A. BUILDING ____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345291

B. WING ____________________________

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

11/19/2019

STREET ADDRESS, CITY, STATE, ZIP CODE

UNIVERSAL HEALTH CARE / OXFORD

500 PROSPECT AVENUE

OXFORD, NC  27565

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS

An onsite revisit was conducted on 11/19/19 and the facility is back into compliance effective 11/14/19.

F 000

(X5) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

F 000

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.