STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345124	A. BUILDING _____ B. WING _____	C 07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	**560 JOHNSON RIDGE ROAD ELKIN, NC 28621**

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 06/20/24 through 06/26/24. Additional interviews were conducted on 07/05/24. Therefore the exit date was changed to 07/05/24. Event ID: LSCF11. The following intake was investigated NC00128395. 1 of the 2 allegations resulted in a deficiency. Intake NC00128395 resulted in immediate jeopardy. Immediate jeopardy was identified at: CFR 483.80 at tag F880 at scope and severity of K. Immediate Jeopardy began on 5/10/24 and was removed on 6/25/24.	F 000		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		7/22/24

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

Electronically Signed | 07/17/2024

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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arrangement based upon the facility assessment conducted according to §483.70(e) 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.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 2 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 observations, record review, facility policy, and interviews with Resident #1, staff, Local Health Department Representative, State Health Department Representative, State Health Department Medical Provider, Nurse Consultant to the North Carolina Hepatitis Program, facility Attending Physician, facility Medical Director, and Corporate Medical Director, the facility failed to immediately implement effective precautions to prevent further transmission of bloodborne pathogens to other residents who required blood glucose monitoring and failed to immediately begin training on acute hepatitis B following Resident #1's diagnosis of acute hepatitis B. Acute hepatitis B is a serious liver infection caused by the hepatitis B virus. The disease is commonly spread by unsafe injection practices and exposure to infected body fluids. This deficient practice affected 30 of 30 residents including Resident #1 who received glucose monitoring. Immediate jeopardy began on 05/10/24 when Resident #1 readmitted from the acute care hospital with a diagnosis of acute hepatitis B and the facility failed to implement effective precautions to prevent further transmission of bloodborne pathogens. Immediate jeopardy was removed on 06/25/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will	F 880	Corrective action for the residents found to be affected by the deficient practice. On 4/26/24 Resident #1 was sent to the emergency room via ambulance transport for complaints of neck pain and jaundice. On 4/27/24 facility Administrator was notified by the facility attending physician that Resident #1 had tested positive for Hepatitis B while at the hospital. The discharge diagnosis from the hospital showed, Acute hepatitis B with liver failure, Cholangitis is a chronic, life-threatening disease caused by damage to the bile ducts of the liver this is an autoimmune disease, metabolic hepatic encephalopathy, Acute kidney injury with hyperkalemia. Resident #1 required a hospital stay of 13 days in a general med/surg bed at the hospital. On 4/27/24 the facility Administrator notified the Facility Medical Director that Resident #1 who was still in the hospital had a diagnosis of positive hep B. On 5/3/24 the Administrator contacted the local health department for guidance on testing staff members for Hepatitis B. The local health department did not have any recommendation for testing staff and/or residents at this time.	

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F 880	Continued From page 3 remain out of compliance at a E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. The findings included: The facility policy titled, Infection Prevention and Control Plan dated 06/23/23 read in part, this infection prevention and control plan outlines the framework by which all facilities will assess, implement and evaluate an active, effective, comprehensive facility-wide infection prevention and control program. The Medical Director and Director of Health Services are responsible for the identification of appropriate resources and/or resource allocation that supports the infection prevention and control program. The goals of the program are to decrease morbidity/mortality, attributable to infections in residents; prevent and control outbreaks of infection in residents; prevent acquisition of infection by staff members, maintain resident functional status, maintain optimal social environment for residents; limit cost of care attributable to infections. Review of an additional facility policy titled, Infection Control: Glucometer Cleaning and Disinfecting dated 06/29/23 read in part, it is the policy of this facility to promote a safe environment for preventing the transmission of potentially infectious blood-borne pathogens between patients and healthcare professionals. Safe glucose monitoring is a part of standard precautions and is implemented to maintain basic levels of patient safety and partners protection. Review of the operator's manual for the facility's glucometers with no date noted read in part, you	F 880	On 5/8/24 the Facility Administrator coordinated with Local Health Department and set an on-site visit for 5/14/24 with the local and State Health Department to observe blood glucose monitoring, insulin administration, medication preparation, and follow up with front line staff regarding facility practices regarding infection prevention. The local and State health department conducted an onsite visit on 5/14/2024. The goal of the visit was to identify any possible areas of improvement and help guide blood borne pathogens / infection prevention. The facility Administrator and Director of Nursing questioned the onsite need for testing residents and staff. The local and State health department representatives at this time did not think so but would notify the local health department if that changed who would notify the facility Administrator. The facility Administrator received the report from the State Health Department on 5/16/24, the Local /and State Health Department provided written notification of recommendation to the facility stating, Individual glucometers for each resident are preferred. The facility was utilizing two glucometers per medication cart, this provides drying time for each glucometer after disinfection prior to and after use. After consideration the facility continued to utilize two glucometers per medication cart.	

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F 880	Continued From page 4 should perform a control solution test when: using the meter for the first time, at least once per week to verify that the meter and test strips are working properly together. The Centers for Disease Control defines: "An outbreak or an epidemic is the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time". Resident #1 was admitted to the facility on 06/03/23 with diagnoses that included atrial fibrillation, spinal stenosis, weakness, calculus of kidney, diabetes, chronic kidney disease, neuromuscular dysfunction of the bladder, anemia, hypertension, and major depressive disorder. There were no documented diagnosis of hepatic issues. Review of a physician order dated 06/17/23 read, fingerstick glucose check with sliding scale insulin before meals and at bedtime. The quarterly Minimum Data Set (MDS) dated 02/27/24 revealed that Resident #1 was cognitively intact and received 7 days of insulin injections during the assessment reference period. A physician order for a routine lab draw dated 04/25/24 read, Hemoglobin A1C (a blood test that shows what your average blood sugar (glucose) level was over the past two to three months) and Comprehensive Metabolic Panel (a routine blood test). A laboratory report dated 04/25/24 read in part, TBIL (a test that measures the bilirubin in your	F 880	On 6/5/24 the Administrator and Director of Health Services with guidance of the local health department as requested by the Center of Disease Control, identified 30 residents in-house requiring blood glucose testing during the exposure period 11/28/2023 to 4/26/2024 provided by the local health department. On 6/6/24 the facility Director of Health Services and Nurse Managers conducted blood test Hepatitis panel on 24 of the 30 residents who required glucometer monitoring, with 4 residents refusing blood draws. The four residents refusing the Hepatitis panel did consent to blood draw later. 2 residents consented on 6/17/24 and the other 2 residents consented on 6/18/24. Four residents were identified as requiring further blood testing, these further blood testing identified one resident with a false positive, one resident with chronic hepatitis B, 1 with prior infection inactive, and one with current viral load with continued use of universal precautions. The facility Administrator contacted the Hospital laboratory on 6/10/24 for results on lab drawn from 6/6/24 and 6/7/24, prior to the facility receiving the labs on 6/10/24 there was no notification of abnormal labs by the Hospital laboratory. 6/10/24 12:36 the local health Department notified the facility Administrator that three lab results had flagged. No recommendations currently.	

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F 880	Continued From page 5 blood was 7.0. AST (Aspartate Aminotransferase) was 1095. ALKP (a test that measures the alkaline phosphatase in your blood) was 462, ALT (used to diagnose liver disorder) 937. All of the lab values were reported as high which indicated that the resident may have liver disease. The report was finalized and reported to the facility on 04/26/24 at 3:42 PM. Nurse Aide (NA) #1 was interviewed on 06/20/24 at 11:07 AM who confirmed that she worked with Resident #1 six days in a row for 16 hours per day and was very familiar with her. About two days before Resident #1 fell (fall occurred on 04/26/24) and was transferred to the hospital she had noted a yellow tint on her entire face, but it was very light and contributed it to the lighting in the room. NA #1 stated she even asked another NA if she thought Resident #1 was yellow and that NA stated no, but thought it was just the lighting in the room. She added that Resident #1 had not been sick and had no complaints, so she just believed that the lighting in her room was making her face appear yellow. NA #1 stated a couple of days later she took Resident #1 to the shower room and when she got her into the shower room under different lights, she was definitely yellow, and she went and reported it to Nurse #1 who ended up sending Resident #1 to the hospital because she had a fall and was complaining of neck pain. A progress note written by Nurse #1 dated 04/26/24 at 12:05 AM read, "resident complained of neck pain, resident yellow in color, neurological checks done as order, resident complained her neck was hurting, swelling edema 3+, complaining when turning head of popping sound or feeling to left side small hematoma to right side	F 880	6/12/24 the Facility Administrator emailed the local health department and asked if they would like all the lab results on the requested residents. The local health department confirmed, and facility sent the lab results via email on 6/13/24. On 6/14/24 at 7:50pm the facility Administrator was notified by the local health department that the facility was in outbreak status for Hepatitis B and the State health department was now requiring an individual glucometer for each resident on blood glucose monitoring. The facility Administrator contacted their Senior Vice President of Clinical Services for the company to assist in obtaining glucometers at 8:00 pm. The facility Administrator also contacted the facility Medical Director at 8:36 pm of being placed in an outbreak status per phone call from the local health department to the facility Administrator. The Senior Vice President of Clinical Services of the company contacted the Senior Nurse Consultant to assist in obtaining glucometers for the facility due to the outbreak status. The facility received the glucometers on 6/15/24 around 1:30am and implemented the resident specific glucometers. Corrective action for other residents having the potential to be affected by the same deficient practice. On 6/14/24 at 8:36pm the Administrator notified the Medical Director of the	

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F 880	Continued From page 6 of head observed. O2 sats (oxygen saturations) 81 at room air, O2 started at 2 liters sat 91 on call notify of status new orders given to send to [hospital name]." Normal oxygen saturations range from 95% to 100%. Nurse #1 was interviewed on 06/20/24 at 6:32 PM. Nurse #1 stated that when she came to work on 04/26/24 she had gotten report that Resident #1 had fallen on the previous shift and was getting neurological checks. She stated that when she went down to see Resident #1, she was complaining of neck pain and was yellow in color in her face area and "just looked different" and Nurse #1 stated "she was concerned." Nurse #1 stated she had not seen Resident #1 in a couple of days and when she last saw her, she was not yellow in color. She added that Resident #1's oxygen saturation level was 81% so she started oxygen at 2 liters, and her oxygen saturation level came up to 91%. She stated she called the on-call provider and told them what was going on. They stated to send Resident #1 to the Emergency Room (ER). Review of a discharge summary from the local hospital dated 05/10/24 read in part, discharge diagnoses: Acute hepatitis B with liver failure, concern for primary biliary cholangitis (serious infection of the liver's bile ducts), metabolic/hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease). The discharge summary read Resident #1 denied previously known history of liver disease but was noted to have jaundice over the last three days. Labs were notable for liver enzymes and bilirubin that were elevated. A computed tomography (CT) scan of the liver showed a normal sized liver with no intrahepatic	F 880	requirement of the local Health Department to obtain individual glucometers for all residents receiving blood glucose monitoring due to current outbreak status for hepatitis B. He agreed with the plan. On 6/15/24 the facility placed each individual glucometer in a Ziplock bag with resident□s name identifier on the bag, these zip lock bags prevent the possibility of cross contamination between glucometers. The glucometers are removed from the baggy prior to entering the resident room and then cleaned, disinfected and dried per manufactures recommendation, prior to being replaced in the baggy. The glucometers are stored in toolboxes designated for glucometer storage and the toolboxes are stored on each unit within the facility. On 6/22/24 the residents□ names were applied to the individual glucometer. When residents are discharged from the facility the glucometer is sent home with the discharging resident or discarded and not reused. This process was changed to reduce the risk of blood borne pathogen transmission. The facility rational for storing in toolboxes versus resident room include confused residents who may remove their glucometer from the room and carry throughout the facility and potential for visitors to access the glucometer. On 6/15/24 all new Admission and residents with new glucometer testing orders will be given a new glucometer by	

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bile duct dilation. Hepatology (doctor that specializes in the liver) was consulted and indicated that Resident #1 was not a liver transplant candidate due to age and co-morbidities. Recommended to continue with current treatment and if no improvement will need to consider palliative care. Infection Control notified and Center for Disease Control (CDC) notified.

Resident #1 returned to the facility on 05/10/24.

Resident #1 was interviewed on 06/20/24 at 10:46 AM. She stated that she had been at the facility since June 2023 and recently slid out of bed and hit her head and ended up going to the hospital. She stated prior to her fall she had not been sick. She explained that she spent a couple of days in the ER and had numerous daily blood draws and they determined that she had hepatitis. Resident #1 stated that she was involved in a terrible car crash back in the 1970s and required multiple blood transfusions. Following the blood transfusions, she was told that she had contracted hepatitis although she could not recall which type and would never be able to donate blood. Resident #1 did recall the day before going to the ER on 04/26/24 NA#1 had walked by her door and said something about being yellow in color and they drew blood that but the next day she had a fall and ended up going to the hospital for the fall. Resident #1 could not recall going out to any doctor appointment since she was admitted to the facility. She stated she went out with a family member one time shopping, but she stayed in the car. She added that the podiatrist had trimmed her toenails one time and she had not been sexually active since her husband passed away years prior. Resident #1 stated that

the nurse receiving the order and/or admitting nurse. The new glucometers are stored in the medication room. The nurse and/or admitting nurse will label the glucometer and baggy with resident□s name and it will be placed in the toolbox for the unit the resident is assigned.

The Administrator of the facility notified the Director of Health Services and/ or Nurse Managers to begin education to the Licensed Nurses on the specific resident use of glucometers, storage, and quality control testing of glucometers on 6/15/ 2024 due to the high likelihood of transmission of blood borne pathogens including Hepatitis B, Hepatitis C and HIV. This education included the cleaning and storage of individual glucometers. All Licensed Nurses who have not received the education by 6/24/2024 will be removed from the schedule until the education has been completed. The education related to cleaning and storage of individual glucometers has been added to the general orientation of newly hired Licensed Nurses. The Administrator and/or Director of Health Services is responsible for ensuring all Licensed Nurses are educated by 6/24/24. Licensed nurses who are scheduled to work will receive the in-person education; Licensed Nurses who are not scheduled to work will receive verbal education over the phone with review of education by Nurse Management and/or Administrator upon next scheduled shift. The Administrator and/or Clinical Competency Coordinator maintains the employee roster of those

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she had diabetes, and the facility checked her glucose levels multiple times a day and gave her insulin from a vial. She explained that when she was at home, she had a pen that she gave herself insulin from but since coming to the facility they used a vial of insulin.

The Local Health Department Representative and State Health Department Representative visited the facility on 05/14/24. A letter dated 05/15/24 from the State Health Department Representative to the facility read in part, thank you again for your partnership during our site visit on 05/14/24. The goal of this visit was to identify any possible areas of improvement and help guide blood borne pathogen/infection prevention recommendations going forward. Visit Summary and Recommendations: The recommendations included: "individual glucometers for each resident are preferred." "I understand that the quality control corporate policy is cumbersome but recommended considering the benefits of individual glucometers." This letter and recommendations were delivered via email to the facility Administrator on 05/16/24.

The Local Health Department Representative was interviewed via phone on 06/20/24 at 9:12 AM. She stated that on 04/29/24 she received notification from the local hospital that Resident #1 had tested positive for acute hepatitis B. The representative stated she noticed from the report that Resident #1 resided in a nursing facility and so she made the State Health Department aware of the acute case of hepatitis B. The Local Health Department Representative stated that on 05/14/24 they did an onsite infection control visit with the State Health Department Representative and there were recommendations made to the

who have been educated and who require review.

On 6/16/24 the facility removed and discarded the prior glucometers that were being utilized for multi resident use.

On 6/17/24 the Corporate Medical Director advised the facility to draw a hepatitis panel on all residents within the facility who have not had a hepatitis panel completed, these hepatitis panels were to be drawn between 6/17/24 and 6/18/24. And to hold new admissions on the evening of 6/17/24 and 6/18/24 to obtain all residents blood draws. Admissions were reopened on 6/19/24.

Systemic changes made to ensure that the deficient practice will not recur.

On 6/18/2024 the Blood Glucose policy was reviewed and revised by the Pruitt policy committee to include individual usage of glucometers to enhance the prevention of blood borne pathogens. The revisions included following the manufacturers guidelines of weekly waive testing (quality control testing) and disinfecting per manufacturer instructions.

On 6/18/24 The Facility Administrator directed the Director of Health Services and/or Nurse Managers to begin education to Licensed Nursed on the revised Blood Glucose policy to include waive testing weekly. The waive testing is completed on the 11:00 pm to 7:00 am shift weekly with each resident glucometer

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facility to help prevent the spread and transmission of infections including hepatitis B. She stated that Resident #1 was scheduled to have additional lab work completed on 06/20/24 and that would be collected at the facility and taken to the local health department for transportation to the state lab and once the results were available, she would communicate those to the facility.

A follow up interview was conducted with the Local Health Department Representative via phone on 06/25/24 at 11:27 AM. She stated that during their onsite visit to the facility on 05/14/24 they made the recommendation to the Administrator about getting glucometers for each resident that required glucose testing and the Administrator shared with them that they were not going to implement individual glucometers at that time because of the cumbersome quality control check's that the glucometers required each night. She stated that they encouraged the Administrator to reach out to the corporation because it was in the best interest of the facility to implement individual glucometers to stop or prevent any transmission of infectious agents. When the Local Health Department Representative was notified after the additional testing of other residents who were of concern for having hepatitis B it became a matter of a public health emergency and the Representative had direction from the State Health Department Medical Provider to put in a public health order if the facility gave any push back on implementing the individual glucometers. However, when the Local Health Department Representative called the facility on 06/14/24 they gave no push back and made it happen very quickly. On 6/14/24 at 7:50pm the facility Administrator was notified by

being assigned a specific day of the week identified on the top of the waive testing sheet for each resident. All Nurses who have not been educated by 6/24/24 will be removed from the schedule until the education is completed. This education related to the revised blood glucose monitoring has been added to the general orientation of all newly hired nurses. The Administrator and/or Director of Health Services is responsible for ensuring all Licensed Nurses are educated by 6/24/24. Licensed nurses who are scheduled to work will receive in-person education; Licensed Nurses who are not scheduled to work will receive verbal education over the phone with review of education by the Nurse Manager and/or Administrator upon next scheduled shift. The Administrative and/or Clinical Competency Coordinator maintains the employee roster of those who have been educated and who require review.

On 6/21/24 the Infection Prevention and Control Plan was reviewed and revised by the corporate policy committee to include Comply with the state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. The policy revision was to enhance the prevention of the highly likelihood of transmission of blood borne pathogen including hepatitis B, Hepatitis C and HIV, On 6/21/24 the Senior Nurse Consultant educated the Facility Administrator Director of Nursing and Nurse Navigator on the revised Infection Prevention and

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F 880	Continued From page 10 the local health department that the facility was in outbreak status for Hepatitis B and the State health department was now requiring an individual glucometer for each resident on blood glucose monitoring. An interview was conducted with the State Health Department Representative on 06/20/24 at 8:39 AM via phone. She stated that on 04/29/24 she got a call from the Local Health Department Representative letting her know that Resident #1 who was recently admitted to the acute care hospital was diagnosed with acute hepatitis B. It had been reported that Resident #1 had been in a car wreck in the 1970s and received blood transfusions and was told she had hepatitis but could not say which type A, B, or C. The State Health Department Representative stated the records in the state where the accident occurred only went back to 2005 so they had no record of Resident #1 ever officially having hepatitis. She stated that state hepatitis program reviewed Resident #1's case and determined it to be acute infection based on her symptoms of being jaundiced and her hepatitis panel being extremely elevated and deoxyribonucleic acid (DNA) that showed a viral load (amount of infection in her body) was "incredibly high" and was only that high in acute infections. Resident #1 was very sick for a while and initially could not be interviewed. The State Health Department Representative stated the first step in their investigation was to conduct an onsite infection control assessment which was conducted on 05/14/24 which revealed some issues with hand hygiene and the realization that the facility was using shared glucometers. The State Health Department recommended switching to individual glucometers but "we had push back from the facility" because of the quality	F 880	Control policy. On 6/21/24 the Administrator directed the Director of Nursing and/or Nurse Managers to begin education to all staff regarding the infection prevention and control practices changes with include Comply with the state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. All staff who have not received the education related to Infection Prevention and Control Plan by 6/24/2024 will be removed from the schedule until the education has been completed. The Administrator and/or Director of Health Services is responsible for ensuring all staff are educated by 6/24/24. All Staff who are scheduled to work will receive in-person education; Staff who are not scheduled to work will receive verbal education over the phone with review of education review of education by the Nurse Manager and/or Administrator upon next scheduled shift. The Clinical Competency Coordinator maintains the employee roster of those who have been educated and who require review. The education related to the revision of the Infection Prevention and Control Plan has been added to the general orientation of all newly hired employees. On 7/16/24 the Facility Administrator contacted the Quality Improvement Organization (QIO) to assist the facility in providing implementation of effective precautions to prevent transmission of	

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F 880	Continued From page 11 control testing that had to be conducted on each glucometer each night. She added that switching to individual glucometers was the biggest recommendation made as a result of the visit. She explained that they got involvement from the hepatitis program at the CDC and the decision was made to screen all residents still in the facility that received glucose monitoring from November 2023 to April 2024. There were 27 residents identified who required glucose monitoring. The State Health Department Representative stated that on or around 06/14/24 they received the initial results of the testing of the residents still in the facility that received glucose testing, there were three residents presumed positive for hepatitis, and at that point, they contacted the facility and insisted that they obtain individual glucometers. They were able to do that over the weekend of 06/15/24 because the facility was officially in outbreak status. The State Health Department Representative stated that they consider one positive resident an outbreak and we were not sure "if the facility understood or if they were deflecting" but it did appear that the corporation was on board with the insistence of obtaining individualized glucometers. She added that those entities involved were going to meet with the facility next week to do some additional education to the facility to help them have a better understanding of the situation. An interview was conducted with the Nurse Consultant to the North Carolina Hepatitis Program via phone on 06/20/24 at 9:31 AM. She stated she was notified in May 2024 of an acute hepatitis B case in the nursing home and because it was an acute case they started an investigation. Because they consider one case of acute hepatitis B in a nursing home an outbreak,	F 880	bloodborne pathogens, training on acute hepatitis B, managing outbreak of infectious disease, and collaboration with local / state health departments for a root cause analysis. The facility management has a meeting scheduled with the QIO on July 24th at 9:45am. The QIO has contacted the North Carolina state wide program for infection control and epidemiology (SPICE) to schedule an initial meeting and recommendations. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator, Director of Health Services and/or Nurse Managers are responsible for auditing the performance of the Nurses to ensure the Blood glucose monitoring and that Waive testing is performed per policy / manufacturer recommendations. The Administrator, Director of Health Services and/or Nurse Manager will audit five Nurses three times per week for one month, then five nurses weekly thereafter to validate compliance with blood glucose monitoring and waive testing per policy / manufactures recommendations. The Director of Health Services will present the analysis of the blood glucose monitoring and Waive testing audits to the Administrator at the monthly Quality Assurance and Performance Improvement Committee meeting for review and recommendations. The Administrator will report all	

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F 880	Continued From page 12 the Nurse Consultant to the North Carolina Hepatitis program reported it to the CDC on 05/03/24 as well. She stated she attempted to get records from the hospital that treated Resident #1 after her accident in the 1970s and was unable to get any records. There is no known history of hepatitis B with this patient except for her verbal report that she was in an accident the 1970s and was told she had hepatitis and could not donate blood. When she was transferred to the hospital on 04/26/24 Resident #1's skin and sclera (eyes) were jaundiced, and the hospital did further testing which revealed she had hepatitis B. This was based on the hepatitis B surface agent which is a measure of the actual hepatitis B in the blood stream and that test was positive. That positive test along with her symptoms and other blood work told us that this was indeed an acute hepatitis B infection. The question became where had Resident #1 contracted hepatitis B from since she had been in the nursing home for over a year. Per Resident #1's reports she had not had any outside procedures, no extensive podiatry care, no barber services. When the testing of residents from November 2023 to April 2024 came back initially with 4 positive, the resident's medical history was reviewed and determined that they all received glucose checks so the CDC honed in on the glucometers that were being shared because beautician care, wound care, blood transfusion were ruled out. When Resident #1 returned to the facility the staff were convinced that this was a reactivation case (meaning she had hepatitis B in the past and then suddenly the resident has an increase of hepatitis B in their blood stream) so she (the Nurse Consultant) set up a meeting with the facility to provide education and explain how this was not a case of reactivation this is an acute case of hepatitis B.	F 880	recommendations of the Quality Improvement Organization and the State and Local Health Department to the Quality Assurance and Performance Improvement Committee monthly for review and recommendations. Date of compliance: 7/22/2024	

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Symptoms of hepatitis B usually occur 9-21 weeks after exposure and her jaundice was reported on 04/23/24 so that timeframe encompasses November 2023 to January 2024 for exposure. The Nurse Consultant explained that the facility switched to individual glucometers on 06/15/24 to help mitigate any risk of transmission since it was not determined where Resident #1 contracted the virus.

An interview was conducted with the State Health Department Medical Provider via phone on 06/20/24 at 11:37 AM. She explained that she and her team were notified of a possible acute hepatitis B infection who was admitted to the hospital but had resided in the nursing home. Initially the team was trying to discern if this was actually an acute case and if so, that would mean that exposure would have happened a month or so before her diagnoses or was this a reactivation case which is where someone had the virus and then cleared it but then some other infection caused the virus to reactive. If this would have been a reactivation case, we would not have been suspicious that transmission occurred in the health care setting but if this was an acute case, and we know that Resident #1 had been living in the nursing home since June of 2023 then our assumption was that she was exposed to Hepatitis B in the nursing home setting. One of the team members involved in the investigation coordinated additional testing and the Local Health Department Representative and State Health Department Representative conducted an onsite infection control visit to ensure the facility was doing things to prevent transmission of bloodborne pathogens. The only two things that stood out from that visit were that the alcohol-based hand sanitizer was not as

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accessible as we would like and that they were using shared glucometers after disinfecting them between residents. The State Health Department Representative shared with the facility that individual glucometers were definitely preferred even if disinfecting between residents. Ultimately there was discussion amongst all the agencies involved and the conclusion became that Resident #1 was an acute case of hepatitis B and was not a case of reactivation. After the testing of the other residents in the facility that received glucose checks revealed additional residents of concern "we were obliged to take public health action on the presumption of 2 active cases of hepatitis B" and we had to protect the population from further transmission. The two active cases were identified as Resident #1 and Resident #2. Last week the Local Health Department Representative was able to talk to the facility and get them to implement individual glucometers and the facility was able to procure them by Saturday 06/15/24. The State Health Department Medical Provider stated that the facility initially stated that they did not implement the individual glucometers because the quality checks that had to be conducted each night on each glucometer to ensure it was measuring correctly was logistically a burden for them, so they elected to continue to use the shared glucometers with disinfection.

An observation of Resident #1 and Resident #2's room were made on 06/20/24 at 10:45 AM. Their rooms were noted to be located on the same hallway directly across from one another. Further observation revealed that Resident #1 and Resident #2's medications and glucometers were stored on the same medication cart.

The Director of Nursing (DON) was interviewed

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on 06/20/24 at 1:01 PM. Shortly after Resident #1 was admitted to the hospital the Local Health Department called and stated that they had an acute case of hepatitis B. She stated that they immediately started doing education on hand washing, education about universal precautions and when the health department made recommendations we followed them. The DON explained that the facility currently did not have an Infection Preventionist and had not one since March 2024 and she was assisting with providing the education to the staff. The DON could not recall what the recommendations were, but she did recall that they had to draw blood from residents that had glucose checks that were still in the facility. When Resident #1 returned from the hospital she told us that she had been in a car wreck in the 1970s and had multiple blood transfusions and had contracted hepatitis B although she did not know which type and could never donate blood. The DON stated that about a week ago the facility switched to individual glucometers and stated that they had not done so earlier because we did not have a policy for that, so we had to obtain a policy before switching over to individual glucometers. The DON stated she felt like Resident #1's case of Hepatitis B was a "historical" case and "could not see how she got it here."

The Administrator was interviewed via phone on 06/20/24 at 5:44 PM who stated that on 04/27/24 Resident #1's attending Physician notified her that Resident #1 had hepatitis B. She stated Resident #1 was readmitted to the facility on 05/10/24 and she had talked about it with the Attending Physician, and we do not know where it came from or what made it became active because she had been in the facility for years.

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Representatives from the Local/State Health Departments came in on 05/14/24 and did not see any major issues, they talked to the nurses, looked at hand sanitizer etc. then we got a report from them, and we followed the recommendations. However, we thought it was ok to continue with our protocol of the shared glucometers with disinfection between use, mainly because the facility had so many residents that required glucose checks and that would have been a lot of glucometers. The Administrator stated that they communicated via email and answered any and all questions that the Health Department had until Friday 06/14/24 at 7:50 PM when she got a call from the Local Health Department Representative who stated that they had talked to the State Health Department Representative, and we needed to get individual glucometers tonight because we were in outbreak status. The Administrator stated she contacted and notified her MD and her corporate office, and they were able to procure enough glucometers and began using them on 06/15/24. She stated that the main reason for not implementing the individual glucometers sooner was due to the large number of residents with diabetes that we had and the quality control testing that each glucometer would require each night. The MD had been made aware of the recommendations made by the Local/State health department and was aware that we were going to continue to use shared glucometers with disinfection between uses and he was ok with that because he did not believe we had an issue.

A follow-up interview was conducted with the Administrator on 06/25/24 at 11:10 AM who stated that initially stated when they were asked by the Local Health Department on 06/05/24 for a

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list of residents who required glucose testing that still resided in the facility which was provided to them. The list contained 30 names including Resident #1. The Local Health Department requested blood samples from those 30 residents on 06/06/24. The Administrator stated that they did not redraw Resident #1's blood, but obtained 23 samples, 4 residents refused the blood draw, and 2 residents had transferred to the hospital but were tested at a later date.

The Attending Physician was interviewed on 06/21/24 at 9:06 AM. He stated Resident #1 had been back and forth to the hospital. The Attending Physician stated a few days into Resident #1's hospitalization one of his colleagues at the hospital notified him of Resident #1's acute hepatitis B. The Physician stated Resident #1 had essentially returned to her baseline, and other than controlling her diabetes, she was fine. He stated he was aware of the recommendation made to the facility to switch to individual glucometers but did not have anything to do with the decision to continue using the shared glucometers. Looking at the case, "I just don't think she got it from here, she had been here more than 6 months and had been in and out of hospital." "Her risk of getting it from the glucometer is zero risk, she was exposed with way more things in the hospital." Finally, the Attending Physician stated, "she had more opportunities to get it from anywhere but here."

Review of Resident #1's medical record from 06/03/23 through 06/20/24 revealed that she had not been discharged from the facility to the acute care hospital since 06/12/23 and was readmitted on 06/17/23. Resident #1 remained in the facility from 06/17/23 to 04/26/24.

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The facility Medical Director (MD) was interviewed via phone on 06/20/24 at 3:47 PM who stated, "I don't think we have an outbreak. We have one case of reactivation of hepatitis B." He stated he was notified about Resident #1's case three weeks ago when she returned from the hospital. He stated he had not been kept up to date on the recommendations made by the Local/State Health department and was upset that no medical doctor had been involved in the decision-making process. The MD stated that initially when Resident #1 admitted to the facility the Attending Physician was concerned, she had MASH and did a workup for that, but when she got to the hospital, she had positive hepatitis B DNA in her blood and that was very indicative of reactivation of hepatitis B. We want to do what is right but "we don't think this is an outbreak. I don't think this was spread from glucometers because that is rare." There are other possibilities of where she contracted hepatitis B from dentist, she has family members that are intravenous (IV) drug users, shared insulin pens etc. The Medical Director stated he would argue that this was not an acute case, as she had other liver problems. The MD was aware of the Local/State Health Department Representative onsite visit but was not aware of the recommendations and had not seen any report from the visit. He added that he had spoken to the Local Health Department Representative earlier in the day and she was very vague in her communication and very nonspecific, but they called a week ago and stated we had an outbreak and needed to get a glucometer for each person that required glucose testing by midnight. The Medical Director stated he would expect the facility to follow the recommendations made by the Local/State

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Health Department and to also let me know what the recommendations were.

A follow up interview was conducted with the MD on 07/03/24 at 12:58 PM via telephone. The MD again confirmed that he was made aware of Resident #1's acute hepatitis B diagnoses when she returned to the facility on 05/10/24. He also confirmed that he was aware of the recommendation made the Local Health Department on 05/14/24 and was also aware the facility elected to not implement the recommendation. He did state he was not involved in the decision, that decision was made between the facility Administration and the Corporation. The MD stated that at some point before 06/14/24 he was made aware that the facility had given Resident #1 her own individual glucometer but could not say when that occurred. He stated that he had reviewed all the lab work from the residents that were tested for hepatitis B and was aware of the results but thought they were unrelated and the first time the MD heard the facility was in an outbreak was on June 14, 2024. The MD stated he was surprised that the acute hepatitis B did not require different isolation and surprised that we did not investigate staff.

A follow-up interview was conducted with the Administrator on 07/03/24 at 1:14 PM via telephone who stated the MD was aware of Resident #1's acute hepatitis B diagnoses on 04/27/24 but did not get involved until she readmitted on 05/10/24. She stated that the facility gave Resident #1 her own glucometer about a week and half after the health department made their onsite visit on 05/14/24 but she could not recall he exact date that the induvial glucometer was issued to Resident #1. The

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Administrator stated that she had since been educated on the definition of outbreak status and that initially she thought it was more than one case but when she asked, she really never received a definitive answer and the first time she was aware that they were in an outbreak was on 06/14/24 when the local health department called and reported it to her.

A follow up interview was conducted with the Administrator via telephone on 07/05/24 at 12:44 PM who stated that initially they set aside a glucometer for Resident #1, but they failed to follow through with the education to the staff and could not provide evidence that Resident #1 had her own individual glucometer prior to 06/15/24.

The Corporate Medical Director was interviewed via phone on 06/20/24 at 4:21 PM who stated she had not heard about Resident #1 or understood the gravity of the case until 06/14/24 at 8:00 PM when she received a call from the Administrator who stated they had to get individual glucometers and the facility was in an outbreak of acute hepatitis B. They then began filling her in on Resident #1's history and her subsequent hospitalization. To her understanding the State Health Department came in on a non-regulatory visit to observe infection control practices and procedures and indicated that they recommended individual glucometers. The Corporate Medical Director stated that she needed time to research Resident #1's case and review all the lab work and see what was going on but in the meantime, she made the decision to stop all admissions and made the decision to test all current residents which was done. Resident #1 was definitely an acute case of hepatitis B, but her question was whether or not she has antimitochondrial DNA

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and this was a flair up of some chronic hepatitis B. The biggest issue she had seen with this case was the lack of communication. She stated when she read the recommendations made the Local/State Health Department made on 05/15/24 her first question was why did we not implement the individual glucometers at that time, it would have been simple and easy, but those conversations never occurred with the facility MD. She stated when she read the email of the recommendation "it was fire drill to get the supplies that we needed" but I think the wording could have been stronger so that it was not left up for debate and "if I would have been involved earlier, I would have said" this is an easy thing to do just get everyone their own glucometer. The facility was correct when they stated that the corporation did not have a policy for individual glucometers but "when the state says it has to be done then it has to be done." "I still don't have a full grasp of how this happened and still find it hard to believe." The Corporate Medical Director stated that on Friday 06/14/24 when everyone became aware we implemented the recommendations made on 05/14/24, but as soon as I read the recommendations it was crystal clear to me the recommendations were a mitigation recommendation and should have been implemented when recommended.

In the absence of the Administrator, the Director of Nursing was notified of immediate jeopardy on 06/20/24 at 7:03 PM.

The facility provided the follow credible allegation of immediate jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

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a result of the noncompliance.

On 4/26/24 Resident #1 was sent to the emergency room via ambulance transport for complaints of neck pain and jaundice. On 4/27/24 facility Administrator was notified by the facility attending physician that Resident #1 had tested positive for Hepatitis B while at the hospital. The discharge diagnosis from the hospital showed, Acute hepatitis B with liver failure, Cholangitis is a chronic, life-threatening disease caused by damage to the bile ducts of the liver this is an autoimmune disease, metabolic hepatic encephalopathy, Acute kidney injury with hyperkalemia. Resident #1 required a hospital stay of 13 days in a general med/surg bed at the hospital.

On 4/27/24 the facility Administrator notified the Facility Medical Director that Resident #1 who was still in the hospital had a diagnosis of positive hep B.

On 5/3/24 the Administrator contacted the local health department for guidance on testing staff members for Hepatitis B. The local health department did not have any recommendation for testing staff and/or residents at this time.

On 5/8/24 the Facility Administrator coordinated with Local Health Department and set an on-site visit for 5/14/24 with the local and State Health Department to observe blood glucose monitoring, insulin administration, medication preparation, and follow up with front line staff regarding facility practices regarding infection prevention.

The local and State health department conducted an onsite visit on 5/14/2024. The goal of the visit

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was to identify any possible areas of improvement and help guide blood borne pathogens / infection prevention. The facility Administrator and Director of Nursing questioned the onsite need for testing residents and staff. The local and State health department representatives at this time did not think so but would notify the local health department if that changed who would notify the facility Administrator.

The facility Administrator received the report from the State Health Department on 5/16/24, the Local /and State Health Department provided written notification of recommendation to the facility stating, "Individual glucometers for each resident are preferred." The facility was utilizing two glucometers per medication cart, this provides drying time for each glucometer after disinfection prior to and after use. After consideration the facility continued to utilize two glucometers per medication cart.

On 6/5/24 the Administrator and Director of Health Services with guidance of the local health department as requested by the Center of Disease Control, identified 30 residents in-house requiring blood glucose testing during the exposure period 11/28/2023 to 4/26/2024 provided by the local health department.

On 6/6/24 the facility Director of Health Services and Nurse Managers conducted blood test Hepatitis panel on 24 of the 30 residents who required glucometer monitoring, with 4 residents refusing blood draws. The four residents refusing the Hepatitis panel did consent to blood draw later. 2 residents consented on 6/17/24 and the

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other 2 residents consented on 6/18/24.

Four residents were identified as requiring further blood testing, these further blood testing identified one resident with a false positive, one resident with chronic hepatitis B, 1 with prior infection inactive, and one with current viral load with continued use of universal precautions. The facility Administrator contacted the Hospital laboratory on 6/10/24 for results on lab drawn from 6/6/24 and 6/7/24, prior to the facility receiving the labs on 6/10/24 there was no notification of abnormal labs by the Hospital laboratory.

6/10/24 12:36 the local health Department notified the facility Administrator that three lab results had flagged. No recommendations currently.

6/12/24 the Facility Administrator emailed the local health department and asked if they would like all the lab results on the requested residents. The local health department confirmed, and facility sent the lab results via email on 6/13/24.

On 6/14/24 at 7:50pm the facility Administrator was notified by the local health department that the facility was in outbreak status for Hepatitis B and the State health department was now requiring an individual glucometer for each resident on blood glucose monitoring. The facility Administrator contacted their Senior Vice President of Clinical Services for the company to assist in obtaining glucometers at 8:00 pm. The facility Administrator also contacted the facility Medical Director at 8:36 pm of being placed in an outbreak status per phone call from the local health department to the facility Administrator.

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The Senior Vice President of Clinical Services of the company contacted the Senior Nurse Consultant to assist in obtaining glucometers for the facility due to the outbreak status. The facility received the glucometers on 6/15/24 around 1:30am and implemented the resident specific glucometers.

Specify the action the entity will take 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 6/14/24 at 8:36pm the Administrator notified the Medical Director of the requirement of the local Health Department to obtain individual glucometers for all residents receiving blood glucose monitoring due to current outbreak status for hepatitis B. He agreed with the plan.

On 6/15/24 the facility placed each individual glucometer in a Ziplock bag with resident's name identifier on the bag, these zip lock bags prevent the possibility of cross contamination between glucometers. The glucometers are removed from the baggy prior to entering the resident room and then cleaned, disinfected and dried per manufactures recommendation, prior to being replaced in the baggy. The glucometers are stored in toolboxes designated for glucometer storage and the toolboxes are stored on each unit within the facility. On 6/22/24 the residents' names were applied to the individual glucometer. When residents are discharged from the facility the glucometer is sent home with the discharging resident or discarded and not reused. This process was changed to reduce the risk of blood borne pathogen transmission. The facility rational

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for storing in toolboxes versus resident room include confused residents who may remove their glucometer from the room and carry throughout the facility and potential for visitors to access the glucometer.

On 6/15/24 all new Admission and residents with new glucometer testing orders will be given a new glucometer by the nurse receiving the order and/or admitting nurse. The new glucometers are stored in the medication room. The nurse and/or admitting nurse will label the glucometer and baggy with resident's name and it will be placed in the toolbox for the unit the resident is assigned.

The Administrator of the facility notified the Director of Health Services and/ or Nurse Managers to begin education to the Licensed Nurses on the specific resident use of glucometers, storage, and quality control testing of glucometers on 6/15/ 2024 due to the high likelihood of transmission of blood borne pathogens including Hepatitis B, Hepatitis C and HIV. This education included the cleaning and storage of individual glucometers. All Licensed Nurses who have not received the education by 6/24/2024 will be removed from the schedule until the education has been completed. The education related to cleaning and storage of individual glucometers has been added to the general orientation of newly hired Licensed Nurses. The Administrator and/or Director of Health Services is responsible for ensuring all Licensed Nurses are educated by 6/24/24. Licensed nurses who are scheduled to work will receive the in-person education; Licensed Nurses who are not scheduled to work will receive verbal education over the phone with review of education by Nurse Management and/or

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Administrator upon next scheduled shift. The Administrator and/or Clinical Competency Coordinator maintains the employee roster of those who have been educated and who require review.

On 6/16/24 the facility removed and discarded the prior glucometers that were being utilized for multi resident use.

On 6/17/24 the Corporate Medical Director advised the facility to draw a hepatitis panel on all residents within the facility who have not had a hepatitis panel completed, these hepatitis panels were to be drawn between 6/17/24 and 6/18/24. And to hold new admissions on the evening of 6/17/24 and 6/18/24 to obtain all residents blood draws. Admissions were reopened on 6/19/24.

On 6/18/2024 the Blood Glucose policy was reviewed and revised by the Pruitt policy committee to include individual usage of glucometers to enhance the prevention of blood borne pathogens. The revisions included following the manufacturers' guidelines of weekly waive testing (quality control testing) and disinfecting per manufacturer instructions.

On 6/18/24 The Facility Administrator directed the Director of Health Services and/or Nurse Managers to begin education to Licensed Nursed on the revised Blood Glucose policy to include waive testing weekly. The waive testing is completed on the 11:00 pm to 7:00 am shift weekly with each resident glucometer being assigned a specific day of the week identified on the top of the waive testing sheet for each resident. All Nurses who have not been educated by 6/24/24 will be removed from the schedule

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until the education is completed. This education related to the revised blood glucose monitoring has been added to the general orientation of all newly hired nurses. The Administrator and/or Director of Health Services is responsible for ensuring all Licensed Nurses are educated by 6/24/24. Licensed nurses who are scheduled to work will receive in-person education; Licensed Nurses who are not scheduled to work will receive verbal education over the phone with review of education by the Nurse Manager and/or Administrator upon next scheduled shift. The Administrative and/or Clinical Competency Coordinator maintains the employee roster of those who have been educated and who require review.

On 6/21/24 the Infection Prevention and Control Plan was reviewed and revised by the corporate policy committee to include "Comply with the state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks". The policy revision was to enhance the prevention of the highly likelihood of transmission of blood borne pathogen including hepatitis B, Hepatitis C and HIV, On 6/21/24 the Senior Nurse Consultant educated the Facility Administrator Director of Nursing and Nurse Navigator on the revised Infection Prevent and Control policy.

On 6/21/24 the Administrator directed the Director of Nursing and/or Nurse Managers to begin education to all staff regarding the infection prevention and control practices changes with include "Comply with the state and local public health authority requirements for identification, reporting, and containing communicable diseases

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and outbreaks". All staff who have not received the education related to Infection Prevention and Control Plan by 6/24/2024 will be removed from the schedule until the education has been completed. The Administrator and/or Director of Health Services is responsible for ensuring all staff are educated by 6/24/24. All Staff who are scheduled to work will receive in-person education; Staff who are not scheduled to work will receive verbal education over the phone with review of education review of education by the Nurse Manager and/or Administrator upon next scheduled shift. The Clinical Competency Coordinator maintains the employee roster of those who have been educated and who require review.

The education related to the revision of the Infection Prevention and Control Plan has been added to the general orientation of all newly hired employees.

The Nursing Facility does not utilize medication aides and/or Agency Nurses.

Alleged date of immediate jeopardy removal: 6/25/24

A validation of immediate jeopardy removal was conducted on 06/26/24. Observations were made of the facility's medication rooms and were noted to have a stock of glucometers available for new residents and extras if one of the glucometers malfunctioned. The toolboxes on each unit were observed and revealed that each glucometer was labelled with the resident name and placed in a plastic bag that was also labelled with the resident's name and room number. Each bag contained a glucometer, strips, lancets, alcohol

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wipes, and control testing supplies. There was a notebook on each toolbox that had each resident's glucometer was listed with the day of the week that quality control testing would be conducted. The Local/State Health department onsite visit recommendations were reviewed and verified that all had been implemented. Observation of glucose monitoring was conducted and revealed appropriate cleaning and disinfection. All lab work that had been drawn was reviewed. Interviews with nursing staff across all shifts revealed that they had been educated on the infection control policy and the changes that had been made. They were able to verbalize the steps for glucose testing and also cleaning and disinfecting of the meters after use, how and where they were stored. They were also able to verbalize the quality control testing procedures and where to find the logbook. Interviews across all other departments revealed that they had been educated on infection control and way to stop/prevent the transmission of infectious disease. They were able to verbalize how they identified residents on precautions, what they needed to do before entering the room and what to do before exiting the room. The staff were aware of the location of all personal protective equipment and where extras were kept for restocking them. They were able to verbalize the steps for handling infectious laundry and other objects. The immediate jeopardy removal date of 06/25/24 was validated.