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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matthews Health & Rehab Center	600 Fullwood Lane Matthews, NC 28105

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43643 Based on record review, and staff and resident interviews, the facility failed to provide resolution of Resident Council Meeting grievances for 6 of 6 Resident Council Meetings (08/27/24, 09/24/24, 10/23/24, 11/05/24, 11/20/24, and 12/30/24). The Resident Council had repeated concerns regarding call lights not being answered and snacks not being provided. The findings included: On 08/27/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner. The Resident Council Follow-Up form attached to the 08/27/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 09/24/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner. The Resident Council Follow-Up form attached to the 09/24/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 10/23/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner. The Resident Council Follow-Up form attached to the 10/23/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 11/05/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner and snacks were not being offered and provided in the evening. The Resident Council Follow-Up form attached to the 11/05/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 11/20/24 the Resident Council Meeting Minutes noted nursing staff were not responding to call lights in a timely manner and snacks were not being offered and provided in the evening. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Council Follow-Up form attached to the 11/20/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 12/30/24 the Resident Council Meeting Minutes noted snacks were not being offered and provided in the evening. The Resident Council Follow-Up form attached to the 12/30/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. Interviews conducted with Resident #4, Resident #5, Resident #8, and Resident #81 during the Resident Council Meeting on 02/04/25 at 10:00 AM revealed there had been no resolution with the ongoing concerns of snacks not being provided at night and call bells not being answered in a timely manner. The residents further revealed staff had not discussed or explained how issues with snacks and call bell lights were going to be resolved. The residents felt like facility staff did not care about the ongoing concerns. An interview conducted with the Activity Director (AD) on 02/04/25 at 10:30 AM revealed she had addressed concerns during stand-up meetings and with department heads but had no documentation to show that concerns were resolved. The AD revealed she had discussed concerns in stand-up meetings and the head of the departments were responsible for carrying out resolution to the concerns. The AD stated she was aware issues had been ongoing and had addressed department heads but was unaware of any improvement from issues addressed. The AD indicated sometimes department heads would indicate they had resolved concerns but it was not communicated how concerns were being resolved. An interview conducted with the Administrator on 02/05/25 at 11:30 AM revealed he was not aware grievances and concerns were not being completed and resolved from Resident Council meetings. The Administrator indicated all concerns were addressed at stand-up meetings, but was not aware snacks and call bell lights had been an ongoing issue. The Administrator further revealed he expected concerns to be addressed and followed up on and documentation to be included within the Resident Council minutes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13811 Based on observations, record review, staff and Physician interviews, the facility failed to maintain wound vac (negative pressure wound therapy to help heal wounds) treatment as ordered and failed to follow treatment orders for when the wound vac malfunctioned or was broken for stage 4 sacral pressure ulcer for 1 of 3 residents reviewed for pressure ulcer (Resident #318). Findings included: Resident #318 was admitted to the facility on [DATE] with diagnoses that included chronic sacral decubitus, type 2 diabetes and peripheral artery disease. The hospital discharge summary on 1/31/25 revealed that Resident #318 was seen for stage 4 sacral full-thickness pressure ulcer with non-viable tissue on admission to the hospital. Resident #318 was found septic due to the infected large sacral pressure ulcer. She received intravenous antibiotics and completed the treatment. Resident #318 deferred surgical intervention and opted wound care with wound vac. The hospital discharge summary recommended to continue with wound vac after her discharge. It stated that without the wound vac, there would be a high risk of the sacral pressure ulcer to have active infection and potentially leading to worsening clinical status. The initial admission assessment worksheet dated 1/31/25 revealed that Resident #318 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. The admission notes on 1/31/25 revealed that Resident #318 was weak on both upper extremities and unable to bend finger to finger on both hands. The resident had a contracture to her left hand and complained of pain when moving her arms. It was documented that the resident used mechanical lift for transfer and required total care for all activities of daily living (ADL). The skin was dry and warm to touch with a stage 4 sacral wound with wound vac in place. A physician order on 1/31/25 revealed wound vac therapy at 125 mm/Hg (millimeter of mercury a pressure measurement for the vacuum). The order instruction was to change the wound vac on Monday, Wednesday, and Friday (MWF). The order instruction included that if the wound vac malfunctioned or broken, they can remove the wound vac. Then clean the sacral wound with wound cleanser, fill the cavity with a disinfectant solution to moisten the gauze, and cover with a protective dressing as needed. The Treatment Nurse wrote on her note on 1/31/25 that she cleaned and applied the wound vac on Friday at 4:12 pm. A nurse's note written by Nurse #1 on 2/1/25 at 6:55 pm showed that wound care was completed with wet to dry dressing until the wound vac can be replaced on Monday. An observation of Resident #318 on 2/2/25 at 11:40 am showed that the wound vac machine was sitting on the windowsill of the resident's room. Resident #318 was lying flat on the bed with no tube connection seen to the wound vac. The resident was too sleepy to talk and excused herself to go back to sleep. A follow-up observation to the room of Resident #318 at 2:37 pm revealed the wound vac machine was still in the windowsill. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another nurse's note written by Nurse #1 on 2/2/25 at 6:08 pm revealed the wet to dry wound dressing was intact from 2/1/25. A physician order dated 2/2/25 written by Nurse #1 revealed to treat the sacral pressure ulcer with wet to dry dressing until treatment nurse assess the wound. Nurse #1 was interviewed on 2/4/25 at 9:00 am. She stated that she did the sacral pressure ulcer treatment on Saturday (2/1/25) with normal saline (NS) wet-to-dry dressing and reinforced the wound dressing on Sunday (2/2/25). She stated she was told by her supervisor to do wet to dry dressing on 2/1/25 when she reported that the wound vac suction was leaking from the dressing. Nurse #1 stated the Treatment Nurse would place the wound vac on Monday (2/3/25). She stated that the wound vac machine was not broken. An interview with Nurse # 4 on 2/5/25 at 10:41 am revealed she worked on Saturday (2/1/25) and Sunday (2/2/25) night with the resident. She stated that the wound vac was not in use. She was also told at shift changed that they would use wet to dry dressing when needed. Nursing Aide (NA) #4 was interviewed on 2/4/25 at 9:29 am and stated that she worked on Baylor Shift (weekend staffing) and took care of Resident #318 on 2/1/25 and 2/2/25. She said there was no wound vac used as she checked and cleaned the resident. The follow-up observation on 2/3/25 at 9:56 am revealed the wound vac was still on Resident #318's windowsill and was not in use. The Treatment Nurse was observed on 2/3/25 at 1:55 pm for wound treatment dressing. The Treatment Nurse removed the old dressing from the wound and showed the stage 4 sacral pressure ulcer with tunneling. The Treatment Nurse followed the treatment orders for the wound vac. The wound vac functioned well. Interview with the Treatment Nurse on 2/3/25 at 2:22 pm stated that the wound vac machine was in proper working order and was not broken. The Treatment Nurse stated that wet to dry (NS) was not acceptable treatment. The use of disinfectant solution with wet gauze was ordered on admission. She further stated that she would discontinue the order on 2/2/25 for wet-to-dry wound dressing. On 2/5/25 at 9:09 am the Physician was interviewed, and he stated that Resident #318 had a severe sacral pressure ulcer. He stated that wet-to-dry (NS) dressing was not an appropriate treatment and that wound vac should have been used. The Physician stated that he was not made aware of the wet-to-dry dressing and that the treatment was not recommended because of the high possibility of infection. He stated that the only time it's acceptable to not have wound vac was when the wound vac malfunctioned or broken, and they would exchange the wound vac machine just for few hours not all weekend or days. Interview with the Director of Nursing (DON) on 2/5/25 at 11:34 am stated the nurses should have followed the treatment order as written. The interview with the Administrator on 2/5/25 at 11:34 am stated that the nurses should have followed the doctor's order and was not aware the wound vac was not used on the weekend.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13811 Based on observation, record review, and staff and physician interviews, the facility failed to secure the indwelling urinary catheter to reduce tension for 1 of 2 residents (Resident #3) reviewed for urinary catheter. Findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of bladder. The physician order dated 7/25/24 was to use indwelling urinary catheter for neuromuscular dysfunction of bladder. There was no order for urinary catheter securing device to be used. The Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was moderately cognitively impaired and was coded to have a urinary catheter. The care plan dated 1/23/25 for the indwelling urinary catheter revealed a goal to have reduced risk for signs and symptoms of Urinary Tract Infection (UTI). The approaches included enhanced barrier precaution, and to assess signs and symptoms of UTI. The care plan, goals, or approaches did not mention securing the indwelling urinary catheter tubing. An observation on 2/2/25 at 11:44 am revealed Resident #3 was lying on her bed with the indwelling urinary catheter tubing observed on the right side of the bed connected to the urinary drainage bag. The urinary drainage bag was hanging on the right side of the bed. The resident stated that she had had her indwelling catheter for a long time. An observation of the indwelling urinary catheter tubing revealed there was no securing device attached to the urinary catheter. She stated that she didn't know what a securing device looked like and that the nursing staff didn't put any in place. Resident #3 was observed on 2/3/25 at 9:59 am and 2:31 pm. Both observations revealed the indwelling urinary catheter tubing was not secured. Another observation of Resident #3 on 2/4/25 at 9:56 am revealed that there was no securing device attached to the indwelling urinary catheter tubing. An observation of urinary catheter care was conducted in conjunction with an interview with Nurse Aide (NA) #5 and NA #6 at 1:34 pm. NA #5 and NA #6 revealed the indwelling urinary catheter tubing was not secured. NA #5 stated the resident didn't have a device to secure her indwelling urinary catheter tubing. NA#5 and NA#6 stated some residents in the facility had securing devices for indwelling urinary catheters, but they had not seen such devices to secure the indwelling urinary catheter tubing for Resident #3. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #3 was interviewed on 2/5/25 at 9:28 am and stated Resident #3's catheter was not secured because they didn't have a supply of devices to secure indwelling urinary catheter tubing in the facility. During an observation Nurse #3 opened a drawer of her medication cart and an indwelling urinary catheter securing device was observed in the drawer of the medication cart. The Physician was interviewed on 2/5/25 at 9:19 am and stated an indwelling urinary catheter securing device should be used for all residents with indwelling urinary catheters. The physician stated it was a standard recommendation to secure indwelling catheters to prevent injury. The Administrator and the Director of Nursing (DON) were interviewed on 2/5/25 at 9:30 am. The DON and Administrator stated the facility had a supply of securing devices for indwelling urinary catheter tubing and nursing staff should use them.

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F 0727 Level of Harm - Potential for minimal harm Residents Affected - Many	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. 13811 Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 2 of 30 days reviewed for staffing (4/20/24 and 4/21/24). Findings included: A review of the Payroll Based Journal (PBJ) staffing data report from the Certification and Survey Provider Enhanced Report (CASPER) database revealed the facility failed to submit RN coverage on 4/20/24, 4/21/24, 5/05/24, and 6/02/24. On 2/5/25 at 11:04 am an interview with the Administrator and Director of Nursing revealed that they had RN coverage, and they stated that they would show a timecard for the days with missing coverage. The Administrator provided a timecard that supported on 5/05/24 and 6/02/24, there was RN coverage for 8 consecutive hours in the facility. There was no additional timecard that was provided for 4/20/24 and 4/21/24. A follow-up interview with the Administrator on 2/5/25 at 12:04 pm stated that he was still looking for evidence of RN coverage on 4/20/24 and 4/21/24. The Administrator stated that there should be an RN for 8 consecutive hours in the building. There was no additional timecard information provided by the Administrator.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43643 Based on resident and staff interviews the facility failed to have systems in place for providing evening snacks to residents for 2 of 3 halls (100 hall and 400 hall). The deficient practice had the potential to affect residents requesting an evening snack. The findings included: An interview conducted during a Resident Council Meeting on 02/04/25 at 10:00 AM revealed residents had not received or been offered snacks in the evenings by nursing staff. The Resident Council President (Resident #106), Resident #4, Resident #5, Resident #8, and Resident #81 stated nursing staff did not offer evening snacks frequently and when residents asked nursing staff for snacks, they were told nursing staff were unable to get in the kitchen or there were no snacks available. It was further revealed it had been reported to the Dietary Manager (DM) and it continued to be an issue. An interview conducted with Nurse #5 on 02/04/25 at 7:35 PM revealed nursing staff were often unable to access the kitchen at night to retrieve snacks. The Nurse further revealed there had been multiple evenings snacks were not provided for distribution to residents. Nurse #5 stated she had reported the concerns to the DM. An interview conducted with Nurse Aide (NA) 7 on 02/05/25 at 7:50 PM revealed she worked second shift and residents during second shift (3:00 PM to 11:00 PM) had not received a bedtime snack on multiple days because kitchen staff had failed to deliver evening snacks and nursing staff was unable to get access to the kitchen. The NA indicated she had reported this to a Nurse on duty over the past few months but could not recall which Nurse. An interview conducted with the Dietary Manager on 02/05/25 at 10:05 AM revealed she had recently been made aware nursing staff had reported snacks had not been provided. The Dietary Manager indicated dietary staff checked and stocked snack bins daily and felt that nursing were not offering bedtime snacks as needed for the residents. The Dietary Manager indicated she had tried to educate staff on providing bedtime snacks to all residents. An interview conducted with the Director of Nursing (DON) and the Administrator on 02/05/25 at 11:30 AM revealed they had expected there to always be snacks available for residents. The Administrator indicated he was not aware evening snacks had been an issue.

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F 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** 37281 Based on record review, observations, and staff, Health Department Nurse, and Physician interviews, the facility failed to implement the facility's infection control policy and procedures in accordance with current Centers for Disease Control and Prevention (CDC) guidance. The facility had been in outbreak status since 1/18/25 when 2 staff members tested positive and only residents and staff with COVID symptoms and staff that requested were tested for COVID. The facility failed to initiate contact tracing COVID testing for staff and residents on 1/18/25 after 2 staff members tested positive for COVID and failed to initiate broad-based approach COVID testing when a resident on the 200 hall and the 400-hall tested positive for COVID. No contact tracing or broad-based COVID testing was initiated until after surveyor intervention on 2/4/25. Before broad-based COVID testing was implemented on 2/4/25, a total of 9 staff members and 7 residents tested positive for COVID. Results of the broad-based testing from 2/4/25 through 2/7/25 resulted in 1 resident and 1 staff member positive for COVID on 2/4/25, 1 resident positive for COVID on 2/5/25, and 1 resident positive for COVID on 2/7/25. Additionally, the facility failed to implement staff source control to help prevent transmission and facility staff failed to wear all personal protection equipment (PPE) required according to CDC guidance when they entered resident rooms under transmission-based precautions (TBP) for COVID. The facility also failed to restrict staff from returning to work after testing positive for COVID in accordance with current CDC guidance. The resident census at the time of the survey was 123 and 62% of the residents were vaccinated for COVID. These cumulative practices and system failures occurred during a COVID-19 outbreak and had the high likelihood of continued transmission of COVID-19 to residents and staff and a serious adverse outcome. Immediately Jeopardy began on 1/18/25 when 2 staff members tested positive for COVID, and the facility failed to implement contact tracing COVID testing. Immediate Jeopardy was removed on 2/7/25 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of E (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: On 2/3/25 a request was made for the facility's infection control policy and procedures for COVID testing, transmission-based precautions, masking for source control during a COVID outbreak, and return to work guidelines for staff after testing positive for COVID. The Infection Preventionist (IP) provided the CDC guidance and reported the facility utilized the CDC guidance for their policy and procedures. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The facility provided CDC COVID testing guidance, with a review date of 11/20/24 read, in part: Newly identified COVID positive staff or resident in the facility can identify close contacts: test the staff, regardless of vaccination status, that had a higher-risk exposure with a COVID positive individual. If negative, test again 48 hours later, and if negative, 48 hours after the 2nd test. Test the residents, regardless of vaccination status, then had close contact with a COVID positive individual. If negative, test again 48 hours later, and if negative, 48 hours after the 2nd test. Newly identified COVID positive staff or resident in a facility that is unable to identify close contacts: Broad Based approach. Test all staff regardless of vaccine status, if staff are assigned to a specific location where the new case occurred (unit, floor, or other specific areas of the facility). If negative, test again 48 hours later and if negative, 48 hours after the 2nd test. In general, testing should continue every 3-7 days until 14 days have passed without any new cases. Test all residents, regardless of vaccination status, facility-wide or at a group level (unit, floor, or other specific areas of the facility). If negative, test again 48 hours later and if negative, 48 hours after the 2nd test. In general, testing should continue every 3-7 days until 14 days have passed without any new cases. Test results will be tracked and reported as required by local, state, and federal entities. The CDC guidance Outbreak Response when a new facility-onset case of COVID is identified with a date of 2/2022 was reviewed and read in part: Does the facility have the expertise, resources, or ability to identify all close contacts? If yes: Perform individual contact tracing by identifying staff with higher-risk exposure and residents with close contact to the individual with COVID. Close contacts should be tested immediately (but not sooner than 24 hours after exposure) and if negative, again 48 hours later, again 48 hours after the 2nd negative test. If testing reveals additional residents or staff with COVID, contact tracing should continue to identify residents with close contact or staff with higher-risk exposure to the newly identified individuals. Strong consideration should be given to shifting to the broad-based approach if additional cases are identified. If no: Perform broad-based testing: test all staff and residents immediately but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the 1st negative test and, if negative again 48 hours after the 2nd negative. Were new cases identified: if Yes: testing should continue every 3-7 days until there are no new cases for 14 days. A broad-based approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Outbreak response: residents and staff should wear source control; consider implementing universal PPE use, visitors should wear source control and only go to and from resident's room or a designated visiting area; communal activities may continue but source control should be used, and physical distancing maintained whenever possible, unless otherwise directed by public health. The infection control line listing for December 2024 and January 2025 for the facility was reviewed and included the following information. The outbreak started on 1/18/25 when the Maintenance Director and the Maintenance Assistant tested positive for COVID. - Maintenance Assistant tested positive for COVID on 1/18/25. - The Maintenance Director also tested positive for COVID on 1/18/25. - Resident #78 (200 hall) tested positive for COVID on 1/19/25. - Resident #14 (400 hall) tested positive for COVID 1/20/25. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The Rehabilitation Director tested positive for COVID on 1/20/25. - The Director of Nursing tested positive for COVID on 1/20/25. - The Admissions Director tested positive for COVID on 1/20/25. - Resident #42 (200 hall) and tested positive for COVID on 1/21/25. - Physical Therapy Aide #1 tested positive for COVID on 1/21/25. - Resident #97 (400 hall) tested positive for COVID on 1/23/25. - Physical Therapy Aide #2 tested positive for COVID on 1/23/25. - NA #6 tested positive for COVID on 1/26/25. - Laundry Aide #1 tested positive for COVID on 1/26/25. - Resident #79 (400 hall) tested positive for COVID on 1/27/25. - Resident #69 (100 hall) tested positive on 1/27/25. No contact tracing or broad-based COVID testing was initiated until after surveyor intervention on 2/4/25. - Resident #170 (100 hall) tested positive for COVID on 2/4/25 - Kitchen Staff #1 tested positive for COVID on 2/4/25 outside of the facility. - Resident #112 (100 hall) tested positive for COVID on 2/5/25. - Resident #98 (100 hall) tested positive for COVID on 2/6/25. The Infection Preventionist (IP) was interviewed on 2/3/25 at 2:12 PM. The IP reported she was the infection control nurse and the Assistant Director of Nursing for the facility and had been in her position for almost 9 months. The IP reported that she emailed the Health Department on 1/21/25 to notify the Senior Nurse about the COVID cases. The IP explained the facility was not testing all residents and staff for COVID and they were testing only contacts of the residents who were positive for COVID. The IP noted because the residents who had symptoms of COVID before they tested positive and were placed on TBP she had not tested contacts for the residents because they were under TBP and would not have exposed anyone. The IP reported the facility was only testing symptomatic residents and staff. (continued on next page)

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Matthews Health & Rehab Center	600 Fullwood Lane Matthews, NC 28105

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An email from the Senior Nurse at the Department of Health/Communicable Disease (Health Department Nurse) sent to the IP dated 1/21/25 was reviewed and read, in part: I have attached the monitoring log for reporting .regarding when to test residents and staff, I copied this section for you from the (CDC) website: 'If additional cases are identified, strong consideration should be given to shifting to the broad-based approach (regarding testing for COVID) if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3 to 7 days until there are no new cases for 14 days .' Included in the email were links to the CDC website for additional guidance regarding infection control and guidance for risk assessment. The Health Department Nurse was interviewed by phone on 2/5/25 at 11:31 AM. The Nurse reported the IP had emailed her on 1/21/25 with the report of 3 resident positive COVID cases on the 200 hall, and 1 resident positive case on the 400 hall. The Health Department Nurse explained she had sent the IP CDC guidance for testing residents and staff using broad-based testing, quarantining residents, and how long staff should stay out of work. The IP was interviewed again on 2/5/25 at 12:02 PM and she reported when she received the email from the Health Department Nurse, she missed the part of the email about broad-based testing. The IP and the Director of Nursing were interviewed on 2/4/25 at 8:32 AM. The IP reported she provided infection control surveillance for the facility and monitored all new infections. The IP explained residents with any respiratory symptoms were placed on droplet precautions and a chest x-ray was ordered if they were coughing. The IP reported she tracked the infections and the residents with signs and symptoms on a respiratory tracking form. The IP further explained she had multiple forms for tracking infections in the facility, including event tracking in the electronic documentation system, a spreadsheet, and a facility map that she color-coded to identify trends and outbreaks of infections. The IP reported she had noticed the COVID infections were popping up on different halls, but didn't occur to her the facility was in outbreak status. The IP explained when a resident had sign or symptoms of a respiratory infection, they were placed on droplet precautions immediately and she thought because the resident was isolated, there was no need to conduct contact testing. The DON stated the IP was exclusively responsible for the infection control data, but the other nursing department heads assisted with monitoring the staff for correct PPE use, but the facility had not conducted monitoring. The DON reported she had tested positive for COVID on 1/20/25 and was out of work until 1/30/25 and she was not available during the first part of the outbreak. The DON reported she was not aware the facility was testing only symptomatic residents, and the facility should have initiated broad-based COVID testing for residents and staff. The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator explained the IP had misunderstood the guidance from the CDC website did not know that broad-based testing should have started on 1/20/25. The Administrator reported the broad-based testing was not initiated by the IP when the residents tested positive on 1/19/25 and he expected COVID guidelines to be followed. The Administrator reported he was aware the IP was testing only symptomatic residents and staff, and he thought that was the guidance she had received from the Health Department. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NA #1 was interviewed on 2/2/25 at 12:51 PM and when asked why she had entered the room without PPE, NA #1 reported she had been off work for a few days and had not noticed the sign on the door. NA #1 was interviewed by phone on 2/4/25 at 11:05 AM. NA #1 reported she was not aware she had to apply full PPE to deliver a meal tray. NA #1 explained after the observation on 2/2/25, she took a break and changed her mask after her break. During an interview with the Infection Preventionist nurse (IP) on 2/4/25 at 8:32 AM, the IP reported that NA #1 should have applied full PPE to deliver the meal tray to Resident #69 and she would have expected her to change her mask and perform hand hygiene after removing the PPE. Review of NA #1's education revealed NA #1 received infection control education and use of standard precautions on 4/23/24. NA #1 additionally had a skills review that was completed 8/10/24 which included demonstration of infection control and prevention and demonstrated adherence to the infection control policies. On 2/2/2025 at 4:45 pm NA #2 was observed in Resident #79's room from the hall. Resident #79 had signage on her door for special droplet precautions. A caddy was outside of the door with PPE, including gowns, gloves, N95 masks, and eye protection. Instructions on the signage included completing hand hygiene, applying gloves, protective gown, N95 mask, and eye protection before entering the room. Resident #79 was upset and yelling and NA #2 was observed standing beside Resident #79's bed, within 2 feet of Resident #79, with her N95 mask pulled below her nose, attempting to calm her. NA #2 was not wearing eye protection, a gown, or gloves. NA #2 made eye contact with the surveyor and pulled her mask up over her nose. NA #2 was observed to leave NA #2 did not remove the N95 mask or replace the N95 mask when she exited Resident #79's room. NA #2 was interviewed on 2/2/2025 at 4:46 pm and she stated she saw the Special Droplet and Contract Precautions sign on Resident #79's door but thought Resident #79 was off precautions because she was told the resident tested negative for COVID. NA #2 stated she did not remember who told her Resident #79's precautions were removed. NA #2 stated she should have worn eye protection, a gown and gloves and kept her mask over her nose and mouth. Review of NA #2's education revealed NA #2 received infection control education and use of standard precautions on 5/31/24. NA #1 additionally had a skills review that was completed 8/12/24 which included demonstration of infection control and prevention and demonstrated adherence to the infection control policies. During an interview with the IP on 2/2/2025 at 4:47 pm she stated Resident #79 should still be on Special Droplet and Contact Precautions because she had not completed the required isolation period since she had tested positive. The IP further stated she would have taken the precautions sign from Resident #79's door if she was off precautions and NA #2 should have worn a gown and gloves, and NA #2 would be required to always wear a mask that covered her nose and mouth. The DON was interviewed on 2/7/2025 at 1:04 pm and she stated NA #2 should have worn her mask over her nose and put on eye protection, a gown and gloves on before entering Resident #79's room on 2/2/2025 since the resident was on Special Droplet and Contact Isolation. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/7/2025 at 1:09 pm the Administrator was interviewed and stated NA #2 should have worn eye protection, a gown and gloves and worn her mask over her nose while entering a room that was on Special Droplet and Contact Isolation. An observation of Nurse #4 without a mask on during a medication administration observation was made on 2/4/2025 at 7:45 am on the 300 hall. Nurse #4 had prepared medications for Resident #278 and was getting ready to enter his room, when she was stopped and asked if she should be wearing a mask. Nurse #4 stated she was not required to wear a mask if she was not in a room with precautions in place. An attempt was made to interview Nurse #4 again, but she had left the facility and did not return phone calls with requests for an interview. Nurse #4 received infection control education and use of standard precautions during orientation to the facility on [DATE]. Nurse #4 additionally had a skills review that was completed 8/21/24 which included demonstration of infection control and prevention and demonstrated adherence to the infection control policies. The IP was interviewed on 2/4/2025 at 8:32 am and she reported she was educating all the nursing staff on PPE use because of the observations of NA #1 and NA #2 not wearing the PPE required for Special Droplet and Contract Precautions made on 2/2/25. The IP explained all staff should be wearing masks during the COVID outbreak. The IP stated Nurse #4 received in-service education regarding personal protective equipment yesterday and was not compliant with wearing a mask for source control today. The IP was unable to answer why Nurse #4 was not wearing her mask after receiving education on 2/3/25. The IP explained she conducted surveillance for PPE use and hand hygiene in the facility but had not conducted any surveillance during the outbreak until 2/2/25. The IP reported the process for monthly PPE surveillance was she typically watched 3 staff members apply and remove PPE and provided education if they had problems. The IP explained she did not keep records of the surveillance of PPE. The Director of Nursing (DON) was interviewed with the IP on 2/4/25 at 8:32 AM. The DON explained she and other nurse managers had not routinely assisted with PPE surveillance, but the unit managers had started to monitor staff PPE use since 2/2/25. The DON reported she expected all staff to follow the guidelines for PPE use for residents on special droplet precautions. The DON was interviewed on 2/7/2025 at 1:04 pm and DON and stated Nurse #4 should have been wearing a mask at all times due to the outbreak status of the facility. The Physician was interviewed on 2/5/25 at 9:20 AM. The Physician reported PPE use was important source control to prevent the spread of COVID and he would expect all staff to adhere to PPE guidelines. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. The Centers for Disease Control and Prevention (CDC) guidance for Health Care Personnel (HCP) returning to work updated 9/23/22 was reviewed and read, in part: HCP with mild to moderate illness who are not immunocompromised could return to work after the following criteria is met: 7 days since symptoms first appeared if a negative (COVID) test is obtained 48 hours prior to returning to work (or 10 days if testing is not performed), 24 hours since the last fever and symptoms (shortness of breath, cough) have improved. (Either NAAT [Nucleic Acid Amplification Test] (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later). HCP who were asymptomatic throughout their infection and not moderately to severely immunocompromised could return to work after the following criteria is met: at least 7 days have passed since the date of their first positive viral test if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed). (Either NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later). HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: at least 10 days and up to 20 days have passed since symptoms first appeared, and at least 24 hours have passed since the last fever without the use of fever-reducing meds, and symptoms (shortness of breath, cough) have improved. HCP who are symptomatic could return to work after the following criteria are met: resolution of fever without the use of fever-reducing medications, improvement in symptoms, results are negative from at least 2 consecutive respiratory specimens collected 48 hours apart. The infection control line listing for December 2024 and January 2025 for the facility was reviewed for staff. The Maintenance Assistant tested positive for COVID on 1/18/25 and returned to work on 1/24/25. There was no negative COVID test documented on the line listing. An interview was conducted with the Maintenance Assistant on 2/5/25 at 9:53 AM. The Maintenance Assistant reported he left work on 1/17/25 because he felt bad and he tested at home for COVID on 1/18/25 and it was positive. The Maintenance Assistant reported he worked in all areas of the building prior to becoming sick. The Maintenance Assistant reported he returned to work on 1/24/25 and he had not retested for COVID prior to returning to work. The Maintenance Assistant explained he was told to stay out of work for 7 days by the Infection Preventionist (IP). The Maintenance Director tested positive for COVID on 1/18/25 at home and 1/22/25 at the facility and returned to work on 1/23/25. There was no negative COVID test documented on the line listing for the Maintenance Director. The Maintenance Director was interviewed on 2/5/25 at 9:41 AM. The Maintenance Director reported he started feeling bad at home on Saturday 1/18/25 and he tested on [DATE] and it was positive. The Maintenance Director reported the week before he was sick, he worked in all areas and halls of the building. The Maintenance Director reported he notified the facility on 1/19/25 that he was positive and stayed out of work until 1/23/25 when he came to facility briefly to put salt on the pavement in preparation for a winter storm. The Maintenance Director reported he was told to stay out of work for 5 days by the IP and returned to work on 1/24/25. The Admissions Director tested positive for COVID on 1/20/25 and returned to work on 1/28/25. There was no negative COVID test documented on the line listing for the Admissions Director. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/23/25 Resident #97 (400 hall) tested positive for COVID. Broad-based COVID testing was not initiated by the facility policy and Center for Disease Control and Prevention (CDC). Contract tracing or broad-based approach COVID testing was not initiated until 2/04/25 after surveyor intervention. Facility policy/procedure was not implemented for testing. Contact tracing or broad-based COVID testing was not completed; staff and residents were not tested per facility policy and CDC guidance. Therefore, Infection Preventionist failed to follow facility policy/procedure for testing and current CDC guidance. On 2/2/25 NA #1 was observed entering a COVID positive room wearing only a KN95 mask. NA #1 was observed assisting the resident to sit up in bed and setting up the resident's meal tray. NA #1 exited wearing the KN95 mask and did not perform hand hygiene. On 2/2/25 NA#2 was observed in a COVID positive room assisting the resident wearing only an N95 mask which was positioned below her nose. NA #2 exited the room wearing the N95 mask. On 2/4/25 Nurse #1 was observed on the hall not wearing a mask for source control while administering medications and stated during interview she only wore a mask into rooms if a resident was on precautions. The facility did not implement policy and procedures for return-to-work criteria for Healthcare Personnel per facility policy and current CDC guidance. The Maintenance Director tested positive for COVID on 1/18/25 and returned to work on 1/23/25. The Maintenance Assistant tested positive for COVID on 1/18/25 and returned to work on 1/24/25. The Admissions Coordinator tested positive for COVID on 1/20/25 and returned to work on 1/28/25. Residents who did not receive the COVID vaccine are most susceptible to serious illness. Residents who are not up to date and Residents who did not test positive may be affected. On 2/4/2025 the Director of Nursing notified the Medical Director of the need for broad-based COVID testing. On 2/4/2025 Residents and/or Responsible Party were notified of the outbreak and the need for the broad-based testing. The management team, which includes the nurse managers, admissions managers, activities manager, and social workers made calls on 2/04/25 to the responsible parties of all residents to inform them of the COVID outbreak and broad-based testing. Communication was in person or via telephone. On 2/4/25, upon awareness of noncompliance with COVID testing guidelines, the facility Infection Preventionist