STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING ______ B. WING ______	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTHEWS HEALTH & REHAB CENTER	**600 FULLWOOD LANE MATTHEWS, NC 28105**

(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
E 000	Initial Comments An unannounced recertificaton and complaint investigation survey was conducted from 2/2/2025 through 2/6/2025. A surveyor returned to the facility on 2/7/2025 to validate the credible allegation of IJ removal plan. Therefore, the exit date was changed to 2/7/2025. The facility was found in complaince withthe requirement CFR 483.73, Emergency Preparedness. Event ID # UBEL11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertificaton and complaint investigation survey was conducted from 2/2/2025 through 2/6/2025. A surveyor returned to the facility on 2/7/2025 to validate the credible allegation of IJ removal plan. Therefore, the exit date was changed to 2/7/2025. The following intakes were investigated: NC00226454, NC00225407, NC00220139, NC00213892, NC00212369, NC00211767, and NC00211682. 1 of the 24 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.8 tag F880 at a scope and severity of K. Immediate Jeopardy began on 1/18/2025 and was removed on 2/7/2025.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group,	F 565		3/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/06/2025

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.

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F 565	Continued From page 1 to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to provide resolution of Resident Council Meeting grievances for 6 of 6 Resident Council Meetings (08/27/24, 09/24/24, 10/23/24, 11/05/24, 11/20/24, and 12/30/24). The Resident Council had repeated concerns regarding call lights not being answered and snacks not being provided.	F 565	1) Concerns from the resident council that were found to not be followed up on were immediately addressed with the appropriate department/manager. 2) All Residents who attend resident	

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F 565	Continued From page 2 The findings included: On 08/27/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner. The Resident Council Follow-Up form attached to the 08/27/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 09/24/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner. The Resident Council Follow-Up form attached to the 09/24/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 10/23/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner. The Resident Council Follow-Up form attached to the 10/23/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 11/05/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner and snacks were not being offered and provided in the evening. The Resident Council Follow-Up form attached to the 11/05/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council.	F 565	council have the potential to be affected. An audit of concerns brought up by resident council for the last 3 months were reviewed on 2/21/2025 by the Director of Social Work and Director of Activities to ensure that any concerns brought up in resident council were addressed. 3) On 2/25/2025 Administrator educated the Director of Activities and the Director of Social Work on the Resident Council Policy to include ensuring that concerns brought up in resident council are documented on the Resident/Family Concern Form and forwarded to the facility Administrator for the appropriate follow-up. Resident Council Meeting minutes will be reviewed by the Administrator to ensure concerns are being addressed by the appropriate department. 4) The Administrator will audit resident council concerns weekly to ensure follow up and that any concerns were addressed. Audits will be conducted weekly for 12 weeks. Administrator will audit Resident Council Follow-up Form to ensure the facility’s response to grievances is demonstrated. Audit will be conducted monthly for 3 months. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.	

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F 565	Continued From page 3	F 565		

Continued From page 3

On 11/20/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner and snacks were not being offered and provided in the evening.

The Resident Council Follow-Up form attached to the 11/20/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council.

On 12/30/24 the Resident Council Meeting Minutes noted snacks were not being offered and provided in the evening.

The Resident Council Follow-Up form attached to the 12/30/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council.

Interviews conducted with Resident #4, Resident #5, Resident #8, and Resident #81 during the Resident Council Meeting on 02/04/25 at 10:00 AM revealed there had been no resolution with the ongoing concerns of snacks not being provided at night and call bells not being answered in a timely manner. The residents further revealed staff had not discussed or explained how issues with snacks and call bell lights were going to be resolved. The residents felt like facility staff did not care about the ongoing concerns.

An interview conducted with the Activity Director (AD) on 02/04/25 at 10:30 AM revealed she had addressed concerns during stand-up meetings and with department heads but had no documentation to show that concerns were resolved. The AD revealed she had discussed

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F 565	Continued From page 4 concerns in stand-up meetings and the head of the departments were responsible for carrying out resolution to the concerns. The AD stated she was aware issues had been ongoing and had addressed department heads but was unaware of any improvement from issues addressed. The AD indicated sometimes department heads would indicate they had resolved concerns but it was not communicated how concerns were being resolved. An interview conducted with the Administrator on 02/05/25 at 11:30 AM revealed he was not aware grievances and concerns were not being completed and resolved from Resident Council meetings. The Administrator indicated all concerns were addressed at stand-up meetings, but was not aware snacks and call bell lights had been an ongoing issue. The Administrator further revealed he expected concerns to be addressed and followed up on and documentation to be included within the Resident Council minutes.	F 565		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		3/10/25

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and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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F 623	Continued From page 6	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 7 relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, staff and Ombudsman interviews, the facility failed to notify the resident and his family member in writing of a transfer to the hospital for 1 of 3 residents reviewed for hospitalization (Resident #73) and failed to notify the Ombudsman each month of facility transfers and discharges for 3 of 3 months (November 2024, December 2024, and January 2025). The findings included: 1. Resident #73 was admitted to the facility on 6/7/23 and readmitted 1/7/25. A nursing note dated 12/27/24 documented Resident #73 was transferred to the hospital for a change in condition. A nursing note dated 1/7/25 documented Resident #73 was readmitted to the facility after hospitalization for an upper respiratory infection. The quarterly Minimum Data Set assessment dated 1/11/25 assessed Resident #73 to be cognitively intact. Review of Resident #73's electronic medical record revealed no letter of transfer was provided to Resident #73 or his representative. Resident #73 was interviewed on 2/2/25 at 12:27 PM and he reported he was hospitalized for an upper respiratory infection in December 2024 and returned to the facility in January 2025. Resident #73 reported he had not received a letter from the	F 623	1) Resident #73 did not receive notification of discharge or transfer. Facility failed to notify Ombudsman monthly of facility transfers to hospital. 2) All residents have the potential to be affected. On 2/21/2025 the Business Office Manager and Social Worker audited the last 30 days of discharges to the hospital to ensure the Bed Hold Policy and Transfer Policy were provided to residents and/or family and that the Ombudsman was notified. Any issues identified were addressed. 3) On 2/21/2025 the Business Office Manager and Social Workers were educated by the Administrator on sending the Bed Hold and Transfer Policies to the resident's family and/or Responsible Party via certified mail if a resident is discharged to the hospital and notifying the Ombudsman of all discharges monthly. On 2/21/2025 the Director of Nursing and/or Designee educated the Licensed Nurses. Education has been added to orientation for newly hired Social Workers, Business Office Managers and Licensed Nurses.	

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F 623	Continued From page 8 facility regarding his transfer. Social Worker (SW) #1 was interviewed on 2/4/25 at 1:33 PM. The SW reported she was not certain which staff member was responsible for the letters of transfer. The Business Office Manager was interviewed on 2/4/25 at 1:42 PM and she reported she was not certain who was responsible for the letters of transfer. An interview was conducted with SW #2 at 2/4/25 at 4:00 PM and she reported she did not know who was responsible for the letters of transfer. The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator reported the facility had a change in the social work department and the social work department should be writing letters of transfer to the resident and their representative. 2. The record of discharges report from 8/1/24 to 10/31/24 was reviewed. Attached to the report was an email dated 11/4/24 that indicated that the file had been emailed to the Ombudsman. The record of discharges report from 11/1/24 to 12/31/24 was reviewed. Attached to the report was an email dated 1/6/25 that indicated that the files had been emailed to the Ombudsman. There were no discharge reports that had been sent to the Ombudsman for January 2025. An interview was conducted with Social Worker (SW) #1 on 2/4/25 at 12:27 PM. SW #1 reported the former Administrator was sending the list of	F 623	4) To monitor and maintain compliance the Administrator will audit 5 transfer/discharges weekly for 12 weeks to ensure that the Bed Hold and Transfer Policies were sent with the resident to the hospital, the Business Office Manager mailed a copy of the Bed Hold and Transfer Policies to the family and/or Responsible Party via certified mail, and that the Transfer/Discharge Information Observation was completed. Administrator will conduct monthly audit for 3 months to ensure the Ombudsman was notified of transfers/discharges. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.	

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F 623	Continued From page 9 transfers and discharges to the Ombudsman, and when he left the company, she had been told she would be responsible for the communication to the Ombudsman. SW #1 explained that the former Administrator left in July 2024 and the interim Administrator sent the discharge reports to the regional Ombudsman in November 2024. SW #1 explained that she had not emailed January 2025 discharges to the Ombudsman. The Ombudsman was interviewed by phone on 2/5/25 at 11:09 AM. The Ombudsman reported she had not received August, September, or October 2024 discharges until November 2024, and had not received any discharge report from the facility since November 2024. The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator reported the facility had a change in the Administrator and the social work department would be responsible for notifying the Ombudsman of transfers and discharges.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		3/10/25

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F 625	Continued From page 10 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Ombudsman interviews, the facility failed to provide a bed hold notice for 1 of 3 residents reviewed for hospitalization (Resident #73). The findings included: Resident #73 was admitted to the facility on 6/7/23 and readmitted 1/7/25. Diagnoses for Resident #73 included lung disease. The quarterly Minimum Data Set assessment dated 1/11/25 assessed Resident #73 to be cognitively intact. A nursing note dated 12/27/24 documented Resident #73 was transferred to the hospital for a change in condition. A nursing note dated 1/7/25 documented Resident #73 was readmitted to the facility after	F 625	1) Resident # 73 did not receive the bed hold policy at the time of discharge/transfer from facility. 2) All residents have the potential to be affected. On 2/21/2025 the Business Office Manager and Social Worker audited the last 30 days of discharges to the hospital to ensure the Bed Hold Policy was provided to resident, family and/or Responsible Party. Any issues identified were addressed. 3) Director of Nursing and/or designee will educate licensed nurses on the bed hold policy to include giving the resident a copy at the time of	

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F 625	Continued From page 11 hospitalization for an upper respiratory infection. Review of Resident #73's electronic medical record revealed no bed hold notice. Resident #73 was interviewed on 2/2/25 at 12:27 PM and he reported he was hospitalized for an upper respiratory infection in December 2024 and returned to the facility in January 2025. Resident #73 reported he had not received a bed hold notice when he was transferred to the hospital. Social Worker (SW) #1 was interviewed on 2/4/25 at 1:33 PM. The SW reported she was not certain which staff member was responsible for providing the written bed hold notice when a resident was transferred to the hospital. The Business Office Manager was interviewed on 2/4/25 at 1:42 PM and she reported she was not certain who was responsible for bed hold notices. An interview was conducted with SW #2 at 2/4/25 at 4:00 PM and she reported she did not know who was responsible for the bed hold notices. The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator reported the facility had a change in the social work department and the social work should be providing the written bed hold notice to residents or their representative when the resident was transferred to the hospital.	F 625	discharge/transfer. Additionally, the education requires the nurse to the complete the Transfer/Discharge Summary Discharge Observation to document the bed hold policy was sent with resident. The Director of Nursing and clinical team will review discharges during clinical morning meeting daily. The education will be completed by 3/1/2025. This education will be included in new hire orientation and to agency staff. On 2/21/2025 the Administrator educated the Business Office on completing the Medicaid Bed Hold Letter and send to the appropriate parties via certified mail with receipt request. The Medicaid Bed Hold Letter can be given directly to the responsible party if they are present. 4) The Administrator will audit 5 residents to ensure certified letter was sent or given in person. Audits will be conducted weekly for 12 weeks. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		3/10/25

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F 686	Continued From page 12 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Physician interviews, the facility failed to maintain wound vac (negative pressure wound therapy to help heal wounds) treatment as ordered and failed to follow treatment orders for when the wound vac malfunctioned or was broken for stage 4 sacral pressure ulcer for 1 of 3 residents reviewed for pressure ulcer (Resident #318). Findings included: Resident #318 was admitted to the facility on 1/31/25 with diagnoses that included chronic sacral decubitus, type 2 diabetes and peripheral artery disease. The hospital discharge summary on 1/31/25 revealed that Resident #318 was seen for stage 4 sacral full-thickness pressure ulcer with non-viable tissue on admission to the hospital. Resident #318 was found septic due to the infected large sacral pressure ulcer. She received intravenous antibiotics and completed the treatment. Resident #318 deferred surgical intervention and opted wound care with wound	F 686	1) Resident #318 was assessed by the Wound Nurse Practitioner on 2/7/2025. 2) Residents with wounds have the potential to be affected. On 2/17/2025 the Director of Nursing, Assistant Director of Nursing, and Unit Manager reviewed treatment orders for residents with wounds to ensure the correct treatment is in place on the resident. Any issues identified were addressed. 3) Director of Nursing and/or designee will educate licensed nurses on the wound care policy to include following physician’s orders for treatments. Additionally, the education will include what to do if a wound vac malfunctions or the seal breaks. The education will be completed by 3/1/2025. This education will be included in new hire	

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F 686 Continued From page 13

vac. The hospital discharge summary recommended to continue with wound vac after her discharge. It stated that without the wound vac, there would be a high risk of the sacral pressure ulcer to have active infection and potentially leading to worsening clinical status.

The initial admission assessment worksheet dated 1/31/25 revealed that Resident #318 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15.

The admission notes on 1/31/25 revealed that Resident #318 was weak on both upper extremities and unable to bend finger to finger on both hands. The resident had a contracture to her left hand and complained of pain when moving her arms. It was documented that the resident used mechanical lift for transfer and required total care for all activities of daily living (ADL). The skin was dry and warm to touch with a stage 4 sacral wound with wound vac in place.

A physician order on 1/31/25 revealed wound vac therapy at 125 mm/Hg (millimeter of mercury a pressure measurement for the vacuum). The order instruction was to change the wound vac on Monday, Wednesday, and Friday (MWF). The order instruction included that if the wound vac malfunctioned or broken, they can remove the wound vac. Then clean the sacral wound with wound cleanser, fill the cavity with a disinfectant solution to moisten the gauze, and cover with a protective dressing as needed.

The Treatment Nurse wrote on her note on 1/31/25 that she cleaned and applied the wound vac on Friday at 4:12 pm.

F 686

orientation and to agency staff. Any new hires or new agency staff will receive education before being allowed to work on the floor.

4) The Director of Nursing or designee will audit
5 residents with wounds to ensure the treatment orders are being followed by going to the bedside to verify. Audits will be conducted weekly for 12 weeks. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.

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A nurse's note written by Nurse #1 on 2/1/25 at 6:55 pm showed that wound care was completed with wet to dry dressing until the wound vac can be replaced on Monday.

An observation of Resident #318 on 2/2/25 at 11:40 am showed that the wound vac machine was sitting on the windowsill of the resident's room. Resident #318 was lying flat on the bed with no tube connection seen to the wound vac. The resident was too sleepy to talk and excused herself to go back to sleep. A follow-up observation to the room of Resident #318 at 2:37 pm revealed the wound vac machine was still in the windowsill.

Another nurse's note written by Nurse #1 on 2/2/25 at 6:08 pm revealed the wet to dry wound dressing was intact from 2/1/25.

A physician order dated 2/2/25 written by Nurse #1 revealed to treat the sacral pressure ulcer with wet to dry dressing until treatment nurse assess the wound.

Nurse #1 was interviewed on 2/4/25 at 9:00 am. She stated that she did the sacral pressure ulcer treatment on Saturday (2/1/25) with normal saline (NS) wet-to-dry dressing and reinforced the wound dressing on Sunday (2/2/25). She stated she was told by her supervisor to do wet to dry dressing on 2/1/25 when she reported that the wound vac suction was leaking from the dressing. Nurse #1 stated the Treatment Nurse would place the wound vac on Monday (2/3/25). She stated that the wound vac machine was not broken.

An interview with Nurse # 4 on 2/5/25 at 10:41 am revealed she worked on Saturday (2/1/25) and

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F 686	Continued From page 15	F 686		

Sunday (2/2/25) night with the resident. She stated that the wound vac was not in use. She was also told at shift changed that they would use wet to dry dressing when needed.

Nursing Aide (NA) #4 was interviewed on 2/4/25 at 9:29 am and stated that she worked on Baylor Shift (weekend staffing) and took care of Resident #318 on 2/1/25 and 2/2/25. She said there was no wound vac used as she checked and cleaned the resident.

The follow-up observation on 2/3/25 at 9:56 am revealed the wound vac was still on Resident #318's windowsill and was not in use.

The Treatment Nurse was observed on 2/3/25 at 1:55 pm for wound treatment dressing. The Treatment Nurse removed the old dressing from the wound and showed the stage 4 sacral pressure ulcer with tunneling. The Treatment Nurse followed the treatment orders for the wound vac. The wound vac functioned well.

Interview with the Treatment Nurse on 2/3/25 at 2:22 pm stated that the wound vac machine was in proper working order and was not broken. The Treatment Nurse stated that wet to dry (NS) was not acceptable treatment. The use of disinfectant solution with wet gauze was ordered on admission. She further stated that she would discontinue the order on 2/2/25 for wet-to-dry wound dressing.

On 2/5/25 at 9:09 am the Physician was interviewed, and he stated that Resident #318 had a severe sacral pressure ulcer. He stated that wet-to-dry (NS) dressing was not an appropriate treatment and that wound vac should

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F 686	Continued From page 16 have been used. The Physician stated that he was not made aware of the wet-to-dry dressing and that the treatment was not recommended because of the high possibility of infection. He stated that the only time it's acceptable to not have wound vac was when the wound vac malfunctioned or broken, and they would exchange the wound vac machine just for few hours not all weekend or days. Interview with the Director of Nursing (DON) on 2/5/25 at 11:34 am stated the nurses should have followed the treatment order as written. The interview with the Administrator on 2/5/25 at 11:34 am stated that the nurses should have followed the doctor's order and was not aware the wound vac was not used on the weekend.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		3/10/25

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indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff and physician interviews, the facility failed to secure the indwelling urinary catheter to reduce tension for 1 of 2 residents (Resident #3) reviewed for urinary catheter.

Findings included:

Resident #3 was admitted to the facility on 1/13/23 with diagnoses that included neuromuscular dysfunction of bladder.

The physician order dated 7/25/24 was to use indwelling urinary catheter for neuromuscular dysfunction of bladder. There was no order for urinary catheter securing device to be used.

The Minimum Data Set (MDS) dated 11/27/24 revealed Resident #3 was moderately cognitively impaired and was coded to have a urinary

F 690

1. Resident #3 in which the deficient practice was identified was immediately offered a catheter anchor, it was applied.

2. All residents with indwelling catheters have the potential to be affected. On 2/17/2025 an audit was done by Director of Nursing and Assistant Director of Nursing of all residents who have indwelling catheters to ensure that they had a catheter anchor in place, and if they refused to have one, that it was documented and was added to their care plan.

3. All licensed nurses were educated by the Director of Nursing and the Assistant Director of Nursing on ensuring that residents who have catheters have a catheter anchor in place and is secure.

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catheter.

The care plan dated 1/23/25 for the indwelling urinary catheter revealed a goal to have reduced risk for signs and symptoms of Urinary Tract Infection (UTI). The approaches included enhanced barrier precaution, and to assess signs and symptoms of UTI. The care plan, goals, or approaches did not mention securing the indwelling urinary catheter tubing.

An observation on 2/2/25 at 11:44 am revealed Resident #3 was lying on her bed with the indwelling urinary catheter tubing observed on the right side of the bed connected to the urinary drainage bag. The urinary drainage bag was hanging on the right side of the bed. The resident stated that she had had her indwelling catheter for a long time. An observation of the indwelling urinary catheter tubing revealed there was no securing device attached to the urinary catheter. She stated that she didn't know what a securing device looked like and that the nursing staff didn't put any in place.

Resident #3 was observed on 2/3/25 at 9:59 am and 2:31 pm. Both observations revealed the indwelling urinary catheter tubing was not secured.

Another observation of Resident #3 on 2/4/25 at 9:56 am revealed that there was no securing device attached to the indwelling urinary catheter tubing.

An observation of urinary catheter care was conducted in conjunction with an interview with Nurse Aide (NA) #5 and NA #6 at 1:34 pm. NA #5 and NA #6 revealed the indwelling urinary

F 690

Additionally, the education included the steps to take if a resident refuses or has behaviors of taking the securement device off. The education will be completed by 3/1/2025. This education will be included in new hire orientation and to agency staff. Any new hires or new agency staff will receive education before being allowed to work on the floor.

4. The Director of Nursing or designee will audit 3 residents with catheters each week to ensure that they have catheter anchors in place. If the resident expresses that they do not want one, the Director of Nursing will offer them one, and if they still do not want one, a progress note for refusal will be entered and their care plan updated to reflect their wishes. Audits will be conducted weekly for 12 weeks. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.

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F 690	Continued From page 19 catheter tubing was not secured. NA #5 stated the resident didn't have a device to secure her indwelling urinary catheter tubing. NA#5 and NA#6 stated some residents in the facility had securing devices for indwelling urinary catheters, but they had not seen such devices to secure the indwelling urinary catheter tubing for Resident #3. Nurse #3 was interviewed on 2/5/25 at 9:28 am and stated Resident #3's catheter was not secured because they didn't have a supply of devices to secure indwelling urinary catheter tubing in the facility. During an observation Nurse #3 opened a drawer of her medication cart and an indwelling urinary catheter securing device was observed in the drawer of the medication cart. The Physician was interviewed on 2/5/25 at 9:19 am and stated an indwelling urinary catheter securing device should be used for all residents with indwelling urinary catheters. The physician stated it was a standard recommendation to secure indwelling catheters to prevent injury. The Administrator and the Director of Nursing (DON) were interviewed on 2/5/25 at 9:30 am. The DON and Administrator stated the facility had a supply of securing devices for indwelling urinary catheter tubing and nursing staff should use them.	F 690		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at	F 727		3/10/25

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least 8 consecutive hours a day, 7 days a week.

§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 2 of 30 days reviewed for staffing (4/20/24 and 4/21/24).

Findings included:

A review of the Payroll Based Journal (PBJ) staffing data report from the Certification and Survey Provider Enhanced Report (CASPER) database revealed the facility failed to submit RN coverage on 4/20/24, 4/21/24, 5/05/24, and 6/02/24.

On 2/5/25 at 11:04 am an interview with the Administrator and Director of Nursing revealed that they had RN coverage, and they stated that they would show a timecard for the days with missing coverage.

The Administrator provided a timecard that supported on 5/05/24 and 6/02/24, there was RN coverage for 8 consecutive hours in the facility. There was no additional timecard that was provided for 4/20/24 and 4/21/24.

A follow-up interview with the Administrator on

F 727

1) The schedule for the upcoming week was immediately reviewed by the Administrator to ensure that there was appropriate RN coverage of 8 consecutive hours per day. The schedule reflected that there was
indeed at least 8 hours of consecutive RN coverage each day.

2) All residents have the potential to be affected by the deficient practice. On 2/25/2025 the staffing schedules for the past 3 months were reviewed by the Administrator to ensure 8 hours of RN coverage daily.
No issues identified.

3) On 2/21/2025 the Scheduler and Human Resource Director were educated by the Director of Nursing on the staffing regulation that there must be 8
hours of consecutive RN coverage each day. The scheduler will communicate staffing concerns to the Director of Nursing and Administrator for further guidance.

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F 727	Continued From page 21 2/5/25 at 12:04 pm stated that he was still looking for evidence of RN coverage on 4/20/24 and 4/21/24. The Administrator stated that there should be an RN for 8 consecutive hours in the building. There was no additional timecard information provided by the Administrator.	F 727	4) The Director of Nursing or designee will review the schedules 3x/week to ensure that there is 8 hours of consecutive RN coverage each day. The audits will be conducted weekly for 12 weeks. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.	
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to have systems in place for providing evening snacks to residents for 2 of 3 halls (100	F 809	1. On 2/7/2025 residents were immediately offered snacks to ensure compliance with the deficient practice and	3/10/25

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F 809	Continued From page 22 hall and 400 hall). The deficient practice had the potential to affect residents requesting an evening snack. The findings included: An interview conducted during a Resident Council Meeting on 02/04/25 at 10:00 AM revealed residents had not received or been offered snacks in the evenings by nursing staff. The Resident Council President (Resident #106), Resident #4, Resident #5, Resident #8, and Resident #81 stated nursing staff did not offer evening snacks frequently and when residents asked nursing staff for snacks, they were told nursing staff were unable to get in the kitchen or there were no snacks available. It was further revealed it had been reported to the Dietary Manager (DM) and it continued to be an issue. An interview conducted with Nurse #5 on 02/04/25 at 7:35 PM revealed nursing staff were often unable to access the kitchen at night to retrieve snacks. The Nurse further revealed there had been multiple evenings snacks were not provided for distribution to residents. Nurse #5 stated she had reported the concerns to the DM. An interview conducted with Nurse Aide (NA) 7 on 02/05/25 at 7:50 PM revealed she worked second shift and residents during second shift (3:00 PM to 11:00 PM) had not received a bedtime snack on multiple days because kitchen staff had failed to deliver evening snacks and nursing staff was unable to get access to the kitchen. The NA indicated she had reported this to a Nurse on duty over the past few months but could not recall which Nurse.	F 809	were immediately assessed for signs and symptoms of distress related to missing a snack, of which, none were found. 2. All residents who are not NPO have the potential to be affected. A facility wide review and audit of residents was done on 2/21/2025 by the Social Worker to ensure they were being offered snacks. 3. Certified Nursing Assistants and Licensed Nurses were educated by the Director of Nursing and Assistant Director of Nursing on 2/21/2025 on the regulation that requires staff to offer residents snacks. Each evening staff will ask residents if they would like a snack. The education will be completed by 3/1/2025. This education will be included in new hire orientation and to agency staff. Any new hires or new agency staff will receive education before being allowed to work on the floor. 4. The Director of Activities and/or activity staff will interview 5 residents on each unit and ask them if they are being offered snacks. Audits will be conducted weekly for 12 weeks. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed.	

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An interview conducted with the Dietary Manager on 02/05/25 at 10:05 AM revealed she had recently been made aware nursing staff had reported snacks had not been provided. The Dietary Manager indicated dietary staff checked and stocked snack bins daily and felt that nursing were not offering bedtime snacks as needed for the residents. The Dietary Manager indicated she had tried to educate staff on providing bedtime snacks to all residents.

An interview conducted with the Director of Nursing (DON) and the Administrator on 02/05/25 at 11:30 AM revealed they had expected there to always be snacks available for residents. The Administrator indicated he was not aware evening snacks had been an issue.

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F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/10/25

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,

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F 880	Continued From page 24 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and staff, Health Department Nurse, and Physician interviews, the facility failed to implement the facility's infection control policy and procedures in accordance with current Centers for Disease Control and Prevention (CDC) guidance. The facility had been in outbreak status since 1/18/25 when 2 staff members tested positive and only residents and staff with COVID symptoms and staff that requested were tested for COVID. The facility failed to initiate contact tracing COVID testing for staff and residents on 1/18/25 after 2 staff members tested positive for COVID and failed to initiate broad-based approach COVID testing when a resident on the 200 hall and the 400-hall tested positive for COVID. No contact tracing or broad-based COVID testing was initiated until after surveyor intervention on 2/4/25. Before broad-based COVID testing was implemented on 2/4/25, a total of 9 staff members and 7 residents tested positive for COVID. Results of the broad-based testing from 2/4/25 through 2/7/25 resulted in 1 resident and 1 staff member positive for COVID on 2/4/25, 1 resident positive for COVID on 2/5/25, and 1 resident positive for COVID on 2/7/25.
Additionally, the facility failed to implement staff source control to help prevent transmission and facility staff failed to wear all personal protection

F 880

What corrective actions will be done for those residents found to be affected?

Residents #69, #79, and #278 were immediately assessed for signs and symptoms of distress related to the deficient practice, of which, none were found.

A root cause analysis was done on 2/4/2025 as to why the Infection preventionist (IP) and the facility did not follow CDC guidelines regarding COVID testing and determined that the root cause was incorrect interpretation of the COVID guidelines for COVID testing. It was also noted that the IP implemented the facility's contingency staffing plan for return-to-work criteria for healthcare personnel incorrectly.

How will you identify other residents having the potential to be affected by the same deficient practice?

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equipment (PPE) required according to CDC guidance when they entered resident rooms under transmission-based precautions (TBP) for COVID. The facility also failed to restrict staff from returning to work after testing positive for COVID in accordance with current CDC guidance. The resident census at the time of the survey was 123 and 62% of the residents were vaccinated for COVID. These cumulative practices and system failures occurred during a COVID-19 outbreak and had the high likelihood of continued transmission of COVID-19 to residents and staff and a serious adverse outcome.

Immediately Jeopardy began on 1/18/25 when 2 staff members tested positive for COVID, and the facility failed to implement contact tracing COVID testing. Immediate Jeopardy was removed on 2/7/25 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of E (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

The findings included:

On 2/3/25 a request was made for the facility's infection control policy and procedures for COVID testing, transmission-based precautions, masking for source control during a COVID outbreak, and return to work guidelines for staff after testing positive for COVID. The Infection Preventionist (IP) provided the CDC guidance and reported the facility utilized the CDC guidance for their policy and procedures.

F 880

All residents have the potential to be affected.

What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

On 2/4/2025 the Director of Nursing educated the Infection Preventionist on guidelines for COVID testing, return to work guidance criteria for healthcare professionals, and guidelines for when to implement broad based testing and contact tracing. The Director of Nursing also educated the infection preventionist on guidance for when contingency or crisis staffing could be used. In addition, the Director of Nursing educated the Infection Preventionist on testing schedules for the facility when in a COVID outbreak.

The Director of Nursing and Infection Preventionist re□educated all staff in all departments including agency and contractors on ensuring the correct PPE is worn for each particular type of precaution. Additionally, the Director of Nursing and Infection Preventionist re-educated all staff in all departments, including agency and contracted staff on return-to-work criteria for healthcare workers.

Directed plan of correction In servicing will be conducted by a regional nurse consultant and will include

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F 880	Continued From page 27 1. The facility provided CDC COVID testing guidance, with a review date of 11/20/24 read, in part: "Newly identified COVID positive staff or resident in the facility can identify close contacts: test the staff, regardless of vaccination status, that had a higher-risk exposure with a COVID positive individual. If negative, test again 48 hours later, and if negative, 48 hours after the 2nd test. Test the residents, regardless of vaccination status, then had close contact with a COVID positive individual. If negative, test again 48 hours later, and if negative, 48 hours after the 2nd test. Newly identified COVID positive staff or resident in a facility that is unable to identify close contacts: Broad Based approach. Test all staff regardless of vaccine status, if staff are assigned to a specific location where the new case occurred (unit, floor, or other specific areas of the facility). If negative, test again 48 hours later and if negative, 48 hours after the 2nd test. In general, testing should continue every 3-7 days until 14 days have passed without any new cases. Test all residents, regardless of vaccination status, facility-wide or at a group level (unit, floor, or other specific areas of the facility). If negative, test again 48 hours later and if negative, 48 hours after the 2nd test. In general, testing should continue every 3-7 days until 14 days have passed without any new cases. Test results will be tracked and reported as required by local, state, and federal entities." The CDC guidance Outbreak Response when a new facility-onset case of COVID is identified with a date of 2/2022 was reviewed and read in part: "Does the facility have the expertise, resources, or ability to identify all close contacts? If yes: Perform individual contact tracing by identifying staff with higher-risk exposure and residents with	F 880	all staff. Training will include appropriate PPE use and appropriate contact tracing according to policy and CDC guidelines. Training will begin on 3/7/2025 and will be concluded by 3/11/2025. Any staff that has not completed the training will not be allowed to work on the floor until training is completed. Any new staff will be trained in orientation. How will the facility monitor its corrective actions to ensure that the practice is being corrected and will not recur? To ensure compliance with COVID testing schedules, the Director of Nursing and Administrator will audit 25% of employees during a COVID outbreak to ensure that the correct testing schedule is being implemented and followed. Audits will be conducted weekly for 4 weeks and monthly for 2 months. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed. To ensure compliance with staff wearing proper PPE into the rooms, the Infection Preventionist will observe 5 staff members who enter rooms during care to ensure they are following the PPE guidelines. If a staff member is found to	

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F 880	Continued From page 28 close contact to the individual with COVID. Close contacts should be tested immediately (but not sooner than 24 hours after exposure) and if negative, again 48 hours later, again 48 hours after the 2nd negative test. If testing reveals additional residents or staff with COVID, contact tracing should continue to identify residents with close contact or staff with higher-risk exposure to the newly identified individuals. Strong consideration should be given to shifting to the broad-based approach if additional cases are identified. If no: Perform broad-based testing: test all staff and residents immediately but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the 1st negative test and, if negative again 48 hours after the 2nd negative. Were new cases identified: if Yes: testing should continue every 3-7 days until there are no new cases for 14 days. A broad-based approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Outbreak response: residents and staff should wear source control; consider implementing universal PPE use, visitors should wear source control and only go to and from resident's room or a designated visiting area; communal activities may continue but source control should be used, and physical distancing maintained whenever possible, unless otherwise directed by public health." The infection control line listing for December 2024 and January 2025 for the facility was reviewed and included the following information. The outbreak started on 1/18/25 when the Maintenance Director and the Maintenance Assistant tested positive for COVID.	F 880	be out of compliance, they will be re□educated. Audits will be conducted weekly for 4 weeks and monthly for 2 months. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed. To ensure compliance with the COVID guidelines for return to work, the administrator will audit 25% of all staff who have COVID to ensure that they are returning to work at the appropriate time according to CDC guidelines for returning to work. Additionally, the administrator will audit 100% of incidences in which crisis staffing will be used to ensure that it is being implemented according to CDC guidelines. Audits will be conducted weekly for 4 weeks and monthly for 2 months. Results of the audits will be presented to the QA committee for review and recommendations for 3 months or as needed. Orientation on these policies as appropriate.	

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- Maintenance Assistant tested positive for COVID on 1/18/25.

- The Maintenance Director also tested positive for COVID on 1/18/25.

- Resident #78 (200 hall) tested positive for COVID on 1/19/25.

- Resident #14 (400 hall) tested positive for COVID 1/20/25.

- The Rehabilitation Director tested positive for COVID on 1/20/25.

- The Director of Nursing tested positive for COVID on 1/20/25.

- The Admissions Director tested positive for COVID on 1/20/25.

- Resident #42 (200 hall) and tested positive for COVID on 1/21/25.

- Physical Therapy Aide #1 tested positive for COVID on 1/21/25.

- Resident #97 (400 hall) tested positive for COVID on 1/23/25.

- Physical Therapy Aide #2 tested positive for COVID on 1/23/25.

- NA #6 tested positive for COVID on 1/26/25.

- Laundry Aide #1 tested positive for COVID on 1/26/25.

- Resident #79 (400 hall) tested positive for

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COVID on 1/27/25.

- Resident #69 (100 hall) tested positive on 1/27/25.

No contact tracing or broad-based COVID testing was initiated until after surveyor intervention on 2/4/25.

- Resident #170 (100 hall) tested positive for COVID on 2/4/25

- Kitchen Staff #1 tested positive for COVID on 2/4/25 outside of the facility.

- Resident #112 (100 hall) tested positive for COVID on 2/5/25.

- Resident #98 (100 hall) tested positive for COVID on 2/6/25.

The Infection Preventionist (IP) was interviewed on 2/3/25 at 2:12 PM. The IP reported she was the infection control nurse and the Assistant Director of Nursing for the facility and had been in her position for almost 9 months. The IP reported that she emailed the Health Department on 1/21/25 to notify the Senior Nurse about the COVID cases. The IP explained the facility was not testing all residents and staff for COVID and they were testing only contacts of the residents who were positive for COVID. The IP noted because the residents who had symptoms of COVID before they tested positive and were placed on TBP she had not tested contacts for the residents because "they were under TBP and would not have exposed anyone." The IP reported the facility was only testing symptomatic

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residents and staff.

An email from the Senior Nurse at the Department of Health/Communicable Disease (Health Department Nurse) sent to the IP dated 1/21/25 was reviewed and read, in part: "I have attached the monitoring log for reporting ...regarding when to test residents and staff, I copied this section for you from the (CDC) website: 'If additional cases are identified, strong consideration should be given to shifting to the broad-based approach (regarding testing for COVID) if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3 to 7 days until there are no new cases for 14 days ...'" Included in the email were links to the CDC website for additional guidance regarding infection control and guidance for risk assessment.

The Health Department Nurse was interviewed by phone on 2/5/25 at 11:31 AM. The Nurse reported the IP had emailed her on 1/21/25 with the report of 3 resident positive COVID cases on the 200 hall, and 1 resident positive case on the 400 hall. The Health Department Nurse explained she had sent the IP CDC guidance for testing residents and staff using broad-based testing, quarantining residents, and how long staff should stay out of work.

The IP was interviewed again on 2/5/25 at 12:02 PM and she reported when she received the email from the Health Department Nurse, she missed the part of the email about broad-based testing.

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The IP and the Director of Nursing were interviewed on 2/4/25 at 8:32 AM. The IP reported she provided infection control surveillance for the facility and monitored all new infections. The IP explained residents with any respiratory symptoms were placed on droplet precautions and a chest x-ray was ordered if they were coughing. The IP reported she tracked the infections and the residents with signs and symptoms on a respiratory tracking form. The IP further explained she had multiple forms for tracking infections in the facility, including event tracking in the electronic documentation system, a spreadsheet, and a facility map that she color-coded to identify trends and outbreaks of infections. The IP reported she had noticed the COVID infections were popping up on different halls, but didn't occur to her the facility was in outbreak status. The IP explained when a resident had sign or symptoms of a respiratory infection, they were placed on droplet precautions immediately and she thought because the resident was isolated, there was no need to conduct contact testing. The DON stated the IP was exclusively responsible for the infection control data, but the other nursing department heads assisted with monitoring the staff for correct PPE use, but the facility had not conducted monitoring. The DON reported she had tested positive for COVID on 1/20/25 and was out of work until 1/30/25 and she was not available during the first part of the outbreak. The DON reported she was not aware the facility was testing only symptomatic residents, and the facility should have initiated broad-based COVID testing for residents and staff.

The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator explained the IP had

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misunderstood the guidance from the CDC website did not know that broad-based testing should have started on 1/20/25. The Administrator reported the broad-based testing was not initiated by the IP when the residents tested positive on 1/19/25 and he expected COVID guidelines to be followed. The Administrator reported he was aware the IP was testing only symptomatic residents and staff, and he thought that was the guidance she had received from the Health Department.

The Physician was interviewed on 2/5/25 at 9:20 AM. The Physician reported he was not aware the facility was not conducting broad-based testing for residents and there was a risk of COVID spreading throughout the facility and infecting many residents. The Physician explained the residents who were positive for COVID did not have severe illness and only one resident was hospitalized per her family request.

2. The facility policy for "Transmission-based precautions and Isolation Policy" dated 1/2014 and revision date of 4/15/24 was reviewed and it read, in part: "Droplet Precautions: intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances, special air handling and ventilation are not required to prevent droplet transmission; a single patient room is preferred but not required; a mask is worn for close contact with infectious resident; gloves, gown, eye protection are worn adhering to standard precaution guidelines. Airborne Precautions: prevent transmission of the infectious agents that remain infections over long distances when

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F 880	Continued From page 34 suspended in the air; a respiratory protection program that includes N95 (masks), resident should be placed in a private room with the door closed and the healthcare staff provided with N95 or higher respirators; gloves, gown, and eye protection are worn adhering to Standard Precaution guidelines. Facility staff providing care for the residents will be notified by the facility infection preventionist and/or charge nurse regarding needed precautions based on the infectious agent or condition. Signage indicating the appropriate types of precautions and indicating that visitors should stop at the nurse's station before entering will be placed on the resident's door. Handle resident care equipment and instruments/devices, laundry, dishware, or eating utensils and environmental cleaning with Standard Precautions unless more stringent disinfection is indicated. Staff will educate visitors regarding donning appropriate PPE. Transmission-based precautions will remain in effect while the risk of transmission of the infectious agent persists or for the duration of the illness. Isolation and resident placement decisions will be determined based on the potential for transmission of (the illness). Isolation/patient placement decisions will be determined based on the potential for transmission of infectious agents and will include the following: route of transmission, risk factors for transmission in the infected patient, risk factors for adverse outcomes resulting from a healthcare-associated infections in the area or room being considered for patient placement, the availability of single patient rooms, and patient options for room-sharing. Refer to the CDC Types and Duration of Precautions for further information."	F 880		

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The CDC guidance for Outbreak Response when a new facility-onset case of COVID is identified with a date of 2/2022 was reviewed and read in part: Outbreak response: residents and staff should wear source control; consider implementing universal PPE use, visitors should wear source control and only go to and from resident's room or a designated visiting area; communal activities may continue but source control should be used, and physical distancing maintained whenever possible, unless otherwise directed by public health."

A continuous observation was conducted on 2/2/25 at 12:47 PM to 12:51 PM of Nursing Assistant (NA) #1 assisting Resident #69. Resident # 69 had signage on her door notifying she was on special droplet precautions. A caddy was outside of the door with personal protective equipment (PPE), including gowns, gloves, N95 masks, and eye protection. Instructions on the signage included hand hygiene, applying gloves, protective gown, N95 mask, and eye protection before entering the room. NA #1 was observed wearing only a KN95 mask as she took Resident #69's lunch tray into the room. NA #1 did not perform hand hygiene, did not apply gloves, a gown, eye protection, or change her mask to a N95. NA #1 exited the room at 12:51 PM and did not remove her KN95 mask or perform hand hygiene.

NA #1 was interviewed on 2/2/25 at 12:51 PM and when asked why she had entered the room without PPE, NA #1 reported she had been off work for a few days and had not noticed the sign on the door.

NA #1 was interviewed by phone on 2/4/25 at

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11:05 AM. NA #1 reported she was not aware she had to apply full PPE to deliver a meal tray. NA #1 explained after the observation on 2/2/25, she took a break and changed her mask after her break.

During an interview with the Infection Preventionist nurse (IP) on 2/4/25 at 8:32 AM, the IP reported that NA #1 should have applied full PPE to deliver the meal tray to Resident #69 and she would have expected her to change her mask and perform hand hygiene after removing the PPE.

Review of NA #1's education revealed NA #1 received infection control education and use of standard precautions on 4/23/24. NA #1 additionally had a skills review that was completed 8/10/24 which included demonstration of infection control and prevention and demonstrated adherence to the infection control policies.

On 2/2/2025 at 4:45 pm NA #2 was observed in Resident #79's room from the hall. Resident #79 had signage on her door for special droplet precautions. A caddy was outside of the door with PPE, including gowns, gloves, N95 masks, and eye protection. Instructions on the signage included completing hand hygiene, applying gloves, protective gown, N95 mask, and eye protection before entering the room. Resident #79 was upset and yelling and NA #2 was observed standing beside Resident #79's bed, within 2 feet of Resident #79, with her N95 mask pulled below her nose, attempting to calm her. NA #2 was not wearing eye protection, a gown, or gloves. NA #2 made eye contact with the surveyor and pulled her mask up over her nose. NA #2 was observed

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to leave NA #2 did not remove the N95 mask or replace the N95 mask when she exited Resident #79's room.

NA #2 was interviewed on 2/2/2025 at 4:46 pm and she stated she saw the Special Droplet and Contract Precautions sign on Resident #79's door but thought Resident #79 was off precautions because she was told the resident tested negative for COVID. NA #2 stated she did not remember who told her Resident #79's precautions were removed. NA #2 stated she should have worn eye protection, a gown and gloves and kept her mask over her nose and mouth.

Review of NA #2's education revealed NA #2 received infection control education and use of standard precautions on 5/31/24. NA #1 additionally had a skills review that was completed 8/12/24 which included demonstration of infection control and prevention and demonstrated adherence to the infection control policies.

During an interview with the IP on 2/2/2025 at 4:47 pm she stated Resident #79 should still be on Special Droplet and Contact Precautions because she had not completed the required isolation period since she had tested positive. The IP further stated she would have taken the precautions sign from Resident #79's door if she was off precautions and NA #2 should have worn a gown and gloves, and NA #2 would be required to always wear a mask that covered her nose and mouth.

The DON was interviewed on 2/7/2025 at 1:04 pm and she stated NA #2 should have worn her

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mask over her nose and put on eye protection, a gown and gloves on before entering Resident #79's room on 2/2/2025 since the resident was on Special Droplet and Contact Isolation.

On 2/7/2025 at 1:09 pm the Administrator was interviewed and stated NA #2 should have worn eye protection, a gown and gloves and worn her mask over her nose while entering a room that was on Special Droplet and Contact Isolation.

An observation of Nurse #4 without a mask on during a medication administration observation was made on 2/4/2025 at 7:45 am on the 300 hall. Nurse #4 had prepared medications for Resident #278 and was getting ready to enter his room, when she was stopped and asked if she should be wearing a mask. Nurse #4 stated she was not required to wear a mask if she was not in a room with precautions in place.

An attempt was made to interview Nurse #4 again, but she had left the facility and did not return phone calls with requests for an interview.

Nurse #4 received infection control education and use of standard precautions during orientation to the facility on 7/274/24. Nurse #4 additionally had a skills review that was completed 8/21/24 which included demonstration of infection control and prevention and demonstrated adherence to the infection control policies.

The IP was interviewed on 2/4/2025 at 8:32 am and she reported she was educating all the nursing staff on PPE use because of the observations of NA #1 and NA #2 not wearing the PPE required for Special Droplet and Contract Precautions made on 2/2/25. The IP explained

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all staff should be wearing masks during the COVID outbreak. The IP stated Nurse #4 received in-service education regarding personal protective equipment yesterday and was not compliant with wearing a mask for source control today. The IP was unable to answer why Nurse #4 was not wearing her mask after receiving education on 2/3/25. The IP explained she conducted surveillance for PPE use and hand hygiene in the facility but had not conducted any surveillance during the outbreak until 2/2/25. The IP reported the process for monthly PPE surveillance was she typically watched 3 staff members apply and remove PPE and provided education if they had problems. The IP explained she did not keep records of the surveillance of PPE.

The Director of Nursing (DON) was interviewed with the IP on 2/4/25 at 8:32 AM. The DON explained she and other nurse managers had not routinely assisted with PPE surveillance, but the unit managers had started to monitor staff PPE use since 2/2/25. The DON reported she expected all staff to follow the guidelines for PPE use for residents on special droplet precautions.

The DON was interviewed on 2/7/2025 at 1:04 pm and DON and stated Nurse #4 should have been wearing a mask at all times due to the outbreak status of the facility.

The Physician was interviewed on 2/5/25 at 9:20 AM. The Physician reported PPE use was important source control to prevent the spread of COVID and he would expect all staff to adhere to PPE guidelines.

3. The Centers for Disease Control and

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F 880	Continued From page 40 Prevention (CDC) guidance for Health Care Personnel (HCP) returning to work updated 9/23/22 was reviewed and read, in part: "HCP with mild to moderate illness who are not immunocompromised could return to work after the following criteria is met: 7 days since symptoms first appeared if a negative (COVID) test is obtained 48 hours prior to returning to work (or 10 days if testing is not performed), 24 hours since the last fever and symptoms (shortness of breath, cough) have improved. (Either NAAT [Nucleic Acid Amplification Test] (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later). HCP who were asymptomatic throughout their infection and not moderately to severely immunocompromised could return to work after the following criteria is met: at least 7 days have passed since the date of their first positive viral test if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed). (Either NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later). HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: at least 10 days and up to 20 days have passed since symptoms first appeared, and at least 24 hours have passed since the last fever without the use of fever-reducing meds, and symptoms (shortness of breath, cough) have improved. HCP who are symptomatic could return to work after the following criteria are met: resolution of fever without the use of fever-reducing medications, improvement in symptoms, results are negative from at least 2 consecutive respiratory specimens	F 880		

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collected 48 hours apart."

The infection control line listing for December 2024 and January 2025 for the facility was reviewed for staff.
The Maintenance Assistant tested positive for COVID on 1/18/25 and returned to work on 1/24/25. There was no negative COVID test documented on the line listing.

An interview was conducted with the Maintenance Assistant on 2/5/25 at 9:53 AM. The Maintenance Assistant reported he left work on 1/17/25 because he "felt bad" and he tested at home for COVID on 1/18/25 and it was positive. The Maintenance Assistant reported he worked in all areas of the building prior to becoming sick. The Maintenance Assistant reported he returned to work on 1/24/25 and he had not retested for COVID prior to returning to work. The Maintenance Assistant explained he was told to stay out of work for 7 days by the Infection Preventionist (IP).

The Maintenance Director tested positive for COVID on 1/18/25 at home and 1/22/25 at the facility and returned to work on 1/23/25. There was no negative COVID test documented on the line listing for the Maintenance Director.

The Maintenance Director was interviewed on 2/5/25 at 9:41 AM. The Maintenance Director reported he started feeling bad at home on Saturday 1/18/25 and he tested on 1/18/25 and it was positive. The Maintenance Director reported the week before he was sick, he worked in all areas and halls of the building. The Maintenance Director reported he notified the facility on 1/19/25 that he was positive and stayed out of work until

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1/23/25 when he came to facility briefly to put salt on the pavement in preparation for a winter storm. The Maintenance Director reported he was told to stay out of work for 5 days by the IP and returned to work on 1/24/25.

The Admissions Director tested positive for COVID on 1/20/25 and returned to work on 1/28/25. There was no negative COVID test documented on the line listing for the Admissions Director.

An interview was conducted with the Admissions Director on 2/5/25 at 11:49 AM. The Admissions Director explained she tested positive on 1/20/25 and returned to work on 1/28/25. The Admissions Director reported she was not vaccinated for COVID, and she was told to stay out of work for 7 days by the IP.

The IP was interviewed on 2/3/24 at 11:24 AM and she reported she was not aware of the CDC guidance for staff to stay out of work for 10 days if they did not test negative for COVID 48 hours before their return. The IP reported she thought the CDC guidance instructed staff to stay out of work for 7 days after testing positive for COVID.

The Director of Nursing (DON) was interviewed on 2/4/25 at 8:32 AM. The DON reported she had tested positive for COVID on 1/20/25 and was out of work until 1/30/25 and she was not available during the first part of the outbreak. The DON reported she was not aware staff were not staying out of work for 10 days.

A facility Nurse Consultant was interviewed on 2/5/25 at 11:32 AM and reported contingency staffing protocols were used by the facility for

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returning to work after COVID.

A follow-up interview was conducted with the facility Nurse Consultant on 2/5/25 at 12:25 PM and she reported she was not aware the contingency staffing protocol was no longer applicable.

The Physician was interviewed on 2/5/25 at 9:20 AM and he reported staff should follow the CDC guidance for returning to work after COVID.

The Administrator was notified of Immediate Jeopardy on 2/4/25 at 12:26 PM.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to operationalize infection control policy and procedures in accordance with current Centers for Disease Control and Prevention (CDC) guidance for COVID testing, transmission-based precautions and return to work criteria for Healthcare Personnel during a COVID outbreak.

On 1/17/25 Resident #78 (200 hall) reported symptoms of not feeling well (weakness, malaise, and productive cough); chest XRAY was ordered and Resident placed on precautions for rule out of COVID. COVID test on 1/17/25 was negative. Resident was tested on 1/19/25 as part of the Day 1, 3, 5 testing recommendation, result was positive on Day 3. Because the Resident was in a private room with isolation measures in place, contact tracing for COVID testing was not initiated.

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The Maintenance Assistant felt bad on 1/17/25 (Friday) and left work and tested positive for COVID at home on 1/18/25. The Maintenance Assistant worked on all halls the weekdays prior to feeling sick.

On 1/18/25 (Saturday) the Maintenance Director started feeling bad at home and tested positive for COVID. He was exposed to COVID by a family member the week before. The Maintenance Director worked on all halls the weekdays prior to feeling sick.

On 1/20/25 Resident #42 (200 hall) and 3 staff members tested positive for COVID.

On 1/23/25 Resident #97 (400 hall) tested positive for COVID. Broad-based COVID testing was not initiated by the facility policy and Center for Disease Control and Prevention (CDC).

Contract tracing or broad-based approach COVID testing was not initiated until 2/04/25 after surveyor intervention.

Facility policy/procedure was not implemented for testing. Contact tracing or broad-based COVID testing was not completed; staff and residents were not tested per facility policy and CDC guidance. Therefore, Infection Preventionist failed to follow facility policy/procedure for testing and current CDC guidance.

On 2/2/25 NA #1 was observed entering a COVID positive room wearing only a KN95 mask. NA #1 was observed assisting the resident to sit up in bed and setting up the resident's meal tray. NA #1 exited wearing the KN95 mask and did not perform hand hygiene.

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On 2/2/25 NA#2 was observed in a COVID positive room assisting the resident wearing only an N95 mask which was positioned below her nose. NA #2 exited the room wearing the N95 mask.

On 2/4/25 Nurse #1 was observed on the hall not wearing a mask for source control while administering medications and stated during interview she only wore a mask into rooms if a resident was on precautions.
The facility did not implement policy and procedures for return-to-work criteria for Healthcare Personnel per facility policy and current CDC guidance.

The Maintenance Director tested positive for COVID on 1/18/25 and returned to work on 1/23/25.

The Maintenance Assistant tested positive for COVID on 1/18/25 and returned to work on 1/24/25.

The Admissions Coordinator tested positive for COVID on 1/20/25 and returned to work on 1/28/25.

Residents who did not receive the COVID vaccine are most susceptible to serious illness. Residents who are not up to date and Residents who did not test positive may be affected.

On 2/4/2025 the Director of Nursing notified the Medical Director of the need for broad-based COVID testing.

On 2/4/2025 Residents and/or Responsible Party

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F 880	Continued From page 46 were notified of the outbreak and the need for the broad-based testing. The management team, which includes the nurse managers, admissions managers, activities manager, and social workers made calls on 2/04/25 to the responsible parties of all residents to inform them of the COVID outbreak and broad-based testing. Communication was in person or via telephone. On 2/4/25, upon awareness of noncompliance with COVID testing guidelines, the facility Infection Preventionist reviewed the Immunization Control log to identify residents who were not up to date with COVID vaccination and residents who are not vaccinated. The Infection Preventionist notified the Health Department of COVID Outbreak on 1/21/25. Recommendation for broad-based COVID testing was provided but not followed. Specify the action the entity willtake to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 2/4/25 the Administrator, Director of Nursing, and Infection Preventionist completed a root cause analysis regarding as to why the Infection Preventionist (IP) and the facility did not follow CDC guidelines regarding COVID testing and determined that the root cause was incorrect interpretation of CDC guidelines for COVID testing. It was also determined the IP implemented the facility's Contingency Staffing Plan for return-to-work criteria for Healthcare Personnel per facility policy and procedures due to incorrect interpretation of policy and procedures.	F 880		

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On 2/4/25 the Administrator reviewed the facility's policy and procedure for transmission-based precautions, to ensure that it was in compliance with the most recent CDC guidance and recommendations. The facility's policy and procedure regarding transmission-based precautions and testing was up to date and in line with the CDC guidance. Policy and procedures for COVID testing and return to work criteria for Healthcare Personnel was also reviewed on 2/4/25 and were up to date and aligned with current CDC guidance.

On 2/4/25 the Director of Nursing educated the Infection Preventionist (IP) on COVID Testing Guidance and return-to-work criteria for Healthcare Personnel according to the facility's Infection Control Policy and Procedures and CDC guidelines. In addition, the IP was directed to always follow the Health Departments recommendations.

On 2/6/25 the Director of Nursing educated the Infection Preventionist on when contingency or crisis staffing guidance could be used.

On 2/4/25 the facility Administrator, Director of Nursing, and IP completed a root cause analysis on the reason as to why staff did not follow CDC guidelines regarding transmission-based precautions and determined that staff were simply non-compliant. Staff stated, "I forgot".

On 2/4/25 the Director of Nursing and Infection Preventionist will initiate COVID testing for current residents residing in the facility who did not recently test positive. COVID testing will continue every 3 to 7 days until 14 days has passed

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	345103	A. BUILDING ______ B. WING ______	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTHEWS HEALTH & REHAB CENTER	**600 FULLWOOD LANE MATTHEWS, NC 28105**

(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
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without any new cases.

On 2/4/25 the Director of Nursing and Infection Preventionist will initiate COVID testing for all facility staff who did not recently test positive to include: Nursing, Therapy, Dietary, Housekeeping, Maintenance, Activities, Reception, Agency and Administrative staff. COVID Testing will continue every 3 to 7 days until 14 days has passed without any new cases. Director of Nursing and Infection Preventionist will be responsible for tracking when staff have been tested and when they are due for the next COVID test. This information will be shared with Nurse Managers daily and on Friday for the weekend Nurse Managers.

To ensure compliance with COVID testing for staff, a Nurse Manager will be available on every shift and will be responsible for ensuring all staff are tested prior to taking an assignment or being on the floor. On 2/4/25 the DON informed the Nurse Managers about their responsibilities for testing staff before taking an assignment. All new hires will be tested upon hire according to CDC guidelines during outbreak. The IP has been notified by the DON on 2/4/25 of the responsibility to test all new hires prior to their beginning orientation during a COVID outbreak.

As of 2/4/25 any Resident that tests positive will be placed on COVID monitoring and transmission-based precautions with testing to continue. The Medical Director (MD)/Nurse Practitioner (NP) will be notified of positive result(s) by the Infection Preventionist and monitored by the provider.

As of 2/4/25 any staff that tests positive will follow

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the COVID return to work Guidance. The date on which staff is able to return to work will be tracked and determined by the IP. The IP will determine and notify staff when they can return to work by referencing the CDC return to work guidelines.

On 2/4/25 Director of Nursing and Infection Preventionist re-educated all staff in all departments including agency and contracted staff, on ensuring personal protective equipment is donned/doffed per the facility's policy for transmission-based precautions and current CDC guidance, the need to wear a mask for source control during an outbreak, COVID testing guidance. There was emphasis on wearing masks to cover both the mouth and the nose, in addition to adhering to the facility's COVID precaution and prevention policy. Education with a return demonstration was initiated on 2/4/2025. Any staff member that was unable to be educated on 2/4/25 will not be allowed to work until education is completed.

On 2/6/24 the Director of Nursing and Infection Preventionist re-educated all staff in all departments including agency and contracted staff, on return-to-work criteria for Healthcare Personnel.

The DON and or designee will be responsible for tracking staff that have been educated and staff that still need the education. This will be reviewed daily by DON or designee. The IP will be responsible for education on weekdays for the 7-3 pm and 3-11 pm shifts. For staff that have not been educated on off hours and weekends, the Nurse Manager will give them the education in addition to validating their return demonstration to ensure compliance with the donning and doffing

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policy and procedure. The DON will communicate with the Nurse Managers who require education and return demonstration. On 2/4/25 the DON educated and notified the Nurse Managers of this responsibility.

Staff has been notified about the responsibility of the education through the facility's personnel management portal which allows mass communication from the facility to all employees through their email and texts with follow-up phone calls to ensure message was received. This was done on 2/04/25 by the Director of Human Resources.

This education will be part of the new hire orientation, and this education will be conducted by the IP during the first day of orientation. If the IP is not available, the Nurse Manager who is working at that time will receive education by the IP on how to provide this education and how to validate if a return demonstration is done correctly. The IP nurse will educate all nurse supervisors on 2/04/25, and any nurse supervisors who have not received this education by 2/04/25 will not be able to work until they receive this education.
Alleged date of IJ removal: 2/7/2025

The Validation of the Credible Allegation of Compliance was completed on 2/7/2025:
On 2/7/2025 the facility provided documentation of COVID testing for all current residents who did not recently test positive and documentation of COVID testing for all staff who did not recently test positive, and the testing was completed on 2/4/2025 and on 2/6/2024. The facility's Director of Nursing provided Infection Control: COVID Testing Guidance education to the Infection

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F 880	Continued From page 51 Control Preventionist on 2/4/2025; and the Director of Nursing and Infection Control Preventionist provided Infection Control: COVID Testing Guidance Education and appropriate personal protective equipment according to each transmission-based precaution sign to all staff. The personal protective equipment included education on properly wearing a mask to cover the nose and mouth. All staff members were removed from the work schedule until the education was completed. A sample of staff from all disciplines were interviewed and were able to identify when they should be tested; what personal protective equipment should be used; and their mask should fit over their nose and mouth. The Infection Control Preventionist was interviewed and was able to verbalize when transmission-based precautions and testing of residents and staff should be initiated. The facility provided the audits to ensure personal protective equipment was worn correctly in rooms of residents on transmission-based precautions which began on 2/4/2025. The IJ removal dated of 2/7/2025 was validated.	F 880		