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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Oxford	500 Prospect Avenue Oxford, NC 27565

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review and interviews with staff and resident, the facility failed to maintain a resident's dignity when Housekeeper #1 spoke to Resident #13 in a demeaning manner regarding the cleanliness of his room and cursed at the resident. This deficient practice affected 1 of 3 residents reviewed for dignity. Findings included: Resident #13 was admitted on [DATE]. A witness statement written by Housekeeper #2 indicated on 3/03/24 at 2:20 PM she had been making rounds on the hall when she heard and saw Housekeeper #1 in Resident #13's room, cursing him. On 07/03/24 at 8:51 AM an interview with Housekeeper #2 was conducted. She stated on 3/03/24 she had been in the hallway talking with Housekeeper #1 who was talking directly to Resident #13 who was in his room. Housekeeper #1 cursed at Resident #13 and said things about his lack of cleanliness. She explained after Housekeeper #1 had said curse words, he (Housekeeper #1) left the hall, and she did not see him again and thought he had may have been sent home. She stated she immediately reported the incident to Minimum Data Set (MDS) Nurse #1 and wrote up a statement about what happened. She stated the incident happened quickly and she did not understand what had triggered Housekeeper #1. Housekeeper #1 was unable to be contacted for an interview. On 7/03/24 at 9:44 AM an interview with MDS Nurse #1 was conducted. She stated on 3/03/24 when she arrived at the facility, Resident #13 was sitting in the dining room, and he told her the housekeeper (Housekeeper #1) just cursed at him. After talking with Resident #13, he went back to his room. MDS Nurse #1 stated she verified Housekeeper #1 had left the building before she arrived. She stated Housekeeper #2 reported to her she had witnessed the event and wrote a statement. Resident #13's most recent quarterly Minimum Data Set (MDS) dated [DATE] indicated he was cognitively intact. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #13 was conducted on 06/30/24 at 11:32 AM. Resident #13 explained a while ago a staff member had cursed at him. He stated he had no idea what the staff member had been upset about and had not experienced anything like that before or since. He stated the Administrator had spoken with him about what happened, and he had no further concerns regarding this incident. He stated he had not seen that staff member since then and was not afraid of anyone. Resident #13 stated his roommate (Resident #43) had been present when the incident occurred. An interview with Resident #43 was conducted on 06/30/24 at 11:42 AM. He stated he did not recall anyone cursing at his roommate and had not had anyone speak inappropriately to him. An interview with the Administrator was conducted on 7/03/24 at 4:31 PM. She stated on 3/03/24 staff had ensured Housekeeper #1 had left the facility and Resident #13 was safe.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on observation, resident and staff interview, the facility failed to maintain clean and sanitary resident rooms for 2 of 13 rooms on the 500 hall (rooms [ROOM NUMBERS]) observed for clean and homelike environment. The findings included: a. An observation on 6/30/24 at 10:40 AM, revealed the floor in room [ROOM NUMBER] was noted to be sticky with spilled food particles and multiple pieces of paper lying on it. On 6/30/24 at 11:06 AM, an observation and interview was conducted with the resident who resided in room [ROOM NUMBER]. The resident stated he had accidentally dropped candy and snacks on the floor last night. He further stated he left his room after breakfast with the hope that housekeeping staff would clean his room. He stated the housekeeping staff were supposed to clean his room in the morning, however, it had not yet been cleaned. b. An observation of room [ROOM NUMBER] was conducted on 6/30/24 at 11:20 AM. The floor was observed to be sticky. There were 2 empty, crumbled wipes packets (one near the side of the bed and one near the foot of the bed) and pieces of paper on the floor. The packets appeared crumbled and the trash can beside the bed was overflowing with trash. There was a biohazard bin (red color container) near the entrance of the door, which was overfilled with personal protection equipment (Gowns and gloves), which were visible coming out of the container. The couch in room was placed upside down on one side of the room. The side table appeared dusty with visible stains and sticky patches on the surface. An observation of room [ROOM NUMBER] was conducted on 6/30/24 at 1:00 PM. The floor did not appeared to be swept and mopped. The floor appeared sticky and dirty. The 2 crumpled wipes packets were still on the floor. The trash can beside the bed was emptied, but there was an empty trash bag and dirty bed linens on the floor, beside the bed. The couch was still inverted. The biohazard bin was not yet emptied. During an interview on 7/3/24 at 11:30 AM, Housekeeper #3 indicated she was usually assigned on the 500 hallway. She further indicated that she was on the schedule to work the weekend of 6/29/24 and 6/30/24 but had to call out as she had pneumonia. Housekeeper #3 stated she cleaned the resident's rooms daily and this included emptying the trash cans. She added nurse aides were responsible to remove the biohazard waste and place any soiled clothes in the plastic bag for laundry staff to pick them up. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24 at 11:40 AM, Housekeeper #4 indicated that he was a floor tech, but was working as a housekeeping staff for 400 and 500 hallway over the weekend (6/29/24 - 6/30/24) as the assigned staff had called out sick. He further indicated he had started cleaning rooms from 400 hallway and was unable to clean the rooms on the 500 hallway till later that morning. Housekeeper #4 stated he had cleaned the room [ROOM NUMBER], as it had a lot of food on the floor. Regarding room [ROOM NUMBER], he indicated he had observed the overflowing thrash can, and the overflowing biohazard waste bin. He indicated that both were emptied, and clean bags were placed in them. Housekeeper #4 stated he did observe the furniture was inverted and not properly placed in the room. Housekeeper #4 further stated he thought that the maintenance staff were working in the room hence did not report or rearrange the furniture. Housekeeper #4 indicated he thought he had thoroughly cleaned the floor, dusted and disinfected the other furniture in the room. He indicated he did not notice any clothes on the floor. During an interview on 7/3/24 at 11:50 AM, the Maintenance Director indicated the entire 500 hallway and rooms were disinfected last week (6/27/24) as one of the Nurse aides had seen a bedbug on her shoe. The exterminator was called, and the rooms were sprayed. It was during that time that furniture was turned over. The Maintenance Director stated he had forgotten to put the furniture back properly and it was only on Monday (7/1/24) when he noticed that the resident room furniture was not arranged. He set up the furniture on Monday. During an interview on 7/03/24 at 12:23 PM, the Housekeeping Manager stated during the week there were 5 housekeeping staff (1 housekeeping staff for each hallway) and during the weekends there were only 4 housekeeping staff available to clean the resident's rooms. There was only one housekeeping staff assigned to 400 and 500 hallway over the weekend. The Housekeeping Manager further stated that the Assistant Manager was available on the weekends and did an audit over the weekend. She indicated she did not receive any report from the Assistant Manager regarding the rooms not been cleaned on Monday (7/1/24). The Housekeeping Manager stated the biohazard bin was emptied by the Maintenance Director. The housekeeping staff were responsible for emptying the trash can and removing linen on the floor. The Housekeeping Assistant Manager was unavailable to be interviewed. During an interview on 7/3/24 at 3:07 PM, the Administrator stated the 500 hallway was a rehab hallway and the residents in the hallway had different acuity levels and the rooms and hallway required more frequent cleaning. She further stated all resident rooms should be cleaned daily and trash should be disposed of as needed by the housekeeping staff. The biohazard bin should be emptied as needed. The Administrator stated there should be the same number of housekeeping staff on the weekends as there were on the weekdays. All efforts should be made to ensure all resident's rooms were clean and sanitary. The Administrator stated the pest control company had disinfected all the rooms on the 500 hallway on Thursday (6/27/24) due to a single occurrence of bed bug in a newly admitted resident's room. The entire hallway was sprayed, and all protocol followed due to this incident. The Administrator stated the furniture should have been placed back appropriately in all resident's rooms. The Administrator stated the facility Housekeeping Manager and Maintenance Director were responsible for ensuring the facility was clean and furniture properly placed for the safety of all the residents.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38077 Based on observations and staff interviews, the facility failed to post the daily nurse staffing information to residents and visitors for 1 of the 4 days (6/30/24) of the survey period. Finding included: On 6/30/24 during facility initial tour and multiple observations throughout the day including at 9:20 AM and at 1:30 PM, the daily nurse staffing sheet posted near the facility lobby was dated 6/28/24. The posting was not updated to reflect the current date, census, and staffing information. During an interview on 7/3/24 at 2:17 PM, the Scheduler stated she was responsible for completing the staffing information for the week. On Friday, she completed the staff postings from Friday to Monday. These forms were given to the Administrator. The Administrator was responsible for posting the information in the front lobby daily. During an interview on 7/3/24 at 4:00 PM, the Administrator stated the nurse staff posting should be posted daily. The Administrator indicated the Staff Development Coordinator was responsible for ensuring that the daily nurse staffing sheet was accurately completed and was posted in the lobby during the weekend. The Administrator indicated she oversaw the process and ensured the daily nurse staffing sheet was posted and was clearly visible for residents and visitors. The Staff Development Coordinator was unavailable to be interviewed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35122 Based on record review, observations, and staff interviews, the facility failed to secure medications, date opened multi dose medications, and discard expired medications for 3 of 7 medication observations (400 hall medication cart, 500 hall medication storage/prep room, and the100 hall medication cart). Findings included: 1. On 7/03/24 at 10:43 AM the 400 hall medication cart was reviewed with Medication Aide #1. The following were discovered during the review: a. Thirty-two loose unidentifiable tablets in the bottom of the right side second and third drawers. b. One lidocaine 1% 20 milliliter (ml) multidose vial without its security cap with and no opened-on date noted. c. Two lidocaine 1% 10 ml multidose vials without security caps and with no opened-on dates noted. d. One Latanoprost 0.005% eye drops with a prescription filled on date of 4/15/24. Observed with date opened 4/12/24 and an expires 6 weeks after opening 5/22/24 notation. On 7/03/24 at 11:20 AM an interview with Nurse #2 was conducted. She stated the multidose injectable lidocaine vials should have been marked when they were opened and the eyedrops should have been discarded 6 weeks after opening according to the instructions on the prescription package. On 7/03/24 at 11:56 AM an interview with the interim Director of Nursing (DON) was conducted. She stated she expected all medications to be marked when opened and discarded when expired. 2. On 7/03/24 at 11:30 AM the 500 hall medication room was reviewed with Nurse #3. The following were discovered during the review: a. One acetaminophen 650 milligram (mg) rectal suppository with an expiration date of 12/2020 was discovered in the drawer under the medication refrigerator. b. One COVID19 mRNA vaccine with an expiration date of 4/24/2024 was discovered in the refrigerator. An interview was conducted on 7/03/24 at 11:35 AM with Nurse #3. She stated expired medications should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/03/24 at 11:56 AM an interview with the interim Director of Nursing (DON) was conducted. She stated she expected all medications to be marked when opened and discarded when expired. 20906 3. An observation was conducted on 7/3/24 at 9:00 AM-9:10 AM, the medication cart on the 100 hall was left unattended with the medication (2) tablets of Renvela 800 milligrams- Sevelamer carbonate in the medication bubble card in the right corner on top of the medication cart . Nurse #4 left the medication cart to administer medication to another resident at 9:00 AM and did not return to cart until 9:10 AM. An interview was conducted on 7/3/24/24 at 9:10 AM, with Nurse #4 who stated her intentions was to discard the medication card because it was empty, and she did not see the leftover medication in the card. She further stated the medication should not have been left unsecured and she should have checked to make sure the medication card was finished. An interview was conducted on 7/3/24 at 9: 55 AM, with the Administrator who stated all medications should be secured in the medication cart or discarded properly when they are finished. The nursing staff should not leave any medication unattended at any point in time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20906 Based on observations and staff interviews, the facility failed to keep food preparation areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the floor and ceiling vents located over the food prep and food service area. This practice had the potential to affect food served to residents. The findings: During a kitchen tour on 6/30/24 at 9:34 AM, the following observations were made with the kitchen Cook/Dietary Aide: a. The 6- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills. b. The 2-compartment ovens had a heavy grease build-up, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where food was being cooked. There was a dried grease buildup observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven. c. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. The fryer had heavy grease and food build-up inside and outside, food products behind the fryer. d. The floor underneath the stove, fryer, steamer, and ovens had large amounts of dried food, grease puddles and trash. e. The 3 plate warmers had 2 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around. f. The 5-compartment steam table had floating food particles in standing water, the lids of the steam table had large volumes of dried food and greasy build up around edges. g. The 2 ceiling vents and 2 air conditioning units had large volumes of black dust/debris blowing over food service and prep surfaces. An observation was conducted on 6/30/24 at 10:04 AM, the Cook/ Dietary Aide confirmed the 2 rows of clean plates in the plate warmer and 3 rows of clean plate bases into the base warmer. When asked when the last time was the plate and base warmer had been cleaned the response was I don't know, and I am not sure if there was a cleaning checklist. Dietary Aide stated there were not enough staff to clean and cook and they were doing the best they could to get things done and the meal served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/30/24 at 10:50 AM, the Dietary Manager and Kitchen Supervisor stated the kitchen staff were required to wipe down kitchen equipment after each meal and deep cleaned weekly in accordance with the kitchen cleaning checklist. The DM and Kitchen Supervisor further stated they were responsible for ensuring the kitchen staff kept the equipment clean and orderly. The Dietary Manager (DM) and Kitchen Supervisor acknowledged the identified kitchen equipment, the floors, ceiling fan and air condition units had not been cleaned in accordance with the checklist. The DM stated all cleaning checklists and responsibilities would be updated and available for all kitchen staff. An interview was conducted on 7/2/24 at 12:10 PM, the Administrator who stated the dietary manager and kitchen supervisor was responsible for ensuring the kitchen was cleaned and maintained. The Administrator stated the expectation would be for the Dietary Manager to ensure all kitchen cleaning protocols were in place and followed in accordance with kitchen sanitation guidelines. She further stated the Maintenance Director was responsible for ensuring the kitchen ceiling vents/fans were cleaned monthly. She indicated a kitchen and maintenance audit would be conducted to assess the environmental and dietary needs of the facility. An interview and observation were conducted 7/2/24 at 3:44 PM, the Maintenance Director who stated the fans and kitchen vents had not been cleaned in several months and confirmed that they needed to be done it was an oversight on his part.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 20906 Based on observations, and staff interviews, the facility failed to ensure the garbage and refuse was disposed of and keep 4 of 4 dumpsters and surrounding area clean and free from debris. The findings included: During an initial tour observation on 6/30/24, at 9:54 AM, revealed 4 dumpsters located near a wooded area at the back of the facility had large amounts trash bags of garbage and refuse overflowing from the tops and loose paper products, boxes and loose food products outside of containers on the ground and surrounding areas. A follow-up observation and interview were conducted on 7/2/24 at 12:00 PM, with the Dietary Manager revealed the trash bags filled with garbage left on the ground had been removed, however the surrounding area had not been thoroughly cleaned evidence by the remaining paper and food products was still on the ground around the sides and backs of the dumpsters. The Dietary Manager stated the dietary staff were responsible for cleaning the 3 smaller dumpsters daily and the larger rental dumpster should have been emptied on 6/28/24. The rental company did not come to empty the larger rental dumpster after several calls had been made by administrator and maintenance director. An interview was conducted on 7/2/24 at 12:10 PM, the Administrator who stated the dietary manager and kitchen supervisor were responsible for ensuring the dumpsters and surrounding area were clean and maintained. She was aware the company for the rental dumpster had not emptied the dumpster by the 6/28/27 as scheduled. She had contacted the company for removal and the dumpster would be emptied immediately.