STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 recertification and complaint investigation survey was conducted on 01/06/25 through 01/09/25. The credible allegation was validated on 01/14/25, therefore the exit date was changed to 01/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GYM211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/06/25 through 01/09/25. The survey team returned to the facility on 01/14/25 to validate the facility's credible allegation. Therefore, the exit date was changed to 01/14/25. The following intakes were investigated: NC00205486, NC00209708, NC00211955, NC00213077, NC00213139, NC00216465, NC00221821, NC00224500, and NC00225779. Intake NC00211955 resulted in immediate jeopardy. 1 of the 18 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (L) Immediate Jeopardy began on 12/26/24 and was removed on 01/09/25.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		3/7/25

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

Electronically Signed | 02/06/2025

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F 583	Continued From page 1 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to provide privacy during tube feeding administration for 1 of 1 resident (Resident #80) reviewed for tube feeding. A reasonable person would expect privacy when being provided tube feedings.	F 583	Residents rights to privacy education and monitoring of privacy during care and treatment will ensure this practice does not recur. The nurse who did not close the curtain or the door was educated on 1/9/25 by the Director of Nurses. Residents Rights to privacy education was	

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F 583	Continued From page 2 The findings included: Resident #80 was admitted to the facility on 6/14/23 with diagnoses that included aphasia (language disorder that affects a person's ability to communicate) following cerebral infarction (stroke), and gastrostomy (surgical procedure that inserts a feeding tube into the stomach through the abdomen) status. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/29/24 indicated Resident #80 was rarely/never understood and had severely impaired cognitive skills for daily decision making. Resident #80 had a feeding tube while a resident at the facility. An observation was made on 1/8/25 at 11:41 AM when Nurse #1 administered tube feeding to Resident #80 in his room. Nurse #1 left the door wide open. Resident #80 was in the second bed by the window and there was a privacy curtain, but Nurse #1 did not pull it to cover Resident #80. The first bed was not occupied by another resident. Nurse #1 pulled up Resident #80's shirt to expose his feeding tube, and abdomen. While Nurse #1 flushed Resident #80's feeding tube with water and administered his formula, another resident was observed rolling down the hallway in her wheelchair, passed by Resident #80's door and looked at him. There were also several staff members who passed by Resident #80's open door and were able to observe care while it was being provided. An interview with Nurse #1 on 1/8/25 at 11:52 AM revealed she usually pulled the privacy curtain if Resident #80's roommate was in the room. Nurse #1 stated that she did not think about closing the	F 583	sent to staff on 1/30/25 via a online training module and those employees who do not have access to the online training module will be educated in person by the Director of Nurses and Administrative Nurses by 2/28/25. Education will be added to the monthly mandatory in-service x 3 months, upon hire and yearly. The Administrative Nurse staff will do daily rounds and the results will be turned in to the Director of Nurses for review The Quality Assurance Committee (QA) will assure compliance through the internal Quality Assurance Process. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations by the Director of Nurses for x 3 months or until compliance has been achieved. No other residents were identified as not having a curtain pulled or the door closed to provide privacy during care and treatment. Residents Rights to privacy education was sent to staff on 1/30/25 via a online training module and those employees who do not have access to the online training module will be educated in person by the Director of Nurses and Administrative Nurses by 2/28/25. Education will be added to the monthly mandatory in-service x 3 months, upon hire and yearly. The Administrative Nurse staff will do daily rounds and the results will be turned in to the Director of Nurses for review The Quality Assurance Committee (QA) will assure compliance through the internal Quality Assurance Process. All audit results will be submitted	

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F 583	Continued From page 3 door or pulling the privacy curtain even though Resident #80's roommate was not in the room. An interview with the Director of Nursing (DON) on 1/9/25 at 11:39 AM revealed Nurse #1 should have shut the door and provided privacy to Resident #80 when she administered his feeding.	F 583	to the monthly QAPI Committee meeting for review and recommendations by the Director of Nurses for x 3 months or until compliance has been achieved.. To prevent the alleged deficient practice from occurring again, A systemic review of the facility systems including current policy and procedures was completed 1-9-25 thru 1-30-25. This review found that policies and procedures followed State and Federal regulations. In-servicing of staff will be completed on maintaining resident rights to privacy during care and treatment. This in-service was sent to staff on 1/30/25 via a online training module and will also be conducted in person by the Director of Nurses and Administrative Nurses by 2/28/25. Education will be added to the monthly staff training monthly x 3 months. The Director of Nursing is responsible for implementing and overseeing the actions taken with this plan. The Quality Assurance Committee (QA) will assure compliance through the internal Quality Assurance Process. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations by the Director of Nurses for x 3 months or until compliance has been achieved. Monitoring: Residents rights to privacy education and monitoring of privacy during care and treatment will ensure this practice does not recur. The Administrative Nurse Staff will do daily	

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F 583	Continued From page 4	F 583	rounds and the results will be turned into the Director of Nurses for review. a) The Quality Assurance Committee (QA) will assure compliance through the internal Quality Assurance Process. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations by the Director of Nurses for x 3 months or until compliance has been achieved. b) A systemic review of the facility systems including current policy and procedures was completed 1-9-25 thru 1-30-25. This review found that policies and procedures followed State and Federal regulations. c) In-servicing of staff will be completed on maintaining resident rights to privacy during care and treatment. This in-service was sent to staff on 1/30/25 via a online training module and will also be conducted in person by the Director of Nurses and Administrative Nurses staff training monthly x 3 months. The Director of Nursing is responsible for implementing and overseeing the actions taken with this plan. The Administrative Nurse Staff will do daily rounds and the results will be turned into the Director of Nurses for review. Education concerning resident rights to privacy during care and treatment will be included in the monthly mandatory in-service training and will include new hires x 3 months.	

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and Consultant Pharmacist interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication omission and failure to follow a physician order to have the resident their rinse mouth after being given a steroid inhaler (2 medication errors out of 26 opportunities), resulting in a medication error rate of 7.69% for 1 of 3 residents (Residents #19) observed during medication pass. The findings included: Resident #19 was admitted to the facility on 11/4/24 with diagnoses that included acute respiratory failure with hypoxia (absence of oxygen in the tissues to sustain bodily functions), and reduced mobility. a. The Physician's Orders in Resident #19's electronic medical record indicated an active order dated 11/5/24 for Aspirin tablet chewable 81 milligrams (mg) - give 1 tablet by mouth one time a day for DVT (deep vein thrombosis) prophylaxis. On 1/8/25 at 8:33 AM, Nurse #4 was observed as he prepared and administered Resident #19's medications. Nurse #4 did not administer an Aspirin tablet to Resident #19.	F 759	Resident #19 suffered no ill effects relating to the alleged deficient practice and the provider was notified of the medication error on 1/8/25 by the Director of Nurses. Nurse #4 received education concerning the medication error on 1/9/25 and a medication administration competency review was done on 2/5/25 by the Director of Nurses. Licensed nurses and medication aides will be in-serviced on medication administration policies and procedures by the Director of Nurses or designee by 2/28/25, following the MD orders and MDI inhaler use by the Director of Nurses or her designee by 2/28/25. The Director of Nurses or her designee will conduct random medication administration observation audits to ensure continued compliance 2 x week x 4 weeks. The audit will continue on a weekly basis to assure compliance with State and Federal regulations. The results will be taken to the Quality Assurance Committee by the Director of Nurses for further recommendations and evaluation. The alleged deficient practice could affect all residents in the facility who receive medications. Licensed nurses and medication aides will be in-serviced on	3/7/25

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F 759	Continued From page 6 An interview with Nurse #4 on 1/8/25 at 9:51 AM revealed Aspirin was supposed to be one of the medications in the cup which he gave to Resident #19, and he thought he had pulled it first. b. The Physician's Orders in Resident #19's electronic medical record indicated an active order dated 11/5/24 for Trelegy Ellipta inhalation aerosol powder breath activated - 1 puff inhale orally one time a day for COPD (chronic obstructive pulmonary disease). Rinse mouth with water and spit back into a cup. On 1/8/25 at 8:33 AM, Nurse #4 was observed as he administered Resident #19's medications. Nurse #4 activated Resident #19's Trelegy inhaler and handed it to Resident #19 who took a deep breath while inhaling into the inhaler. Resident #19 handed the inhaler back to Nurse #4, and then took a sip of his supplement through a straw. An interview was conducted with Nurse #4 on 1/8/25 at 9:51 AM and he stated that Resident #19 took a sip of his supplement after doing his Trelegy inhaler and that was sufficient to rinse his mouth. A phone interview with the Consultant Pharmacist on 1/8/25 at 3:50 PM revealed Trelegy contained a steroid, so it was necessary to have the resident rinse his mouth after and spit the water out. The Consultant Pharmacist stated that steroid would lower the immune response and could increase the possibility of thrush. He stated Trelegy inhaler could leave residual powder which was why the residents needed to rinse their mouth and spit the water out. He added that	F 759	medication administration policies and procedures by the Director of Nurses or designee which includes following the MD orders and MDI inhaler use by the Director of Nurses or her designee by 2/28/25. The Director of Nurses or her designee will conduct random medication administration observation audits to ensure continued compliance 2 x week x 4 weeks. The audit will continue on a weekly basis to assure compliance with State and Federal regulations. The results will be taken to the Quality Assurance Committee by the Director of Nurses for further recommendations and evaluation. To prevent the deficient practice from occurring, a systemic review of facility systems including current policy and procedures was completed by the Director of Nurses and the RN Supervisor between 1-9-25 and 1-30-25. This review found that policies and procedures followed State and Federal regulations. The Pharmacy Consultant will review and complete medication pass audits quarterly. The Director of nurses or her designee will conduct random medication administration observation audits to ensure continued compliance 2 x week x 4 weeks. The results will be brought to the Quality Assurance Committee monthly by the Director of Nurses for further recommendations and evaluation. The Quality Assurance Committee will assure compliance through the Internal Quality Assurance process on a monthly basis during the QAPI Meeting.	

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F 759	Continued From page 7 taking a sip of water and swallowing was not recommended to prevent oral thrush development. An interview with the Nurse Supervisor on 1/8/25 at 3:25 PM revealed it was not acceptable to have a resident take a sip of water instead of rinsing and spitting the water out after being administered a steroid inhaler. The Nurse Supervisor stated the nurse should prompt the resident and make sure that they do each step correctly. An interview with the Director of Nursing (DON) on 1/9/25 at 11:39 AM revealed the nurses should double check the Medication Administration Record and be mindful of the 5 rights of medication administration to prevent medication errors. The DON stated that the nurse should have given the resident instructions on rinsing his mouth with water and spitting it back into a cup instead of just letting him sip water, because steroid could cause oral thrush.	F 759	Monitoring: Licensed nurses and medication aides will be in-serviced on medication administration policies and procedures by the Director of Nurses or designee which includes following the MD orders and MDI inhaler use by the Director of Nurses or her designee by 2/28/25. The Director of Nurses or her designee will conduct random medication administration observation audits to ensure continued compliance 2 x week x 4 weeks. The audit will continue on a weekly basis to assure compliance with State and Federal regulations. The results of the audits will be taken to the Quality Assurance Committee by the Director of Nurses for further recommendations and evaluation. The Quality Assurance Committee will assure compliance through the Internal Quality Assurance process on a monthly basis during the QAPI Meeting beginning with the next monthly QA meeting on 2/28/25 and on-going.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		3/7/25

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F 761	Continued From page 8 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date medications available for use, store an unopened eye drop bottle in the refrigerator until opened for use, and discard expired medications from 3 of 4 medication carts (400 hall medication cart, 500 hall medication cart, and 200 medication cart). The findings included: a. An observation of the 400 hall medication cart on 1/9/25 at 9:42 AM with Nurse #2 revealed an undated Insulin Glargine pen available for use in the top drawer of the medication cart. A review of the manufacturer's instructions for Insulin Glargine indicated it expired 28 days after first use, and if not refrigerated, it could be stored at a controlled room temperature of 86 degrees Fahrenheit or less for up to 28 days. An interview with Nurse #2 on 1/9/25 at 9:50 AM revealed she was not sure whether the Insulin	F 761	No residents were found to be affected by the undated or unlabeled medication. Medication carts were audited on 1/9/25 by the RN Supervisor and any expired medications were removed. Any undated insulin pens were dated and organized by the route of administration on 1/9/25 by the RN Supervisor. The unopened eye drops located in the medication cart were discarded and replacement eye drops were ordered from the pharmacy on 1/9/25 by the RN Supervisor. All licensed nurses will be re-educated by the Director of Nurses or designee on the medication storage policy and insulin pen policy and procedure specific to dating the label when opening insulin pens or vials by 2/28/25. Audits will be completed nightly by the assigned night nurse, weekly by the Director of Nurses or designee for four weeks and quarterly by the Pharmacy Consultant Nurse for four quarters. The	

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F 761	Continued From page 9 Glargine pen was open or not, but it must be dated when removed from the refrigerator. Nurse #2 stated that it was only given at bedtime, so she didn't notice it. Nurse #2 stated that every nurse should be checking the medication carts for undated and expired medications. b. An observation of the 500 hall medication cart on 1/9/25 at 9:53 AM with Nurse #3 revealed an unopened bottle of Geri-Lanta (liquid antacid) marked with a manufacturer's expiration date of 11/24. The bottle of Geri-Lanta was available for use in the third drawer of the medication cart. An interview with Nurse #3 on 1/9/25 at 9:55 AM revealed she checked the 500-hall medication cart quickly this morning, but she did not notice the expired bottle of Geri-Lanta. c. An observation of the 200 hall medication cart on 1/9/25 at 11:10 AM with Nurse #4 revealed an unopened and undated bottle of Latanoprost eye drops available for use in the top drawer. The bottle had a pharmacy sticker that indicated it expired six weeks after opening. Review of the manufacturer's instruction dated August 2011- Storage: Protect from light. Store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F). During shipment to the patient, the bottle may be maintained at temperatures up to 40°C (104°F) for a period not exceeding 8 days. Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks. An interview with Nurse #4 on 1/9/25 at 11:12 AM revealed that he had no idea when the bottle of Latanoprost eye drops was taken out of the	F 761	Quality Assurance Committee will assure compliance through the Internal Quality Assurance Process. All audit results will be submitted to the monthly QAPI Committee meeting by the Director of Nursing for review and recommendation. All residents have the potential to be affected by the alleged deficiency. Medication carts were audited on 1/9/25 by the RN Supervisor and any expired medications were removed. Any undated insulin pens were dated and organized by the route of administration on 1/9/25 by the RN Supervisor. The unopened eye drops located in the medication cart were discarded and replacement eye drops were ordered from the pharmacy on 1/9/25 by the RN Supervisor. All licensed nurses will be re-educated by the Director of Nurses or designee on the medication storage policy and insulin pen policy and procedure specific to dating the label when opening insulin pens or vials by 2/28/25. Audits will be completed nightly by the assigned night nurse, weekly by the Director of Nurses or designee for four weeks and quarterly by the Pharmacy Consultant Nurse for four quarters. The Quality Assurance Committee will assure compliance through the Internal Quality Assurance Process. All audit results will be submitted to the monthly QAPI Committee meeting by the Director of Nursing for review and recommendation. Systemic Changes to prevent	

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F 761	Continued From page 10 refrigerator, but that it only needed to be dated once it was opened unless there was a new guideline that he didn't know about. Nurse #4 stated that he didn't know it was supposed to kept in the refrigerator until opened for use. Nurse #4 stated that all the nurses were supposed to check the medication carts for expired medications and undated medications. An interview with the Director of Nursing (DON) on 1/9/25 at 11:39 AM revealed she would need to check, but she knew that Insulin Glargine expired after 28 days of opening so it should be dated once opened. She stated that the expired bottle of Geri-Lanta should have been discarded. The DON further stated that it was her understanding that Latanoprost could be used until the whole bottle was depleted regardless of when it was opened, but it needed to be kept in the refrigerator until ready for use. The DON shared that all the floor nurses were responsible for checking the medications in the medication carts with follow-up from the Nurse Supervisor and her.	F 761	The Director of Nurses and Administrative Nurses have been assigned a medication cart and will complete observation audits utilizing a audit tool which will be given to the Director of Nurses of all medication storage carts and rooms to verify medication and biologicals are stored in accordance with State and Federal guidelines beginning 1/30/25 and on-going. Audits will be completed nightly by the assigned night nurse with the results given to the Director of Nurses daily. A audit will be done by the Consultant Pharmacist quarterly beginning 2/20/25 and on-going. Monitoring: The Director of Nurses and Administrative Nurses have been assigned a medication cart and will complete observation audits utilizing a audit tool which will be given to the Director of Nurses of all medication storage carts and rooms to verify medication and biologicals are stored in accordance with State and Federal guidelines beginning 1/30/25 and on-going. Audits will be completed nightly by the assigned night nurse with the results given to the Director of Nurses daily. A audit will be done by the Consulting Pharmacist quarterly beginning 2/20/25 and on-going. The Director of Nurses will present the results of the audits to the Quality Assurance Committee will assure compliance through the Internal Quality Assurance Process. All audit results will	

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F 761	Continued From page 11	F 761	be submitted to the monthly QAPI Committee meeting for review and recommendation beginning with the next scheduled QA Meeting beginning 2/28/25	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove an expired nutritional supplement and expired ready-to-eat personal resident food from 2 of 2 nourishment rooms (North and South hall). The deficient practice had the potential to affect residents residing in the facility. Findings included:	F 812	The outdated items were removed prior to any resident receiving them by the Dietary Manager on 1/8/25. All food items were evaluated for expiration dates and any items not in date were disposed of on 1/8/25 by the Dietary Manager. The deficient practice has the potential to	3/7/25

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F 812	Continued From page 12 An observation of the North nourishment room on 1/8/25 at 10:53 AM with the Dietary Manager (DM) found an expired unopened nutritional supplement stored in a cabinet. The nutritional supplement had an expiration date of 12/9/24. The DM immediately removed the supplement. The DM stated during the observation the nutritional supplement was stocked by the kitchen staff and should have been thrown out when it expired. An observation of the South nourishment room with the DM on 1/8/25 at 10:56 AM found expired resident food in the refrigerator. The refrigerator contained 3 unopened individually packaged ready-to-eat resident food containers with a use by date of 12/31/24. The DM stated during the observation that the nourishment rooms were checked twice daily at 6:00 AM and 3:00 PM and were checked that morning. The DM stated the expired food was overlooked. The Dietary Aide who had checked the nourishment rooms was interviewed on 1/8/25 at 11:04 AM. She stated she did check the nourishment rooms that morning and did not see the expired items. The Administrator stated on 1/9/25 at 1:05 PM the expired resident food and the nutritional supplement should have been removed and disposed when expired.	F 812	affect all residents having access to food items used in the North and South Nourishment rooms. No residents were found to have consumed expired food or supplements from either nourishment rooms on 1/8/25. Systemic Changes: Staff and Residents/Responsible Party who have access to the nourishment rooms were educated via the One Call system on 2/11/25 by the Director of Nurses and this information will be added to the admissions packet going forward beginning 2/28/25 . The dietary manager and employees were educated by the Director of Nurses on 1/31/25 to ensure understanding of the requirement for Food Procurement and Storage to ensure the health and well being of the residents. The dietary manager or designee will audit the removal of expired items, labeling and dating of food items and the packaging of supplements daily x 30 days, then weekly x 4 weeks and monthly x 2 months, followed by random auditing by the Director of Nurses or her designee utilizing a audit tool to document their findings and the solution that was implemented. Audits began on 1/30/25 and will be on-going and will be presented to The Quality Assurance Committee who will assure compliance through the Internal Quality Assurance Process. Audit results will be submitted to the QAPI Committee by the Dietary Manager	

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F 812	Continued From page 13	F 812	monthly for review and recommendations. Monitoring: The dietary manager or designee will audit the removal of expired items, labeling and dating of food items and the packaging of supplements daily x 30 days, then weekly x 4 weeks and monthly x 2 months, followed by random auditing by the Director of Nurses or her designee utilizing a audit tool to document their findings and the solution that was implemented. Audits began on 1/30/25 and will be on-going and will be presented to The Quality Assurance Committee who will assure compliance through the Internal Quality Assurance Process. Audit results will be submitted to the QAPI Committee by the Dietary Manager monthly for review and recommendations beginning with the next QA Meeting scheduled for 2/28/25.	
F 880 SS=L	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	F 880		3/1/25

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F 880	Continued From page 14 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 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.	F 880		

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F 880	Continued From page 15 §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 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, and staff, Nurse Practitioner (NP), and Health Department (HD) Nurse interviews, the facility failed to operationalize updated infection control policy and procedures in accordance with current Centers for Disease Control and Prevention (CDC) guidance. A) The facility failed to implement broad-based approach COVID-19 testing for staff and residents on 12/26/24 when a staff member and residents on two different resident halls tested positive for COVID-19. Broad-based COVID-19 testing per the (CDC) guidance was not implemented until 1/8/24 after surveyor intervention. Before broad-based testing was implemented on 1/8/24, a total of 8 staff members and 17 residents tested positive for COVID-19. Results of the broad-based testing from 1/8/24 and 1/9/24 yielded one (1) staff member and 4 additional residents positive for COVID-19. In addition, the facility failed to implement staff source control to help prevent transmission while working in the facility during the COVID-19 outbreak. B) In addition, the facility failed to provide staff N95 masks for the care of	F 880	For those residents affected: The Nurse Practitioner examined each resident who tested positive for COVID-19 as soon as possible upon learning of the positive test results and reviewed the residents chart at that time. No residents were identified as having suffered serious adverse outcomes. The Director of Nurses and Administrative Nurses broad-base COVID-19 tested all residents and staff not confirmed positive including agency and contracted staff on 1/9/25. Those residents found to be COVID-19 Positive were placed on Transmission based precautions. A systemic review of facility systems including current policy and procedures was completed by the Director of Nurses between 1-9-25 and 1-30-25. The policies and procedures were being followed per the CDC, State and Federal Guidelines.	

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F 880	Continued From page 16 COVID-19 positive residents per CDC guidance. Facility staff failed to wear all personal protection equipment (PPE) required according to CDC guidance when they entered resident rooms under transmission-based precautions (TBP) for COVID-19. C) The facility also failed to restrict staff from returning to work after testing positive for COVID-19 in accordance with current CDC guidance. D) The facility failed to have updated COVID-19 policies and procedures that aligned with current CDC guidance for COVID-19 testing, PPE requirements for transmission-based precautions and work restriction guidance for healthcare personnel. The resident census at the time of the survey was 97. There were 47 residents whose COVID-19 vaccinations were up to date. 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. Immediate Jeopardy began on 12/26/24 when a staff member and residents on two different resident halls tested positive for COVID-19 and the facility failed to implement broad-based approach COVID-19 testing for staff and residents. Immediate jeopardy was removed on 1/9/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of F (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings included: A. A facility policy entitled COVID prevention, response, and reporting dated 12/31/24 read in	F 880	Infection Control and Prevention education was sent to staff on 1/8/25 via a online training module and will also be conducted in person by the Director of Nurses and Administrative Nurses or designee for those staff members who do not have access to SNF Clinic. Education will be completed 2/28/25 The Director of Nurses and the Infection Preventionist (IP) will increase infection control surveillance to ensure PPE Guidelines are adhered to throughout the facility in accordance with the CDC, State and Federal guidelines. N95 Supplies were ordered on 1/9/25 and made available to the staff and mandatory education was provided to the staff by the Director of Nurses and the Infection IP between 1-9-25 and 1-30-25. All non confirmed positive cases, staff including agency and contracted staff were tested on 1/8/25 All residents have the potential to be affected: The Nurse Practitioner examined each resident who tested positive for COVID-19 as soon as possible upon learning of the positive test results and reviewed the residents chart at that time. No residents were identified as having suffered serious adverse outcomes. The Director of Nurses and Administrative Nurses broad-base COVID-19 tested all residents and staff not confirmed positive	

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F 880	Continued From page 17 part: "The facility will perform viral testing for COVID as per national standards such as CDC recommendations." "Responding to a newly identified COVID infected HCP or resident: The facility should defer to the recommendations of the jurisdictions' public health authority when performing an outbreak response to a known case. A single new case of COVID infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad- based approach is preferred if all contact cannot be identified or managed with contact tracing or if contract tracing fails to halt transmission. Perform testing for all resident and HCP identified as close contacts or on the affected units if using a broad-based approach, regardless of vaccination status." "The infection preventionist or designee, will monitor and track COVID related information to include but not limited to: The number of residents and staff who exhibit signs and symptoms of COVID. The number of residents and staff who have suspected or confirmed COVID and date of confirmation. Supply of personal protective equipment and other relevant supplies." A facility policy entitled "Infection prevention and control program" dated 12/31/ 24 read in part: "COVID testing: Anyone with even mild symptoms of COVID, regardless of vaccination status, should receive a viral test for COVID as soon as possible. Asymptomatic residents with	F 880	including agency and contracted staff on 1/9/25. Those residents found to be COVID-19 Positive were placed on Transmission based precautions. A systemic review of facility systems including current policy and procedures was completed by the Director of Nurses between 1-9-25 and 1-30-25. The policies and procedures were being followed per the CDC, State and Federal Guidelines. Infection Control and Prevention education was sent to staff on 1/8/25 via a online training module and will also be conducted in person by the Director of Nurses and Administrative Nurses or designee for those staff members who do not have access to SNF Clinic. Education will be completed by 2/28/25 The Director of Nurses and the Infection Preventionist (IP) will increase infection control surveillance to ensure PPE Guidelines are adhered to throughout the facility in accordance with the CDC, State and Federal guidelines. N95 Supplies were ordered on 1/9/25 and made available to the staff and mandatory education was provided to the staff by the Director of Nurses and the Infection IP between 1-9-25 and 1-30-25. All non confirmed positive cases, staff including agency and contracted staff were tested on 1/8/25 Systemic Changes: a) The Director of Nurses or designee and/or IP will increase infection control	

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F 880	Continued From page 18 close contact with someone with COVID infection should have a series of three viral tests for COVID infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 58 hours after the second negative test. This will typically be at day 1, day 3, and day 5." "If healthcare-associated transmission is suspected or identified, the facility may consider expanded testing of HCP and residents as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. Testing should occur on all symptomatic residents." A review of the facility's list of positive COVID-19 residents and staff revealed the facility's COVID outbreak started on 12/26/24 when the facility Social Worker (SW) tested positive for COVID-19 and a resident on the 400 hall and a resident on the 500-hall tested positive for COVID-19. No contact tracing or broad-based testing was conducted until 01/08/25 after surveyor intervention. - The SW tested positive for COVID on 12/26/24. - Resident #18 in room 408 was positive for COVID on 12/26/24 - Resident #98 in room 518 was COVID positive on 12/26/24 - The front desk Receptionist tested positive for COVID on 12/27/24 - Nurse #6 tested positive for COVID on 12/27/24 - Resident #55 in room 108A was COVID positive	F 880	surveillance rounds to ensure PPE guidelines are adhered to throughout the facility in accordance with CDC, State and Federal guidelines. Any issues identified during this process will be addressed immediately. A PPE usage compliance form will be utilized to document findings. b)The Director of Nurses or designee will complete in-service education for employees on infection control and prevention with a emphasis on PPE usage and broad-based testing during a COVID-19 outbreak. The training will be added to the new hire orientation packet and will be provided annually after completion of of three months of education during the monthly mandatory staff training. c)A systemic review of facility systems including current policy and procedures was completed by the Director of Nurses between 1-9-25 and 1-30-25. The policies and proc d) The Haywood County Health Department Infection Control Nurse will be notified as soon as possible upon a COVID-19 outbreak for updated guidance and directives. Monitoring: a) The Director of Nurses and the IP will increase infection control surveillance to ensure PPE Guidelines are adhered to throughout the facility in accordance with the CDC, State and Federal guidelines	

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F 880	Continued From page 19 on 12/29/24 - Resident #94 in room 519A was COVID positive on 12/29/24 - Resident #48 in room 511B was COVID positive on 12/30/24 - Nurse #4 tested positive for COVID on 12/31/24 - Resident #70 in room 411 was COVID positive on 12/31/24 - An Environmental Services (EVS) staff member tested positive for COVID on 1/2/25 - Resident #19 in room 506A was COVID positive on 1/2/25 - Resident #93 in room 513B was COVID positive on 1/3/25 - Resident #21 in room 514A was COVID positive on 1/3/25 - Resident #97 in room 109A was COVID positive on 1/3/25 - Resident #11 in room 505A was COVID positive on 1/4/25 - Resident #69 in room 505B was COVID positive on 1/4/25 - Resident #99 in room 405 was COVID positive on 1/5/25 - Resident #82 in room 303A was COVID positive on 1/5/25 - Transport Aide #1 tested positive for COVID on 1/7/25. - Transport Aide #2 tested positive for COVID on 1/7/25. - Resident #38 in room 406 was COVID positive on 1/7/25 - Resident #505 in room 409 was COVID positive on 1/7/25 - Resident #45 in room 106A was COVID positive on 1/7/25 The following were the results of COVID-19 testing after broad-based testing was initiated:	F 880	observing five employees weekly for four weeks and document the findings on a PPE usage compliance form. Any issues identified during this process will be addressed promptly and brought to the Director of Nurses for further review. b) The Director of Nurses will continue in-service and educate for employees concerning infection control and prevention with an emphasis on PPE usage and broad-based testing during a COVID-19 outbreak. The education will be added to new hire orientation and will also be provided annually after completion of three months of education in the monthly mandatory staff training. Education will be completed by 2/28/25 c) The Director of Nurses or designee will monitor PPE Supplies weekly to ensure the facility has ample supplies. d) The Quality Assurance Committee will assure compliance through the Internal Quality Assurance process each month during the monthly QAPI meeting. The PPE audits will be taken to QAPI by the Director of Nursing x 3 months. e) The Director of Nurses will track staff using the master staffing roster and schedule which includes all departments and agency staff, to provide testing prior the staff being allowed to work during a COVID-19 outbreak. f) Close contact COVID-19 test will be completed upon identification of a positive	

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F 880	Continued From page 20 - Nurse Aide #6 (NA) tested positive for COVID on 1/8/25 -Resident #95 in room 412 was COVID positive on 1/8/25 -Resident #34 in room 501B was COVID positive on 1/8/25 -Resident #86 in room 510A was COVID positive on 1/8/25 -Resident #101 in room 502A was COVID positive on 1/9/25 An interview was conducted with the Infection Preventionist (IP) on 1/7/25 at 2:41 PM. The IP explained 2 or more confirmed cases of COVID-19 was considered an outbreak. The IP said the facility's COVID-19 outbreak began on 12/26/24 when two residents and a staff member had tested positive for COVID-19. The IP explained the facility had 12 residents currently who were COVID-19 positive. She said residents were placed on transmission-based precautions for 10 days when they tested positive for COVID-19. She did not know if the facility had notified the local Health Department (HD) of the facility's COVID-19 outbreak. The IP said she had not notified the HD. The IP explained that since the outbreak was identified on 12/26/24 the facility had only tested residents and staff for COVID-19 if they had symptoms. She said the facility had not completed contact tracing to determine if there were close contacts of residents or staff who needed to be tested because she thought COVID-19 testing was only supposed to be done if an individual was symptomatic. The IP stated the facility had not performed broad based testing of residents and staff who did not have symptoms because she thought that was not the current CDC	F 880	COVID-19 resident and transition to broad-based testing if indicated. g) N-95 fit testing of staff was done on 1/23/25 by the Director of Nurses and the IP and will continue to be done on new hires. h) The Director of Nurses will present the findings to the Quality Assurance Committee to assure compliance through the Internal Quality Assurance process each month during the monthly QAPI meeting for three months or until substantial compliance has been achieved beginning with the next scheduled QA Meeting 2/28/25. Directed Plan of Correction: 1. Blood Glucose Meters: The facility provides glucose meters for each resident who requires blood glucose monitoring. The equipment is single resident-use, in order to prevent the inadvertent use of the device for additional residents and cross contamination, the blood glucose monitors are cleaned each use with Micro-Kill One and left wet for two minutes per the manufacturers recommendations. The cleaned blood glucose is then placed into a plastic bag that is individually labeled with each residents name and stored in the medication cart. 2. Root Cause Analysis: The facility was not following the most recent guidelines from the CDC, State and Federal Guidelines. The in-house Infection	

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F 880	Continued From page 21 recommendation. She said the current CDC recommendations for COVID-19 testing were to only test someone if they were symptomatic. The IP indicated roommates of COVID-19 positive residents were not tested for COVID-19 unless they had symptoms. The IP was unable to provide information on how the facility monitored residents for COVID-19 symptoms to determine if they needed to be tested. An interview was conducted with the Director of Nursing (DON) on 1/7/25 at 3:45 PM. The DON said more than one case of COVID-19 would be considered an outbreak. The DON said the facility tested residents and staff for COVID-19 only if they had symptoms. The DON explained that the facility followed the CDC guidance for COVID-19 testing and the current guidance said to only test for COVID-19 if someone was symptomatic. The DON thought a roommate of a COVID-19 positive resident would be considered close contact. She additionally said she thought the facility should be doing COVID-19 testing for close contacts. The DON explained that the facility had not been doing COVID-19 testing for close contacts and only tested the roommate if they were symptomatic on a case-by-case basis, because she thought the CDC recommendations for COVID-19 testing had changed and said to only test individuals if they had symptoms. The DON said she thought the roommate of COVID-19 positive residents should be tested and would have the Nurse Supervisor test them today. She said the facility did not test the staff who worked with the COVID-19 positive residents. The DON explained staff were only tested if they were symptomatic. The DON thought the facility no longer needed to report COVID-19 to the HD and said she had not contacted the HD about the	F 880	Preventionist has been changed to a better qualified employee who is currently SPICE Certified at the hospital level and has experience in that area. She will also attend the upcoming SPICE Training in April 2025. Jessica Raney, MSI, CIC, Clinical Infection Prevention Consultant from the SPICE Center for Infection Control reviewed policies and procedures and surveyed the facility on 2/11/25. Jillian Paulk, RN, BSN, CT-DNS, IP, CWS Regional Director of Clinical Services Maximus Healthcare Group is the facilities qualified consultant. The facility received and quickly implemented current infection control policies related to COVID-19, transmission based precautions, staff and resident testing guidelines with details on return to work for staff (policies align with current CDC, State and Federal regulations. PPE was ordered on 1/8/25 and the facility will review the stock of PPE each week and order accordingly. The Director of Nurses and the Infection Preventionist (IP) will increase infection control surveillance to ensure PPE Guidelines are adhered to throughout the facility in accordance with the CDC, State and Federal guidelines. The new IP□s involvement with the plan of correction includes: Working with SDC to educate current staff in real time related to PPE use and transmission-based precautions/hand hygiene; Reviews and verifies proper PPE utilization, including donning and doffing with new hires at orientation; N95 fit-test at orientation Audits med carts and medication rooms	

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F 880	Continued From page 22 facility's COVID-19 outbreak. The DON said she had reached out to the HD today to see if they needed to report the facility's COVID-19 outbreak and had left a message for the communicable disease nurse. An additional interview was conducted with the DON at 1/8/25 at 9:31 AM. The DON said she had spoken with HD Nurse. The DON explained the HD Nurse wanted to be called if the facility had more than one case of COVID-19 to go over systems, processes, any Personal Protective Equipment (PPE) needs, and ideas on how to contain it. The DON explained when she had been told the facility no longer needed to do the COVID-19 spread sheet to report to the HD she had misinterpreted that to mean they no longer needed to report COVID-19 to the HD. The DON explained she consulted with the corporate nurse regarding the facility's infection control/ COVID-19 policies and she said they were not up to date. The DON explained that the corporate nurse was reviewing and updating the infection control/ COVID-19 policies and was going to send the updated policies to her today. An interview was conducted on 1/7/25 at 11:47 AM with the HD Nurse. The HD Nurse said facilities were supposed to call and report to the HD if there were two or more confirmed cases of COVID-19 with 72 hours of each other. She explained the HD would provide guidance and recommendations to the facility to help mitigate the outbreak. She stated the facility had not contacted the HD to report a COVID-19 outbreak. The HD Nurse explained the facility should test anyone who was considered a close contact. She said the roommate of a COVID-19 positive resident would be considered close contact. The	F 880	routinely and PRN for infection control related to compliance issues. Audits PPE utilization/ hand hygiene compliance routinely and PRN Oversees N95-fit testing- fit test fair day with flu/covid immunization was 1/23/2025 Is responsible to deliver information to the DON and Administrator related to any potential communicable/viral outbreaks (more than one individual) in the facility, doing surveillance on both Staff and residents as needed, and will recommend when masking, as source control, is indicated. Has and will maintain logs for tracing (residents/staff) during any situation where contact tracing is necessary. Infection Control and Prevention education was sent to staff on 1/8/25 via a online training module and will also be conducted in person by the Director of Nurses and Administrative Nurses or designee for those staff members who do not have access to SNF Clinic. Education will be completed 2/28/25 No positive COVID-19 cases at this time.	

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HD nurse said the facility should test close contacts on day 1, 3, and 5. She stated if the facility was seeing COVID-19 positive cases unit or facility wide then they needed to do broad based testing of all residents and staff. She explained residents and staff needed to be initially tested then tested every 3-7 days until there were no new COVID-19 cases for 14 days.

An interview was conducted on 1/8/25 at 11:18 AM with the NP. The NP said the facility should follow CDC guidance for health care settings for COVID-19. The NP thought the CDC recommended symptomatic testing. She had not thought the CDC recommended broader based testing just because multiple COVID-19 positive cases had been identified in the building. The NP said she deferred questions regarding COVID-19 testing if needed to the IP. The IP stated the facility should have policies for COVID-19 and should be following those.

An interview was conducted with the Administrator on 1/8/25 at 12:24 PM. The Administrator said she was not a nurse and deferred to the DON and the IP for the management of the COVID-19 outbreak. The Administrator thought the facility had been following the most current CDC guidance.

B. On 1/6/25 the IP was asked to provide the infection control policies the facility used for the management of COVID and transmission-based precautions. The IP provided a facility policy entitled "Infection prevention and control program" dated 12/3/21. Under date reviewed/ revised it read "annually", there was no date to indicate when the policy had last been reviewed/ revised. The policy read in part: "Isolation

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protocols (transmission-based precautions): A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines."

A facility policy dated 12/23/24 entitled "Hand Hygiene" read in part:
"All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors."
"Hand hygiene is indicated and will be performed under the conditions listed in but not limited to the attached hand hygiene table."
-Hand hygiene table conditions listed included "before applying and after removing personal protective equipment (PPE), including gloves. Before and after providing care to residents on isolation."

An updated facility policy entitled "COVID prevention, response, and reporting" dated 12/31/24 was received by the facility on 1/8/25 and read in part:
"The facility will establish a process to identify and manage individuals with suspected or confirmed COVID infection to include: Ensure everyone is aware of the recommended infection prevention control (IPC) practices in the facility by posting visual alerts (e.g signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations. Establishing a process to makes everyone entering the facility aware of recommended actions to prevention transmission to others."

"Source control is recommended more broadly in the following circumstances by residing or working on a unit or area of the facility

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experiencing a COVID or other outbreak of respiratory infection. Facility wide or based on a facility risk assessment, targeted toward higher risk areas or resident populations during periods of higher levels of community COVID or other respiratory virus transmission; have otherwise had source control recommended by public health authorities."

"HCP who enter the room a resident with suspected or confirmed COVID infection should adhere to standard precautions and use a N95 filtration or higher mask, gown, gloves, and eye protection."

On 1/6/25 at 9:50 AM upon entry to the facility an observation was conducted of the reception desk and lobby area. There was no visual signage present at the entrance to alert staff or visitors of the facility's COVID-19 outbreak or infection control practices. There were no surgical masks available on the reception desk countertop for staff or visitors. The Administrator greeted the survey team and was not wearing a mask.

An observation on 01/6/25 at 10:37 AM was conducted of the south nursing station. There was an opened box of surgical masks available on the nursing station desk.

An observation was conducted on 01/6/25 from 10:37 AM to 10:47 AM of the north nursing station and the 500-hall. There were no surgical masks visible at the nursing station desk. NA #3 and NA #4 were observed at the nursing station with surgical masks on that were pulled down under their chin and not covering their nose or mouth. Nurse #4 was observed at the nursing station without a mask. The following rooms 505,506,

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511, 513, 514, and 519 were observed to have a transmission-based precautions sign on the outside of the room door. There were carts located outside of each transmission-based precautions room with surgical masks, gowns, gloves, and eye protection. There were no N95 masks observed on the PPE carts.

A continuous observation was conducted on 1/6/25 from 10:51 AM to 10:58 AM of Nurse #4. He was observed walking in the hallway without a mask. He stopped at a transmission- based precaution room and put on a surgical mask and gloves and entered room 511 at 10:51 AM. He was observed from the hallway leaning over Resident #48's bed to perform a blood glucose check. He entered the bathroom located in the resident room and the water was heard running. When Nurse #4 exited the bathroom to leave the room, he had removed his gloves and mask. Nurse #1 was then observed to walk back up the hallway and entered room 505 which had a transmission- based precautions sign on the door at 10:56 AM. He obtained a surgical mask from the PPE cart located at the room door and put it on and entered the room. He did not put on a gown, gloves, or eye protection. Nurse #4 exited room 505 at 10:58 AM and removed his surgical mask before walking back to the nursing station. He carried his mask with him to the nursing station and disposed of the mask in the trash at the nursing station and performed hand hygiene.

An interview was conducted with Nurse #4 on 01/6/25 at 11:39 AM. Nurse #4 explained the rooms on the 500-hall had transmission-based precautions in place because the residents had COVID-19. He said the rooms were shared resident rooms and if one resident in the room

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tested positive for COVID-19 transmission-based precautions were put into place for the entire room. He said all the COVID-19 positive rooms were identified by an isolation sign on the outside of the door and said if staff went into a transmission-based precautions room to provide care for the roommate who did not have COVID-19 they still needed to wear PPE. Nurse #4 said staff needed to wear gloves, gown, mask, and eye protection when they went into a COVID-19 positive room. Nurse #4 said Resident #48 was COVID-19 positive and he had not put on a gown or eye protection when he went in to Resident #48's room because he had just been checking her blood glucose. He said he would have worn a gown and eye protection if had been in the room longer or been doing more high contact care. Nurse #4 said he had gone into room 511 to set up a pudding cup for Resident #11 on her table. He said Resident #11 was COVID-19 positive, but he did not feel he needed to wear all the PPE to just set up a pudding cup. Nurse #4 said he had been trained on transmission-based precautions and PPE and all required PPE should be worn when going into an isolation room. He did not mention if N95 masks should be used or if they were available at the facility.

An observation of Physical Therapist (PT) #1 was conducted on 1/6/25 at 10:58 AM. PT #1 was observed in transmission-based precautions room 506. He was observed standing at the foot of bed 506 B with a portable therapy exercise bike. PT #1 was observed wearing a surgical mask but was not wearing a gown, gloves, or eye protection. Resident #19 in bed 506 A was COVID-19 positive. He was observed removing the portable therapy exercise bike and exiting the

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room at 11:03 AM. PT #1 exited the room wearing the surgical mask.

An interview was conducted with PT #1 on 1/6/25 at 11:03 AM. PT #1 explained he had been doing in room therapy with Resident #19's roommate. He explained Resident #19 was COVID-19 positive, but his roommate was not. PT #1 said the transmission-based precautions were only for bed 506 A (Resident #19) but were not for the roommate in 506 B. PT #1 said if he had been working with Resident #19 he would have needed to wear a gown, gloves, mask, and eye protection but had not thought he needed to wear it when he was in the room working with Resident #19's roommate. He stated COVID-19 positive rooms were identified using a sign and therapy received an updated list of COVID-19 positive residents every day. PT #1 said he was aware of the isolation sign on the door but had thought it just applied to the COVID-19 positive resident in the room. He said he disinfected the portable therapy exercise bike after it was used in a COVID-19 positive room.

A continuous observation was conducted on 1/6/25 from 12:27 PM to 12:37 PM of Nurse Aide #4 (NA) providing feeding assistance to Resident #14 in transmission-based precaution room 514. Resident #14 was not COVID-19 positive, but her roommate (Resident #21) was COVID-19 positive. NA #1 was observed wearing a gown, gloves, and a surgical mask. She was not observed wearing eye protection. NA #4's surgical mask was pulled down and did not cover her nose. She was sitting at Resident #14's bedside assisting with feeding. She repositioned her mask to cover her nose at 12: 37 PM and continued feeding Resident #14. There were no

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N95 masks observed on the PPE cart outside of the room.

An observation and interview was conducted with NA #4 on 1/7/25 from 10:02 AM to 10:10 AM. NA #4 was observed at the nursing station, walking in the hallway, and entering resident rooms on 500-hall that did not have transmission-based precautions in place. NA #4 had a surgical mask on, but it was pulled down under her chin and not covering her nose or mouth. NA # 4 said wearing a mask for source control was up to staff discretion. She said wearing a mask when going into a transmission-based precautions room was mandatory. NA #4 explained if one of the residents in the room was COVID-19 positive then transmission-based precautions applied to the entire room. NA #4 said she should have worn her mask over her nose and eye protection when she was in transmission-based precaution room 514 assisting Resident #14 with her meal on 1/6/25. She said she had forgotten to wear eye protection. NA #4 said she had received education on PPE and what PPE needed to be worn when entering a COVID-19 positive room. She said a gown, mask, gloves, and eye protection were needed when entering a COVID-19 positive room. NA #4 said she had never been told by the facility that an N95 mask needed to be worn for care of COVID-19 positive residents. She did not know an N95 should be worn when caring for a COVID-19 positive resident. NA #4 said the facility only provided surgical masks and was not sure if N95 masks were available at the facility.

NA #4's employee education record was reviewed and revealed she had received infection control training in February 2024 and July 2024.

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An observation was conducted on 1/6/25 at 12:38 PM of NA #3 delivering meal trays on 500-hall. NA #3 was observed entering transmission-based precaution room 506 wearing a surgical mask, gown, and gloves. The surgical mask was positioned below her chin and not covering her nose or mouth. NA #3 was not wearing eye protection. She did not remove or change her surgical mask after exiting room 506 and the mask was still positioned under her chin after exiting the room. NA #3 removed her gown and gloves and disposed of them in the trash when she exited the room and performed hand hygiene.

An interview and observation was conducted with NA #3 on 1/7/25 from 9:53 to 9:59 AM. NA #3 was observed at the nursing station and in the hallway on 400-hall. She was not wearing a mask. NA #3 said staff only had to wear a mask when going into a COVID-19 positive resident room and the mask should cover the nose and mouth. NA #3 said she had thought she had her mask pulled up over her nose when she had gone into the transmission-based precautions rooms to deliver meal trays on 1/6/25. She explained transmission-based precautions were for the entire room even if only one resident in the room was COVID-19 positive. NA #3 said she had worked at the facility since 2023 and had received education on transmission-base precautions, PPE, and what PPE needed to be worn when entering a COVID-19 positive room. NA #3 stated staff needed to wear a gown, mask, and gloves when they went into a COVID-19 positive room. She was not sure if staff needed to wear an N95 mask when caring for COVID-19 positive residents. She stated she had only ever

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seen surgical masks at the facility and was not sure if N95 masks were available at the facility. NA #3 recalled she had never been told by anyone at the facility staff needed to wear a mask for source control if there was a COVID-19 outbreak. NA #3 explained wearing a mask was individual staff choice. NA #3 further stated she had forgotten she needed to wear eye protection.

NA #3's employee education record was reviewed and revealed she had received infection control training in February 2024 and July 2024.

A continuous observation was conducted on 1/7/25 from 9:13 AM to 9:40 AM of Housekeeper #1. She was observed entering transmission-based precaution room 506 to clean. She was wearing a gown, gloves, and a surgical mask. At 9:19 AM housekeeper #1 exited room 506 and removed the gown and gloves and disposed of them in the trash on her cleaning cart. Housekeeper #1 did not perform hand hygiene or remove her mask. She donned new gloves and went to room 504 to clean, which was not a COVID-19 positive room. She exited room 504, removed her gloves and disposed of them in the trash on her cleaning cart. Housekeeper #1 had the same surgical mask in place and did not perform hand hygiene after exiting room 504 before donning new gloves and entering room 503 to clean which was not a COVID-19 positive room. She exited room 503, removed her gloves and disposed of them in the trash on her cleaning cart. She did not perform hand-hygiene and had the same surgical mask in place. She donned new gloves and a gown to enter transmission-based precaution room 505 to clean. Housekeeper #1 was stopped as she was entering the room.

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An interview was conducted with Housekeeper #1 on 1/7/25 at 9:41 AM. Housekeeper #1 said she had forgotten to perform hand hygiene after removing her PPE and before putting on new gloves. She stated she needed to wear all the PPE on the transmission-based precaution sign when she entered an isolation room. Housekeeper #1 explained she knew she needed to wear eye protection when she went into a COVID-19 positive room but had forgotten. She said she had been educated to change her mask after exiting a transmission-based precaution room but had forgotten. Housekeeper #1 said a surgical mask was the only mask offered by the facility; and did not know she needed an N95 mask when she went into a COVID-19 positive room.

On 1/7/25 at 9:17 AM Nurse #3 was observed entering transmission-based precaution room 513. Nurse #3 was wearing a surgical mask, gown, and gloves but she was not wearing eye protection. She removed the gown and gloves and performed hand hygiene before exiting the room. Nurse #3 did not remove and change her surgical mask when she exited the room.

An interview and observation was conducted on 1/7/25 at 10:11 AM with Nurse #3. Nurse #3 was observed at the north wing nursing station (500-hall) not wearing a mask. She said staff had to wear a mask when they went into a COVID-19 positive room. Nurse #3 thought staff should wear a mask whey they went into all resident rooms because there was currently a lot of COVID-19 positive residents, and no one knew who might test positive for COVID-19 next. She said earlier she had been wearing a mask on the hall, but she

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had removed her mask when she had come to the nursing station. Nurse #3 stated staff did not have to wear a mask except for in COVID-19 positive rooms. She had forgotten to wear eye protection when she went into the COVID-19 positive rooms because of her eyeglasses. Nurse #3 said she had received training on PPE and said a gown, mask, gloves, and eye protection should be worn for the care of COVID-19 positive residents.

Nurse #3's employee education record was reviewed and revealed she had received infection control training in February 2024 and July 2024.

An observation and interview was conducted on 1/8/25 at 8:51 AM of NA #5. She was observed walking out of a resident room that was not on transmission-based precautions on the 500-hall. She was not wearing a mask. NA #5 stated staff did not need to wear a mask except for when going into a COVID-19 positive room.

An observation and interview was conducted on 1/8/25 at 8:52 AM of Nurse #4 preparing medications at the medication cart on 500-hall and was not wearing a mask. Nurse #4 stated staff were only required to wear a mask in COVID-19 positive rooms, but that staff did not have to wear a mask anywhere else.

An interview was conducted on 1/7/25 at 11:47 AM with the HD Communicable Disease Nurse. She stated a gown, gloves, N95 mask, and eye protection should be used by staff for COVID-19 positive rooms. She explained ideally the patient should be in a private room but if unable to remove the infected patient, then the roommate needed to be isolated as well. She said universal

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staff masking was recommended and best practice during a COVID-19 outbreak.

An interview was conducted on 1/7/25 at 2:41 PM with the IP. The IP stated she had been the facility's IP since 2018 and had attended the State Program for Infection Control and Epidemiology (SPICE) several times. She had most recently attended SPICE in March 2021. The IP indicated staff should follow transmission-based precautions and wear a mask, gown, gloves, and eye protection when entering a COVID-19 positive room. The IP explained the transmission-based precautions were for the entire room and included the roommate if only one resident in the room was positive. The IP said staff should perform hand-hygiene after removing PPE and before putting new gloves on. She stated staff masks should cover their nose and mouth entirely if they went into a transmission-based precaution room. The IP stated staff should throw their mask away and get a new one after exiting an isolation room. The IP explained it was staff choice if they wanted to wear a mask in non-COVID-19 positive rooms and in common areas. She said staff did not have to wear a mask unless going into a COVID-19 positive room. The IP explained the facility had an outside trainer come to the facility right before Christmas to train them on how to do fit testing for N95 masks. She said the facility had ordered fit testing supplies and N95 masks but that they had not been delivered yet. She did not say when the fit testing supplies and N95 masks had been ordered. The IP said the facility had used KN95 masks during the pandemic and the facility had started using surgical masks because they had thought KN95 masks were no longer allowed to be used. The IP stated staff had received training

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on infection control practices, hand-hygiene, transmission-based precautions, and PPE. The IP explained staff received training on hire and then twice a year, typically in January and July. The IP said staff received infection control training last in July 2024. The IP did not know why Housekeeper #1 had not known she needed to perform hand-hygiene after she removed her PPE and gloves, but said she needed additional education.

A follow up interview was conducted with the IP on 1/9/25 at 10:55 AM. She explained the facility had received the COVID-19 prevention and response policy from corporate on 1/8/25 and according to the policy staff needed to use an N95 mask when entering COVID-19 positive rooms. The IP explained she used the facility's transmission-based precaution signs to educate staff on the different types of transmission-based precautions and what PPE to wear for each type of precaution. The IP said the facility had been using an older version of transmission-based precaution/ sign for COVID-19 positive residents that indicated a surgical mask could be used. The IP said she had not been aware the transmission-based precautions/ sign for COVID-19 had changed and no longer included a surgical mask could be used. The IP said she had not realized the transmission-based precaution/ sign the facility was using was not the current version until the surveyor had brought it to her attention on 1/7/25.

An interview was conducted on 1/07/25 at 3:45 PM with the Director of Nursing (DON). The DON said staff should follow transmission-based precautions and wear a mask, gown, gloves, and eye protection when entering a COVID-19

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positive room. She stated staff should perform hand-hygiene after removing PPE. The DON said staff used a surgical mask for COVID-19 positive residents. The DON explained the facility had an outside trainer come to the facility and train them on how to do fit testing right before Christmas. The DON said the facility had N95 masks, but the staff had not been fit-tested yet to use them. She stated the facility had KN95 masks, but she was not sure if they could be used. The DON explained someone had told them they could no longer be used but she did not remember who had told her KN95 masks could no longer be used. The DON said she had not contacted the HD to obtain guidance or recommendations regarding N95 or KN95 mask use for staff. The DON stated it was staff choice if they wanted to wear a mask in non-covid rooms or common areas for their protection, but they did not have to wear them unless going into a COVID-19 positive room.

A follow up interview was conducted with the DON on 1/9/25 at 12:27 PM. The DON explained she thought the facility had N95 masks in house but said the N95 masks had been ordered but had not arrived yet. The DON said she had spoken with the HD and the HD Communicable Disease Nurse on 1/8/25 and they had said the facility could have staff use KN95 masks until the N95 masks arrived. She said the facility had not had the COVID-19 Prevention and Response policy in-house to reference until they had received it from corporate on 1/8/25. She said the facility did not have a separate specific transmission-based precautions policy. She explained the older version of the transmission-based precautions sign the facility had been using for COVID-19 positive resident

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had said a surgical mask could be used. The DON had not realized the transmission-based precautions sign the facility was using for COVID-19 positive residents had changed and was not current. The DON said the COVID-19 Response and Reporting policy the facility had received on 1/8/25 said an N95 mask was needed by staff for COVID-19 positive rooms and during an outbreak staff needed to wear a mask for source control. The DON said the facility had not had the COVID-19 policy to reference and did not know the guidance had changed. She said the facility had a COVID-19 plan from the pandemic but that it had not been updated, was not current, and the facility no longer used it. She said prior to receiving the updated policy from corporate on 1/8/25 the facility had used CDC guidance and had thought they had been following the most current guidance. The DON said she did not have an explanation except that with all the CDC guidance changes/ updates the facility did not know what the most current guidance was.

A follow up telephone interview was conducted on 1/13/25 at 11:55 AM with the DON and Administrator. The DON explained the IP had been responsible for ordering N95 masks and fit testing supplies and had not ordered them. The DON said she had ordered N95 masks for the facility on 1/8/25. She said she had also had to order a new fit test kit because the kit the facility had in-house expired. The DON stated the facility had received the N95 mask order. She explained the HD said it was okay for staff to use the N95 masks for care of COVID-19 positive residents without fit testing in the interim until fit testing could be completed.

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An interview was conducted with the NP on 1/8/25 at 11:18 AM. The NP said staff should wear a gown, N95 mask, gloves, and eye protection when going into COVID-19 positive rooms. She said the facility should follow CDC guidance for COVID-19. She was not sure if it was still recommended for staff to wear a mask for source control. She stated the facility should have infection control policy's for COVID-19 and should be following those. The NP said she wore a mask in the facility and when seeing residents but that every facility had different infection control policies and handled an outbreak differently.

An interview was conducted on 1/8/25 at 12:24 PM with the Administrator. She said staff should follow transmission-based precautions and wear all required PPE recommended by the CDC when going into a COVID-19 positive room. She said staff should perform hand-hygiene after removing PPE. The Administrator said face masks were not mandated for staff to wear except for in COVID-19 positive rooms.

C. A facility policy entitled "Return to work guidance for COVID positive employees" dated 9/23/22 read in part:
"Conventional staffing:
Healthcare personnel (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and at least 24 hours have passed since last fever without the use of fever reducing

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medications and symptoms have improved. 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 are not moderately to severely immunocompromised could return to work after the following criteria have been 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 or if a positive test at day 5-7). 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 last fever without the use of fever-reducing medications, and symptoms have improved. The test-based strategy as described for moderately to severely immunocompromised HCP can be used to inform the duration of work restrictions."

"Contingency staffing:
Employees with mild illness: At least 5 days have passed since symptoms first appeared (day 0), and at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms have improved.
Asymptomatic employees who are NOT immunocompromised: At least 5 days have passed since the date of their first positive viral test (day 0)."

"Crisis staffing:

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Consult with corporate before implementing. No work restriction with prioritization considerations (example- type of patients they care for, symptoms, degree of patient interaction)"

The facility's list of COVID positive staff was reviewed with the IP during an interview with the IP on 1/9/25 at 10:50 AM and revealed:
- On 12/26/24 the Social Worker (SW) tested positive for COVID. The IP said the SW was working on 12/26/24 and was sent home when she tested positive. The IP stated the SW returned to work on 12/30/24 which was day 4 after testing positive for COVID.
-On 12/27/24 the front desk Receptionist tested positive for COVID. The IP said the Receptionist was working on 12/27/24 and was sent home when she tested positive. The IP stated the Receptionist returned to work on 1/1/25 which was day 5 after testing positive for COVID.
-On 12/27/24 Nurse #6 tested positive for COVID. The IP said Nurse #6 returned to work on 1/3/25 which was day 7 after testing positive for COVID and worked on the 100-hall.
-On 12/31/24 Nurse #4 tested positive for COVID. The IP said Nurse #4 last worked on 12/30/24 on the 500-hall. The IP stated Nurse #4 returned to work on 1/6/25 which was day 6 after testing positive for COVID and worked on 500-hall on 1/6/25 and 1/8/25.
- On 1/2/25 an Environmental Services (EVS) staff member tested positive for COVID. The IP said the EVS staff member last worked on 1/2/25 on the 400-hall. The IP stated the EVS staff member returned to work on 1/7/25 which was day 5 after testing positive for COVID and worked on the 400- hall.

The CDC guidance for "Interim Guidance for

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Managing Healthcare Personnel (HCP) with COVID (SARS-CoV-2) Infection or Exposure to SARS-CoV-2" last updated March 18, 2024, read in part:
"Return to Work Criteria for HCP with SARS-CoV-2 Infection
The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immuno-compromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.
HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and
-At least 24 hours have passed since last fever without the use of fever-reducing medications, and
-Symptoms (e.g., cough, shortness of breath) have improved.
*Either a 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 who were asymptomatic throughout their

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infection and are not moderately to severely immunocompromised could return to work after the following criteria have been 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 or if a positive test at day 5-7).
*Either a 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 last fever without the use of fever-reducing medications, and
-Symptoms (e.g., cough, shortness of breath) have improved.
-The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.
The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immuno-compromising conditions should be considered when determining the appropriate duration for specific HCP.
HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date

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of their first positive viral test.
-Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work."

An interview was conducted with the IP on 1/9/25 at 10:52 AM. The IP was unable to provide information about the presence of staff symptoms, onset of symptoms, or resolution of symptoms. The IP explained staff were kept out of work for 5-7 days after testing positive for COVID-19. The IP stated staff had not been retested for COVID-19 prior to being allowed to return to work. The IP said the return-to-work guidance the facility had been using for staff said staff could come back to work after 5 days and that was what they had been going by. The IP said the facility had not had the updated return to work policy on hand to reference and had received it on 1/8/25 from the corporate nurse. The IP reviewed the updated return to work criteria policy dated 11/1/24. She said according to the policy staff may have returned to work too soon after having COVID-19. The IP agreed staff could still be contagious if they returned to work too soon and could contribute to the spread of COVID-19 within the facility.

An interview was conducted with the DON on 1/9/25 at 12:27 PM. The DON said the guidance the facility had been using said staff could come back to work 5 days after having COVID-19. The DON reviewed the facility's updated return-to-work criteria policy and said according to the policy staff may have come back to work too soon. The DON explained before they had received the updated policy on 1/8/25 the facility

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had been using an inaccurate policy that said staff could return to work in 5 days.

A follow up telephone interview was conducted on 1/13/25 at 11:55 AM with the DON and Administrator. The DON explained the facility had been using an older and inaccurate return to work guidance policy that needed to be updated. She said the older return to work policy had not aligned with the current CDC guidance. She explained the return-to-work policy the facility had been using had included a contingency option for staff to return to work after 5 days and that had been what the facility had been using. The DON said the facility had not been using a contingency staffing plan. She said they had used the same return to work guidance for so long she had not realized it had changed with of all the CDC guidance updates. The DON stated the IP had been responsible for determining when staff could return to work after COVID-19.

An interview with the Administrator was conducted on 1/9/25 at 1:06 PM. She said she had thought the facility had been following the most current CDC guidance. The Administrator said she had deferred to the DON and IP to review the CDC guidance to mitigate the COVID-19 outbreak. She said the facility had received the return-to-work criteria policy from corporate on 1/8/25.

D. On 1/6/25 the IP was asked to provide the infection control policies used by the facility for the management of the facility's COVID-19 outbreak. The IP provided a return-to-work guidance for COVID-19 positive employees policy dated 9/23/22, COVID-19 testing guidance updated 5/8/23, and an Infection prevention and

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control program policy dated 12/3/21. The infection prevention and control program policy had a "date reviewed/ revised" section that read "annually", the policy did not indicate the date it had last been reviewed/ revised.

An interview with the IP was conducted on 1/7/25 at 2:41 PM. The IP stated the facility did not have any other infection control policies than the policies provided.

An interview was conducted with DON on 1/7/25 at 3:45 PM. She said the facility used CDC guidance for the management of the COVID-19 outbreak. She stated the facility did not have any other infection control policies than what had been provided on 1/6/25.

An additional interview was conducted with the Director of Nursing on 1/8/25 at 9:31 AM. The DON said the infection control policies provided on 1/6/25 were the policies the facility had on hand and had been using. The DON stated the facility did not have access to policies electronically. The DON explained she had contacted the corporate nurse about the facility's infection control policies after being asked about the policies by the surveyor. She stated the corporate nurse told her the infection control policies the facility had needed to be updated. The DON explained that the corporate nurse was reviewing/updating the infection control policies and was going to send her the updated policies today (1/8/25). The DON said the facility had used CDC guidance for COVID-19 prior to receiving the updated policies today and had thought they had been following the CDC guidance correctly but were not.

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An interview was conducted with the Administrator on 1/8/25 at 12:24 PM. The Administrator said the facility had received the updated infection control policies from corporate on 1/8/25. She explained prior to receiving the infection policies from corporate they had not really had a policy and were going by the CDC recommendations.

On 01/9/25 at 01:06 PM an interview was conducted with the Administrator. She explained she thought the facility had been following current CDC guidance for the management of the COVID-19 outbreak but said they were not. She said they had not realized the guidance they had been following for the management of COVID-19 was not the current CDC recommendations. The Administrator said the facility had not had up to date in-house infection control policies to resource and follow for the management of the COVID-19 outbreak until 1/8/25. She stated the facility should have had updated infection control policies on hand at the facility to resource and follow that aligned with current CDC guidance.

A follow up telephone interview was conducted on 1/13/25 at 11:55 AM with the DON and Administrator. The DON explained that the infection control policy and procedures the facility had prior to 1/8/25 had not aligned with current CDC guidance for COVID-19 management, testing, and staff return to work. She said they had been using policies that were inaccurate and needed to be updated. The DON stated she consulted with the corporate nurse who reviewed/updated the infection control policies and sent the updated infection control policies to her on 1/8/25. The DON explained with all the updates and changes in CDC recommendations/

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guidance they had not realized the guidance had changed and the policies needed to be updated.

The facility's Administrator was informed of the immediate jeopardy on 1/8/25 at 12:47 PM.

The facility submitted the following credible allegation of immediate jeopardy removal.

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
On 12/26/2024 Resident #18 (400 hall) and Resident #98 (500 hall) tested positive for COVID and were placed on isolation precautions on 12/26/24. The facility determined this to be the start of an outbreak but did not initiate contact tracing or broad-based testing for staff or other residents within the facility in accordance with Centers for Disease Control and Prevention (CDC) guidelines.

On 01/07/2025 staff were observed by surveyors to not utilize source control and transmission-based precautions per facility policy and in accordance with CDC guidelines while caring for residents with confirmed COVID illness.

When the outbreak was identified the facility did not have a supply of N-95 masks for staff to wear while providing care to COVID positive residents who required transmission-based precautions per facility policy and CDC guidance. N-95 mask were ordered by the Director of Nursing on 1/8/25. The facility contacted and obtained permission from the local Health Department's Communicable Disease Nurse on 1/9/25 to utilize the KN-95 masks until the N-95 are obtained. The staff were provided KN-95 masks by the Director

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Seventeen residents and four staff tested positive between 12/26/2024 and 01/07/2025.

The facility was not following policy and procedures per CDC guidance for isolation and work restriction guidance for healthcare personnel for 6 staff members who tested positive for COVID. The facility was utilizing an incorrect policy which stated the staff would be out of work for five days after a positive episode.

The facility failed to notify the local health department of the COVID outbreak and failed to ensure staff were using recommended source control per CDC guidelines.

On 01/08/2025 The Director of Nursing notified the local health department of the COVID outbreak. Recommendations given by the health department were to continue broad-based testing and ensure staff members caring for confirmed positive residents are following CDC guidelines for transmission-based precautions.

On 01/08/25 The Director of Nursing and administrative nurses completed COVID testing on all residents not confirmed positive and all staff in all departments, including agency and contracted staff. Three additional residents and no additional staff were positive. The Director of Nursing will track staff using the master staffing roster and schedule, which includes all departments and agency staff, to provide testing prior to them being permitted to return. No staff will be allowed work until COVID testing and education has been completed beginning 01/08/2025.

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COVID testing for all staff and residents will continue per facility policy and CDC guidelines every 3-7 day until there is a 14-day interval of no new positive cases.

The Nurse Practitioner examined each resident who tested positive for Covid 19 as soon as possible upon learning of the positive test result and reviewed the resident chart at that time. No residents were identified as having suffered serious adverse outcomes as a result of the deficient practice. A total of 21 residents and 5 staff have tested positive as of 01/08/2025. All but one have experienced mild to no symptoms and have not required intervention. One resident experienced moderate illness but has fully recovered since receiving Paxlovid. No residents have been hospitalized or expired due to the outbreak.

All residents were identified as having the potential of serious adverse outcomes as a result of the deficient practice especially those who have declined the COVID vaccination. Of 97 current residents 47 have been vaccinated.

2. 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 1/08/25 the Director of Nursing (DON), Infection Preventionist, and Regional Nurse reviewed the current COVID-19 policy and procedures to ensure it aligned with the latest CDC guidance for COVID-19 including testing and PPE requirements/transmission-based precautions and work restriction guidance for

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COVID-19 policy and procedures to ensure it aligned with the latest CDC guidance for COVID-19 including testing and PPE requirements/transmission-based precautions and work restriction guidance for healthcare personnel and found it to be incorrect in these areas. The facility's policies and procedures for these infection control areas were updated to align with current CDC guidance on 1/08/25 by the Regional Nurse, Infection Preventionist and the DON. The Infection Preventionist, Administrator, Director of Nursing and Nurse Practitioner were educated on the corrected infection control policies and procedures on 1/08/25 by the Regional Nurse and the Director of Nurses

Beginning 1/08/25 the Director of Nursing will be responsible for ordering PPE and ensuring there is an adequate supply of all PPE supplies and was notified of this responsibility on 1/8/25 by the Administrator.

All staff present in the facility on 01/08/25 were educated on the infection control policy and procedures including personal protective equipment (PPE) for COVID including source control and transmission-based precautions and CDC guidelines by the Director of Nursing and administrative nurses. The Director of Nursing will track staff using master staffing roster and schedule, which includes all staff in all departments and agency/contracted staff, to provide in person education prior to them being permitted to return to work. Facility staff, Agency and contracted staff will not be allowed to work until education has been completed beginning 01/08/2025.

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All of the above education with be included new hire orientation for all staff in all departments, including agency staff. The Nurse Educator was informed of this responsibility on 1/8/25 by the Director of Nursing.

All cases of COVID will be reported to the local health department by the DON.

The facility alleges the immediate jeopardy was removed on January 9, 2025. The Administrator is responsible to implement the plan.

On 1/14/25 the facility's credible allegation of immediate jeopardy removal was validated by the following:

An interview with the DON was conducted on 1/14/25, and revealed all residents in the facility and all staff members entering the facility were tested for COVID-19. The facility identified one more COVID-19 positive staff member on 1/11/25 and another staff member on 1/14/25. No further COVID-19 positive cases were identified among the residents. The DON stated that she ordered N95 masks on 1/8/25 and the N95 masks became available for use on 1/10/25. She further stated that all staff had been educated on N95 mask use. She also stated that she will continue to report any new COVID-19 positive cases to the health department.

The IP began in-servicing of all staff on donning of PPE, including a KN95 mask or an N95 mask and goggles or face shields for all who enter a COVID-19 positive room. Signed rosters were reviewed.

Staff on multiple hallways were observed on

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1/14/25 wearing a surgical mask for source control, there were no staff members observed without a surgical mask. Staff were observed following policy and procedures for transmission-based precaution rooms and were observed donning PPE (including N95 mask, gown, gloves, and eye protection) before entering transmission-based precaution COVID-19 positive rooms. Staff were observed performing hand hygiene prior to going into a resident's room, after performing care, and before/after PPE use.

Interviews with staff revealed in-services were completed on the use of PPE when caring for residents with confirmed or suspected COVID-19 and the proper donning and doffing of PPE. They were also in-serviced on source control and transmission-based precautions.

Review of staff COVID-19 positive logs revealed the facility was following return to work policy and procedures for the staff who were COVID-19 positive. The facility's infection control policy and procedures:" Infection prevention and control Program policy, "COVID prevention, response, and reporting policy", and "Return to work criteria for healthcare personnel with COVID infection or exposure to COVID policy" were reviewed and were up to date with current CDC recommendations.

The IJ removal date of 1/09/25 was validated.