STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted on 3/6/20 to 3/7/20. One of the nine allegations was substantiated.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		3/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/16/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 1	F 585		

(meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 2 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and family interview the facility failed to follow through on grievances lodged by family members for two (Resident #5 and Resident #6) of four residents reviewed for grievances. Findings included: 1. Resident #5 was readmitted to the facility on 1/3/20. Documentation on the most recent quarterly minimum data set assessment dated 1/10/20 coded the resident as cognitively intact with no behaviors and requiring extensive assistance of two people for bed mobility. Documentation on the same assessment revealed Resident #5 did not do any walking or locomotion during the assessment period.	F 585	F585 On March 10, 2020, the social worker provided the follow up information to resident #5 and resident #6 concerning the grievances lodged by the family members. The information provided to them included the fact that the grievance had been noted, investigated and how it was investigated, and the fact that interventions were put in place to prevent this from reoccurring. This was provided in writing to both patients. The actual complaint had already been investigated by the Social Worker and ADON on 2/24/20 and an intervention was put in place to attempt to prevent a wandering resident from entering their	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 3 Resident #3 was admitted to the facility on 7/16/18. Documentation on a quarterly minimum data set assessment dated 1/23/20 coded the resident as severely cognitively impaired, with a wandering behavior that occurred 1 to 3 days during the assessment period. Resident #5 was interviewed on 3/6/20 at 10:15 AM. Resident #5 revealed that Resident #3 had come into his room three times on the prior evening (3/5/20). He indicated he was concerned for the safety of Resident #3 because at night there was usually one nurse aide for the hall. He recounted Resident #3 had pulled on his covers at night while he was sleeping. He declared he did not want wandering residents to come into his room. An interview was conducted on 3/7/20 at 6:59 AM with a nurse aide (NA #1) who was assigned to care for Resident #3 on the 11:00 PM to 7:00 AM shift beginning on 3/6/20. NA #1 revealed that Resident #3 does wander throughout the facility, but everyone watches out for her, including the other residents. NA #1 revealed that the staff on other halls would let her know if Resident #3 was where she shouldn't be, so Resident #3 could be returned to her hall but occasionally she could slip by the staff monitoring her. NA #1 offered that Resident #3 "loved" to go to the hall for which Resident #5 resided and "we don't know she is up there." An interview was conducted with the facility social worker at 9:14 AM on 3/7/20. The social worker revealed she had received a phone call from a family member of Resident #5 a couple of weeks ago but could not recall the exact date. The social worker indicated the family member of Resident	F 585	room. The intervention included a mental health reassessment, a stop sign was placed on the door and additional monitoring of the resident was implemented. The department managers and all staff were re-educated on the importance of documentation of all grievances by the Administrator, staff development coordinator and /or department managers starting on 3/13/20 and will be completed on 3/16/20. Education included the importance of reporting all grievances received to the Administrator and/or the Social Worker. The SW and/or the Grievance Coordinator will then log all grievances, both written and verbal, on the grievance log, the importance of immediate investigation by the appropriate department manager and follow up with the complainant within 72 hours verbally and in writing. During the morning stand up meeting, held each morning Monday through Friday and attended by all Department Managers, any written and verbal grievances or concerns voiced by a resident and/or responsible party will be reviewed. Each grievance will be posted on the clinical white board and will remain posted until the grievance has been investigated and results returned to the complainant. Any person not reporting a grievance and any department manager not investigating the grievance will receive disciplinary action that may include termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 4 #5 brought to her attention that a wandering female was going into the room of Resident #5 at night and this needed to stop. The social worker related that she did not write the concern from the family member as a grievance but brought the information to the morning clinical meeting so, the issue could be addressed as a team. The social worker thought that the resolution that was decided on by the team was a mental health consult for Resident #5. The social worker stated that she had not gone to talk to Resident #5 about the wandering resident and she herself had not communicated with the family member to let him know a resolution was being attempted for the concern of a wandering resident. The social worker was unaware if any other staff members had responded to the family member of Resident #5 regarding his concern. An interview was conducted with the family member of Resident #5 on 3/7/20 at 10:24 AM. The family member confirmed that he had called the social worker a couple of weeks ago regarding a wandering female resident coming into the room of Resident #5. The family member stated he had not received any response from the facility on this issue. Documentation on a list of grievances for the month of February 2020 did not include any concerns regarding Resident #5 or Resident #3. An interview was conducted on 3/7/20 at 4:00 PM with the facility Administrator. The Administrator recalled hearing a concern regarding the wandering of Resident #3, but he could not recall on which day it was. The Administrator confirmed the concern was not written up as a grievance and indicated it was not presented to him as a	F 585	Results of the audit will be reported to the QAPI committee monthly by the Social Worker for 3 months and then every 6 months for a period of one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 5	F 585		

grievance. The Administrator indicated the process for handling grievances could be improved.

2. Resident #6 was initially admitted to the facility on 7/20/18. Documentation on the quarterly minimum data set assessment dated 1/27/20 coded the resident as cognitively intact with no behaviors. Documentation on the same assessment coded the resident as not walking during the assessment period.

Resident #3 was admitted to the facility on 7/16/18. Documentation on a quarterly minimum data set assessment dated 1/23/20 coded the resident as severely cognitively impaired, with a wandering behavior that occurred 1 to 3 days during the assessment period.

An interview was conducted on 3/7/20 at 6:59 AM with a nurse aide (NA #1) who was assigned to care for Resident #3 on the 11:00 PM to 7:00 AM shift beginning on 3/6/20. NA #1 revealed that Resident #3 does wander through out the facility, but everyone watches out for her, including the other residents. NA #1 revealed that the staff on other halls would let her know if Resident #3 was where she shouldn't be, so Resident #3 could be returned to her hall but occasionally she could slip by the staff monitoring her. NA #1 offered that Resident #3 "loved" to go to the hall for which Resident #6 resided and "we don't know she is up there."

Resident #6 was interviewed on 3/6/20 at 10:02 AM. Resident #6 related that he never gets out of bed and Resident #3 came into his room at night and tried to crawl into bed with him. Resident #6 insisted Resident #3 continues to come into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 6	F 585		

room and if he told her to get out, she would "pitch a fit." Resident #6 revealed he told the social worker about unwanted visits to his room by Resident #3, during a recent care plan meeting held in his room. Resident #6 indicated a family member called the business office manager to relay a concern about a wandering resident coming into the room of Resident #6. Resident #6 complained that nothing was being done to stop Resident #3 from coming in his room.

An interview was conducted with the facility social worker at 9:14 AM on 3/7/20. The social worker confirmed that a care plan meeting for Resident #6 was held in his room on 1/28/20. The Social Worker denied discussing a concern regarding Resident #3 coming into the room in that care plan meeting. She indicated she would have written down and addressed the concerns of Resident #6 if he had any at that time.

An interview was conducted with the business office manager on 3/7/20 at 10:34 AM. The business office manager confirmed that a family member for Resident #6 did call her a couple weeks ago regarding a concern for a wandering female resident coming into the room of Resident #6. The business office manager added that the concern was that the female resident was hard to redirect. The business office manager indicated she was not given a name, but she assumed the family member was referring to Resident #3. The business office manager stated that the phone call was after the morning staff meeting so she went to the Administrator to see if a Velcro stop sign could be purchased for the doorway of Resident #6 to impede Resident #3 from entering the room. The business office manager did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING ______ B. WING ______	C 03/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 7 think that the family member wanted a formal response back regarding the concern she voiced. The business office manager stated, referring to the family member, "I told her if I needed her I would call her back, but she didn't ask to be called back." The facility maintenance director stated on 3/7/20 at 11:35 AM, "I need to put a stop sign on [Resident #6's] door." A stop sign was observed on the door of Resident #6 on 3/7/20 at 11:37 AM. Documentation on a list of grievances for the month of February 2020 did not include any concerns regarding Resident #6 or Resident #3. The facility Administrator was interviewed on 3/7/20 at 4:00 PM. The Administrator recalled hearing a concern regarding the wandering of Resident #3, but he could not recall on which day it was. He remembered the business office manager telling him of the concern for the wandering of Resident #3. He recalled asking central supply to order a Velcro stop sign to affix to a doorway. The Administrator stated he knew the staff were watching Resident #3 more but could not say if she had been in the room of Resident #6 lately. The Administrator indicated the process for handling grievances could be improved.	F 585		