

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Wilkesboro Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 204 Old Brickyard Road North Wilkesboro, NC 28659	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51142</p> <p>Based on record review and staff interviews, the facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) by omitting the estimated out of pocket cost for care for 4 of 4 residents reviewed for beneficiary notices (Residents #4, #151, #45, #11).</p> <p>The findings included:</p> <p>a. Resident #4 was admitted to the facility on [DATE].</p> <p>The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was relayed by phone on 8/21/24 to Resident #4's representative. The notice indicated that Medicare coverage for skilled services was to end on 8/23/24. Resident #4 remained in the facility when Medicare coverage ended.</p> <p>Review of Resident #4's record indicated the SNF ABN dated 8/21/2024 had no estimated cost for care documented on the form.</p> <p>b. Resident #151 was admitted to the facility on [DATE].</p> <p>The medical record revealed a CMS-10123 NOMNC was relayed to Resident #151's representative on 8/16/24. The notice indicated that Medicare coverage for skilled services was to end on what 8/20/2024. Resident #151 remained in the facility when Medicare coverage ended.</p> <p>Review of Resident #151's record indicated the SNF ABN dated 8/16/2024 had no estimated cost for care documented on the form.</p> <p>c. Resident # 45 was admitted to the facility on [DATE]. Medicare part A services began on 1/5/2024.</p> <p>The medical record revealed a CMS-10123 NOMNC was signed by Resident #45 on 4/16/2024. The notice indicated that Medicare coverage for skilled services was to end on 4/18/2024. Resident #45 remained in the facility when Medicare coverage ended.</p> <p>(continued on next page)</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #45's record indicated the SNF ABN dated 4/16/2024 had no estimated cost for care documented on the form.</p> <p>d. Resident # 11 was admitted to the facility on [DATE]. Medicare part A services began on 3/27/2024.</p> <p>The medical record revealed a CMS-10123 NOMNC was signed by Resident #11 on 6/18/2024. The notice indicated that Medicare coverage for skilled services was to end on what 6/20/2024. Resident #11 remained in the facility when Medicare coverage ended.</p> <p>Review of Resident #11's record indicated the SNF ABN dated 6/18/2024 had no estimated cost for care documented on the form.</p> <p>During an interview on 9/10/2024 at 9:31 am with Business Office Employee #1, she said she presented SNF ABN to the resident, or resident representative after she was notified in the weekly meeting on Thursdays where the Medicare A cases were reviewed and talked to the resident or representative about the rates but had not written the rate on the SNF ABN form. Review of the SNF ABN form with Business Office Employee #1 revealed private pay was written in the block for estimated cost. Business Office Employee #1 verified 4 of 4 forms reviewed did not have the estimated cost provided on the SNF ABN form. She stated she had never been told it had to be a specific amount.</p> <p>During an interview on 9/10/2024 at 9:40 am with the Administrator she said a weekly meeting was held on Thursdays and all Medicare part A cases were reviewed. She said the business office gave SNF ABN notifications to residents or resident representatives. Resident #4, Resident #151, Resident #45, and Resident #11's SNF ABN form was verified with the Administrator that private pay was written in the block for estimated cost on the SNF ABN form. The Administrator stated she did not know and had not been told previously that a specific amount needed to be placed in the estimated cost section of the SNF ABN form.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>51089</p> <p>Based on observations and staff interviews, the facility failed to maintain the privacy of a resident's record by leaving a medication cart laptop unattended with resident information exposed in an area accessible and visible to the public on 1 of 6 medication carts (Medication cart #3).</p> <p>The findings included:</p> <p>During an observation of 200 hall on 09/09/24 at 4:04 PM, medication cart #3 was observed unattended. The laptop screen was open and displayed resident names, medications, and diagnoses. Staff were observed in the area and the treatment nurse passed by while the residents' information was visible on the open laptop screen at 4:06 PM.</p> <p>On 09/09/24 at 4:07 PM, a resident passed by the open laptop screen on the medication cart #3 while residents' information remained visible. Medication Aide (MA) #2 was observed returning to the 200 hall with medication cart #2 at 4:10 PM.</p> <p>An interview with MA #2 was completed on 09/09/24 at 4:10 PM. She stated she was assigned to two medication carts (cart #2 and cart #3). She verbalized that she usually clicked the walkaway tab when she left the medication cart unattended, so resident information was not visible. MA #2 indicated she thought she had hit the button to minimize the screen before she left the hall.</p> <p>An interview with the Assistant Director of Nursing was completed on 09/09/24 at 4:21 PM. She stated staff clicked the walkaway button on the computer screen of the laptop when they left the medication cart unattended.</p> <p>An interview with the Director of Nursing (DON) was completed on 09/09/24 at 4:38 PM. She explained to protect the health privacy of residents, the laptops on medication carts were minimized if staff were not in attendance of the medication carts. The DON verbalized MA #2 should have made sure the laptop screen was locked, and no personal health information was visible prior to leaving the medication cart unattended.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51093</p> <p>Based on record review, resident, and staff interviews, the facility failed to ensure a prompt resolution to a grievance and failed to provide a written summary about a grievance for 1 of 1 resident reviewed for grievances (Resident #43).</p> <p>The findings included:</p> <p>Facility Grievance/Complaint filing policy stated resident or any family member of the resident could file a grievance/ complaint orally or in writing. Upon receipt of a grievance /complaint the Grievance Officer would review and investigate the allegations and submit a written report of such findings to the Administrator within 5 working days of having received the grievance/ complaint. The Grievance officer, Administrator and Staff would take immediate action to prevent further potential violations of resident rights while the alleged violation was being investigated. The Administrator would review the findings with the Grievance Officer to determine what corrective actions, if any, needed to be taken. The Resident or person filing the grievance/complaint on behalf of the resident would be informed (verbally and in writing) of the findings of the investigation and the actions that would be taken to correct any, identified problems.</p> <p>Resident #43 was admitted to the facility on [DATE].</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #43 was cognitively intact.</p> <p>Record Review revealed on 07/03/2024 Resident #43 had filed a grievance with the facility Social Worker for missing 4 to 5 embroidered sheets: blue, pink yellow and peach color, 3 gowns, tote bag, and a Yeti cup.</p> <p>On 07/03/2024 the Social Worker documented on the grievance form under investigation/finding that the resident's room was searched, and the items were not found.</p> <p>The Investigation resolution on the grievance form dated 07-03-2024, had documentation by the Social Worker that she left a message for the resident's family member inquiring about when the items were delivered to the resident and inquired about the cost and quantity of the lost items. The Social Worker further documented the facility would not resolve the grievance until these items were found.</p> <p>An interview with Resident # 43 on 09/08/24 at 12:37PM revealed the resident had filed a grievance back in July 2024 about some personal items missing from her room. She stated she was missing embroidered sheets and gowns. She stated the facility staff had not found her items. She went on to state she had informed the staff, and the facility Social Worker. She added the housekeeping and laundry staff looked for these items and had not found them. She stated she was aggravated and gave up. She stated she was verbally informed that her missing items were not found but the facility would continue to look for it.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Guest/ Family member follow up documentation dated 09/09/2024 on the grievance form revealed, the Social Worker documented that she left a message with the resident's family member and then spoke to the resident's family member and explained to her that the grievance was not yet resolved because they were hoping the lost items would reappear. The facility settled the grievance with Resident #43 on 09/09/2024. The facility agreed to replace the resident's lost items on 09/09/2024</p> <p>A follow up interview with Resident #43 on 09/10/2024 at 9:00AM revealed the facility had agreed to settle Resident # 43's grievance on 09/09/2024 evening. Resident stated the Social Worker had verbally informed her that the facility would be settling her grievance by purchasing new bed sheets and gowns for her and would embroider Resident # 43's name on it.</p> <p>In an interview conducted with the Social Worker who was also the Grievance Officer on 09/09/24 at 3:37PM she stated the facility's handbook documented the facility was not responsible for lost items. She stated the facility's policy for grievance resolution was to resolve within 5 days. She stated during their last care plan meeting dated 07/28/2024 Resident #43's family member who had attended the care plan meeting via telephone along with the Resident# 43 informed the care team that several embroidered sheets along with Resident #43's gowns were missing. She stated she informed the family member a grievance was already filed by Resident # 43; she stated the facility had already looked for the missing items and did not find them. She stated she informed the family member they would keep looking for the missing items.</p> <p>Interview with the Director of Nursing (DON) on 09/09/24 at 4:02PM indicated a grievance could be filed by anyone with the facility social worker. The grievance was then forwarded to the respective department to be processed even if it was on a weekend, as some grievance need immediate attention and cannot wait till Monday. She stated the grievance resolution time varied; it depended on the item. She stated they searched the whole facility and sometimes it took them about a month to resolve a grievance. She stated they had tried to resolve grievance faster for the short-term residents. For the long-term residents, it may take about a month to month and a half to resolve the grievance. She further stated if the lost items were not found the facility reimbursed the resident the value of the item. She stated she became aware of the grievance dated 07/03/2024 on 08/05/2024 when Resident #43's family member informed her. She stated none of the staff had seen these items mentioned in the grievance. She stated she had directed staff to look for the lost bedsheets one more time on 09/09/2024; if not found instructed staff to buy Resident # 43 new bedsheets and get them embroidered.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow up interview with the Social Worker on 09/10/2024 at 9:11AM, the Social Worker stated she knew it had been over 2 months since Resident #43 had filed her grievance and said it was a long time to settle a grievance, but she was hoping these items would show up. She stated it was not unusual for facility to take this long to settle grievance regarding lost clothing items because many times they were found a few weeks later. She stated she informed Resident #43 on 07/03/2024 that they were going to look for these items. The Social Worker stated that she had informed the laundry and housekeeping staff, but they were unable to find these items. She stated she kept inquiring with the resident if her items had showed up each time, she was in the resident's room but had not documented the follow ups or able to recall when the encounters with Resident#43 occurred. The Social worker did not provide a summary of investigation provided to Resident #43. The Social Worker stated they had not seen Resident #43's belongings. She stated that she had tried to contact Resident # 43's family member to determine the value of the items missing and left her a message to return her call. She stated the family member had not returned her call. Social worker did not clarify when or how attempts were made by her to contact Resident # 43's family member. She stated she decided to settle the grievance on 09-09-2024 because it was sitting on my desk and I wanted it off my desk. She stated she then contacted the family member the on 09/09/2024 and the family member said to settle the matter. The Social Worker stated they would replace the bed sheets and get them embroidered and replace all the other lost/ stolen items.</p> <p>On 09/09/24 at 4:18PM the Administrator was interviewed about the facility's grievance policy. She stated anyone could file a grievance which was then forwarded to the facility social worker. She stated typically they resolved the grievance within 5 days. She stated that she believed the facility handbook stated grievances were to be resolved within 5 days. She stated they very rarely had problems with missing items. When they did have a grievance, the facility would replace or reimburse the resident immediately. She stated she would contact the resident's family to determine the monetary value of the lost item and would settle the grievance. She further added sometimes the family members took time to provide the information. She stated to her knowledge Resident # 43's family member was contacted immediately by the facility social worker to determine the value of the lost items, but the family member did not follow up with the facility promptly therefore was unable to resolve this grievance sooner. The Administrator did not provide any verification of a written summary to provide to Resident #43.</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51089</p> <p>Based on observations and staff interviews, the facility failed to discard expired food and food items with signs of spoilage stored for use in 1 of 1 walk-in cooler. The facility also failed to label and date food items in 1 of 1 walk in cooler and in 1 of 2 nourishment room freezers (Hall 100). Additionally, the facility failed to store a dry ingredient scoop in a manner to prevent cross-contamination of food. These practices had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>a. An initial tour of the kitchen was made on [DATE] at 11:13 AM. The following food items were observed in the walk-in-cooler:</p> <p>soy sauce 3.79 Liters (L) opened: ,d+[DATE]with no use by or best before date</p> <p>salsa 8 pounds (lbs.) opened: ,d+[DATE] with no use by or best before date</p> <p>egg salad with the manufacturer use by date [DATE]</p> <p>ricotta cheese 3 lbs. unopened - Use by date: [DATE]</p> <p>1 piece of egg on top of a cracked eggshell that was stuck on the egg carton noted to have fuzzy, black specks of dirt formed surrounding the cracked eggshell</p> <p>A follow up observation of the walk-in cooler on [DATE] at 11:07AM revealed the cracked eggshell with fuzzy, black specks was still present.</p> <p>During an interview on [DATE] at 2:34 PM, the Certified Dietary Manager (CDM) verbalized that for labeling and dating, they go by the manufacturer's expiration date or the day it came in from the supplier. He also mentioned that he completed daily rounds within the kitchen and the facility to check on food items and discard when expired.</p> <p>b. During the initial tour of the kitchen made on [DATE] at 11:43 AM an observation of the dry ingredient bins revealed, a plastic scoop (inclusive of handle) observed resting in flour bin and not stored in scoop holder.</p> <p>During an interview on [DATE] at 2:34 PM, the Certified Dietary Manager (CDM) stated the flour scoop (including the handle) should not have been resting in the flour. The flour scoop should have been stored in the scoop holder of the flour bin.</p> <p>c. During an observation on [DATE] at 3:30 PM, two sausage breakfast sandwiches were observed inside the nourishment room freezer on the 100 Hall. These items were outside of their original cardboard packaging. Ice crystals were noticed to form inside the plastic packaging. No name and use by date indicated. There was a handwritten date of [DATE] on the clear packaging.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up interview with the CDM on [DATE] at 4:04 PM, he explained he put out sandwiches (variety), juices and milk cartons. The CDM explained the two frozen sausage breakfast sandwiches must be from a resident or a resident's family. He verbalized he has educated the nursing staff on all halls to place proper labels and dates on food or beverage items being placed in the nourishment refrigerators.</p> <p>During an interview with the Administrator on [DATE] at 11:57 AM, she verbalized that she conducted daily rounds of the facility including the nourishment rooms and refrigerators. She stated that dietary was responsible for throwing food items away that were not properly labelled, dated or expired.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51142</p> <p>Based on record review, resident, resident representative, and staff interviews the facility failed to explain the arbitration agreement to a resident, or the resident's representative, prior to having them sign the agreement This occurred for 1 of 3 residents (Resident #296) reviewed for arbitration.</p> <p>The findings included:</p> <p>Review of the facility's Agreement for Arbitration which was not dated, revealed by signing the Agreement for Arbitration, the resident and/or resident's representative acknowledged they had read and understood the agreement.</p> <p>Resident # 296 was admitted to the facility on [DATE].</p> <p>Review of Resident # 296's Agreement for Arbitration revealed the resident had signed the agreement on 09/05/2024 along with the rest of the admission paperwork.</p> <p>An attempt was made to interview Resident #296 on 09/10/2024 at 10:15 am. The resident was not able to understand or remember having been informed about an arbitration agreement. At the time of the interview, the resident was only oriented to person, and was unable to identify where she was, or the date and time. During the interview, the resident was unable to answer questions beyond her name.</p> <p>During a telephone interview on 09/10/2024 at 10:54 am with Resident # 296's family member, he said he did not think the resident would have been able to understand what the arbitration agreement meant. The family member said the facility should have asked one of her family members about the arbitration agreement because he did not think Resident #296 was able to sign to acknowledge she understood the agreement because she was too confused.</p> <p>During an interview on 09/10/24 at 01:14 pm with the admission coordinator, she said residents, or their representative were asked to sign the facility's Agreement for Arbitration on admission with their admissions paperwork. She stated she went over everything in the admission packet and the resident, or the resident representative, signed by using the electronic DocuSign. The admission coordinator said the facility had a paper titled Understanding the Arbitration Agreement, that she would offer to the resident and/or representative. The admission coordinator said she explained everything to the resident/representative before they sign and asked if they were willing to participate in the Arbitration process. The Admissions coordinator said if she was talking with a resident and the resident did not understand, or wasn't able to sign, then she would talk to their family/representative about the arbitration agreement. She said if a representative signed the arbitration agreement the representative's name would be on the arbitration agreement. During the interview with the admission coordinator, she verified Resident #296's name was listed as the person who signed the Agreement for Arbitration. The admission coordinator said she had gone over it with Resident #296, and that Resident #296 seemed fine during the admission process and was not sure why the resident could not remember.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51140</p> <p>Based on observation, record review, and staff interviews the facility failed to follow their infection control policy when the Medical Records Assistant delivered a lunch tray to a resident on Enhanced Droplet Precautions without donning a mask, gloves, gown, and/or eye protection for 1 of 1 resident who required Enhanced Droplet Precautions (Resident #19).</p> <p>The findings included</p> <p>The facility's COVID-19 Infection Control Practices policy was updated on May 8, 2023. The policy stated that staff should wear an N 95 mask, gown, gloves, and eye protection.</p> <p>The resident was diagnosed with COVID on September 7, 2024.</p> <p>On September 8, 2024, at 1:28pm, an observation was made of the lunch meal trays being delivered to residents. During the observation, the Medical Records Assistant was observed to remove Resident #19's lunch tray from the meal cart and enter the resident's room. The door to Resident #19's room was observed to have an Enhanced Droplet precaution sign that stated staff were to wear gown, an N95 mask, gloves and either face shield or goggles. Resident #19's door also had a metal holder that contained gowns, gloves, and masks. There was a small 3 drawer container next to the room with extra gowns and eye covering. The Medical Records Assistant entered the room with no gown, mask, gloves, or eye covering. The Medical Records Assistant proceeded to stand in front of Resident #19 and assist the resident in setting up her meal tray. The Medical Records Assistant was in the room in front of Resident #19 for approximately 1.5 minutes. When the Medical Records Assistant left Resident #19's room, she performed hand hygiene with hand sanitizer that was available on the wall in the hall.</p> <p>On September 8, 2024, at 1:32 PM, an interview took place with the Medical Records Assistant who confirmed that she had taken a lunch tray to Resident #19 that day. The Medical Records Assistant stated she was unaware of the resident being positive for COVID and that the resident was on enhanced droplet precautions. She did acknowledge there was an enhanced droplet precaution sign on the resident's door but stated I was trying to hurry and did not read what the sign said. The Medical Records Assistant stated she had received infection control training in January of 2024. The Medical Records Assistant also stated that she was aware of the need to wear the required Personal Protective Equipment (PPE) when a resident was placed on enhanced droplet precautions.</p> <p>On September 8, 2024, at 2:00 PM the Infection Prevention (IP) Nurse/Assistant Director of Nursing was interviewed. She stated staff had their annual infection control training in March of 2024. The IP nurse explained that staff would be aware of a resident having COVID by the Enhanced Droplet precaution sign on their door. She further stated that the Medical Records Assistant only came out of her office at mealtimes to help pass trays and probably did not look to see if the resident was on any precautions. She said that the Medical Records Assistant had received infection control training in March of 2024. The IP nurse voiced that the Medical Records Assistant should have looked prior to entering Resident #19's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Wilkesboro Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  204 Old Brickyard Road North Wilkesboro, NC 28659	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On September 8, 2024, at 3:00 PM the Director of Nursing (DON) was interviewed. The DON stated that she was unsure when the last infection control training was held. She explained that when the facility learned of Resident # 19 being positive for COVID on September 7, 2024, an education was sent out to all employees via an electronic messaging system on September 7, 2024. This education message included when and what PPE was involved, and instructions included reading the signage on the resident's door. The DON confirmed the Medical Records Assistant should have received the message on September 7, 2024, but stated that the Medical Records Assistant only came out of her office at mealtime for meal tray passing and did not read the signage on the resident's door.</p> <p>At 11:34 AM on September 9, 2024, an interview was completed with the Physician. The Physician stated that staff should have worn an N95 mask and all other required PPE due to Resident #19 being on enhanced barrier precautions.</p> <p>At 2:06 PM on September 8, 2024, the Administrator was interviewed. She stated that annual infection control training was on a computerized training system and was provided as needed when any infection control breaches occurred. The Administrator stated that staff would be made aware if a resident tested positive for COVID by the signage on the resident's door. She further stated that if staff did not understand the signage, then they were required to ask a nurse. She expressed that the Medical Records Assistant just did not read the signage on the door of Resident 19's room but should have.</p>