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	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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 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. The findings included: Resident #80 was admitted to the facility on [DATE] 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 [DATE] 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 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.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41069 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 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 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 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: An observation of the North nourishment room on [DATE] 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 [DATE]. 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 [DATE] 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 [DATE]. 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 [DATE] 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 [DATE] at 1:05 PM the expired resident food and the nutritional supplement should have been removed and disposed when expired.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 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 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 part: The facility will perform viral testing for COVID as per national standards such as CDC recommendations. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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 [ROOM NUMBER] was positive for COVID on 12/26/24 - Resident #98 in room [ROOM NUMBER] 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 [ROOM NUMBER]A was COVID positive on 12/29/24 - Resident #94 in room [ROOM NUMBER]A was COVID positive on 12/29/24 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- Resident #48 in room [ROOM NUMBER]B was COVID positive on 12/30/24 - Nurse #4 tested positive for COVID on 12/31/24 - Resident #70 in room [ROOM NUMBER] 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 [ROOM NUMBER]A was COVID positive on 1/2/25 - Resident #93 in room [ROOM NUMBER]B was COVID positive on 1/3/25 - Resident #21 in room [ROOM NUMBER]A was COVID positive on 1/3/25 - Resident #97 in room [ROOM NUMBER]A was COVID positive on 1/3/25 - Resident #11 in room [ROOM NUMBER]A was COVID positive on 1/4/25 - Resident #69 in room [ROOM NUMBER]B was COVID positive on 1/4/25 - Resident #99 in room [ROOM NUMBER] was COVID positive on 1/5/25 - Resident #82 in room [ROOM NUMBER]A 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 [ROOM NUMBER] was COVID positive on 1/7/25 - Resident #505 in room [ROOM NUMBER] was COVID positive on 1/7/25 - Resident #45 in room [ROOM NUMBER]A was COVID positive on 1/7/25 The following were the results of COVID-19 testing after broad-based testing was initiated: - Nurse Aide #6 (NA) tested positive for COVID on 1/8/25 -Resident #95 in room [ROOM NUMBER] was COVID positive on 1/8/25 -Resident #34 in room [ROOM NUMBER]B was COVID positive on 1/8/25 -Resident #86 in room [ROOM NUMBER]A was COVID positive on 1/8/25 -Resident #101 in room [ROOM NUMBER]A was COVID positive on 1/9/25 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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 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: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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, 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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 [ROOM NUMBER] 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 [ROOM NUMBER]. 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 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 [ROOM NUMBER]. 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 N95 masks observed on the PPE cart outside of the room. (continued on next page)

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	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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 [ROOM NUMBER] 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. 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 [ROOM NUMBER] to clean. She was wearing a gown, gloves, and a surgical mask. At 9:19 AM housekeeper #1 exited room [ROOM NUMBER] 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 [ROOM NUMBER] to clean, which was not a COVID-19 positive room. She exited room [ROOM NUMBER], 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 [ROOM NUMBER] before donning new gloves and entering room [ROOM NUMBER] to clean which was not a COVID-19 positive room. She exited room [ROOM NUMBER], 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 [ROOM NUMBER] to clean. Housekeeper #1 was stopped as she was entering the room. 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 [ROOM NUMBER]. 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 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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 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