING         A BUILDING	MENT OF HEALTH AND HUMAN SERVICES         FOR           S FOR MEDICARE & MEDICALD SERVICES         (MB N           or demonstration of the combative behavior on lact definition on the care plan was updated with the interventions of frequent the interventions of Resident #1.         (M2 NULTIPLE CONSTRUCTION A BUILDING         (M2 NULTIPLE CONSTRUCTION A BUILDING

Facility ID: 943387

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		MEDICAID SERVICES				MB NO. 0938-0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	()	X3) DATE SURVEY COMPLETED	
						с	
		345291	B. WING			10/18/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS,	, CITY, STATE, ZIP CODE		
	AL HEALTH CARE / OXF	ORD	500 PROSPECT AVENUE				
UNIVERO				OXFORD, NC 27	7565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLET DATE	
F 689	Continued From page	e 33	F 6	39			
		s from the facility related to			ded employee for all		
		and restlessness. Some of			s started on 10/5/2016. This		
	the interventions inclu				ncluded identifying wandering		
		er peers as appropriate, at			buse policy and procedures,		
	risk wandering protoc	col, and allow to ventilate		proper repo	rting, appropriate actions to b	be	
	feelings related to sta	ay at the facility.			sidents with wandering		
					wandering assessment		
		ocumentation of wandering			requirements per protocol an	d	
	Resident #1 from 9/7	in the nursing notes for			safety for all residents. This vill be completed by 10/6/2018	0	
		/18/10/9/23/18:			ee not educated by 10/6/18	0,	
	The documentation in	n an incident report, written			allowed to work until educated	4	
	by Nurse #1, regardir	-			irement. Effective 10/6/2018.		
		stated, "Resident (#1) was			ion will be added on new hire		
		resident's room (female		orientation e	education for all new facility		
	Resident #3) by 2 sta	aff member, leaning over			This education will also be		
		on the mouth and had his		provided an	nually for all staff.		
		ontinence) brief and his left					
		hen staff entered room, he			plans to monitor its		
		er room, placed on another		· · ·	e to make sure that solutions		
	hall and 15 minute ch			are sustaine			
		entation on the incident amily of Resident #1 was			0/07/2018 the Director of sistant Director or Nursing, R		
		no injuries were noted as			will review daily		
		the physician, DON, and			tion and 24 hours reports to		
	Administrator.				indication of wandering		
					Any issues identified during		
		noses of aphasia and		this monitor	ing process will be addressed	d	
	history of cerebral va				indings from this monitoring		
		annual MDS assessment			be documented on a daily		
		Resident #3 as severely			ort form and filed in clinical		
		with cognitive decision		-	der after proper follow ups ar	e	
		e was totally dependent on all activities of daily living.			monitoring process will take (M-F) for 2weeks, weekly x 2		
		an activities of daily living.			s, then monthly x 3 months or		
	Resident #3 was obs	erved on 10/5/18 at 11:28			tern of compliance is		
		back in a low bed. The		maintained.	-		
		ng sounds but did not			/6/2018, Executive Director		
	communicate verbally				ctor of Nursing will report		

Facility ID: 943387

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STATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED
	CONTECTION	BENTI IGATION NUMBER.	A. BUILDING		C
		345291	B. WING		10/18/201
NAME OF P	ROVIDER OR SUPPLIER			1 10/10/201	
UNIVERS	AL HEALTH CARE / OXF	ORD		500 PROSPECT AVENUE OXFORD, NC 27565	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPL
F 689	Continued From page	e 34	F 68		
	The documentation in regarding Resident #3 stated, "Resident (#3) bed, another resident kissing her in the mou- brief. Resident was no lying there calmly." The incident report indicat noted as well as notified DON and Administrat Nurse #1, a nursing s on 10/5/18 at 4:12 PM was the nurse on the found in the room of F Nurse #1 indicated sha aides that Resident #3 immediately returned was assessed for any Administrator was no #1 revealed the Admi move Resident #1 to hallway. Nurse #1 rev resident to another ha minute checks were in Nurse #1 stated she a on the hall to write sta incident. Nurse #1 state was notified the next evening of 9/19/18. The documentation of (Nurse Aide) #1 state was on in Room [Nur-	an incident report 3 dated 9/19/18 at 10:15 PM ) was observed lying in her was standing over her uth and had his hand in her ot yelling out for help, was he documentation in the ted there were no injuries ication of the physician, or. supervisor, was interviewed <i>A</i> . Nurse #1 confirmed she hall when Resident #1 was Resident #3 on 9/19/18. he was notified by two nurse 1 was inappropriately . She said Resident #1 was to his room, Resident #3 <i>v</i> injuries, and the tified of the incident. Nurse nistrator instructed her to another room on another		findings of this monitoring process facility Quality Assurance and Performance Improvement Commi any additional monitoring or modifi of this plan monthly for three mon- until the pattern of compliance is maintained. The QAPI committee of modify this plan to ensure the facil remains in substantial compliance. The title of the person responsible implementing the acceptable plan correction Effective 10/06/2018 the facility ex Director and the Director of Nursin be ultimately responsible for the implementation of this plan of correct to ensure the facility attains and m substantial compliance.	ttee for cation ths, or can ty for of ecutive g will ection

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG			PLETED
		345291	B. WING				C 18/2018
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		OPD		-	500 PROSPECT AVENUE		
UNIVERS	IVERSAL HEALTH CARE / OXFORD				OXFORD, NC 27565		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG				(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
F 000		<b></b>	_		_		
F 689	Continued From page		F	689	9		
		his private part back in his n what he was doing, l					
	-	e then exited the room."					
		f the incident from NA #2					
		/ay after CNA (certified ked [Resident #3 what he					
		ver [Resident #3's] bed and					
		rt out and then he put [it]					
	back in his pants."						
	An intonviow was con	ducted with the social					
		4:56 PM. The social worker					
		s notified of the behavior of					
		orning of 9/20/18. The					
		ed the nursing staff were					
	•	ing of Resident #3 and that esident #3 on 9/20/18.					
		shift nursing supervisor,					
		0/6/18 at 8:41 AM. She					
		n the evening of 9/19/18 was r for Resident #1. She					
		sually have problematic					
		ander in the hallways.					
		ewed on 10/5/18 at 4:15 PM.					
	The DON indicated s						
	behavior of Resident						
	9/20/18. She stated th	nat the intervention put in					
	-	nt was the removal of the					
		allway, every 15 minutes a					
		f the resident, a mental ing of the urine for possible					
		s as needed, redirection,					
	-	ent of facility activities. The					
		nentation of the 15 minute					
		dent initiated on 9/19/18 and					
		nitoring time interval varied					

Facility ID: 943387

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEF AND PLAN OF CORR	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345291	B. WING				C 18/2018
NAME OF PROVIDE	ER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERSAL HE	ALTH CARE / OXF	ORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
as the varies the restarts re	ed. The DON india monitoring interva amount of wander ed if Resident #1 y nterval was every view of the docum behavior monitori various time inter resident. The docu /18 beginning at /18 beginning at /18 beginning at /18 at 2:30 PM. Interview was cond /18 at 8:04 AM. N 1/18 she was assi shift and part of th cated she monitor utes or 30 minutes en on the behavior dicted the nursing rmine the monitor #3 stated Residen y day since he ar ed she was told R had to be moved Resident #1 was go into female res	e behavior of Resident #1 cated the nurses staff varied al for the resident based on ring he was doing. The DON was walking around more y 15 minutes to check on hentation on the location ing for Resident #1 indicated vals were used to monitor umentation shows that on 10:15 PM Resident #1 was ninutes until 6:45 AM on h/behavior log 20/18 from 7:00 AM to ducted with NA #3 on IA #3 stated that on 9/20/18 igned to Resident #1 on the he second shift. NA #3 ed the resident every 15 is depending what was on or log on the clip board. NA# assistants did not ring interval for Resident #1. it #1 has been monitored rived on the hallway. NA #3 esident #1 had been in a e something inappropriate to another hall. NA#1 stated being monitored so he did	F	689			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345291	B. WING				C 18/2018
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 689	assigned to Resident second shift and mon minutes. NA #5 was interviewe #5 indicated Resident he did not go into othe indicated she would in to 30 minutes based of monitoring sheet at the indicated she was ass 9/20/18-9/21/18 for the monitored the resident 9/20/18. NA #5 stated got up to use the bath time she went in to ch sleeping. The documentation of monitoring for Reside indicated the resident hour. The documentation behavior monitoring fo 9/26/18-9/27/18 chan Documentation indicated was monitored every documentation for mo 9/29/18-9/30/18. The behavior monitoring m minutes from 10/1/18 Documentation in a p dated 10/1/18 stated, to 100 Hall because h molesting another resident that the only way to h	#1 on 9/20/18 on the itored the resident every 15 ed on 10/6/18 at 8:10 AM. NA t #1 was being monitored so er people's rooms. NA #5 nonitor the resident every 15 on what was on the ne nurses station. NA #5 signed to Resident #1 on the third shift. She stated she at every 15 or 30 minutes on a once or twice Resident #1 proom but the majority of the neck on him he was still an the location and behavior nt #1 for 9/21/18-9/25/18 twas monitored every half tion for the location and or Resident #1 for ged to every hour. ted on 9/28/18 Resident #1 half hour. There was no ponitoring of Resident #1 for documentation indicated the esumed for every 15	F	689			

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CENTERS FOR MEDICARE & MEDIC						1 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE	SURVEY LETED
	345291	B. WING				, 18/2018
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSAL HEALTH CARE / OXFORD				00 PROSPECT AVENUE XFORD, NC 27565		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689 Continued From page 38		F6	689			
<ul> <li>The physician was interview 10:45 AM. The physician in can't communicate due to a which left him unable to head He stated he was notified on Resident #1 had with Reside #3. He stated Resident #2 on by Resident #1 coming in h touch her. He stated he was other additional incidents si moved to another hallway.</li> <li>The Administrator was inter 4:15 PM. The Administrator notified of the 9/19/18 incident from Nurse #1 late that nigh not recall sending a report to the 9/19/18 incident with Reacknowledged it was the far The DON was interviewed on She indicated it was her explanately of the residents Resis been and was removed from DON said the priority was the safe. She stated it was her residents be assessed, fam reporting, care planning, staneeded, and incident report allegation of sexual miscon On 10/6/18 at 12:27 PM the informed of the immediate j provided a credible allegation of care care to the size of the sise of the size of the site of the size of the sise of th</li></ul>	dicated Resident #1 a traumatic brain injury ar and speak clearly. f both the incident lent #2 and Resident was scared a little bit er room but he did not s not aware of any nce Resident #1 was viewed on 10/5/18 at confirmed he was ent by a phone call ht. He stated he did to the state regarding esident #1 and cility policy to do so. on 10/6/18 at 4:24 PM. pectations that for the dent #1 should have m the situation. The the situation. The the sep the residents expectation that willy notified, proper aff in-services as the filled out after an duct by a resident.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/16/2018 APPROVED D: 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345291	B. WING				C 18/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE			
ONIVERO					OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page Credible Allegation of		F	689	9			
	The creation of this Leconstitutes a written a Preparation and subm constitute an admission provider of the truth of correctness of the correct surveyor agency. This because of requirement law, and to demonstration by the provider to impleach resident. Date: 10/06/2018 Corrective action accorresidents found to have deficient practice. On 5/19/2018 at 10:00 observed in the room Resident #1 was atten under resident #2's corrective action accorrect bed. Resident #1 was licensed nurse #1. He for resident #2 complete on 5/19/2018 no injuring placed on every 15 m days and was discont to show no behaviors & #2 attending physic notified. On 9/19/18 at 10:15 p observed in the room 1 was leaning over re- observed kissing resident	etter of Credible allegation allegation of compliance. hission of this letter does not on or agreement by the f the facts alleged or the holusions set forth by the s letter is solely prepared ent under state and federal ate the good faith attempts prove the quality of life of omplished for those we been affected by the 0 pm, Resident #1 was by the licensed nurse #1. mpting to put his hands over while resident #2 was in a removed from the room by ead to toe skin assessment eted by licensed nurse #1 ies noted. Resident #1 was inutes watch check for 3 inued as resident was noted of wondering. Resident #1 ian and responsible party						

Facility ID: 943387

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/16/2018 1 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION			LETED
		345291	B. WING		_	( 10/	) 18/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	AL HEALTH CARE / OXF			500 PROSPECT AVENUE			
ONIVEROF				OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	hand was observed p pants. Two Nurse Aid # 1 and immediately r The CNAs reported it completed head to too # 3 and found no sign called the administration the incident. He advise patient #1 to the 100 R esident #3. Residen moved to another roo checks by licensed nur go in any room other 9/19/18 at 10:45 pm f 7:00am then was reduce resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes cheu until 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 3pm hourly as resident exhibited no days. 30 minutes at 9/26/2018 at 9/26/2018 at 9/26/2018 at 9/26/2018 a	n resident #3 brief and left utting his P back in his es, #1 and #2, saw resident emoved him from the room. to licensed nurse #1 who e skin assessment resident is of injury. Charge nurse #1 or at @11:30pm to inform of sed the nurse to move hall which is away from t # 1 was immediately m and placed on 15 minute urse #1 to ensure he did not than his own, effective or 3 days until 9/22/18 at uced to 30 minutes check as wandering behavior for 3 ck was continued for 5 days in when it was reduced to hibited no wandering 0n 9/28/18 Resident was and down the hall more nsed nurse #2 increased by 30 minutes completed by on duty continue until resident was noted hallways. Every 15 minutes today. Ever	F 68				
	#3 family members w nurse #1. Both reside at the time and no new	ere notified at the time by nt's physicians were notified w orders by licensed nurse					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345291	B. WING				C 18/2018
NAME OF PF	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	potential to be affected practice. 100% of wandering ri- current residents with completed by the Direc- to identify if any resid- behaviors in the past identified with wander days. 100% interview of all resident was completed Assistant Director of N services, Registered of Central Supplies super resident to include Re- their room uninvited a inappropriate behavior any concern regarding resident related to war 100% interview of all interviewed by the Ex- Nursing and/or Direct 10/5/2018 and 10/6/2 wandering behaviors any resident to includ deficit. No other staff for any additional resi and #3. Any staff mer 10/6/2018 at 11:59pm work until interviewed Measures will be put	se residents having the d by the same deficient sk assessments for all wandering behavior ector of Nursing on 10/6/18 ent exhibited wandering 7 days, no other resident ring attempt in the last 7 current alert and oriented ed on 10/6/2018 by Nursing, Director of Social nurse supervisor and/or ervisor to identify any esident #1 has wandered in and exhibited any or. No other resident voiced g resident #1 or any other indering behaviors current employees on duty ecutive Director, Director of or of Social Services on 018 to identify if any for resident #1 was noted to e residents with cognitive member voiced concerns dents beside, resident #2, nber not interviewed by n will be not be allowed to l.	F	689			
		vill be made to ensure that will not occur.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/16/2018 // APPROVED ). 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		345291	B. WING				C 18/2018	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					500 PROSPECT AVENUE			
UNIVERSI	AL HEALTH CARE / OXF	ORD			OXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	assessments for all re admission/re-admissis significant changes of whenever a resident i behaviors/attempts. A addressed and correct immediately; intervent and resident's care pl updated immediately care staff will be notifi forth by a licensed nu guide which are locate Effective 10/6/2018, th team, which includes nurse #1, MDS numb Social worker #1, and Executive director init reviewing any resident inappropriate wonder root cause of the beha an appropriate interve reoccurrence. Interve limited to prompt psyc service consultation, of medication evaluation appropriate. Any iden addressed promptly a as indicated. This rev through Friday effective Effective 10/6/2018, w and/or designated lice resident who is noted wandering behaviors the behavior exhibited appropriate intervention	omplete Wandering risk esidents on on, quarterly, with any f resident's condition, and/or s noted to exhibit wandering any noted concerns will be eted by licensed nurses tions will be implemented an will be revised and by licensed nurses. Direct ed of new interventions put rse through resident's care ed in each nursing station. The center interdisciplinary Director of Nursing, MDS er #2, Registered nurse, I Activity Coordinator #1, iated a process for at who is noted with ing behaviors to identify the avior exhibited and put forth ention to prevent the ntion to include but not chiatric evaluation, social one on one care, and/or a will be implemented when tified issues will be and plan of care developed iew will take Monday ve 10/6/18 veek end RN supervisor ensed nurse reviewing any with inappropriate to identify the root cause of d and put forth an	F	68%				

Facility ID: 943387

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	
		345291	B. WING				_ 18/2018
	ROVIDER OR SUPPLIER	ORD	1	:	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PROSPECT AVENUE OXFORD, NC 27565		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	service consultation, medication evaluation appropriate. Any iden addressed promptly a as indicated. This rev Sunday through Frida Executive Director, D Dietary Manager, Dire and/or Staff Developr re-education for curre part time and as need departments started of education included id residents, abuse polic reporting, appropriate residents with wanded assessment completing protocol and provision This education will be any employee not edu allowed to work until requirement. Effective will be added on new for all new facility emp also be provided annu. The facility plans to m make sure that solution Effective 10/07/2018 Assistant Director or I review daily document to identify any indicati Any issues identified process will be addre from this monitoring p	chiatric evaluation, social one on one care, and/or a will be implemented when tified issues will be and plan of care developed iew will take Saturday and ay effective 10/6/18. irrector of Nursing, Certified ector of Social Services nent Coordinator conducted ent scheduled staff, full time, ded employee for all on 10/5/2016. This entifying wandering by and procedures, proper e actions to be taken for ring behaviors, wandering on requirements per n of safety for all residents. e completed by 10/6/2018, ucated by 10/6/18 will not be educated on this e 10/6/2018. This education hires orientation education ployees. This education will ually for all staff.	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345291	B. WING	ing	,		C
NAME OF PI	ROVIDER OR SUPPLIER	0.0201		Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	18/2018
					500 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD			OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page meeting binder after p This monitoring proces (M-F) for 2weeks, wer monthly x 3 months o compliance is maintai Effective 10/6/2018, E Director of Nursing wi monitoring process to Assurance and Perfor Committee for any ad modification of this pla months, or until the parameter and the for any ad responsible for the person implementing the acc Effective 10/06/2018 and the Director of Nur responsible for the im correction to ensure to maintaines substantial Compliance Date 10/07 The credible allegatio 10:00 AM as evidence observation, staff and Interviews were cond members from all thre re-education was con	e 44 proper follow ups are done. ess will take place daily ekly x 2 more weeks, then r until the pattern of ined. Executive Director and/or ill report findings of this the facility Quality rmance Improvement ditional monitoring or an monthly for three attern of compliance is 1 committee can modify this cility remains in substantial n responsible for eptable plan of correction the facility executive Director ursing will be ultimately uplementation of this plan of he facility attains and compliance. 06/2018 n was verified on 10/7/18 at ed by record review, I resident interviews. ucted with a sample of staff es shifts to verify ducted for all employees wandering residents, abuse		68	DEFICIENCY)		
		be taken for residents with wandering assessment ents per protocol and					

Facility ID: 943387

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345291	B. WING	_			C
NAME OF P	ROVIDER OR SUPPLIER	545251	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2018
UNIVERS	AL HEALTH CARE / OXF	ORD			00 PROSPECT AVENUE DXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689 F 711 SS=B	provision of safety for sample of staff memb assure the facility inte additional residents e behavior of Resident Interviews were cond and oriented resident facility to verify they h regarding wandering for room uninvited and est behavior. Observations were m wandering residents w Documentation of wat in-service records, an behavior/wandering for reviewed. All of the evidence ind completed the correct Physician Visits - Rev CFR(s): 483.30(b)(1)- §483.30(b)(1) Review of care, including med each visit required by section; §483.30(b)(2) Write, s notes at each visit; an	all residents. The same ers were interviewed to prviewed them regarding ffected by the wandering #1. ucted with a sample of alert s on all of the halls of the ad been interviewed residents coming in their khibiting inappropriate ade to confirm the were doing so safely. Indering risk assessments, d the current og for Resident #1 were dicated the facility had tive action by 10/6/18. view Care/Notes/Order -(3) Visits the resident's total program dications and treatments, at paragraph (c) of this		689			10/20/18

Event ID: GHQ711

Facility ID: 943387

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRU			10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		345291	B. WING			C 10/18/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	· · ·	0/10/2010	
				500 PROSPI	ECT AVENUE			
UNIVERS	AL HEALTH CARE / OXF	FORD		OXFORD, I	NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 711	Continued From page	e 46	́ с -	11				
1 7 11								
	exception of influenzation vaccines, which may	a and pneumococcal						
	physician-approved f							
	assessment for contr							
		T is not met as evidenced						
	by:							
		view and staff interviews the		F711				
	facility failed to obtain	n physician signatures on		Monthl	ly Physician orders not sig	gned		
	monthly orders for Se			timely.				
		10, and #12) of 5 residents			entified resident□s physic			
		physician signatures on			signed immediately after t			
	orders. Findings inclu	uded:			ontacted by the medical re			
	1 Decident #9 was a	admitted to the facility on			The Medical director was	•		
		gnoses of heart failure,			cility at the time reported a diately signed orders for h			
	dementia, and hyper	-		resider		10		
		al record for Resident #8 on			was a 100% audit comple			
		September 2018 physician			al records clerk for missin	-		
	orders were not a pa	rt of the record.		-	ures, notes or placement			
	An interview was son	ducted with the medical			as completed on 10/8/18	•		
		nducted with the medical n 10/6/18 at 12:45 PM. The			l found to be deficient was e physician⊡s immediate s	•		
		bloyee indicated that the			Physiolan is inimediale s	signature.		
		nt #8 requested the physician		Medica	al Records was in-service	ed by the		
		s be put in a folder and put in			on the importance of adhe			
		ar the 500 Hall nurses			on maintaining records a	0		
		records employee stated the			any issues as needed for	follow-up		
		r Resident #8 were in a			DON on 10/8/18.			
	folder awaiting the sig	gnature of the physician.			dministrator, Medical Rec			
					e DON spoke with all MD			
		rse #6 on 10/6/18 at 12:47			importance of timely visit			
		sician was in the building ast in the building on 10/4/18.			g of their patient⊟s medic required time frames.  Th			
		251 III IIIE DUIIUIIIY UIT 10/4/10.			plished on 10/9/18.	13 Was		
	An interview was cor	nducted with the						
	Administrator on 10/6				eviewing Physician orders			
		ed that it was his expectation			each month, they will be	•		
	the physicians sign the physicians are sign the physicians are sign to the physicians are sign to the physician sector.	he monthly orders and it was		to the	physician on a timely bas	is for their		

Facility ID: 943387

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 11/16/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE S COMPL	SURVEY .ETED
		345291	B. WING			C 10/1	;  8/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD		00 PROSPECT AVENUE DXFORD, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 711	a problem the facility 2. Resident #9 was at 8/8/17 and had diagn mellitus, hypertension pulmonary disease. Review of the medica 10/6/18 revealed the physician orders were record. An interview was com- records employee on medical records empl physician for Residen monthly physician orc his patients for his rev medical records empl September 2018 mon and needed to be put so her physician could An interview was com- Administrator on 10/6 Administrator indicate the physicians sign th a problem the facility 3. Resident #10 was a 12/13/16 and had diag chronic kidney diseas Review of the medica 10/6/18 revealed the physician orders were An interview was com-	needed to fix. dmitted to the facility on oses of Type 2 diabetes h, and chronic obstructive al record for Resident #9 on September 2018 monthly e not a part of the medical ducted with the medical 10/6/18 at 1:00 PM. The oyee indicated that the t #9 requested that all ders be put in the charts of view and signature. The oyee stated that the thly orders were in a folder in the chart of Resident #9 d sign them. ducted with the /18 at 4:24 PM. The ed that it was his expectation ne monthly orders and it was needed to fix. admitted to the facility on gnoses of hypertension,	F 711	signature as per guid Medical records will a for 4 weeks then mor compliance. Any tren discussed with the Q committee monthly for every quarter for 1 ye	audit charts weekly nthly thereafter for nds or issues will b uality Assurance or three months the	e	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 11/16/2018 APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345291	B. WING			C 10/18/2018	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				ŧ	500 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		(	OXFORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 711	Continued From page 48 medical records employee indicated the physician for Resident #10 requested that all the monthly orders be transported to his office in a folder, he signed them, transportation picked them up at the office and returned the orders to the facility. The medical records employee indicated the orders		F	711	1		
	were in the physician	5					
	An interview was con Administrator on 10/6 Administrator indicate the physicians sign th a problem the facility 4. Resident #12 was	ducted with the 5/18 at 4:24 PM. The ed that it was his expectation he monthly orders and it was					
		ementia, and chronic obstructive					
	10/6/18 revealed the physician orders were	al record for Resident #12 on September 2018 monthly e in the medical record but he physician for Resident					
	records employee on medical records empl for Resident #9 reque physician orders be p patients for his review record employee india Resident #12 was in t sign the September of An interview was con Administrator on 10/6 Administrator indicate	out in the charts of his v and signature. The medical cated the physician for the building daily and would orders on 10/7/18. ducted with the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		345291	B. WING _			C 10/18/2018			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
UNIVERS	AL HEALTH CARE / OXF	ORD		500 PROSPECT AVENUE OXFORD, NC 27565					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			K (EACH CORI	RECTIVE ACTION SHOULD BE				
F 711	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO					

Event ID: GHQ711

Facility ID: 943387

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