

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Pisgah Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 Holcombe Cove Road Candler, NC 28715	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51142</p> <p>Based on observations and staff interviews, the facility failed to date and seal leftover frozen food stored in 1 of 1 walk-in freezer. This practice had the potential to affect foods served to the residents.</p> <p>The findings included:</p> <p>On 3/23/2025 at 10:05 AM the initial kitchen observation was conducted with the Dietary Director and revealed the following:</p> <p>a. Walk-in freezer</p> <p>- A clear plastic bag open to air which was a quarter full of breaded fish filets with no date on the bag, edges of breaded fish filets were observed with a thin white layer around the edges.</p> <p>During an interview on 3/23/2025 at 10:11 AM the Dietary Director stated that all opened foods should be dated and sealed.</p> <p>During an interview on 3/25/2025 at 11:55 AM the Registered Dietitian stated opened food should be dated and sealed.</p> <p>During an interview on 3/25/2025 at 4:22 PM the Administrator stated the Registered Dietitian completed rounds every Monday morning and the breaded fish filets would have been thrown away on 3/24/2025 after rounds were completed. The Administrator provided a menu that showed baked fish had been served on 3/21/2025. The Administrator stated that opened food should have a date on it when put back in the refrigerator or freezer, but she was not sure if it needed to be sealed.</p>

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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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046</p> <p>Based on observations, record review, and staff, Medical Director, and Health Department (HD) Nurse interviews, the facility failed to operationalize infection control policy and procedures in accordance with current Centers for Disease Control and Prevention (CDC) guidance. A) The facility failed to implement a broad-based approach to COVID testing for staff and residents when contact tracing testing failed to stop the transmission of COVID. Broad-based COVID testing per the (CDC) guidance was not implemented until 3/25/25. Before broad-based testing was implemented on 3/25/25, a total of 7 staff members and 14 residents tested positive for COVID. Results of the broad-based testing from 3/25/25 to 3/31/25 yielded one (1) staff member and 8 additional residents positive for COVID. B) In addition, the facility failed to implement staff source control to help prevent transmission while working in the facility during the COVID outbreak. C) The facility also failed to restrict staff from returning to work after testing positive for COVID in accordance with current CDC guidance. D) The facility failed to have updated COVID policies and procedures that aligned with current CDC guidance for source control and work restriction guidance for healthcare personnel. The resident census at the time of the survey was 106; there were 59 residents whose COVID vaccinations were up to date. The facility provided a list of 128 staff members and reported there were 11 staff members whose COVID vaccinations were up to date. These cumulative practices and system failures occurred during a COVID outbreak and had the high likelihood of continued transmission of COVID to residents and staff and a serious adverse outcome.</p> <p>Immediate Jeopardy began on 3/11/25 when 3 staff members and 5 residents on three different resident halls tested positive for COVID and the facility failed to implement a broad-based approach COVID testing for staff and residents. Immediate jeopardy was removed on 3/27/25 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.</p> <p>Findings included:</p> <p>A. A facility policy entitled COVID response program dated as last approved on 2/2025 read in part:</p> <p>Perform COVID viral 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 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Create a process to respond to COVID exposures among health care personnel (HCP) and others: Exposures will be investigated by the infection control practitioner and other team members. Decisions to test all contacts will depend on the ability to identify all of the contacts. In cases where contacts are not identified then broad based of facility wide testing for resident and HCP will be initiated. Initial testing will be completed as a three series test. This process is described above. After the three series, testing is finished then the testing group will continue to be tested every 3-7 days until there are no new cases for 14 days.</p> <p>Responding to a newly identified COVID infected HCP or resident: When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdictions' public health authority. 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 contacts 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. 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 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5. If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility as part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days) should be considered.</p> <p>A review of the facility's COVID testing logs and list of COVID positive residents and staff revealed the facility's COVID outbreak started on 3/11/25 when Nurse #1, Nurse #2, and the Speech Therapist tested positive for COVID and two residents on K hall, two residents on F hall, and one resident on S hall tested positive for COVID. Additional residents on halls F, K, and S tested positive from 3/11/25 through 3/16/25. Facility testing logs indicated all Residents on F and K hall were tested and most of the residents on S hall were tested ; the log indicated rooms S18, S19, and S20 were not tested . The COVID testing log indicated a resident on C hall tested positive on 3/15/25 and a resident on W hall tested positive on 3/17/25. The COVID testing logs revealed no additional residents were tested from C hall or W hall until 3/25/25. Broad-based testing was not conducted until 3/25/25.</p> <ul style="list-style-type: none"> - On 3/11/25 Nurse #1 tested positive for COVID. - On 3/11/25 Nurse #2 tested positive for COVID. - On 3/11/25 the Speech Therapist tested positive for COVID. - On 3/11/25 Resident #8 in room F10 was positive for COVID. - On 3/11/25 Resident #92 in room K1 was positive for COVID. - On 3/11/25 Resident #95 in room F9 was positive for COVID. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted on 3/25/25 at 2:43 PM 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 with 72 hours of each other. She said the HD used an outbreak reporting email system. The HD nurse reported she went through all her emails, logs, and phone call records and she did not have any information or contact from the facility. The HD further reported the last contact with the facility had been after a large storm in September 2024 when the HD reached out to the facility to see if they needed anything. The HD nurse explained that the HD also held quarterly calls with the local facilities and had a call last week, and the facility had not been present on the call. The HD nurse reported that she had received an email from the Administrator this morning (3/25/25). She reported the email content from the Administrator had said she was following up on an email she had sent last week. The HD said the email from this morning (3/25/25) had a forwarded email attached that looked like it had been sent on 3/17/25. The HD Nurse said she had double checked and could not find anything in the HD email that had been sent on 3/17/25 from the facility. The HD nurse stated the email she had received from the facility today had said 2 employees were positive for COVID. The HD Nurse explained if the facility had gotten in touch with the HD on 3/11/25 she would have asked if the staff were symptomatic, where they had worked, and who they had taken care of on those shifts. She reported that if the positive staff had worked on several hallways or if residents had tested positive on several hallways, she would have recommended testing all residents and staff in the facility and would have also recommended wearing masks for source control. The HD Nurse said if staff were not wearing a mask there could be more exposure. She stated as soon as the facility had additional positive staff or residents on the initial serial testing, they should have moved up to broad-based facility wide testing of residents and staff. She indicated it was hard to contact trace and identify all the potential contacts when there were that many positive cases on multiple units. The HD nurse said after the initial 1-, 3-, and 5-day testing the facility should have continued testing residents and staff every 3 days or two times a week until they had no new cases for 14 days. She further stated the facility should have also implemented face masks for source control on 3/11/25 when multiple residents and staff had tested positive for COVID because the facility would have been in outbreak status. The HD Nurse stated the facility would not have continued to see more cases typically after 5 days if they were doing everything right and wearing masks. She reported the facility should have notified the HD on 3/11/25 or at least within a few days. The HD Nurse explained if for some reason the facility was not able to get in touch with the HD or she was not available the information was available on the CDC website. The HD Nurse reported there was a packet that she sent via email to all facilities in outbreak status that had specific infection control practices to implement and follow to help mitigate the outbreak.</p> <p>An additional interview was conducted with the DON on 3/25/25 at 3:58 PM. She reported that the facility had received a phone call from Resident #99's son on 3/24/25 who communicated Resident #99 had tested positive for COVID at the hospital on 3/22/25. The DON stated Resident #99 had been transferred to the hospital on 3/21/25 for evaluation due to a fall. The DON explained the facility tested Resident #99's roommate (Resident #39) on 3/24/25 and she had also been positive for COVID. She said the facility decided to branch out and do more testing today (3/25/25) because they did not have a known source of COVID exposure for Resident #99. The DON reported they had decided to test all of the residents on C hall. She said when additional residents on C hall (Residents #91, #43, #9, and #45) tested positive, they decided to test the NA assignment from yesterday (3/24/25), which was split between C and W hall. She said the residents at the top of W hall were tested and 2 residents (Resident #16 and #70) were positive. She was not sure if they had tested all the residents on W hall.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview was conducted with the Administrator on 3/25/25 at 5:44 PM. The Administrator said she felt like what the facility was doing was working to mitigate the facility's COVID outbreak. Even though there was a positive COVID resident located on C hall (C10B) and W hall (W4), the Administrator reported she thought the new COVID cases on C hall and W hall were a separate outbreak from the original outbreak because there had been 5 days since the last COVID case had been identified. She said they had more staff who had been tested but did not have an official log of who. The Administrator said she had spoken with the HD Nurse by phone this afternoon but had not spoken to anyone at the HD before today. The Administrator indicated she had emailed the HD Nurse on 3/11/25 that the facility had COVID cases and then she had followed back up with her today. The Administrator reported that she was not sure what happened that the HD Nurse had not received the email on 3/11/25. The Administrator indicated that when she spoke with the HD Nurse today, she gave the HD Nurse all the information and discussed the facility's thought process for contact tracing. She reported she explained the facility rational with how they had identified and tracked the positive COVID cases and had explained what they had been doing. The Administrator reported the HD Nurse was comfortable with what the facility was doing and what they were doing for staff.</p> <p>A report dated 3/26/25 from the HD Nurse was provided after she had talked to the facility on [DATE]. The report indicated the facility's positive COVID cases from 3/11/25 through 3/16/25 on halls F, K, S had been discussed and the cases from 3/22/25 through 3/25/25 on halls W and C had been discussed. The report did not include the positive case that occurred on C hall on 3/15/25 or W hall on 3/17/25. The report indicated corrective actions identified were facility masking and testing staff. The HD nurse indicated that the facility Administrator had contacted her on the morning of 3/26/25 with updated information that additional C hall residents and one resident on F hall had tested positive. The HD nurse indicated the facility was conducting facility wide testing of all staff and residents going forward. The HD nurse reported that the facility planned to test all residents and staff twice weekly going forward, until there were no new cases for 14 days.</p> <p>An interview was conducted on 3/31/25 at 1:49 PM with the Medical Director. The Medical Director indicated that since the end of the pandemic the CDC guidance was not as clear and not as distinct. He stated the CDC tried to establish the standard of practice. He said who to test, when to test, and how long to test afterwards was not clear cut. He reported the CDC was not as clear as they could be and that it was hard to keep up with the guidance for a little while with all the changes and there was a lot of confusion about the requirements and standard of care and what that should be. He said the facility was following its policy whether it was correct or not he was not sure, but it was a corporate policy. He thought broad based testing should be used if there was a significant outbreak. He said for him a significant outbreak would be 2 or more cases and indicated the facility outbreak that started on 3/11/25 was significant. He explained the only way to find asymptomatic people that were COVID positive would be to test the asymptomatic people. The Medical Director stated asymptomatic individuals could still be infectious and pass the virus. The Medical Director further stated, if there was a significant outbreak the facility should follow their testing policy to identify individuals who were COVID positive and isolate people. He reported there was not a lot of testing that had been going on since 3/11/25 and that the broad-based COVID testing was not being done. The Medical Director said there were a few residents who had gone to the hospital due to COVID symptoms. He reported Resident #99 had gone to the hospital for evaluation on 3/21/25 after a fall and had tested positive for COVID at the hospital on 3/22/25. The Medical Director indicated the residents were okay, there were no deaths, and the residents were treated with antivirals.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Pisgah Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 104 Holcombe Cove Road Candler, NC 28715	

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Additional COVID testing logs for residents and staff were provided on 3/31/25 by the Administrator. The Administrator indicated the COVID testing logs included staff and Residents who were tested due to possible exposure. The COVID testing log and daily staff schedules were reviewed. There were no therapy staff, except for the Speech Therapist listed on the COVID testing log.</p> <p>Nurse #3 worked on:</p> <p>3/11/25, 3/15/25, 3/17/25 on F hall, K hall, S hall</p> <p>3/16/25 and 3/20/25 on B hall</p> <p>A negative COVID test was documented on 3/11/25 and 3/13/25. There was no additional testing for exposure documented for Nurse #3.</p> <p>NA #3 worked on:</p> <p>3/9/25 on halls B, W, and S</p> <p>3/11/25 on halls K and S</p> <p>3/18/25 on halls C, W, and S</p> <p>There was no documentation of COVID testing for NA #3</p> <p>Medication Aide #1 worked on:</p> <p>3/11/25, 3/15/25, 3/16/25, 3/17/25 on halls F, K, and S</p> <p>3/14/25 on halls F and K</p> <p>3/19/25 on halls B and W</p> <p>A negative COVID test was documented on 3/20/25 but no prior testing was documented for Medication Aide #1.</p> <p>Nurse #4 worked on:</p> <p>3/11/25 and 3/13/25 on halls F, K, and S</p> <p>There was no documentation of COVID testing for Nurse #4</p> <p>NA #4 worked on:</p> <p>3/11/25, 3/12/25, and 3/13/25 on halls F and K</p> <p>There was no documentation of COVID testing for NA #4</p> <p>Medication Aide #2 was also an NA and worked on:</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>3/11/25 and 3/15/25 on halls F, K, and S (Medication Aide)</p> <p>3/12/25 on halls B and W (NA)</p> <p>3/13/25 and 3/16/25 on halls W and S (NA)</p> <p>3/17/25 on hall S (NA)</p> <p>There was no documentation of COVID testing for Medication Aide #4</p> <p>Nurse #5 worked on:</p> <p>3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, 3/17/25 on halls W, C, and S.</p> <p>There was no documentation of COVID testing for Nurse #5</p> <p>Medication Aide #3 worked on:</p> <p>3/9/25, 3/13/25, 3/14/25, 3/17/25 on halls F, K, and S.</p> <p>There was no documentation of COVID testing for Medication Aide #3</p> <p>NA #5 worked on:</p> <p>3/12/25 on hall S</p> <p>3/17/25 on halls F and K</p> <p>There was no documentation of COVID testing for NA #5</p> <p>Medication Aide # 4 also worked as a NA and worked on:</p> <p>3/9/25 and 3/16/25 on halls F, K, and S (Medication Aide)</p> <p>3/10/25 on halls C and E (NA)</p> <p>3/11/25 on halls B and W</p> <p>3/13/25 on halls C and W</p> <p>A negative COVID test was documented on 3/11/25 but no additional testing was documented for Medication Aide #4.</p> <p>NA #6 worked on:</p> <p>3/10/25 and 3/15/25 on halls F, K, and S</p> <p>3/9/25 on halls F and K</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>3/16/25 on halls A, E, and C</p> <p>There was no documentation of COVID testing for NA #9</p> <p>A follow-up interview with the Administrator was conducted on 3/31/25 at 11:04 AM. The Administrator said the original resident COVID testing log provided on 3/24/25 was for the initial exposure testing. She explained the facility had also tested the residents on halls F, K, and S two more times after the initial 1, 3, and 5-day testing. She reported the original testing log provided was not clear, she said there were a couple different formats people were using, and they were tracking things differently and that needed to be merged. She said the residents were tested again on 3/18/25 and 3/20/25. When asked why the testing was not included in the log originally provided, she said the information had been kept in different places by several different staff. The Administrator said the facility had a transition of management roles and that was why they did not have a clear and concise list of who was tested and how things were monitored. The Administrator stated historically she had kept up the COVID testing log but that as things progressed the DON and SDC had started tag teaming that. She reported they had to sit down and get everything on one comprehensive list. The Administrator indicated the facility had tested staff due to symptoms and exposure from working on units that had COVID positive residents because they were not masked. She said most staff who worked on halls F, K, and S were tested. She stated the facility tested staff for exposure on days 1, 3, and 5. The Administrator said some staff had not been tested and had not had repeat testing depending on their work schedule, such as if it was a part time or as needed staff member that did not work again for a while. She said some staff were not tested because they were beyond the exposure risk time frame when they returned to work. The Administrator reported she wanted to do what was best and felt like they had been following their systems and processes for doing that.</p> <p>An interview was conducted with the PA on 3/31/25 at 4:46 PM. She reported her symptoms had started on 3/8/25 and she had tested positive on 3/12/25. The PA said she had last been at the facility on 3/7/25. The PA stated the facility had not asked her what residents she had seen on 3/7/25 but that they could determine that. The PA explained she always emailed a list of all the residents she saw every day she was at the facility and said the facility would have the list of who she saw from 3/7/25. The PA said she notified the facility when she tested positive on 3/12/25.</p> <p>A follow-up interview was conducted with the DON on 4/1/25 at 3:30 PM. The DON explained the testing for staff had not been logged because several individuals were involved in testing and the information had not been compiled. She reported some of the staff had not been tested who had worked on the exposed units because they had been following their policy and had only been testing staff who had symptoms. She explained the policy was a corporate policy and she had assumed it aligned with the CDC recommendation. The DON had not been aware that NA #2 who tested positive for COVID on 3/16/25 had worked on 3/15/25 on halls S and W. She agreed that the residents residing on W hall should have been tested due to exposure if NA#2 had worked on the hall.</p> <p>B. A facility policy entitled COVID response program dated as last approved on 2/2025 read in part:</p> <p>Source control is recommended: Universal source control is not required but is recommended when a person</p>		