STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345196	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Vista Health Park	106 Mountain Vista Health Park Road Denton, NC 27239

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and physician and staff interviews, the facility failed to implement their Infection Control Policy for transmission-based precautions when Nursing Assistant (NA) #1 and NA #2 failed to perform hand hygiene, apply a face mask prior to entering a room with droplet precautions in place and failed to complete hand hygiene upon exiting the room. This was for 2 of 5 staff members observed for infection control practices (NA #1 and NA #2).The findings included:Review of the droplet precautions sign with a revision date of 1/20/22 revealed instructions for entering the room including:Everyone must clean hands before entering and leaving the roomEveryone must wear a surgical/procedure mask when entering the room and remove after exiting the room.Additional personal protective equipment (PPE) may be required per Standard PrecautionsPPE: apply in this order: alcohol-based handrub or wash with soap and water (if visibly soiled); mask (cover nose, mouth, and chin)Take off and dispose of in this order: mask (do not grasp front of the mask when removing); alcohol-based handrub or wash hands with soap and water if visibly soiled.The facility policy Isolation: Categories of Transmission-based Precautions with a revision date of 9/2022 specified droplet precautions were implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning. The policy indicated an individual should be placed in a private room if possible, but when a private room is not available, residents may share a room with a resident infected with the same microorganism or with limited risk factors, or on a case-by-case basis after considering infection risks to other residents. The policy specified that masks were worn when entering the room, gloves, gown, and goggles were worn if there was a risk of spraying respiratory secretions.An observation was conducted on 4/27/26 at 12:16 PM. Resident #45's door frame had the sign droplet precautions with instructions to perform hand hygiene and apply a face mask prior to entering the room. NA #1 entered Resident #45's room to deliver a lunch tray to Resident #45 (Resident #52's roommate). Resident #45 was sitting in a chair, and her bed was closest to the door. NA #1 did not perform hand hygiene prior to entering the room. NA #1 was noted to move the over-the-bed tray closer to Resident #45 and remove the lid from the plate of food. NA #1 did not perform hand hygiene after leaving the room. An alcohol-based handrub dispenser was noted on the wall beside the door.NA #1 was interviewed on 4/27/26 at 12:19 PM immediately after she exited the room and she reported she did not think she had to perform hand hygiene or apply a face mask to deliver a meal tray because the droplet precautions were in place for Resident #52 but not Resident #45. NA #1 reported she saw the droplet precautions sign.NA #2 was observed entering Resident #52's room with a lunch tray on 4/27/26 at 12:17 PM. Resident #52's door frame had the sign droplet precautions with instructions to perform hand hygiene and apply a face mask prior to entering the room. NA #2 did not perform hand hygiene or apply a face mask prior to entering the room. No face mask was applied by NA #2 before she entered the room. NA #2 was observed setting up Resident #52's lunch tray and adjusting the over-the-bed tray. NA #2 exited the room and did not perform hand hygiene. An alcohol-based handrub dispenser was noted on the wall beside the door.NA #2 was interviewed on 4/27/26 at 12:21 PM immediately after she exited the room and she reported she was aware Resident #52 had droplet precautions in (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place. NA #2 reported she had applied a face mask earlier in the shift to assist Resident #52 with grooming and dressing but did not think she had to perform hand hygiene or apply a face mask for tray delivery. NA #2 reported she saw the droplet precautions sign.On 4/27/26 at 2:49 PM, the Director of Nursing was interviewed with NA #1 and NA #2 present. Both NAs stated they had received education on precautions and PPE but could not recall the dates. NA #1 reported she became confused about the precautions in place and did not realize she needed to wear a face mask when delivering a tray to Resident #45, who was not on droplet precautions, and said she was nervous because she was being observed. NA #2 reported she knew Resident #52 was on droplet precautions but, due to nervousness, did not think to perform hand hygiene or apply a face mask before delivering a meal tray. Both NAs stated they were told during morning report on 4/27/26 that Resident #52 tested negative for COVID, influenza, and RSV, and they thought the droplet precautions sign was going to be removed; they also said they did not recall touching anything in the room that would have required hand hygiene. The DON stated both NAs had infection control education in the past and should have performed hand hygiene and worn a face mask before entering a room with droplet precautions, and she acknowledged that Resident #52 had a negative PCR test but remained on droplet precautions, adding that she expected staff to read and follow posted precaution signs and apply required PPE before entering the room.An interview was conducted with the Infection Control Preventionist (IP) on 4/29/26 at 9:03 AM. The IP reported Resident #52 had signs and symptoms of respiratory infection and special droplet precautions were implemented. The IP explained Resident #52 was tested for COVID, influenza, and RSV. The IP explained the rapid test was negative for COVID, and the PCR was negative for COVID, influenza, and RSV, but because Resident #52 had a cough, the facility kept her on droplet precautions and discontinued the special droplet precautions. The IP explained that if one resident was on droplet precautions in a room, the roommate was considered exposed and on droplet precautions. The IP explained that this meant the facility staff should wear a surgical mask when entering the room to provide care, as well as perform hand hygiene before and after care, including delivering meal trays to the resident under droplet precautions and their roommate.The Administrator was interviewed on 4/29/26 at 2:08 PM. The Administrator reported she and the DON discussed the incident and determined because NA #1 and NA #2 had been told in morning report on 4/27/26 that Resident #52 was negative for COVID, influenza, and RSV, they thought Resident #52 was going to be taken off droplet precautions, and it was okay to deliver the meal tray without performing hand hygiene or applying a face mask. The Administrator reported she expected all staff to follow the instructions on precaution signs posted on a resident's door.The facility Physician was interviewed on 4/29/26 at 2:46 PM. The Physician reported he had ordered loratadine (used to treat allergy symptoms) for Resident #52 based on her symptoms and medical history, but he had not examined her on 4/26/26. The Physician reported that the rapid and PCR test for COVID, influenza, and RSV were negative and Resident #52 remained on droplet precautions due to a cough, which he felt the allergy medication would help. The Physician reported he was concerned about the potential for infectious disease spread when he learned NA #1 and NA #2 did not follow the droplet precaution sign instructions by not performing hand hygiene or applying a face mask prior to delivering a meal tray to Resident #45 and Resident #52.