STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	**05/27/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the facility's policy related COVID-19 pandemic guideline the facility failed to implement their policy about staff wearing facemasks, when 3 of 14 staff members were observed in resident care areas either not wearing a facemask or had a face mask on that did not cover their nose. This failure was observed during the COVID-19 survey. Findings included: Review of the facility's resident placement, COVID - 19 pandemic guideline which was revised 5/26/20 and effective 3/31/20 indicated all healthcare professionals and housekeeping staff should wear a mask as personal protection equipment (PPE) while working in unaffected area, except for nebulizer treatment were N95 and eyewear were used as PPE. For healthcare professional working in the new admission area, the PPE includes disposable sleeves, plastic apron, cloth gown and masks. N95 and eyewear for nebulizer treatment. The signage used in this area was contact precaution and PPE sequence. Review of the facility self-assessment dated [DATE], under infection prevention and control practices revealed the facility has implemented universal use of facemask for all staff, residents and visitors while in the facility. 1. On 5/26/20 at 12:15 PM, Restorative Nurse Aide (NA) #1 was observed distributing lunch to Resident #2. The NA's facemask was not properly secured. The facemask did not cover NA's nose and was resting above the lip and below the nose. The NA #1 placed the food tray on the over-the-bed table, moved the table, continued to set up the meal tray for the resident and adjusted the resident to a comfortable position on his bed. The NA exited the room performed hand hygiene and continue to take another tray for another resident on the hallway with her face mask not covering her nose. During an interview on 5/26/20 at 12:17 PM, NA #1 stated she was not aware that her facemask was not properly secured and that her mask kept slipping off even with a clip across her head. She further stated she was aware she could get a new facemask if the facemask got dirty or if it became loose. During an interview with the Director of nursing (DON) on 5/26/20 at 1:30 PM, she stated all staff were provided multiple training related to proper use/wear of PPE including face masks. She stated as staff had to wear face mask for the entire shift, the staff were also provided with clip that went around the head and could hold the face mask in place. She indicated that staff should be discarding their facemask if when soiled, torn or loose and wear a new one. During an interview on 5/27/20 at 4:33 PM, the Administrator stated that all facility staff should be wearing a facemask while in the facility. Administrator indicated the facility had adequate supply of facemasks and staff should be wearing them appropriately, change them when needed. 2. On 5/26/20 at 12:35 PM, Nurse #1 was observed on the hallway instructing another staff member about a resident's room change. The Nurse was wearing a facemask however, the facemask was not tightly secure and was not covering her nose. Interview with Nurse #1 on 5/26/20 at 12:35 PM revealed she had pinched the face mask multiple times near the nose since morning, that it had probably become loose and had been sliding down her nose. Nurse #1 indicated she was aware she needed to wear a new one and that she knew where she could obtain a new mask if needed. During an interview with the Director of nursing (DON) on 5/26/20 at 1:30 PM, she stated all staff were provided multiple training related to proper use/ wear of PPE including face masks. She stated as staff had to wear face mask for the entire shift, the staff were also provided with clip that went around the head and could hold the face mask in place. She indicated that staff should be discarding their facemask if when soiled, torn or loose and wear a new one. During an interview on 5/27/20 at 4:33 PM, the Administrator stated that all facility staff should be wearing a facemask while in the facility. Administrator indicated the facility had adequate supply of facemasks and staff should be wearing them appropriately, change them when needed. 3. On 5/26/20 at 12:35 PM, NA # 2 was observed on the isolation/new admission hallway (500 hallway), talking to another NA. NA # 2 was not wearing a facemask. During an interview on 5/26/20 at 12:45 PM, NA# 2 stated she had assisted with resident care and was wearing her full PPE (gown, gloves and face shield with attached mask) during that time. She indicated after discarding the PPE, she had forgotten to put a new facemask on. She was aware that all staff should be wearing a facemask while working in the facility. During an interview with the Director of nursing (DON) on 5/26/20 at 1:30 PM, she stated all staff were provided multiple training related to proper use/ wear of PPE including face masks. She stated as staff had to wear face mask for the entire shift, the staff were also provided with clip that went around the head and could hold the face mask in place. She indicated that staff should be discarding their facemask if when soiled, torn or loose and wear a new one. During an interview on 5/27/20 at 4:33 PM, the Administrator stated that all facility staff should be wearing a facemask while in the facility. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.