STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Blumenthal	3724 Wireless Drive Greensboro, NC 27455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276 Based on observations, record review, and resident and staff interviews, the facility's interdisciplinary team failed to assess and document the ability of a resident to self-administer medications for 2 of 2 residents (Resident #6 and Resident #12) who were reviewed for medication self-administration. Findings included: 1. A review of the electronic health record revealed Resident #6 was admitted to the facility on [DATE]. A care plan dated 07/05/24 revealed Resident #6 did not have a care plan to address self-administration of medications. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #6 was cognitively intact. A review of physician orders dated 09/30/24 for Resident #6 revealed an order for Senna (a stool softener) Oral Tablet 8.6 milligrams (mg). Give 2 tablets by mouth at bedtime for constipation. There was no order discovered for Resident #6 to self-administer medications. Review of Resident #6's 10/20/24 Medication Administration Record (MAR) revealed Nurse #12 had signed off Senna 8.6 mg as having been administered at 9:00 PM. Attempts to interview Nurse #12 were unsuccessful. On 10/21/24 at 9:07 AM during an interview with Resident #6 a medicine cup with the resident's room number written on it was observed on the overbed table. The medicine cup contained two round orange-colored tablets. Resident #6 stated the tablets were stool softeners and she told the nurse to leave them in the cup because she did not want to take them at that time, the resident did not elaborate on when the nurse had given her the stool softener tablet. She stated the nurse usually brought her medications and stayed while she took all of them, but she told the nurse she would hold on to the stool softener until later and the nurse left it. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 2:22 PM an observation revealed the medicine cup with Resident #6's room number written on it was still observed on the overbed table. The medicine cup still contained two round orange-colored tablets. In an interview with Nurse #9, on 10/21/24 at 2:24 PM, which was conducted in conjunction with an observation of Resident #6's room, she stated there were no residents who currently resided in the facility who were authorized or assessed for self-administration of medications. Nurse #9 stated she was a night shift supervisor who had been called to come in on day shift to supervise. The nurse observed the medications on Resident #6's overbed table and removed the cup to discard them. The nurse stated they appeared to be stool softeners. Nurse #9 stated the nurse was expected to stay and observe the resident as medications were taken. She stated it was not standard practice to leave medications in a resident's room. She stated she was not the nurse who had administered the medication. 2. A review of the electronic health record revealed Resident #12 was admitted to the facility on [DATE]. A care plan dated 10/09/24 revealed Resident #12 did not have a care plan to address self-administration of medications. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #12 was cognitively intact. A review of physician orders for Resident #12, dated 09/27/24, revealed an order for Lactobacillus Capsule give 1 capsule by mouth two times a day for probiotic and an order for Gabapentin 100 milligrams capsule take 1 capsule by mouth every 12 hours for neuropathy. There was no discovered order for Resident #12 to self-administer medications. Review of Resident #12's 10/21/24 Medication Administration Record (MAR) revealed Nurse #11 had signed off the probiotic was administered at 8:00 AM and the gabapentin was signed off as being administered at 9:00 AM. Attempts to interview Nurse #11 were unsuccessful. During an interview with Resident #12 on 10/22/24 at 8:45 AM, two orange tablets and one white capsule in were observed in a medication cup on the resident's overbed table. Resident #12 stated the medications in the cup were gabapentin and a probiotic. The resident stated the nurse usually stayed while she swallowed her medications, but she was on phone with her insurance company, so the nurse left the cup of medications for her to take on her own that morning, 10/22/24. She was unable to state the nurse's name. The resident stated the nurse left a total of 8 pills in the cup and she had already taken 5 of the pills. The resident was then observed to swallow the remaining medications in the cup. The resident stated the nurse was usually good about staying with her while she took her medications. The resident explained the nurse left the pills with her because she was on an important call, and she told the nurse she would take them on her own. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 11:32 AM an interview was conducted with Nurse #10, the Unit Manager, and she stated no residents in the facility were authorized to self-administer medications. She stated it was not the facility's policy to leave medications at the bedside unless a resident was assessed and authorized to self-administer medications. She stated the nurse should stay with the resident until all medications were taken. Nurse #10 added any medications not taken or refused should be disposed of and documented. An interview was conducted with the Director of Nursing on 10/25/24 at 12:02 PM and she stated no residents at the facility had been assessed and authorized to self-administer medications. She stated the nurse was expected to stay with the resident while a resident swallowed their medications, and no medications should be left at bedside.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50642 Based on observations and staff interviews, the facility failed to maintain the walls in the residents' rooms in good repair for 8 of 11 sampled residents' rooms: 3206, 3217, 3222, 3251, 3242, 3243, 3214 and 3225. The findings included: a. An observation on 10/21/24 at 08:16 AM of room [ROOM NUMBER] revealed the wall behind the bed was excoriated (measuring approximately 24 inches). b. An observation on 10/21/24 at 08:30 AM of room [ROOM NUMBER] revealed the wall behind the bed had stripped paint. c. An observation on 10/21/24 at 08:38 AM of room [ROOM NUMBER] revealed that the wall behind the bed was extremely excoriated (measuring approximately 24 inches). d. An observation on 10/21/24 at 09:05 AM of room [ROOM NUMBER] revealed excoriation of walls behind the table located near the middle of the room. e. An observation on 10/21/24 at 09:40 AM of room [ROOM NUMBER] revealed wall next to bed in front of table with excoriation. f. An observation on 10/21/24 at 09:49 AM of room [ROOM NUMBER] revealed excoriated walls behind the bed (measuring approximately 18 inches). g. An observation on 10/21/24 at 09:59 AM of room [ROOM NUMBER] revealed several areas on the walls in the room with paint missing from walls. h. An observation on 10/22/24 at 08:30 AM of room [ROOM NUMBER] revealed excoriation of walls behind the bed (measuring approximately 12 inches) An interview conducted on 10/25/24 at 05:44 PM with the Maintenance Director revealed that she was aware that the walls in the rooms need to be fixed. She reported that the facility was in the process of fixing the walls and renovating the rooms. The Maintenance Director reported that the challenge was doing the work while residents were in the rooms. She confirmed that there was an electronic reporting system, but the current process was that the housekeepers told her which room, and she goes there. The Maintenance Director stated most of the beds now have a bump stop (at the head of the bed) to prevent further damage to the walls.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on record reviews, and interviews with the responsible party (RP) and Administrator, the facility failed to maintain documentation of the results of grievances reported by the RP for 1 of 1 sampled resident (Resident #190). Findings included: Resident #190 was admitted to the facility on [DATE]. Review of the clinical records indicated Resident #190 discharged from the facility on 3/24/24. On 10/25/24 at 9:54 a.m., a telephone interview was conducted with the RP of Resident #190. The RP revealed she had filed multiple grievances with the facility throughout the resident's stay at the facility concerning Resident #190's inadequate ADL (activities of daily living) care. She was unable to provide dates of any of the grievances' submissions. A review of the facility's grievance records revealed no grievance documentation available concerning Resident #190. During an interview on 10/25/24 at 11:33 a.m., the Administrator stated he searched every storage area in the facility but was unable to locate any of the facility's grievances dated prior to June 2024. He stated he was not familiar with Resident #190 or the resident's family. The Administrator revealed the facility was purchased by the current owners effective June 2024. He also revealed the previous owners removed boxes of documents from the facility in August 2024 which they claimed as belonging to them. He stated he had no knowledge of what the contents of the boxes were, only knew boxes contained paper files.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on medical record review and staff interview, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 2 residents (Residents #15) reviewed for hospice services. Findings included: Resident #15 was admitted to the facility on [DATE] with diagnosis which included malignant neoplasm of the right lung. Resident #15 was admitted to Hospice Services on 4/16/24. A review of the MDS assessments revealed a Significant Change in Status MDS Assessment was not completed after Resident #15 was admitted to hospice services. During an interview on 10/24/24 at 10:35 a.m., the MDS Coordinator revealed she began working at the facility two months ago. She stated she was informed by the Regional MDS Consultant that the facility did not have a MDS Coordinator for over a year; instead, the facility utilized traveling MDS Nurses to complete the MDS' and different facility staff to conduct onsite interviews and observations. After a review of Resident #15's medical record, the MDS Coordinator acknowledged that a Significant Change in Status MDS should have been completed within fourteen days of Resident #15's admission to hospice services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on observations, record reviews and staff interviews, the facility failed to accurately code the minimum data set (MDS) assessments in the areas of falls (Resident #42), range of motion (Resident # 59) and failed to assess (Resident #69) and code the MDS assessment for cognition, mood, behavior, functional abilities, bowel and bladder continence, and oral/dental status. This was for 3 of 30 sampled residents reviewed for MDS accuracy. Findings included: 1. Resident #59 was admitted to the facility on [DATE] with the diagnosis which included: hemiplegia and hemiparesis following a cerebrovascular accident affecting the right dominant side and a right-hand contracture. Review of the annual minimum data set (MDS) assessment dated [DATE] indicated Resident #59 was severely, cognitively impaired and had no range of motion impairments of his upper or lower extremities. The review of the Occupational Therapy (OT) Discharge Summary dated 12/29/23 recommended Resident #59 receive a Functional Maintenance Program for right wrist/hand/finger orthosis in place-using a right grip splint. Nursing education was provided. The prognosis to maintain CLOF (current level of function) was excellent with consistent staff support. On 10/21/24 at 2:03 p.m., Resident #59 was observed in his room in his wheelchair. The resident's right hand was fisted. When asked if he was able to open the hand, the resident nodded his head no. There was no splinting device observed in the room. During an interview on 10/23/24 at 1:53 p.m., the Rehabilitative Director revealed he had worked at the facility since 8/26/24. The Rehabilitative Director stated that after speaking with this Surveyor earlier and visiting with Resident #59, he was able to locate a right-hand grip splint in the nightstand of the resident's room. He stated the resident allowed him to apply the splint and it continued to fit comfortably, indicating Resident #59's range of motion had been maintained. He stated Resident #59's most recent rehabilitative services received dated from 12/19/23 to 12/29/23 for splinting/contracture management. During an interview on 10/24/24 at 10:35 a.m., MDS Director stated she had been employed at the facility for two months but, was informed by the Regional MDS Consultant the facility did not have a MDS Coordinator in over a year. She stated she was informed that the facility used traveling MDS nurses to code the MDS assessments and different facility staff would conduct the onsite interviews and observations during that period of time. The MDS Director was unable to explain why the previous MDS nurse did not accurately complete the range of motion section of the MDS assessment. 2. Resident #69 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease. Review of the quarterly MDS assessment dated [DATE] indicated Resident #69 was not assessed for cognition, mood, behavior, functional abilities, bowel and bladder continence, and oral/dental status. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 10:35 a.m., the MDS Director stated she had been employed at the facility for two months but was informed by the Regional MDS Consultant the facility did not have a MDS Coordinator in over a year. She revealed she was informed the facility used traveling MDS nurses and different facility staff would conduct the onsite interviews and observations during that period of time. The MDS Director was unable to explain why the previous MDS nurse did not complete the sections of the MDS assessment for the resident's cognition, mood, behavior, functional abilities, bowel and bladder continence, and oral/dental status. 42007 3. Resident 42 was admitted to the facility 6/14/24 following a fractured pelvis and septic shock resulting in generalized muscle weakness. Resident #42's hospital discharge summary dated 6/14/24 included diagnoses of schizophrenia and Post-Traumatic Stress Disorder (PTSD). The diagnoses on Resident #42's EMR face sheet did not include schizophrenia or PTSD. Record reviewed showed schizophrenia and PTSD were listed on the Medical Doctor's admission note dated 6/15/24 which stated he was being followed by psychiatry. The psychiatry notes had both diagnoses listed, and psychiatric diagnoses were listed on the medication administration record. Resident #42's admission Minimum Data Set assessment dated [DATE] did not include any psychiatric diagnoses. During an interview with the MDS coordinator on 10/24/24 at 10:31 a.m. she stated she had been in this role for two months and had been aware that some MDS assessments had errors which she was correcting. She stated Resident #42's admission MDS assessment should have included the diagnoses of schizophrenia and PTSD. During an interview with the Director of Nursing on 10/24/24 at 11:25 a.m., she stated that all residents should have complete and accurate diagnoses in their charts. She stated the MDS Coordinators will be working close with the nursing staff to make sure all charts contain accurate and complete information going forward.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on observations, record reviews and staff interviews, the facility failed to apply the right-hand grip splinting device as recommended by the occupational therapist for 1 of 1 sampled resident (Resident #59) with a contracture of his right hand. Findings included: Resident #59 was admitted to the facility on [DATE] with the diagnosis which included: hemiplegia and hemiparesis following a cerebrovascular accident affecting the right dominant side and a right-hand contracture. Review of the annual Minimum Data Set assessment dated [DATE] indicated Resident #59 was severely cognitively impaired and had no impairments of his upper or lower extremities. The care plan did not include Resident #59's right-hand contracture and the application of a splinting device. The review of the Occupational Therapy (OT) Discharge Summary dated 12/29/23 recommended Resident #59 receive a Functional Maintenance Program for right wrist/hand/finger orthosis in place-using a right grip splint. Nursing education was provided. The prognosis to maintain CLOF (current level of function) was excellent with consistent staff support. There was no physician order in the medical record for the application of the grip splint for Resident #59's right hand. On 10/21/24 at 2:03 p.m., Resident #59 was observed in his room in his wheelchair. The resident's right hand was fisted. When asked if he was able to open the hand, the resident nodded his head no. There was no splinting device observed out in the open in the room. During an interview on 10/24/24 at 3:25 p.m., Nurse Aide (NA) #8 revealed she worked with Resident #59 since his admission but had been on leave of absence for one month and returned on 10/22/24. She stated the resident has had the splint applied since 10/22/24. NA #8 stated the nurses and nursing assistants were able to apply the splint to the resident's hand. NA #8 revealed she was unsure where the resident's splinting device was stored. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 1:53 p.m., the Rehabilitation Director revealed he had worked at the facility since 8/26/24. The Rehabilitation Director stated that after speaking with this Surveyor earlier and visiting with Resident #59, he was able to locate a right-hand grip splint in the nightstand of the resident's room. He stated the resident allowed him to apply the splint and it continued to fit comfortably, indicating Resident #59's range of motion had been maintained. He stated Resident #59's most recent rehabilitative services received dated from 12/19/23 to 12/29/23 for splinting/contracture management. He revealed the Occupational Therapist would be re-evaluating Resident #59 the next day as part of his quarterly evaluation. The Rehabilitation Director revealed he did not know who was responsible for applying the splint to the resident's right hand because he was unable to locate Resident #59's previous therapy records due to facility ownership change. On 10/24/24 at 3:05 p.m., Resident #59 was observed in his room with a visitor who revealed she was the resident's POA (power of attorney). A blue colored hand splint was observed on the resident's right hand. The visitor/POA indicated she frequently visited the resident she had not observed the splint on the resident's hand in two years.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35930 Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the physician prescribed rate for 1 of 1 resident sampled for respiratory care (Resident #14). The findings included: Resident #14 was admitted to the facility on [DATE] with diagnoses which included hypoxemia (a low level of oxygen in the blood) and congestive heart failure. A review of Resident #14's quarterly Minimum Data Set (MDS), dated [DATE], revealed she was moderately cognitively impaired and was on oxygen therapy. A review of Resident #14's Physician Orders read, oxygen at 2 liters per minute via nasal cannula and was written on 09/25/24. A review of Resident #14's Care Plan, last revised on 10/14/24, indicated she was at risk for respiratory complications secondary to her supplemental oxygen requirement. Interventions included to administer oxygen as ordered. A review of Resident #14's vital signs revealed an oxygen saturation of 96% on 10/19/24 and 98% on 10/01/24. There were no other documented oxygen saturation values in the record. An observation of Resident #14 was made on 10/21/24 at 11:48 A.M. Resident #14 was lying in her bed with her eyes closed with no shortness of breath noted. She had oxygen in her nose via nasal cannula. The oxygen concentrator was placed next to her bed and was set to deliver 3.5 liters per minute of oxygen. A second observation of Resident #14 was made on 10/21/24 at 3:54 P.M. Resident #14 was lying in her bed with her eyes closed with no shortness of breath noted. She had oxygen in her nose via nasal cannula. The oxygen concentrator was placed next to her bed and was set to deliver 3.5 liters per minute of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #4 on 10/23/24 at 12.53 P.M. The nurse confirmed she worked on 10/21/24 from 7:00 A.M. until 7:00 P.M. and had been assigned to care for Resident #14. Nurse #4 stated one of Resident #14's visitors informed her that she was moaning. She was unsure of the time of day. Nurse #4 stated she immediately went to the resident's room to assess her. Nurse #4 indicated she took Resident #14's vital signs which included her oxygen saturation rate. The nurse stated she remembered the oxygen saturation rate being in the high 90s and thought it might have been 97%; however, she did not document the resident's vital signs in her medical record. She indicated that she repositioned Resident #14 which seemed to alleviate her discomfort and then she left the room. When asked why she had not documented the resident's vital signs and oxygen saturation in the medical record, Nurse #4 explained that she only documented vital signs on a resident if they had been scheduled as a task, or if the results were abnormal. Nurse #4 clarified that because the resident had not appeared to be in respiratory distress at that time, she had not checked the settings on the oxygen concentrator. The nurse added that because there were a lot of visitors in the room at that time, she did not want to appear rude by asking them to move around in order for her to get to the concentrator to check the settings. Nurse #4 stated that if Resident #14's oxygen saturation values had been abnormal, she would have checked the settings on the oxygen concentrator regardless of how many visitors were in the room at the time. An interview was conducted with Nurse Practitioner (NP) #1 on 10/23/24 at 11:25 A.M. NP #1 stated he had been asked to assess Resident #14 after her oxygen concentrator had been discovered to have been set to deliver her oxygen therapy at 3.5 liters per minute on 10/21/24. He stated that obtaining her oxygen saturation rate was difficult due to her wearing gel nail polish on her nails but confirmed she had no signs and symptoms of dyspnea (shortness of breath) or air hunger, and that she had good capillary refill. He explained Resident #14 does not have a diagnosis of chronic obstructive pulmonary disease and had been receiving oxygen therapy due to her diagnosis of hypoxemia. He further explained that while no harm came to the resident on 10/21/24, he stated he had instructed the staff to continue her oxygen therapy at the prescribed rate of 2 liters per minute and encouraged them to monitor the settings on the concentrator. NP #1 stated it was his expectation that nursing staff follow the physician's orders for oxygen therapy and to also monitor the settings on the oxygen concentrators. An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 2:06 P.M. The DON stated that after she had been informed of Resident #14's oxygen concentrator having been set to deliver her oxygen therapy at 3.5 liters per minute on 10/21/24, she had asked NP #1 to assess the resident. She explained she had also spoken to nursing staff who informed her they felt Resident #14's visitors often fiddled with the settings during their visits with her. The DON indicated there were no new orders after NP #1's assessment, however he had stated that he did not want her oxygen therapy to be delivered at 3.5 liters per minute. The DON stated it was her expectation that nursing staff observe all aspects of a resident's care when they are in a resident's room. An interview was conducted with the Administrator on 10/23/24 at 12:44 P.M. The Administrator stated it was his expectation that nurses follow physician's orders and monitor residents receiving oxygen therapy as per the facility's policy and procedure.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42007 Based on record reviews and staff interviews, the facility failed to have licensed nursing coverage 24 hours/day in the facility for 17 out of 120 days reviewed for staffing. The failure to have a licensed nurse in the facility at all times had a high likelihood of impacting every resident in the facility. The findings included: Review of the staffing data submitted by the facility through the CMS (Centers for Medicare and Medicaid Services) Payroll-Based Journal (PBJ) system for quarter 3 (April 1, 2024 through June 30, 2024) indicated there was no licensed nurse coverage 24 hours/day in the facility on 4/6/24, 4/5/24, 4/13/24, 4/14/24, 4/20/24, 4/21/24, 4/27/24, 4/28/24, 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/18/24, 5/19/24, 5/25/24, 5/26/24 and 5/27/24. The facility was unable to locate the Staff Schedule/Assignment Sheets, timecard reports or payroll reports to review for licensed nursing staff for April through June of 2024. During an interview with the Staff Development Coordinator (SDC) on 10/23/24, she stated she had been in the role of SDC, Infection Preventionist and the Assistant Director of Nursing since the new company took over in June 2024. The SDC indicated they had been using a lot of agency staff prior to the new company taking over and was unable to provide any information to confirm or deny whether facility actually had licensed nurses (registered nurses or licensed practical nurses) in the building 24 hours a day on those specific days. During an interview with the Facility Scheduler on 10/23/24, she stated, she had been in her role since June 2024. She stated was aware of the regulation that stated the facility must have licensed nurse coverage 24 hours/day. The Facility Scheduler was unable to speak to any scheduling issues that occurred prior to June 2024 and did not know who handled that job prior to her.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42007 Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours per day, 7 days per week for 17 out of 120 days reviewed for staffing. The findings included: Review of the staffing data submitted by the facility through the CMS (Centers for Medicare and Medicaid Services) Payroll-Based Journal (PBJ) system for quarter 3 (April 1, 2024 through June 30, 2024) indicated indicated there was no RN coverage for eight consecutive hours on 4/5/24, 4/6/24, 4/13/24, 4/14/24, 4/20/24, 4/21/24, 4/27/24, 4/28/24, 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/18/24, 5/19/24, 5/25/24, 5/26/24 and 5/27/24. The facility was unable to locate the Staff Schedule/Assignment Sheets, RN timecard reports, or payroll reports to review for the time period of April 1, 2024 through June 30, 2024. During an interview with the Staff Development Coordinator (SDC) on 10/23/24 at 11:14 AM, she stated she has been in the role of SDC, infection preventionist and the assistant director of nursing since the new company took over in June 2024. She stated they currently had four RNs on staff and had been using a lot of agency staff prior to the new company taking over. The SDC was unable to provide any information to confirm or deny whether facility actually had RN coverage at least 8 consecutive hours per day in the building on those specific days. The SDC indicated she was not currently assist with scheduling. During an interview with the Facility Scheduler on 10/23/24 at 11:20 AM, she stated she had been in her role since June 2024. She stated she was aware of the regulation that stated the facility must have RN coverage for 8 consecutive hours. The Facility Scheduler was unable to speak to any scheduling issues that occurred prior to June 2024 and did not know who handled that job prior to her. During an interview with the facility Administrator on 10/23/24 at 1:00 PM, he stated he began working at the facility in June 2024 when the new company took over. He stated he had searched everywhere he could think of and was unable to locate any timecard reports, staffing sheets, or daily postings prior to June 2024.

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45276

Based on observations, staff interviews and record reviews, the facility failed to prevent a significant medication error when a nurse failed to administer insulin before a meal as scheduled as specified in the physician's order. This occurred for 1 of 1 sampled resident (Resident #25).

The findings included:

Resident #25 was admitted to the facility on [DATE]. Her diagnoses included, in part, diabetes mellitus and dementia.

A review of the resident's physician's orders included the following:

- Humalog Insulin Solution (Insulin Lispro) Inject as per sliding scale (where the dose of insulin administered was dependent on the resident's current blood glucose level): The sliding scale insulin was ordered to be administered before meals and at bedtime as follows:

-If the blood glucose was 101 - 150 milligrams (mg)/deciliter (dL), give 2 unit of insulin.

-If the blood glucose was 151 - 200 mg/dL, give 3 units of insulin.

-If the blood glucose was 201 - 250 mg/dL, give 5 units of insulin.

-If the blood glucose was 251 - 300 mg/dL, give 7 units of insulin.

-If the blood glucose was 301 - 350 mg/dL, give 9 units of insulin.

-If the blood glucose was 351 - 400 mg/dL, give 11 units of insulin. Call MD for blood sugar < or >400.

Humalog insulin is a rapid-acting insulin with peak serum blood levels typically seen 30 to 90 minutes after its administration. Humalog insulin is injected subcutaneously (A subcutaneous injection is a method of administering medication by injecting it into the fatty layer of skin, or subcutis, just below the dermis and epidermis).

A review of Resident #25's October 2024 Medication Administration Record (MAR) revealed Humalog Insulin was transcribed to the MAR to be administered at 7:30 AM, 11:00AM, and 4:00 PM.

A review of the facility's meal delivery times revealed breakfast meal trays were scheduled for delivery to Resident #25's hall between 7:15 AM - 7:30 AM daily. Resident #25's mealtime Humalog insulin coverage for the morning meal was scheduled for administration at 7:30 AM (prior to the meal).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 9:50 AM, Nurse #4 was observed as she checked Resident #25's blood glucose level. The resident's blood glucose result was 252 mg/dL. Nurse #4 returned to the medication cart, reviewed the physician's orders to determine the dose of insulin needed, then drew up 7 units of Humalog insulin for administration to the resident. Nurse #4 explained Resident #25 needed to be given 7 units of Humalog based on her orders for sliding scale insulin. On 10/24/24 at 9:55 AM, Nurse #4 was observed as she injected 7 units of Humalog insulin subcutaneously (under the skin) into Resident #25's left arm via the Resident's Humalog KwikPen. The Humalog KwikPen is a disposable single-patient-use prefilled pen containing Humalog insulin. An interview was conducted on 10/24/24 at 9:55 AM with Nurse #4. At that time, the nurse was asked why Resident #25's Humalog insulin was administered more than 2.5 hours late. The sliding scale Humalog insulin (7 units) was scheduled for administration at 7:30 AM but was not administered to the resident until 9:55 AM. Nurse #4 responded by stating the late administration was due to the heavy medication pass workload and the time it was taking to test and transfer COVID positive residents to other rooms. An interview was conducted on 10/25/24 at 1:50 PM with the facility's Director of Nursing (DON). During the interview, the concern regarding the late administration of Resident #25's Humalog insulin was discussed. The DON stated the nurses on the halls have enough time to pass medications within the timeframes. She stated if a nurse needed assistance with getting a medication pass completed within the timeframe the administrative nurses (e.g., Unit Manager, Infection Preventionist, or she herself) could assist as needed. The DON stated education would need to be provided to Nurse #4. The DON stated if Resident #25's Humalog insulin was ordered to be given at 7:30 AM, Nurse #4 should have given the insulin within one hour before its scheduled time for administration.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42007 Based on staff interviews and record review, the facility failed to maintain a complete medical record in the area of diagnoses for 1 of 5 residents (Resident #42) reviewed for unnecessary medications. The findings included: Resident #42 was admitted to the facility 6/14/24 following a fractured pelvis and septic shock resulting in generalized muscle weakness. Review of Resident #42's hospital discharge summary 5/22/24 showed diagnoses schizophrenia and post-traumatic stress disorder (PTSD). Review of Resident #42's electronic medical record cumulative diagnosis face sheet did not include schizophrenia or PTSD. During an interview with the Director of Nursing on 10/24/24 at 11:25 AM, she stated that all residents should have complete and accurate diagnoses in their charts. She stated the MDS Coordinators will be working close with the nursing staff to make sure all charts contain accurate and complete information going forward.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276 Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to implement a broad-based approach COVID-19 testing for staff and residents on 10/13/24 when residents tested positive for COVID-19 on two resident halls. The facility had been in outbreak status since 10/08/24 when a staff member tested positive and only residents/staff with symptoms, roommates of residents that tested positive and staff that requested or were symptomatic tested for COVID-19. Broad-based COVID-19 testing per the Centers for Disease Control and Prevention (CDC) guidance was not implemented until 10/23/24. Before broad-based testing was implemented on 10/23/24, a total of 4 staff members and 22 residents had tested positive for COVID-19. Results of the broad-based testing from 10/23/24 through 10/25/24 yielded one (1) staff member and 6 additional residents positive for COVID-19. In addition, 11of 14 staff members failed to wear surgical masks covering both their mouth and nose for source control to help prevent transmission while working in the facility during the COVID-19 outbreak and one staff member (Nurse Aide #6) entered a resident room under transmission-based precautions for COVID-19 without wearing eye protection. The facility's infection control policy and procedures for outbreak testing did not conform with CDC guidance. had not initiated the administration of any 2024-2025 COVID-19 vaccinations for residents. The resident census at the time of the survey was 129. The facility had their first 2024-2025 COVID-19 vaccination clinic on 10/16/24 through10/18/24. These cumulative practices and system failures occurred during a COVID-19 outbreak and had the high likelihood for continued transmission of COVID-19 to residents and staff and a serious adverse outcome. Immediate Jeopardy began on 10/13/24 when COVID positive residents were identified on the 200-hall and 400-hall and broad-based testing of staff and residents was not initiated. Immediate jeopardy was removed on 10/25/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of E (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. The findings included: A. The facility policy titled Policies and Procedures [Infection Prevention and Control], Section Emerging Infectious Disease(s), Policy Name COVID-19 Effective date 03/11/24 revealed the center followed the Centers for Disease Control and Prevention (CDC) and standards of practice for prevention of COVID-19 to protect employees and patients. Section 4 revealed Infection Prevention and Control measures may include, but were not limited to: i. Employee and patient testing according to current standards (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Per the CDC guidelines dated 6/24/24, 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 potential contacts cannot be event identified or managed with contact tracing or if contact tracing fails to halt transmission. If additional cases are identified, strong consideration should be given to shifting to broad based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach testing should continue on affected units or facility wide every 3-7days until there are no new cases for 14 days. If antigen testing is used more frequent testing (every three days) should be considered. A review of the facility document titled COVID-19 Contact Tracing Investigation revealed the following: - The COVID outbreak started on 10/08/24 when the facility Social Worker tested positive for COVID. - The Receptionist tested positive on 10/10/09/24. - On 10/13/24 four residents on the 200-hall (Resident #98, Resident #126, Resident #442, and Resident #443) and 1 resident on the 400-hall (Resident #5) tested positive for COVID. - On 10/14/24 two residents on the 400-hall (Resident #90 and Resident#92) and 1 resident on the 700 hall (Resident #67) tested positive for COVID. - On 10/15/24 one resident on the 200-hall (Resident #68) and one resident on the 700-hall (Resident #3) tested positive for COVID. - On 10/17/24 one resident on the 200-hall (Resident #29), one resident on the 300-hall (Resident #55), one resident on the 400-hall (Resident #111), and two residents on the 700-hall (Resident #107 and Resident #116). - On 10/18/24 one resident on the 300-hall (Resident #39) and two residents on the 700-hall (Resident #4 and Resident #119) tested positive. - On 10/21/24 one resident on the 300-hall (Resident #13) tested positive. - On Tuesday, 10/22/24, two more residents and one staff member tested positive. - On Wednesday, 10/23/24, one additional resident and one staff member tested positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/23/24 at 11:09 AM an interview was conducted with the Infection Preventionist (IP)/Assistant Director of Nursing /Staff Development Coordinator, and she stated residents were tested when they were symptomatic or the roommate of a COVID positive resident. She further stated staff were tested when they requested or if they were symptomatic. The IP stated the facility Social Worker tested positive for COVID on 10/8/24 and on 10/09/24 the Receptionist tested positive for COVID. She stated on 10/13/24 five residents on the 200 hall and one resident on the 400-hall tested positive. On 10/14/24 there were 2 more residents on the 400-hall who tested positive for COVID and 1 resident on the 700-hall. On 10/15/24 another resident on the 700-hall and 1 resident on the 200-hall tested positive. On 10/17/24 a total of 5 more residents tested positive - 1 on the 200-hall, 1 on the 300- hall, 1 on the 400-hall and 2 on the 700-hall. On 10/18/24 another resident on the 300-hall and 2 residents on the 700-hall tested positive. She stated on Monday, 10-21-24, there were19 COVID+ residents and zero COVID+ staff. On Tuesday, 10/22/24 two more residents and 1 staff tested COVID+. On Wednesday, 10/23/24, 1 additional resident and 1 staff tested positive. The IP stated residents were tested on ly when they were symptomatic or if they were roommates of a resident who tested positive. She stated a COVID outbreak was when 6 or more residents and/or staff were positive. The Infection Preventionist stated she had spoken with her corporate clinical nurse consultant who had informed her that she did not have to report the COVID outbreak to the Health Department as they had in the past because the facility reported to National Healthcare Safety Network (NHSN). She said she reported this outbreak to the health department on 10/18/24 when the number of COVID+ residents reached 18. The IP stated she felt the spread of COVID throughout the building was largely due to noncompliant residents and the agency staff working at different facilities and getting exposed from numerous sources. The IP stated she felt they did all the protocols they should have initiated. The IP stated COVID+ residents were quarantined for 10 days and then they're off of quarantine and they do not re-test those residents after the 10-day quarantine. The interview further revealed the facility had a COVID-19 vaccine clinic In an interview with Nurse Aide (NA) #6 on 10/22/24 at 12:43 PM she stated she had not been tested for COVID by the facility. On 10/23/24 at 11:09AM the IP stated the facility had a COVID vaccine clinic from 10/16/24 through 10/18/24 and had one scheduled for that week (the week of 10/21/24) but cancelled it due to the survey. An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 2:06 PM and she stated she expected all nurses (staff and agency) to follow the standards of nursing and to follow the infection prevention/infection control practices. The DON deferred questions regarding testing and education to the IP. A follow up interview with the DON was conducted on 10/25/24 5:00 PM revealed all residents in the facility and all staff members entering the facility were tested for COVID beginning on 10/23/24. The facility identified 6 more COVID+ residents on Wednesday, 10/23/24 and one staff member on Friday, 10/25/24. No positive cases were identified on Thursday 10/24/24. B. The facility policy titled Infection Prevention and Control Committee, updated 08/02/2024, revealed the Infection Prevention and Control Committee was responsible for implementing established program plans and standards of practice that promoted, monitored, and maintained an environment that reduced the risk of transmission and acquisition of center-acquired infections. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility policy titled Policies and Procedures [Infection Prevention and Control], Section Emerging Infectious Disease(s), Policy Name COVID-19 Effective date 03/11/24 revealed the center followed the Centers for Disease Control and Prevention (CDC) and standards of practice for prevention of COVID-19 to protect employees and patients. Section 4 revealed Infection Prevention and Control measures may include, but were not limited to: a. Source control (well-fitting face mask/face covering): - For those with suspected or confirmed respiratory infection - For those who have had close contact with someone with COVID-19 for 10 days after contact - For those who reside or work in an area of the facility experiencing COVID-19 outbreak with uncontrolled transmission, or - When otherwise recommended by public health authorities - Even if not otherwise required by the facility, individuals should always be allowed to wear source control based on personal preference. c. Respiratory Hygiene/cough etiquette d. Visual alerts posted to inform current infection control practices f. Appropriate staff use of PPE, when indicated On 10/21/24 at 7:45 AM an interview and observation was conducted upon entry with Receptionist #1, and she informed the survey team masks were in use due to COVID-19 infection in the facility. Receptionist #1 was wearing mask during the interview. A box of yellow surgical masks and a box of black N-95 masks were available on the reception desk. There was no signage at the entrance to alert staff and visitors of a COVID outbreak, visual alerts for infection control practices or instructions about when to use personal protective equipment and hand hygiene. On 10/22/24 at 12:26 PM in an interview with Receptionist #2 she stated the front door was kept locked, so all visitors had to ring the bell to enter. She was wearing a mask covering her nose and mouth during the interview. She further stated visitors were directed to sign-in at the digital kiosk. Receptionist #2 stated that while she did not talk about the COVID status in the facility, she did talk to visitors about protecting themselves and also helping to protect the residents. She stated and offered the visitors a mask, either a surgical, KN95 or N95. Receptionist #2 stated it was not mandatory for visitors to wear masks while in facility. Receptionist #2 added she was unsure of what the mask policy was for staff working in the facility. On 10/21/24 at 3:08 PM an observation revealed Nurse Aide (NA) #2 walking down the 700-hall without wearing a mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 10/21/24 at 3:19 PM after she was observed removing her mask to speak to a resident in the Unit 2 common area. The DON stated she removed her mask to talk to the resident because he was hard of hearing. She further stated the purpose of the masks was to stop the spread of COVID. An observation on 10/22/24 at 10:38 AM revealed a housekeeper enter and exit 2 rooms on the 600-hall with a mask worn under his chin not covering his mouth and nose. An observation on 10/22/24 at 10:41 AM revealed Nurse #5 was reviewing medication administration records while seated in the Unit 2 common area. Nurse #5 was wearing a surgical mask tucked under her chin and the other nurse had on an N95 mask as well as a face shield. On 10/22/24 at 1:42 PM an observation and interview were conducted with Nurse #6 while she prepared to pass medications on the 600-hall. There were no COVID positive residents on the 600-hall. She was observed wearing a surgical mask below her nose. Nurse #6 stated when working on a COVID hall staff wore masks and the facility preferred for staff to wear N95 masks during the COVID outbreak. An interview was conducted with NA#3 on 10/22/24 at 1:45 PM as she entered the 600-hall from the therapy department hall. She was not wearing a face mask. NA #3 stated she was assigned to obtain weights on residents throughout the facility who were due weights. NA #3 added she was not assigned to weigh any residents with COVID. She said since the COVID outbreak masks were to be worn by staff and staff could wear the mask of their preference. On 10/22/24 at 1:52 PM an observation and interview were conducted with NA #4 on the 600 Hall. Her mask was under her nose. NA #4 stated she did not think the facility had an outbreak. NA #4 further stated an outbreak was when 50 or more residents were positive for COVID. She added the type of mask staff wore was an individual preference. On 10/23/24 at 10:04 AM Nurse #8 was observed as she prepared to administer medications on the 200-hall (a hall where there were COVID positive residents). Her surgical mask did not cover her mouth or nose. On 10/23/24 at 10:43 AM Nurse #8 was observed as she stood at a medication cart across from a room with droplet precaution signage on the 200-hall. Nurse #8 was wearing her surgical mask below her chin, not covering her mouth or nose. On 10/23/24 at 10:49 AM the Medical Director was observed walking down the 200-hall to the 400- hall then to 600-hall with his surgical mask under his nose. On 10/23/24 at 5:20 PM the IP brought staff folders to the conference room with no mask on. On 10/22/24 at 1:59 PM an observation and interview were conducted with Nurse #7 while she was walking through the Unit 2 common area. Nurse #7 was wearing a surgical mask, which covered her nose and mouth, and she stated the facility was considered in a COVID outbreak. She further stated masks were required, either surgical or N95. Nurse #7 added masks should be worn for the duration of the shift and should cover both the nose and mouth to keep from breathing in or out droplets. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Blumenthal	3724 Wireless Drive Greensboro, NC 27455

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility policy titled Policies and Procedures [Infection Prevention and Control], Section Precautionary Measures Policy Name Transmission Based Precautions- General Practice Effective date 12/01/21 revealed the facility initiates transmission-based precautions to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease. The TBPs will be based on the type of pathogens, knowledge of the natural history of certain diseases and studies of epidemiology. The TBP measures will be the least restrictive possible for the patient under the circumstances. Measures included: 19. If protective attire is determined necessary, when donning the protective attire follow these steps: a. Wash hands or perform hand hygiene with alcohol-based hand rub b. Put on gown c. Apply mask over mouth and nose, (1) Pinch the metal band above the nose to make the mask fit to the contour of the face. (2) The mask must be replaced if it becomes moist or after 20 minutes (3) Do not touch the mask once it is positioned until it is removed (4) Remove the mask when leaving the room and discard immediately, (5) Do not reuse the mask. d. Put on goggles or face shield if required. Place over eyes and adjust to fit. e. Put on gloves. An observation on 10/22/24 at 12:43 PM was conducted of NA #6 as she passed lunch trays to residents on the 200-hall. Prior to entering a COVID+ resident's room (room [ROOM NUMBER]), she sanitized her hands and then donned PPE which consisted of an N95 mask, gown and gloves. She did not wear eye protection as she entered the room. When NA #6 exited the room, she was asked why she had not donned eye protection. NA #6 pointed towards the top of her head and patted a pair of goggles. NA #6 explained that she had been busy, moving fast to get the lunch trays passed out and had forgotten to put them on. NA #6 stated she was an agency NA, and it was her first time working in the facility. When asked if she had been made aware of the COVID outbreak in the facility, she confirmed the DON told her that morning. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 10/23/24 at 11:09 AM with the Infection Preventionist (IP) and she stated she educated staff in all departments related to COVID protocol. The IP stated masks were mandatory during COVID outbreaks. She stated education for donning and doffing personal protection equipment (PPE) was provided during orientation, during yearly competencies, and in-services as needed. When informed of observations of staff not wearing their masks over both their nose and mouth, she stated she tried to make rounds periodically throughout the day to check to make sure staff were using PPE correctly. She stated when she saw staff not wearing their masks correctly, she reminded them to cover both their nose and mouth with the mask. She stated all staff were fit-tested for N95 masks and had been instructed on the proper application of masks and PPE. An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 2:06 PM and she stated she expected all nurses (staff and agency) to follow the standards of nursing and to follow the infection prevention/infection control practices. The DON deferred questions regarding testing and education to the IP. In an interview with the Nurse Practitioner (NP) on 10/23/24 at 3:53 PM she stated staff not wearing masks properly can increase the transmission of COVID from staff to staff and from staff to resident. She stated none of her residents who tested COVID+ had been hospitalized . On 10/22/24 at 2:14 PM an interview was conducted with the Administrator, and he stated it was his expectation that any staff member caring for a COVID+ resident wear an N95 mask. C. The facility policy titled Infection Prevention and Control Committee, updated 08/02/2024, revealed the Infection Prevention and Control Committee was responsible for implementing established program plans and standards of practice that promoted, monitored, and maintained an environment that reduced the risk of transmission and acquisition of center-acquired infections. The facility policy titled Policies and Procedures [Infection Prevention and Control], Section Emerging Infectious Disease(s), Policy Name COVID-19 Effective date 03/11/24 revealed the center followed the Centers for Disease Control and Prevention (CDC) and standards of practice for prevention of COVID-19 to protect employees and patients. Section 4 revealed Infection Prevention and Control measures may include, but were not limited to: i. Employee and patient testing according to current standards A review of the CDC's policy for COVID testing dated June 2024 revealed the following guidance for nursing homes: - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. - Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/23/2024, during the annual certification survey for [NAME] Health and Rehabilitation, it was noted that the facility had multiple residents affected by COVID. These residents were noted to be located on more than one hallway throughout the facility. During the survey it was noted that multiple staff did not employ appropriate source control throughout the facility. The facility did not initiate broad-based testing on all staff and residents with the increase in COVID cases throughout the facility. It is also noted that the facilities policy did not meet the CDC's guidance related to testing. On 10/23/24, the Director of Nursing and Infection Preventionist completed broad-based testing on all staff and residents within the facility. The facility will complete testing on all residents and staff twice per week until there is a 14-day interval of no new positive cases. The Infection Preventionist was notified on 10/24/24 and will be responsible for continuing testing until resolution of the outbreak. Specify action the entity will take to alter the process or system to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed. On 10/23/2024 the Regional Nurse Consultant educated the Director of Nursing, Staff Development Coordinator/Infection Preventionist, and the Unit Managers regarding Special Droplet Contact Precautions when a resident tested positive for COVID-19. All staff, including medical director and Nurse Practitioner, will perform hand hygiene using soap and water and/or alcohol-based hand rub before entering and before exiting the room. All staff, including medical director and nurse practitioner will wear a gown when entering the room, remove before exiting the room. All staff, including medical director and nurse practitioners, will wear an N95 when entering the room and remove before exiting the room. All staff, including the medical director and nurse practitioner will wear eye protection such as a face shield or goggles when entering the room and remove them before exiting the room. All staff, including the medical director and nurse practitioner will wear gloves when entering the room and remove them before leaving the room. Education completed 10/23/2024. On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education with current staff and providers, including the medical director and nurse practitioners, regarding source control to include wearing face mask throughout the building during outbreak status regardless of if they are in a covid positive room or not. On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education with current staff and providers, including the medical director and nurse practitioners, regarding Special Droplet Contact Precautions when a resident test positive for COVID-19. All staff, including the medical director and nurse practitioners, will perform hand hygiene using soap and water and/or alcohol-based hand rub before entering and before exiting the room. All staff, including the medical director and nurse practitioner, will wear a gown when entering the room, remove before exiting the room. All staff including the medical director and nurse practitioner will wear an N95 when entering the room and remove before exiting the room. All staff, including the medical director and nurse practitioners will wear eye protection such as a face shield or goggles when entering the room and remove them before exiting the room. All staff, including the medical director and nurse practitioners, will wear gloves when entering the room and remove them before leaving the room. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift in person. This education will be by 10/24/24. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/23/2024 the Regional Nurse Consultant educated the Director of Nursing, Staff Development Coordinator, and the Unit Managers regarding how to properly [NAME] Personal Protective Equipment. The gown will fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. Then fasten behind neck and waist. Once the gown is fastened, the mask or respirator will be secure with ties or elastic bands at middle of head and neck and ensure the flexible band to nose bridge fits properly. The fit of the mask should be snug to the face and below chin. All staff, including the medical director and nurse practitioners will then Fit-check respirator by gently exhaling while blocking any paths for air to escape. If air is escaping, reposition the respirator and check again until you feel no air escaping. All staff, including the medical director and nurse practitioners will then place goggles or face shield over their face or eyes and adjust to fit. Then the staff will don the glove and extend to cover wrist of isolation gown. Education completed 10/23/2024. On 10/23/2024 the Regional Nurse Consultant educated the Director of Nursing, Staff Development Coordinator, and the Unit Managers regarding how to properly Doff Personal Protective Equipment. All staff, including the medical director and nurse practitioners will use a gloved hand, grasp the palm area of the other gloved hand and peel off the first glove, hold removed glove in gloved hand, slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove. All staff, including the medical director and nurse practitioners will then discard gloves in a waste container. All staff, including the medical director and nurse practitioners will then remove goggles or face shield from the back by lifting head band or earpieces. Otherwise, discard in a waste container. All staff, including the medical director and nurse practitioners will unfasten the gown ties and take the gown off by taking care that sleeves don't contact your body when reaching for ties. The gown will then need to be pulled away from neck and shoulders, touching inside of gown only. All staff, including the medical director and nurse practitioners, will then remove the mask or respirator by grasping the bottom ties or elastics, then the ones at the top, and remove without touching the front and discarding in a waste container. All staff, including the medical director and nurse practitioners, will then wash their hands or use an alcohol-based hand sanitizer immediately after removing all personal protective equipment. Education completed 10/23/2024. On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education regarding how to properly [NAME] Personal Protective Equipment with current staff. The gown will fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. Then fasten behind neck and waist. Once the gown is fastened, the mask or respirator will be secure with ties or elastic bands at middle of head and neck and ensure the flexible band to nose bridge fits properly. The fit of the mask should be snug to the face and below chin. All staff, including the medical director and nurse practitioners will then Fit-check respirator by gently exhale while blocking any paths for air to escape. If air is escaping, reposition the respirator and check again until you feel no air escaping. All staff, including the medical director and nurse practitioners will then place goggles or face shield over their face or eyes and adjust to fit. All staff, including the medical director and nurse practitioners will don the glove and extend to cover wrist of isolation gown. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift in person. Education will be completed by the Staff Development Coordinator or Director of Nursing. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education regarding how to properly Doff Personal Protective Equipment with current staff. All staff, including the medical director and nurse practitioners will use a gloved hand, grasp the palm area of the other gloved hand and peel off the first glove, hold removed glove in gloved hand, slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove. All staff, including the medical director and nurse practitioners will then discard gloves in a waste container. The staff will then remove goggles or face shield from the back by lifting head band or earpieces. Otherwise, discard in a waste container. All staff, including the medical director and nurse practitioners will unfasten the gown ties and take the gown off by taking care that sleeves don't contact your body when reaching for ties. The gown will then need to be pulled away from neck and shoulders, touching inside of gown only. All staff, including the medical director and nurse practitioners will then remove the mask or respirator by grasping the bottom ties or elastics, then the ones at the top, and remove without touching the front and discarding in a waste container. All staff, in [TRUNCATED]