	-	ID HUMAN SERVICES			FO	RM APPROVED
		MEDICAID SERVICES				<u>NO. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			ATE SURVEY DMPLETED
		345291	B. WING			C 09/01/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	E ACTION SHOULD BE COM TO THE APPROPRIATE	
E 000	Initial Comments		E 00	0		
F 000	was conducted on 8/2 was found in Complia	OVID-19 Focused Survey 26/20-9/1/20. The facility ance with the requirement ncy Preparedness. Event	F 00	0		
	Control Survey and c conducted on 8/17/20 found not in complian infection control regu the CMS and Centers	OVID-19 Focused Infection omplaint investigation were 0 -9/1/20. The facility was ace with 42 CFR §483.80 lations and has implemented s for Disease Control and commended practices to 9.				
	One of two complaint substantiated at F880).				
	Immediate Jeopardy	was identified at:				
	CFR 483.80 at tag F8 (J)	380 at a scope and severity				
F 880	was removed on 08/2 survey was conducte Infection Prevention 8	& Control	F 88	0		9/30/20
SS=K	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)				
	infection prevention a designed to provide a comfortable environm development and tran diseases and infectio	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable ns.				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					09/21/2020

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345291	B. WING			09/01/2020	
NAME OF PI	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE / OXF	ORD) PROSPECT AVENUE (FORD, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD				(X5) COMPLETION DATE
F 880	Continued From page	1	F8	80			
	and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possible circumstances. (v) The circumstances	blish an infection prevention IPCP) that must include, at ring elements: Im for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of se or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to:					

Facility ID: 943387

If continuation sheet Page 2 of 25

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/07/2 FORM APPRO OMB NO. 0938-0	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/01/2020	
		345291	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD		500 PROSPECT AVENUE DXFORD, NC 27565		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	
F 880	Continued From page	e 2	F 880			
	disease or infected sl contact with residents	kin lesions from direct s or their food, if direct				
	contact will transmit t (vi)The hand hygiene by staff involved in di	procedures to be followed				
	§483.80(a)(4) A syste identified under the fa corrective actions tak					
	§483.80(e) Linens.	lle store process and				
	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.					
		view. Ict an annual review of its ir program, as necessary.				
		is not met as evidenced				
	interviews and review	n, staff interviews, physician v of the facility ' s ase Outbreak Preparedness		F 880 INFECTION PREVENTIO	NAND	
	Plan, COVID19 Unit I COVID19 Hand Hygi Doffing Personal Pro	Best Practices policy and ene and Donning and tective Equipment (PPE) ed to prevent an infection		1) Address how corrective action accomplished for those residents have been affected by the deficie practice:	found to	
	the facility 's Commu Preparedness plan a	e by 1. Failing to implement inicable Disease Outbreak nd the facility ' s COVID19 olicy by not providing		On 8/28/2020, the entire quaranti including resident rooms, hallway shower room and the doors to en exit the quarantine unit were clea	rs, ter and	
	housekeeping service clean environment to	es to maintain a sanitary and prevent the spread of the facility ' s COVID positive		Housekeeping and Nursing Staff. cleaning completed, this area was inspected by the Assistant Directo	After s	
	2 shower rooms, hall screening station are	30 of 30 resident rooms, 2 of ways, the unit ' s COVID a and the unit ' s entrance		Nursing and Housekeeping Supe ensure a clean, sanitary orderly environment. No issues were iden	ntified.	
		Failing to implement the d procedures on hand		Because all residents have the po be affected by this alleged	otential to	

Facility ID: 943387

If continuation sheet Page 3 of 25

-	IAN SERVICES AID SERVICES				FORM	D: 10/07/2020 APPROVED D: 0938-039
(X1) PR	OVIDER/SUPPLIER/CLIA	· /			(X3) DATE SURVEY COMPLETED C 09/01/2020	
	345291	B. WING				
PLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
RE / OXFORD						
EFICIENCY MUST E	E PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
PPE when staff and remove the dent care and e f members (Nur worked on the As of 08/26/20, sted positive for s occurred durin copardy began of to provide hous nitary and clean pread of the CC VID positive un s removed 8-28 an acceptable Jeopardy remo- of compliance a " that is not Im- oring systems p included: ' s Communica paredness Plan ; Environmenta vailability of alco vaste receptable rery sink is well- wels for hand w al cleaning using till the Communi- tices-community wash clothes for a instructions to	eir PPE after they xited resident rooms rsing Assistants #4 facility ' s COVID 73 of 118 the facility ' r the COVID19 virus. ng a COVID-19 on 08/17/20 when the ekeeping services to n environment to 0VID 19 virus in the it. Immediate -20 when the facility creditable allegation val. The facility t a lower scope and nediate Jeopardy to out in place are ble Disease n dated March 2020 I Service: would ohol-based gels, as at the facility. stocked with soap ashing. Increased g disinfectants icable disease. r staff will bag the ollowing the determine the	F	880	be conducted by the facility contract Infection Control consultant in collaboration with the facility's Quality Assurance Committee and Corporate Clinical and Operational representativ establish an infection prevention and intervention plan for the identified infe control non-compliance. This will be completed by 9/30/2020. 2) Address how the facility will identify other residents having the potential to affected by the same deficient practic By 9/30/2020, the facility contracted Infection Control consultant will provid education to facility staff on environme sanitation, personal protective equipm and hand hygiene. Any staff not educ by 09/30/2020 will not be able to work educated. This education will be inclu in the new hire orientation process for employees and agency staff. By 9/30/2020, the facility contract Infe Control consultant in collaboration wit Director of Nursing, Administrator and Medical Director will review the facility Long-Term Care (LTC) infection contri- self-assessment to determine an accu- reflection of the nursing facility. Effective 09/25/2020, the facility has f a contract Infection Control consultant who is certified by the NC Statewide Program for Infection Control and	re to ction / b be e: de ental hent, ated cuntil ded r new ction h the l r's ol urate hired t	
	(X1) PR IDE (X1) PR IDE (X1) PR IDE (X1) PR (X1) PR	PLIER RE / OXFORD MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) from page 3 PPE when staff failed to perform a and remove their PPE after they ident care and exited resident rooms ff members (Nursing Assistants #4 b worked on the facility ' s COVID As of 08/26/20, 73 of 118 the facility ' ested positive for the COVID19 virus. as occurred during a COVID-19 eopardy began on 08/17/20 when the to provide housekeeping services to anitary and clean environment to apread of the COVID 19 virus in the VID positive unit. Immediate s removed 8-28-20 when the facility an acceptable creditable allegation a Jeopardy removal. The facility of compliance at a lower scope and that is not Immediate Jeopardy to to oring systems put in place are	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILDI 345291 B. WING PLIER RE / OXFORD MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG rom page 3 F PPE when staff failed to perform e and remove their PPE after they ident care and exited resident rooms ff members (Nursing Assistants #4 o worked on the facility ' s COVID As of 08/26/20, 73 of 118 the facility ' ested positive for the COVID19 virus. is occurred during a COVID-19 eopardy began on 08/17/20 when the to provide housekeeping services to anitary and clean environment to spread of the COVID 19 virus in the V/D positive unit. Immediate s removed 8-28-20 when the facility I an acceptable creditable allegation e Jeopardy removal. The facility of compliance at a lower scope and I" that is not Immediate Jeopardy to toring systems put in place are included: /' s Communicable Disease eparedness Plan dated March 2020 t; Environmental Service: would vailability of alcohol-based gels, vaste receptables at the facility. very sink is well-stocked with soap wels for hand washing. Increased al cleaning using disinfectants kill the Communicable disease. rices-community staff will bag the d wash clothes following the s instructions to determine the method and amounts of chemicals to	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	(X1) PROVIDERSUPPLENCLA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: 345291 345291 B. WING PLIER STREET ADDRESS, CITY, STATE, ZIP CODE S0P PROSPECT AVENUE OXFORD, NC 27565 DEFICIENCY MS TO E DEFICIENCIES D DEFICIENCY MS TO E DEFICIENCY PREX TAG PREX TOM page 3 F 880 PPE when staff failed to perform a and remove their PPE after they dent care and exited resident rooms non-compliance, a root cause analysis se occurred during a COVID 19 virus. se occurred during a COVID 19 virus. se occurred during a COVID 19 virus in the VID positive unit. Immediate VID positive unit. Immediate Jeopardy to toring systems put in place are Streact of Nursing, Administrator and Control consultant will provic educated. This education will be incluin the rew with e rointail to analogia on the originity aff not educated. This education will be incluin the rew with e orientail to analysis paradness Plan dated March 2020 t, 's Communicable Disease paradness Plan dated March 2020 t, 's Communicable Disease program for Infect	CARE & MEDICAID SERVICES OMB INC (X1) PROVIDERSUPPLIERCLIA INDEMINICATION MUMBER (X2) MULTPLE CONSTRUCTION A BUILING (X3) DATE A BUILING (X3) D

Facility ID: 943387

If continuation sheet Page 4 of 25

		MEDICAID SERVICES				O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY	
			A. BUILDING	<u> </u>		С	
		345291	B. WING			09/01/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		9/01/2020	
				500 PROSPECT AVENUE	-		
JNIVERSA	AL HEALTH CARE / OXF	FORD		OXFORD, NC 27565			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC	
F 880	Continued From pag	e 4	F 88	0			
	plan operations woul	d increase environmental		appropriate infection control p	ractices		
	cleaning using disinfe	ectants approved to kill		including proper donning/doffi	ng of		
		ase. Ensure a trash can is		personal protective equipment			
		every resident room to make		hand hygiene, soil linen and tr			
	it easy for employees	s to discard PPE.		handling, containment, and dis			
	TI (111 00) //5			clean, orderly sanitary environ			
	-	019 Units Best Practices		issues identified were immedia	ately		
		2020, read in part: laundry		corrected.	4. <i>i</i>		
	within the COVID un	hen picking up laundry within		Effective 08/27/2020, the facili housekeeping services contra			
		uble bags will be placed in a		terminated. Housekeeping ser			
		taken out of the end hall		provided by another company			
		side and then around to the		8/28/2020, the Housekeeping			
		ndry area. Trash pickup		established a new cleaning sc			
		bags of trash from resident		which includes all areas in the			
	rooms when being pi	icked up are to be placed into		(resident rooms, hallways, sho	ower rooms		
		nd taken out the end hall		and common areas). On 8/28			
	COVID outside door			Housekeeping Supervisor edu			
		s that are in red bags are to		housekeeping staff on expecta			
	be boxed and taken (like trash) out the end of the			resident room cleaning schedu			
	hall door to the desig	•		common area (including show	,		
		17/20 from 11:20 AM to 1:45		cleaning schedule and hi-touc			
		COVID positive unit, which acility ' s 400 and 500		of frequently used items such station counters, keyboards, te	•		
	hallways, revealed th	-		and handrails to ensure clean			
	nanwayo, roveaicu li	ie ienewing.		sanitary conditions of the facili			
	A. On 8/17/20 at 11:2	20 AM, of the entrance to the		Additionally, education was pr			
		on the 400 and 500 hallways,		soil linen and trash handling, o			
		s sealed behind zipper		and proper disposal. All new l			
		nit ' s entrance there were		educated during their orientati			
	•	plies stacked against the		On 08/28/2020, all staff (inclue			
		h soiled linen and trash and		staff) were re-educated by Dire			
	soiled gloves and a r	nask on the floor.		Nursing regarding the facilities			
				Infection Prevention and Cont	-		
		08/17/20 near the COVID unit		proper donning/doffing of pers			
	's exit door revealed			protective equipment (PPE), c hygiene, hand hygiene, soil lin			
	screening station in t	nis area. There were used	1	I nvalene, nand nvalene, soll lin	en and	1	
	-	paper on top of the screening		trash handling, containment a			

Facility ID: 943387

If continuation sheet Page 5 of 25

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-03 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	· · · · ·	IPLETED	
						С	
		345291	B. WING		09	09/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
				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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 880	Continued From page	e 5	F 88	30			
		efs, used juice cups, food	1.00	sanitary environment. A	nv staff not		
		r meal trays were observed		re-educated by 08/28/20			
		screening station 's table.		to work until educated. A			
		creening station 's table was		including agency staff wi	ill be educated		
		brown colored substances,		during their orientation p			
		Two barrels filled with soiled		The facility has secured			
	linen and trash were	at the unit ' s exit door.		three staffing agencies to			
	C Observations on 0)8/17/20 of the unit ' s		adequate nursing staff ir another rapid outbreak.			
		s 401 to 501 were located,		facility will routinely revie			
	-	multiple bags of soiled linen		ensure appropriate cove	-		
		/ay. Observations inside		reviews will be conducte			
		ent rooms on this hallway		Administrator and /or Dir	rector of Nursing		
	revealed there were u	used gloves, used masks,		daily. Also, the facility is	currently utilizing		
		and resident clothing on the		the State Staffing Waive			
		tables in these rooms were		secure Licensed Nurses			
	not clean with dried s	substances.		Assistants and Personal			
	D. Observations on 0	9/17/20 of the unit!		to supplement staffing. (
		s 502 to 512 were located		advertisements for Licer Nursing Assistants is cu			
		barrels filled with trash and		a job posting website. Th	• •		
		ding, wheel chairs and		Development Coordinate			
	boxes of unopened s	-		job posting website for a			
		ay. Observation inside the		(Monday-Friday). The fa			
		s on this hallway revealed		another housekeeping c	ompany to		
		oms were unclean with dried		provide housekeeping se			
		used gloves, briefs and		entire community includi			
		f the shower room on this		quarantined units to ens			
	-	ere was black mold in the f soap residue in the two		sanitary, and orderly env 3) Indicate how the facili			
	-	e bathtub was unclean with a		monitor its performance	• •		
		wn sand like substance and		solutions are sustained:			
	-	d towels, washcloths, gloves		Effective 8/28/2020, to s	support efforts in		
		r of the shower room. There		reducing the spread of C			
	were used gloves, wi	pes, brown matter and areas		facility, the facility will im			
		room ' s sink. The floor		increased infection contr			
		heavy buildup of mold and		rounding including hand			
	soap residue.			protective equipment an			
	E. Ubservations on 0	8/17/20 of the unit ' s short		rounding to ensure a cle	an, sanitary, and	1	

Facility ID: 943387

If continuation sheet Page 6 of 25

		MEDICAID SERVICES				O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		E SURVEY	
	CONTRACTION		A. BUILDING	G			
		345291	B. WING			С	
		345291	B. WING			9/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
UNIVERS	AL HEALTH CARE / OXF	FORD		500 PROSPECT AVENUE			
	1			OXFORD, NC 27565			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETIO DATE		
				DEFICI	ENCY)		
F 880	Continued From pag	e 6	F 88	30			
			1 00				
		is 513 to 515 were located, ay there were used nursing		orderly environment. Th rounds will be conducted			
		sh and beds stored along the		of Nursing, Administrate	-		
		of the three resident rooms		Development Coordinat			
	-	aled gloves, dried fluid spills,		Housekeeping Supervis			
		food on the floors, tray tables		follow our policy related	-		
		s, and trash cans filled with		Placement to ensure an			
		of this hallway 's nurse 's		have signs and symptor			
		d gloves, used masks, and		are properly isolated an			
		blies on the desk and on the		precautions are maintain			
	floor.			will continue to screen e	-		
				residents for signs and s			
	F Observations on (08/17/20 of the area near the		COVID -19 and provide	• •		
		oor revealed five yellow		warranted. The Adminis	-		
		of trash and two grey barrels		Director of Nursing will o			
		I PPE and other used items.		maintain and review any			
		astic bags that contained		symptoms utilizing a res			
	- · ·	dent laundry were piled up		line listing. Routine track			
		litionally, opened and		will be conducted by the			
		briefs and gloves were		Preventionist to identify			
		drails and on tray tables in the		facility Staff Developme	• •		
	hallway.			(SDC)/Infection Prevent			
				Director of Nursing (DO			
	G. Observations on (08/17/20 of the unit ' s		COVID-19 education up	, .		
		is 406 to 415 were located,		staff to ensure facility st			
	-	used gloves and a mask in		any new guidance relate			
		rails and barrels were		the spread of COVID-19	•		
	•	h. Observations of the ten		Development Coordinat	•		
	-	is hallway revealed the floors		new hire staff (including			
		biled linen, used cups, dried		receives training on infe	ction control and		
		er products. Used gauze and		prevention prior to resid			
	medication cups wer	e on the floors near		education will now inclu	de COVID-19		
	unemptied trash can	s in resident rooms. Plastic		specific infection control	l and prevention		
	bags that contained	resident clothing were on the		including cough etiquett	e, handwashing,		
	floor in resident room	ns and in the hallway outside		donning/doffing persona			
	of resident rooms.			equipment, ways to prot COVID-19, N-95/K-95 a			
	H. Observations on (08/17/20 of a shower room		skills checklist and the f			
	-	e rooms 406 to 415 were		placement policy.	,		

Facility ID: 943387

If continuation sheet Page 7 of 25

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
					С			
		345291	B. WING		09/01/2020			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLET			
F 880	Continued From page	e 7	F 880					
	located, revealed mo tiles and floor tiles. Al and resident equipme shower stalls. On 08/17/20 at 11:55 conducted with NA #4 and worked on the fa stated this was her fir s COVID unit and she the transmission of C requirements. NA#4 s any direct training on procedures for the fac unit. NA #4 stated, "I the wipes located in t was no specific place kept, as you can see and disorganized. I w this facility and place unit, and I am trying t fed to the best of my On 8/17/20 at 11:58 A conducted with NA #5 and was working on t #5 stated that he rece the transmission of C practices and handwa stated he had worked in the facility 's COVI very frustrating trying	Id growth was on the wall so, wheelchairs, bedding ent were stored in the AM an interview was 4, who was an agency NA cility ' s COVID unit. NA #4 'st day working in the facility ' e received brief training on OVID 19 infection and unit stated she had not received the cleaning or disinfecting cility ' s COVID19 positive just wipe things down with he resident ' s rooms. There e where the disinfectant was everything is all over the unit 'as asked to come to work at d on the COVID19 positive o keep the residents clean, ability." AM, an interview was 5, who was an agency NA he facility ' s COVID unit. NA eived a very brief training on OVID19, infection control ashing and sanitizing. NA #5 d several back to back shifts ID unit and it was getting to keep residents clean and g the unit clean. NA #5		 Ongoing monitoring will include the Development Coordinator/Infection Preventionist/Nurse Unit Coordinators/Nurse Supervisor/D Nursing conducting Infection Prevation and Control rounds to monitor for appropriate infection control practice proper donning/doffing of personal protective equipment (PPE), hand hygiene, soil linen and trash hand containment and disposal. These will be performed twice daily (including weekends) for (4) week then daily (including weekends) for (8) week identified issues will be immediate corrected, and staff will be re-edu proper infection control practices. Findings from this monitoring will documented on an audit tool and binder. Ongoing monitoring will include the Housekeeping Supervisor or Apper Housekeeping Staff conducting fatours to ensure environmental clee of the facility. These tours will be conducted daily (including weeker (4) weeks then weekly (8) weeks. identified issues will be immediate corrected, and housekeeping staff re-educated on environmental clee responsibilities. Findings from this monitoring will be documented on tool and filed in a binder. 	irrector of vention icces al d lling, rounds uding v ss. Any ely cated on be filed in a ne binted acility anliness nds) for Any ely f will be aning s an audit			
	residents and clean a the shift. NA #5 speci barrels would get full housekeeping staff w	too much to care for in entire unit by the end of fied the trash and linen because there was no orking on the unit and when things off you had to go		Ongoing monitoring will include the Administrator or Manager on Duty performing facility tour of the build ensure environmental cleanliness tours will be conducted daily (inclu- weekends) for (4) weeks then we	/ will ling to These uding			

Facility ID: 943387

If continuation sheet Page 8 of 25

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTIO	N	1	D. 0938-03 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		COMF	PLETED
						С	
		345291	B. WING			09/	/01/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE		
	AL HEALTH CARE / OXF	OPD		500 PROSPECT	AVENUE		
UNIVERS	AL HEALTH CARE / OAF			OXFORD, NC	27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO		ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From page	<u>- 8</u>	F 88	0			
1 000			FOG		widentified issues will be		
		hall to find things. NA #5 I not receive any specific			iy identified issues will be ly corrected, and housekeep	nina	
		ng or disinfecting procedures			ling Housekeeping Supervis	-	
	for the unit. He stated			educated on environmental			
		s placed on the COVID19			esponsibilities. Findings from	า	
	-	his best to clean in between			pring will be documented on		
	caring for the residen				and filed in a binder.		
				The Direct	or of Nursing Service and		
	During an interview o	n 8/17/20 at 12:10 PM,		Administra	ator will report finding of this		
	Nurse #3 stated the fa	acility ' s COVID positive unit		monitoring	process to the facility Quali	ty	
	had several call outs	due to illness or not		Assurance	e and Performance		
	-	Therefore, the current aides			ent Committee for any		
	and nurses had to pit			monitoring or modification of			
		I the resident care was			nonthly for 6 months. The QA		
		tated, the cleaning can get			can modify this plan to ensu	ure	
	difficult at times.			compliance	remains in substantial e.		
	During an interview o	n 8/17/20 at 12:30 PM,					
		to staff working on the		Effective 0	9/30/2020, the Administrato	r	
	facility ' s COVID19 p	ositive unit they were		and Direct	or of Nursing will be ultimate	ely	
	educated and informe	ed on the infection control		responsible	e to ensure implementation	of	
		s for COVID 19 positive unit,			f correction for this alleged		
		washing and sanitizing			ance to ensure the facility		
		cting surfaces. Nurse #4			substantial compliance.		
		nursing staff were required			ility alleged full compliance v	vith	
	to maintain and clean				f correction effective date		
		eing assigned to work on the		9/30/2020.			
		he housekeeping staff					
		and were expected to pick nen at the unit ' s back door.					
		h was not picked up for a					
		ere stored at unit 's back					
		ations on the unit until the					
		ame to pick them up. Nurse					
		crease of COVID positive					
		it became very challenging					
		staff to provide the medical					
		and to properly clean and					
	disinfect the unit.						

If continuation sheet Page 9 of 25

	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	` '	E SURVEY IPLETED
		345291	B. WING			C 09/01/2020	
NAME OF PF	ROVIDER OR SUPPLIER	I		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE / OXF	ORD			PROSPECT AVENUE ORD, NC 27565		
							0(5)
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 880	Continued From page 9 An interview was conducted with the facility ' s contracted Housekeeping Supervisor (HKS) and Housekeeping District Manager (DM) on 08/17/20 at 1:45 PM. The HKS stated the facility ' s		F	380			
	contracted housekeeping staff were only responsible for cleaning the non-COVID area and the nursing staff assigned to the COVID19						
	positive unit were responsible for cleaning the unit. The HKS added that he was responsible for providing the COVID positive unit with cleaning and disinfectant supplies and picking up trash						
	and linen to prevent t He added there was i	he spread of the infection. no housekeeping staff ID positive unit. The HKS					
	further stated the nurs the unit, were in-servi	sing staff, who worked on iced on environmental					
	COVID19 unit, but he provided with other tr	isolation rooms for the was not sure if they were aining on how to clean the					
	he was informed by th	ing District Manager stated he corporate manager that ing on the facility ' s COVID					
	unit would be response disinfect the unit, there						
	the COVID unit. The stated that he was un	District Manager further acertain what kind of					
	that worked on the Co	tion training the nursing staff OVID unit was provided. The pectation was for the COVID					
	unit nursing staff to pl linen in the designate	lace all trash and soiled d barrels and to place the					
	staff to pick up, to pre from walking through	ated door for housekeeping event the housekeeping staff the unit. The DM further					
	pick up these items d	keepers were expected to aily in accordance to the policy and procedures.					

Facility ID: 943387

If continuation sheet Page 10 of 25

		IPLE CONSTRUCTION		D. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		NG	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER			C 09/01/2020	
		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
		500 PROSPECT AVENUE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
	F8	380		
 17/20 at 12:15 PM, the Consultant (RNC) are educated on the poedures and required tration of handwashing infection control disinfecting rooms and e assigned to the unit. What cleaning and ursing staff working on the absence of ag on the unit. She uning were available, but t 's nursing staff to to clean and disinfect uired by the facility 's ind procedures. 17/20 at 2:15 PM, the stated the facility 's ing (ADON) and Staff (SDC) were the COVID19 unit and the unit and the they both became sick The DON explained the nit should use bleach, disinfect to clean es. The DON stated, linen, resident clothing, tover food on the floor DN stated the COVID gnated housekeeper, a few weeks ago and ded by the t. The DON specified ruggled to keep the unit 				
	7/20 at 12:15 PM, the Consultant (RNC) re educated on the cedures and required ration of handwashing affection control disinfecting rooms and e assigned to the unit. what cleaning and rsing staff working on e absence of g on the unit. She ning were available, but t 's nursing staff to to clean and disinfect uired by the facility 's nd procedures. 7/20 at 2:15 PM, the stated the facility 's ng (ADON) and Staff (SDC) were the COVID19 unit and he unit and the hey both became sick The DON explained the nit should use bleach, disinfect to clean es. The DON stated, linen, resident clothing, tover food on the floor DN stated the COVID gnated housekeeper, a few weeks ago and ded by the . The DON specified	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) F 8 7/20 at 12:15 PM, the Consultant (RNC) re educated on the cedures and required ration of handwashing ifection control disinfecting rooms and e assigned to the unit. what cleaning and rsing staff working on e absence of g on the unit. She ning were available, but t 's nursing staff to to clean and disinfect uired by the facility 's nd procedures. 7/20 at 2:15 PM, the stated the facility 's ng (ADON) and Staff (SDC) were the COVID19 unit and he unit and the hey both became sick The DON explained the hit should use bleach, disinfect to clean as. The DON stated, linen, resident clothing, tover food on the floor DN stated the COVID gnated housekeeper, a few weeks ago and ded by the . The DON specified uggled to keep the unit	STREET ADDRESS, CITY, STATE, ZIP CODE 500 PROSPECT AVENUE OXFORD, NC 27565 ENT OF DEFICIENCIES T DE PRECEDED BY FULL ENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) 7/20 at 12:15 PM, the Consultant (RNC) re educated on the cedures and required ration of handwashing flection control disinfecting rooms and e assigned to the unit. what cleaning and rsing staff working on e absence of g on the unit. She ning were available, but ''s nursing staff to to clean and disinfect jired by the facility 's not procedures. 7/20 at 2:15 PM, the stated the facility 's ng (ADON) and Staff (SDC) were the COVID19 unit and the unit and the hey both became sick The DON stated, linen, resident clothing, tover food on the floor DN stated the COVID prated housekeeper, a few weeks ago and ded by the uggled to keep the unit	345291 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE SoD PROSPECT AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE SOD PROSPECT AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE SOD PROSPECT AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE SOD PROSPECT AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE IT BE PRECIDENCIES ID THE PRECIDENCIES PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Facility ID: 943387

If continuation sheet Page 11 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345291	B. WING			09/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD			500 PROSPECT AVENUE DXFORD, NC 27565		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 880	provided and availabl not have much time to the unit. Several resid at one time and things when the ADON and was no management DON stated the admin supervisor were awar During an interview of Administrator stated w Quality Assurance Me determine the cause of outbreak and the active source of the infection determined, but issue environment became not have staff availab The administrator exp housekeeping contract of July 2020, but they contract through the e Administrator stated t housekeeping departu positive unit with desi and follow the Best P Placement Policy to p from the unit. The Add were no housekeepin COVID19 positive unit and the expectation w staff to clean and mai facility ' s COVID positive During a telephone in PM, with a member o Operation (DO) and D	e, but the nursing staff did o maintain the cleanliness of dents were moved to the unit is became dysfunctional SDC became sick and there monitoring of the unit. The nistrator and housekeeping e of the situation. In 8/17/20 at 2:00 PM, the weekly discussions via eetings were held to of the facility ' s COVID on plan. The continued in among staff had not been es with the cleanliness of the an issue as the facility did le to do the proper cleaning. Dained the facility ' s current ct was terminated at the end were working out their end of August 2020. The he expectation was for the ment to supply the COVID19 gnated cleaning supplies ractice Policy and Resident bick up trash and laundry ministrator confirmed there g staff assigned to the it since the end of July 2020 was for the unit ' s nursing ntain the environment of the	F	880			

Facility ID: 943387

If continuation sheet Page 12 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	i	C		
		345291	B. WING			09/01/2020		
NAME OF P	ROVIDER OR SUPPLIER							
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)	BE	(X5) COMPLETION DATE	
F 880	tracking of the COVIE The housekeeping stat the responsibility for c environment had been the new housekeeping start at the end of the housekeeping staffing agency staff, staff from facility was offering stat to ensure coverage w staff were provided bas practices prior to acce- facility. During the survey, no checklist for the agen Additionally, no infect cleaning/disinfection to provided for the staff positive unit or new has During a telephone in PM, the Chief of Nurs contracted staffing ag contract with the facilit 7/16/20 with the agree responsible onsite tra requirements in infect placement and to dette each employees ' job During a telephone in AM, the Medical Direct potentially due to lack cleaning and disinfect	 a) unit, but she was out sick. aff were affected, therefore, cleaning and maintaining the in impacted. The DO stated g contract service would month (August 2020), and g was now being covered by m sister facilities, and the aff overtime and bonus pay vas available. The agency asic infection control training epting a position at the a) in-service or orientation cy staff was provided. ion control, training documents were working on the COVID 19 ires. b) terview on 8/27/20 at 2:48 bing Officer for the facility 's ency stated, the staffing ity was established on ement the facility was ining of the facility tion control prior to ermine the adequacy of o performance. b) terview on 8/25/20 at 9:44 ctor stated he was unable to use for the outbreak was a of adequate housekeeping 	F	88				

Facility ID: 943387

If continuation sheet Page 13 of 25

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/07/2020 MAPPROVED 0. 0938-0391	
STATEMENT O	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		345291	B. WING		C 09/01/2020		
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
			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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	short period of time w resources were limite symptoms when staff facility had enough P available, however, d housekeeping service facility staff and resid "poor cleaning practic Medical Director state the administrator and due to the housekeep quality of cleaning thr significant impact on staff attempted to do and maintain a clean residents. The contra not work in accordance standards. The Medic been made aware the company had been te and the new company August, therefore, un of trying to clean and The Medical Director cleaning standards w had a direct impact o The Medical Director the returned COVID1 increase of positive c continued to review th currently 51 residents COVID 19 unit for the been moved to the st only 23 current active Review of the facility	rol the rapid spread at a vas difficult to manage when d and reporting of were asymptomatic. The PE and cleaning supplies ue to the contracted e company 's practice, the ents were impacted by the ce of the company." The ed, "I had been informed by the director of nursing that bing contract services, the roughout the facility had a the spread of the virus." The their best to provide care environment for the cted housekeeping staff did ce to the professional cal Director stated, "I had e current housekeeping erminated the end of July y would start on end of it staff had the extra burden maintain the environment." indicated the contract ere poor which may have in the spread of the virus. specified, the timeliness of 9 test results revealed an ases each week. He ne cases each week and is who had been on the e past 15 or more days have ep-down unit and there are e cases.	F 880				
		COVID19 virus revealed					

Facility ID: 943387

If continuation sheet Page 14 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/07/2020 MAPPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345291	B. WING		_		C 01/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				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 PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page the following: week of of 7/22/20- 4 resident residents, week of 08, of 08/12/20- 35 reside 08/19/20- 23 resident 2. The facility 's Com Outbreak Preparedne read in part; Prevention staff should practice of handwashing technique to conduct frequent we avoid touching the eye workers should wear Protective Equipment gowns while working of Nursing would ensure training of staff. Ensure hands according to C before and after conta contact with contamin and after removing pe (PPE). The facility 's revised and Donning and Dof infection control check training policy and pro- revealed in part; put 3 soap in the palm of yo together to distribute in care for the individual chapped or dry, apply that is dispensed by a	e 14 7/15/20- 2 residents, week s, week of 07/29/20- 10 /06/20- 12 residents, week ents and the week of s. municable Disease ess plan dated March 2020, on section read in part all good hygiene and ues and would be educated vashing of hands and to es/face area. Healthcare appropriate Personal (PPE) masks, gloves, and with suspected cases. e on-going education and re employees clean their DC guidelines, including act with residents, after nated surfaces or equipment, ersonal protective equipment fing PPE competency klist for nurse aide in becedure dated 8/7/20, 8 to 5 milliliters of antiseptic bur hands. Rub your hands it. After you complete your and if your hands are y lotion or a barrier cream an individual-use dispenser r organization. Wears and/or	F 880				
	uses safety equipmen indicated and properly						
	The facility 's COVID	19 unit special					

Facility ID: 943387

If continuation sheet Page 15 of 25

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETI A. BUILDING 345291 B. WING 09/01/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 09/01/2 UNIVERSAL HEALTH CARE / OXFORD STREET ADDRESS, CITY, STATE, ZIP CODE 500 PROSPECT AVENUE 00/01/2 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION 0 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE C TAG Continued From page 15 SIGN PROSPECT AVENUE CROSS-REFERENCED TO THE APPROPRIATE C C F 880 Continued From page 15 F 880	PRINTED: 10/07/2020 FORM APPROVED OMB NO. 0938-0391			IMENT OF HEALTH AN RS FOR MEDICARE & I	
Image: Name of provider or supplier Street Address, City, State, Zip Code UNIVERSAL HEALTH CARE / OXFORD STREET Address, City, State, Zip Code (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC F 880 Continued From page 15 airborne/contact precaution signage revealed a reminder: HAND HYGIENE must be performed F 880	ILDING COMPLETED	` '	(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT O
S00 PROSPECT AVENUE 0XFORD, NC 27565 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CG F 880 Continued From page 15 airborne/contact precaution signage revealed a reminder: HAND HYGIENE must be performed F 880		B. WING	345291		
UNIVERSAL HEALTH CARE / OXFORD UNIVERSAL HEALTH CARE / OXFORD OXFORD, NC 27565 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO F 880 Continued From page 15 airborne/contact precaution signage revealed a reminder: HAND HYGIENE must be performed F 880 F 880	STREET ADDRESS, CITY, STATE, ZIP CODE	S		PROVIDER OR SUPPLIER	NAME OF PI
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO F 880 Continued From page 15 airborne/contact precaution signage revealed a reminder: HAND HYGIENE must be performed F 880 F 880			ORD	SAL HEALTH CARE / OXF	UNIVERS
airborne/contact precaution signage revealed a reminder: HAND HYGIENE must be performed	CEFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
before entering the potent's room. Observation on the facility's COVID19 positive unit on 8/17/20 from 11:40 AM to 11:45 AM, revealed NA/H entered and exited two different resident rooms on the unit's 400 hall to assist residents with water and snacks touching bed side trays and tables, and picked up solled linen from the floor. NA/H was observed to exit the first resident's room and did not remove her PPE, gloves or wash her hands or use sanitizer before entering the second resident's room. NA/H 4 entered the second resident's room and gloves or wash sobserved exit the second resident's room wearing the second resident's room wearing the second resident's room wearing the same PPE and did not wash or samitize her hands. NA/H 4 carried solled linen from the resident's room and stacked it in already filled barrels at the end of hall. On 8/17/20 at 11:55 AM, an interview was conducted with NA /H4, who was an agency NA and worked on the facility's COVID unit. NA /H4 stated this was her first day working the unit and she was provided brief training on the transmission of COVID 19 infection and unit requirements for handwashing and sanitizing, donning and doffing PPE when entering and exiting resident rooms. NA/H4 confirmed there were occasions she had not removed the PPE or washed her hands as required because she was trying to respond to resident call lights and clean up the unit. NA #4 stated, "I go in a hurry trying to do everything and did not remove my PPE after entering or exiting every resident room where I had ether provided care or bucked wirdraces".	F 880	F 880	aution signage revealed a GIENE must be performed om and following removal of patient ' s room. cility ' s COVID19 positive 11:40 AM to 11:45 AM, ed and exited two different a unit ' s 400 hall to assist and snacks touching bed and picked up soiled linen was observed to exit the first did not remove her PPE, ands or use sanitizer before esident ' s room. NA #4 esident ' s room wearing the place and wiped off a ided wipes. NA#4 was ond resident ' s room E and did not wash or A #4 carried soiled linen bom and stacked it in at the end of hall. AM, an interview was k, who was an agency NA cility ' s COVID unit. NA #4 st day working the unit and ef training on the D 19 infection and unit dwashing and sanitizing, PE when entering and s. NA#4 confirmed there had not removed the PPE or required because she was esident call lights and clean ted, "I got in a hurry trying to not remove my PPE after ery resident room where I	airborne/contact prec reminder: HAND HYG before entering the ro PPE and leaving the p Observation on the fa unit on 8/17/20 from 7 revealed NA#4 enterer resident rooms on the resident rooms on the resident swith water a side trays and tables, from the floor. NA#4 w resident ' s room and gloves or wash her ha entering the second re same PPE, gloves in resident with the prov observed exit the sec wearing the same PP sanitize her hands. N from the resident ' s re already filled barrels a On 8/17/20 at 11:55 A conducted with NA #4 and worked on the fac stated this was her fir she was provided brie transmission of COVI requirements for hand donning and doffing F exiting resident rooms were occasions she h washed her hands as trying to respond to re up the unit. NA #4 sta do everything and did entering or exiting ever	F 880

Facility ID: 943387

If continuation sheet Page 16 of 25

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 880 Continued From page 16 NA #4 explained, things have gotten so overwhelming on the unit with two aides and so many residents to look after. NA #4 stated, that she was asked to come to work at this facility and placed on the COVID19 positive unit, and that she was trying to keep the residents clean, fed to the best of her ability. F 880 Observation on 8/17/20 from 11:45 AM to 11:50 AM, revealed Agency NA #5 was observed in a resident 's room cleaning up the soiled linen and trash and placed the items in plastic bags and placed the bags outside of the resident 's room in the 500 hallway. NA #5 exited this resident 's room, but did not remove the PPE, gloves or perform hand hygiene. NA #5 then entered a second resident 's room wearing the same PPE and gloves and provided this resident with requested fluids. NA#5 was observed to exit the second resident 's room without removing PPE, gloves or performing hand hygiene. NA #5 then entered a third resident 's room wearing the same PPE and gloves. While in the third resident 's room NA#5 was observed to touch unclean		-						FORM	D: 10/07/2020
345291 B. WING 09/01/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SO PROSPECT AVENUE CORRECTIVE ACTION (PO) MAIL 10 SUMMARY STATEMENT OF DEFICIENCIES DD PROVIDER'S FLAN OF CORRECTION (PO) MAIL 00 SUMMARY STATEMENT OF DEFICIENCIES DD PROVIDER'S FLAN OF CORRECTION (PO) PREINK (EACH OEDFICINCY WISTE PRECEDED BO POLL REGULATORY OR LSC IDENTIFYING INFORMATION) DD PREVINC F 880 Continued From page 16 F 880 F 880 F 880 F SO PROSPECT AVENUE DEFICIENCY) CONCENT CONCE	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '				(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE UNIVERSAL HEALTH CARE / OXFORD STREET ADDRESS, CITY, STATE, ZIP CODE OXFORD, NC 27565 OXFORD, NC 27565 (X4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR LIS IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 16 NA #4 explained, things have gotten so overwhelming on the unit with two aides and so many residents to look after. NA #4 stated, that she was asked to come to work at this facility and placed on the COVID19 positive unit, and that she was trying to keep the residents clean, fed to the best of her ability. Observation on 8/17/20 from 11:45 AM to 11:50 AM, revealed Agency NA #5 was observed in a resident 's room cleaning up the solied linen and trash and placed the items in plastic bags and placed the bags outside of the resident 's room in the 500 hallway. NA #5 then entered a second resident's room waring the same PPE and gloves and provided this resident with requested fluids. NA#5 was observed to exit the second resident's room waring the same PPE and gloves. While in the third resident 's room NA#5 was observed to touch unclean			345291	B. WING			_		
UNIVERSAL HEALTH CARE / OXFORD OXFORD, NC 27565 [X1] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILLS IDENTIFYING INFORMATION) ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTLY ACTOR SHOULD BE ORDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNET TAG F 880 Continued From page 16 NA #4 explained, things have gotten so overwhelming on the unit with two aides and so many resident so look after. NA #4 stated, that she was asked to come to work at this facility and placed on the COVID19 positive unit, and that she was trying to keep the residents clean, fed to the best of her ability. F 880 Observation on 8/17/20 from 11:45 AM to 11:50 AM, revealed Agency NA #5 was observed in a resident 's room cleaning up the soiled linen and trash and placed the items in plastic bags and placed the bags outside of the resident 's room in the 500 hallway. NA #5 exited this resident 's room, but did not remove the PPE, gloves or perform hand hygiene. NA #5 then entered a second resident 's room wearing the same PPE and gloves and provided this resident with requested fluids. NA#5 was observed to exit the second resident 's room wearing the same PPE and gloves. While in the third resident 's room NA#5 was observed to touch unclean	NAME OF PF	ROVIDER OR SUPPLIER	L	T	ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		•
(M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x0) comment (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 16 NA #4 explained, things have gotten so overwhelming on the unit with two aides and so many residents to look after. NA #4 stated, that she was asked to come to work at this facility and placed on the COVID 19 positive unit, and that she was trying to keep the residents clean, fed to the best of her ability. F 880 Observation on 8/17/20 from 11:45 AM to 11:50 AM, revealed Agency NA #5 was observed in a resident 's room cleaning up the soiled linen and trash and placed the items in plastic bags and placed the bags outside of the resident 's room, but did not remove the PPE, gloves or perform hand hygiene. NA #5 then entered a second resident 's room wearing the same PPE and gloves and provided this resident with requested fluids. NA#5 was observed to exit the second resident 's room wearing the same PPE and gloves. While in the third resident 's room NA#5 was observed to cloud unclean					50	0 PROSPECT AVENUE			
Preferx TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLET IDATE F 880 Continued From page 16 NA #4 explained, things have gotten so overwhelming on the unit with two aides and so many residents to look after. NA #4 stated, that she was asked to come to work at this facility and placed on the COVID19 positive unit, and that she was trying to keep the residents clean, fed to the best of her ability. F 880 Observation on 8/17/20 from 11:45 AM to 11:50 AM, revealed Agency NA #5 was observed in a resident 's room cleaning up the solied linen and trash and placed the items in plastic bags and placed the bags outside of the resident 's room in the 500 hallway. NA #5 exited this resident 's room, but did not remove the PPE, gloves or perform hand hygiene. NA #5 then entered a second resident 's room wearing the same PPE and gloves and provided this resident with requested fluids. NA#5 was observed to exit the second resident 's room wearing the same PPE and gloves. While in the third resident 's room NA#5 was observed to lock unclean	UNIVERSA	AL HEALTH CARE / OXF	ORD		02	XFORD, NC 27565			
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surfaces including tray tables and remote control without cleaning them. On 8/17/20 at 11:58 AM, an interview was conducted with NA #5, who was an agency NA and worked on the facility ' s COVID unit. NA #5 stated he had received very brief training on the transmission of COVID19, infection control practices, handwashing and sanitizing and donning and doffing PPE. NA#5 stated he had worked several shifts back to back and things were getting very frustrating trying to keep residents clean and cared for as well as keeping the unit clean. NA #5 stated that he knew if he was providing care and handling soiled linens, he	F 880	NA #4 explained, thin overwhelming on the many residents to loo she was asked to com placed on the COVID she was trying to kee the best of her ability. Observation on 8/17/2 AM, revealed Agency resident ' s room clea trash and placed the in placed the bags outsi the 500 hallway. NA # room, but did not rem perform hand hygiene second resident ' s ro and gloves and provid requested fluids. NA# second resident ' s ro gloves or performing entered a third reside same PPE and gloves ' s room NA#5 was ob surfaces including tra without cleaning them On 8/17/20 at 11:58 A conducted with NA #5 and worked on the fac stated he had receive transmission of COVI practices, handwashin donning and doffing F worked several shifts were getting very frus residents clean and c the unit clean. NA #5	gs have gotten so unit with two aides and so k after. NA #4 stated, that ne to work at this facility and 19 positive unit, and that p the residents clean, fed to 20 from 11:45 AM to 11:50 NA #5 was observed in a ning up the soiled linen and items in plastic bags and de of the resident ' s room in <i>t</i> 5 exited this resident ' s ove the PPE, gloves or e. NA #5 then entered a om wearing the same PPE ded this resident with 55 was observed to exit the om without removing PPE, hand hygiene. NA #5 then nt ' s room wearing the s. While in the third resident oserved to touch unclean y tables and remote control n. AM, an interview was 5, who was an agency NA cility ' s COVID unit. NA #5 d very brief training on the D19, infection control ng and sanitizing and PPE. NA#5 stated he had back to back and things strating trying to keep ared for as well as keeping stated that he knew if he	F	380				

If continuation sheet Page 17 of 25

DEPARTMENT OF HEA						FORM): 10/07/2020 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345291	B. WING		_		C 01/2020
NAME OF PROVIDER OR SUPP	LIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			5	500 PROSPECT AVENUE			
UNIVERSAL HEALTH CAP	RE / OXF	ORD	(OXFORD, NC 27565			
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
between each have gotten s trying to keep may have wa and not chan resident. NA# care for resid end of shift. During an inte Nurse #3 stat assigned to th was to provid wearing with gown, K95 m shield or gog staff entered explained, all policy and pro PPE and was the spread of During an inte facility ' s Reg stated all staf policies and p return demon sanitizing pra the unit and in fro hand hygiene the resident ' PPE when ex stated all staf	e his PF n residen o busy v up with lked in a ged his l 5 furthe ents and erview o erview o erview o ent facilit e care fr full PPE ask or s gles. and exit staff ha pcedure: hing and the viru erview o gional Ni f were e procedur stration ctices, in lonning d to wor re were must b s room f f assign ected to	PE and wash his hands ht. NA #5 explained, Things with so many residents and care and cleaning and he and out of resident rooms PPE in between each r stated it was too much to d clean an entire unit by the http://www.care.org/action.com/ r each resident while tor each resident while which included gloves, urgical mask, and face d proper handwashing when ed resident rooms. Nurse #3 we been informed of the unit s for donning and doffing d sanitizing hands to prevent	F 880				

Facility ID: 943387

If continuation sheet Page 18 of 25

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 10/07/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345291	B. WING			_		C 01/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / OXF	ORD			00 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		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	when they touched por The RNC indicated st in resident rooms whe use the provided hand direct handwashing w During an interview of Nurse #4 stated prior COVID19 positive uni educated and informe policy and procedures handwashing and sar and doffing PPE. Nurs were infection control signs posted through perform proper hand and doffing PPE when resident rooms. During an interview of Director of Nursing sta COVID19 positive uni PPE (gloves, gown, K and face shield or gos or physical contact wi unit had signage post perform hand hygiene doffing of PPE and dis PPE. The DON expla sanitize hands prior to mask before entering exited resident rooms wash hands in room a exiting and discarded yellow barrels for tras The DON stated, staff their hands when all F	formed resident care and otentially infected surfaces. aff should wash their hands en sinks were available and d sanitizer in areas where ras not available. In 8/17/20 at 12:30 PM, to any staff working the t they would have been ed of the infection control is for COVID 19 positive unit, nitizing practices, donning se #4 further stated there and contact precaution but the unit as a reminder to hygiene and about donning in staff entered and exited in 8/17/20 at 2:15 PM, the ated all staff assigned to the t were required to wear full (95 mask or surgical mask, ggles) when providing care th the resident. The entire ed to remind staff to	F	880				

Facility ID: 943387

If continuation sheet Page 19 of 25

	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	NG _			
							C
		345291	B. WING			09/	01/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	500 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		0	OXFORD, NC 27565		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE .	DATE
F 880	Continued From page	e 19	F	880)		
	resident room or com	mon areas wearing the					
	same PPE after they	provided care or assistance					
	to a resident. The DO	N stated every resident					
	room on the facility 's	COVID unit had a full PPE					
	cart in front of the roo	m ' s doorway which					
	included full covering	PPE and hand sanitizer.					
	During a telephone in	terview on 8/27/20 at 2:48					
	PM, the Chief of Nurs	ing Officer for the facility ' s					
	contracted staffing ag	ency stated the staffing					
	contract with the facili	ity was established on					
	7/16/20 with the agree	-					
	responsible for onsite						
		tion control prior to the staff					
	member 's placemen	t and to determine the					
	adequacy of each em	ployees ' job performance.					
	The administrator way	s notified of immediate					
		at 11:39 AM. The facility					
		credible allegation of					
	immediate jeopardy r						
	F 880 INFECTION P	REVENTION AND					
	CONTROL						
		ients who have suffered, or					
		serious adverse outcome as					
	a result of the noncor	•					
	-	ollow its Infection Prevention					
	-	as evidence by a quarantined					
		hit with (23) residents having					
		ined/uncovered soiled linen					
		allways and/or resident					
	rooms, staff not perfo						
		d a shower room with black					
		vall on quarantine unit. The					
	-	e infection control training					
		aff members (NA #4 and					
		ency staff did not have a					
	diagnosis of COVID-1	9. Hospice CNA and RN					

Facility ID: 943387

If continuation sheet Page 20 of 25

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/07/2020 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345291	B. WING		_		C 01/2020
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	00 PROSPECT AVENUE			
UNIVERSA	AL HEALTH CARE / OXF	ORD		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 CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 880	Continued From page Supervisor who were have training on infect and this training is in the facility. The first positive staff reported to the facility 7/16/2020, the facility from work. The facility was implemented and exposure to this posit moved to a quarantine investigation (PUI) roo COVID-19. The secon Supervisor) member symptoms of COVID- on 7/14/2020. Mid-shif feel well. This employ being tested by facility results on 7/16/2020, employees were exclu- quarantined for 14 da mass testing of all res 7/14/2020 - 7/15/2020 monitored residents for COVID-19. The facility resident placement por suspected residents w COVID-19 to a dedica under investigation (P and quarantined a min residents ' symptoms	e 20 positive for COVID-19 did tion control and prevention their education file in the member (Hospice CNA) that she was positive on immediately excluded her resident placement policy any resident who has ive staff member was ed person under om and tested for nd positive staff (RN was screened for signs and 19 upon reporting to work ift, she stated she did not ee was sent home after y staff. Her COVID-19 was positive. Both uded from work and ys. The facility implemented sidents and staff on 0. The facility routinely or signs and symptoms of y continued to utilize our olicy and relocated all with signs and symptoms of ated unit called persons CUI) and immediately tested nimum of 14 days. These is were monitored routinely e. Despite these efforts,	F 880			TE	DATE
	increased COVID-19 (2) to sixteen (16) after completed. From 08/0 mass testing was com	positive residents from two er mass testing was 06/2020 to 08/12/2020 after					

Facility ID: 943387

If continuation sheet Page 21 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/07/2020 MAPPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DAT	E SURVEY IPLETED		
		345291	B. WING			C 09/01/2020		
NAME OF PI	ROVIDER OR SUPPLIER		I	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
				50	00 PROSPECT AVENUE			
UNIVERSI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	From 08/19/2020 to 0 increased positive CO forty-seven to (73) por Total facility census of residents. The facility Prevention and Contr (2) two agency staff in potentially lead to the positive residents and evident by observation /COVID-19 unit positi unit upon observation uncontained/uncover floor in hallways and/ shower room with bla on quarantine unit. At agency staff were not between residents an donning/doffing perso On 8/28/2020, the en resident rooms, hallw doors to enter and ex cleaned by Housekee After cleaning comple by the Assistant Direc Housekeeping Super sanitary orderly envir identified. 2) Specify the action the process or system adverse outcome from	psitive COVID-19 residents. p8/26/2020 the facility DVID-19 residents from (47) psitive COVID-19 residents. In 8/26/2020 was 118 y failed to follow its Infection to policies and training of the n infection control which increase in COVID-19 d staff in the facility. This is ons of the quarantined ve with 23 residents. This is revealed soiled floors, ed soiled linen and trash on or resident rooms and a teck substance noted on wall dditionally, the (2) two t performing hand hygiene id inappropriately onal protective equipment. tire quarantine unit including rays, shower room and the it the quarantine unit were eping and Nursing Staff. eted, this area was inspected ctor of Nursing and visor to ensure a clean, onment. No issues were the entity will take to alter n failure to prevent a serious n occurring or recurring, and	F	880				
	Nurse Consultant/Ad of all other nursing ur	rector of Nursing/Regional ministrator conducted a tour hits to ensure the appropriate tices including proper						

Facility ID: 943387

If continuation sheet Page 22 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		PLE CONSTRUCTION	(X3) DATE COMF		
		345291	B. WING			09/01/2020		
NAME OF P	ROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZI		1 00,	•	
					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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 880	(PPE), hand hygiene, handling, containmen orderly sanitary enviro identified were immed 08/27/2020, the facilitic contract was terminat will be provided by an On 8/28/2020, the Ho established a new clei includes all areas in th hallways, shower root On 8/28/2020, House educated housekeepi resident room cleanin (including shower root hi-touch cleaning of fr as nursing station cou- telephones, and hand orderly and sanitary of Additionally, educatio and trash handling, co disposal. All new hire their orientation perior On 08/28/2020, all sta were re-educated by regarding the facilities Prevention and Contr donning/doffing of perior (PPE), cough hygiene and trash handling, co disposal and ensuring environment. Any sta 08/28/2020 will not be educated. All new hire	rsonal protective equipment soil linen and trash t, and disposal and clean, onment. Any issues diately corrected. Effective y housekeeping services ed. Housekeeping services nother company. usekeeping Supervisor aning schedule which he facility (resident rooms, ms and common areas). keeping Supervisor ng staff on expectation of g schedule, common area m) cleaning schedule and requently used items such unters, keyboards, lrails to ensure clean, conditions of the facility. n was provided on soil linen ontainment, and proper es will be educated during d. aff (including agency staff) Director of Nursing s policy on Infection ol including proper rsonal protective equipment e, hand hygiene, soil linen ontainment and proper g a clean, orderly sanitary ff not re-educated by	F	88				

Facility ID: 943387

If continuation sheet Page 23 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/07/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345291	B. WING				C 01/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		000			500 PROSPECT AVENUE		
UNIVERS	AL HEALTH CARE / OXF	ORD		0	OXFORD, NC 27565		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREF	IX	(EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
					DEFICIENCY)		
F 880	Continued From page	23	F	880			
		ontracts with three staffing		000			
		dequate nursing staff in the					
	•						
		d outbreak. Additionally, the eview staffing to ensure					
		This staffing reviews will					
	be conducted by the	•					
		aily. Also, the facility is					
	•						
		State Staffing Waiver to ensed Nurses, Nursing					
		nal Care Assistants to					
	supplement staffing.						
		censed Nurses and Nursing					
		/ posted on a job posting					
		evelopment Coordinator will					
		ig website for applicants					
	daily (Monday-Friday						
		g company to provide					
		es to the entire community					
		ined units to ensure a clean,					
	sanitary, and orderly	environment.					
		the Administrator and					
		ill be ultimately responsible					
	to ensure implementa	•					
		ged noncompliance to					
	ensure the facility ren	nains in substantial					
	compliance.						
		e removal of immediate					
	jeopardy on 8/28/20.						
		ing corrective actions are					
	sustained.						
		the facility ' s credible					
		ate Jeopardy removal, with					
		dy removal date of 8/28/20					
	was validated as evid	enced by licensed and					
	non-licensed, new hir	es and agency staff					
	interviews, facility trai	ning that included infection					

Facility ID: 943387

If continuation sheet Page 24 of 25

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 10/07/2020 FORM APPROVED OMB NO. 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 09/01/2020		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			ATE, ZIP CODE		
UNIVERSAL HEALTH CARE / OXFORD				500 PROSPECT AVENUE OXFORD, NC 27565				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	ICED TO THE APPROPRIA		(X5) COMPLETION DATE
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If continuation sheet Page 25 of 25