STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395410	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Sugar Creek	120 Lakeside Drive Worthington, PA 16262

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to notify the physician and a family representative of a change in condition for two of three residents (Resident R14 and CR8). Findings include: Review of the facility Resident Change in Conditionv or Status policy last reviewed 4/8/24, indicated when a resident exhibits a change in condition from their baseline, the license nurse assigned to the resident will ensure timely notification to charge nurse, physician, and family. Review of the clinical record indicated that Resident R14 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of anxiety, depression, and dementia (loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/21/24, indicated the diagnoses were current. Review of Resident R14's progress note dated 4/25/24, at 11:18 p.m. indicated the resident had 2 XL emesis this evening. It was indicated the Registered Nurse was aware. Review of Resident R14's clinical record on 4/25/24, through 4/26/24, failed to include evidence that a physician and family representative was notified of Resident R14's change in condition. Review of the clinical record indicated that Resident CR8 was admitted to the facility on [DATE], with diagnoses of high blood pressure, dementia, and depression. Review of Resident CR8's MDS dated [DATE], indicated the diagnoses were current. Review of Resident CR8's progress note dated 4/25/24, entered at 2:19 p.m. indicated the resident had four episodes of emesis and two episodes of diarrhea. It was indicated the RN was notified. Review of Resident CR8's clinical record on 4/25/24, failed to include evidence that a physician and family representative was notified of Resident CR8's change in condition. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24, at 12:21 p.m. Licensed Practical Nurse, Employee E6 stated any notification to the physician and family must be documented in the residents clinical record. LPN, Employee E6 indicated she notified the RN Supervisor of CR8's change in condition and stated the RN Supervisor is responsible for calling the physician. During an interview on 5/8/24, at 3:48 p.m. the Director of Nursing confirmed the facility failed to notify a physician and family representative for a change in condition for two of three residents (Resident R14 and CR8). 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.29 (l)(2) Resident rights

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46337 Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed effectively manage the facility to prevent the development and transmission of communicable infections. Findings include: The signed job description for Nursing Home Administrator dated 4/8/24, indicated the purpose of this position is to direct the day-to-day operations of the facility in accordance with current federal, state, and local standards governing long-term facilities and to ensure that the highest degree of resident care and services are delivered and maintained. ' The signed job description for Director of Nursing dated 7/13/23, indicated the purpose of this position is to provide nursing management, set resident care standards for all direct care providers, and provide complete supervision and management for the nursing department. Based on the findings in this report that identified that the facility failed to prevent the transmission of Norovirus for 46 residents, which placed residents in Immediate Jeopardy. The NHA and The DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 5/8/24, at 4:02 p.m. the NHA and DON confirmed they failed to effectively manage the facility to prevent the development and transmission of communicable infections. Refer to F880. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 207.2 (a) Administrator's responsibility. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on Centers for Disease Control and Prevention (CDC) guidance, Pennsylvania Department of Health (PADOH) guidance, facility policy and documents, review of clinical records, and resident and staff interviews, it was determined that the facility failed to maintain an infection prevention and control program by failing to timely investigate and document surveillance, exclude ill staff from working, failed to educate staff on appropriate precautions related to GI illness, and failed to implement preventative measures to address an outbreak of gastrointestinal illness among residents for 10 of 17 residents (Residents R1, R2, R3, R4, R5, R6, R7, CR8, R9, and R14) The facility's failure created a situation in which all 100 of 100 residents were placed in Immediate Jeopardy related to a lack of proper infection control procedures. Findings: The CDC, Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, dated 2/15/17, indicated that healthcare settings that experience an outbreak of gastroenteritis/norovirus should implement the following: -Cohorting (residents with symptoms of illness are moved into the same room) and Isolation Precautions -Avoid exposure to vomitus or diarrhea. -Place patients on Contact Precautions in a single occupancy room if they have symptoms consistent with norovirus gastroenteritis. When patients with norovirus gastroenteritis cannot be accommodated in single occupancy rooms, efforts should be made to separate them from asymptomatic patients. -If norovirus gastroenteritis infection is suspected, adherence to personal protective equipment -PPE (gloves, gowns, masks and/or face shields worn to protect the care giver from infection) use according to Contact and Standard Precautions is recommended for individuals entering the patient care area (i.e., gowns and gloves upon entry) to reduce the likelihood of exposure to infectious vomitus or fecal material. -During outbreaks, place patients with norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients. -Consider minimizing patient movements within a ward or unit during norovirus gastroenteritis outbreaks. -Consider suspending group activities (e.g., dining events) for the duration of a norovirus gastroenteritis outbreak. -Actively promote adherence to hand hygiene among healthcare personnel, patients, and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis. -Consider submitting stool specimens as early as possible during a suspected norovirus gastroenteritis outbreak and ideally from individuals during the acute phase of illness (within 2-3 days of onset). It is suggested that healthcare facilities consult with state or local public health authorities regarding the types of and number of specimens to obtain for testing. Review of the facility PADOH Toolkit for Control of Norovirus Outbreaks in Long-Term Care Facilities dated August 2019, indicated: -Implement daily active surveillance for gastroenteritis among residents and staff using DOH sample line listing. -That for the duration of the outbreak, the facility should increase the frequency of hand hygiene audits and provide written and verbal feedback to staff. -During outbreaks, use soap and water for hand hygiene (do not substitute alcohol-based hand gel). -Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Review of the facility policy Viral Gastroenteritis last reviewed 4/8/24, indicated several different viruses cause this diarrheal illness, including Norovirus. It was indicated the average incubation period is 12-48 hours and symptoms last usually from 24-60 hours. Do not wait to confirm the diagnosis before you set up infection control measures. Review of documentation submitted to the Department of Health by the facility dated 4/30/24, indicated that Registered Nurse (RN) supervisor notified the Director of Nursing on 4/30/2024, that there were several residents that had diarrhea or emesis on the Maple unit which began on 4/29/2024. Facility tracing was initiated. The Certified Registered Nurse Practitioner was in this morning and discussed. No confirmed norovirus, however, with 19 residents that are having emesis and or diarrhea, facility is treating as norovirus outbreak. It was indicated Maple residents will be contained on their hallway. Contact isolation PPE will be utilized for staff when providing care. Masks utilized. Education provided to staff regarding isolation, how the virus is spread, cleaning/disinfecting, handwashing-sanitizer use as per CDC recommendations and facility policy. Families are being updated at this time as well as MD's. Staff will continue to encourage fluids. Activity staff will provide 1:1 activities on unit. The 3 remaining hallways will have group activities on their individual units. The Infection Control (IC) nurse will also be notified as well as the local health department. Visitors are being notified when entering facility and encouraged to wash hands before and after their visit. Review of follow-up documentation submitted by the facility dated 5/2/24, indicated on 4/29/24, there were 19 (out of 42) residents with either vomiting or diarrhea noted on the Maple hallway. IC nurse tracking/trending, noted one resident with nausea on 4/25/24, then emesis/diarrhea on 4/26/24. It was indicated an additional 10 residents were identified throughout facility as of 5/1/24, and three additional residents on 5/2/24. Staff are utilizing PPE contact isolation along with hand hygiene. Residents are in contact isolation for a minimum of 48 hours after the resolution of their symptoms to prevent further exposure to other residents. Follow-up documentation submitted by the facility dated 5/3/24, indicated two additional residents and a total of four staff members developed signs and symptoms of a gastrointestinal (GI) illness. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident CR8's clinical record on 4/25/24, at 12:14 p.m. indicated the resident had three episodes of emesis and was administered 4mg Zofran (anti-nausea medication). Review of Resident CR8's progress note dated 4/25/23, at 2:19 p.m. stated the resident had four episodes of emesis and two episodes of diarrhea. Registered Nurse was notified, and Zofran was ordered and administered. Review of the resident's clinical record failed to indicate a physician was notified of Resident CR8's emesis and diarrhea. Resident CR8 remained cohorted with Resident R9 who was asymptomatic from 4/25/24, until Resident CR8 was discharged on [DATE]. Review of CR8's physician orders from 4/25/24, through 5/1/24, failed to include an order for contact precautions. Review of the facility's line list of residents who had contracted the GI illness dated 4/30/24, indicated Resident CR8 was the first resident to develop symptoms of nausea, emesis, and diarrhea on 4/26/24. The facility failed to timely and accurately complete surveillance tracking for residents with GI illness. Facility began surveillance a total of five days after the first resident (Resident CR8) developed signs and symptoms of a GI illness. Review of Resident R14's progress note dated 4/25/24, indicated the resident had 2 XL emesis this evening. It was indicated the Registered Nurse was aware. Review of the resident's clinical record failed to indicate a physician was notified of Resident R14 ' s emesis. Resident R14 remained cohorted with Resident R15 who remained asymptomatic. Review of R14's physician orders from 4/25/24, through 5/1/24, failed to include an order for contact precautions. Review of the Norovirus Surveillance Tracking dated 4/30/24, indicated 18 residents were positive of signs and symptoms of GI illness. Review of the Education rosters dated 4/30/24, revealed education was provided to staff regarding Norovirus. The education revealed staff were educated that hand sanitizer is an appropriate form of hand hygiene. No other education was provided on any other dates. Review of Resident R1's clinical record indicated the resident complained of nausea and vomiting on 5/1/24. Review of Resident R1's clinical record failed to indicate contact precautions were implemented from 5/1/24, through 5/3/24. Resident R1 was not documented on the facility's surveillance log. Resident of Resident R2's clinical record indicated the resident complained of upset stomach and loose bowel on 5/1/24. Review of Resident R2's clinical record failed to indicate contact precautions were implemented from 5/1/24, through 5/3/24. Resident R2 was not documented on the facility's surveillance log. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's line list of residents who contracted the GI illness on 5/7/24, indicated a total of 44 residents developed signs and symptoms of GI illness. Resident R1 and Resident R2 were not identified on the surveillance log. The facility failed to complete accurate tracking and surveillance of GI illness in residents. Review of Resident R3's clinical record indicated the resident had emesis x1 and complained of an upset stomach on 5/6/24. Review of Resident R3's clinical record failed to include an order for contact precautions from 5/6/24, through 5/7/24. During an interview on 5/7/24, at 9:54 a.m. Registered Nurse (RN), Employee E2 stated for residents that display signs and symptoms of Norovirus, contact precautions must be implemented, and prior to exiting the resident's room, PPE is disposed of in the trash bin. RN, Employee E2 stated if a resident displays new symptoms of nausea, vomiting, or diarrhea, the RN Supervisor is notified, and they are the ones that put in an order for contact precautions. RN, Employee E2 confirmed the facility failed to implement contact precautions for Resident R3 on 5/6/24, and indicated the resident should be on contact precautions. During an observation on 5/7/24, at 10:13 a.m. Housekeeper, Employee E1 was observed cleaning Resident R3's bathroom with a gown, gloves, and face shield with the door open. During an observation and interview on 5/7/24, at 10:15 a.m. Housekeeper, Employee E1 failed to remove her PPE prior to her exiting Resident R3's room. Housekeeper, Employee E1 stated she was wearing PPE because my boss told me to wear it when you come in cause people have the flu. Housekeeper, Employee E1 confirmed she failed to remove PPE prior to exiting Resident R3's room. Review of the facility's Norovirus current symptoms 5/7/24 documentation revealed Resident R4, R5, and R6 were positive for norovirus symptoms. Review of the clinical record on 5/7/24, for Resident R4, R5, and R6's clinical record failed to include an order for contact precautions. Review of the facility's line list on 5/7/24, of residents who contracted the GI illness, revealed Resident R4 developed diarrhea on 5/6/24. During an observation on 5/7/24, at 9:47 a.m. Resident R4's room failed to have contact isolation signage or Personal protective equipment (PPE) observed outside of her room. Laundry aid, Employee E3 was observed entering room without PPE and putting laundry away. During an interview on 5/7/24, at 9:51 a.m. Laundry aide, Employee E3 stated staff must wear gloves and mask if entering a room with Norovirus and sanitize hands too. During an observation on 5/7/24, at 9:44 a.m. a visitor was observed entering the facility and signing in. The receptionist was observed sitting at the front desk and failed to notify the visitor of the current Norovirus outbreak. No postings were observed at the entrance that indicated the facility is currently in an outbreak for Norovirus. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/7/24, at 10:05 a.m. Nurse Aide (NA), Employee E4 stated she developed symptoms of GI illness on Saturday, May 4th, and returned to work Monday, May 6, 2024. Review of NA, Employee E4's time punch revealed she worked 5/6/24, from 6:53 a.m. to 3:23 p.m. The facility failed to exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Review of the facility provided list of staff members with GI illness and staff attendance records indicated the following: -LPN, Employee E6 was noted to have signs and symptoms of a GI illness on 4/28/24. LPN, Employee E6 called off for her scheduled shift on 4/28/24. LPN, Employee E6 worked returned to work on 4/30/24, at 6:53 a.m. until 7:24 p.m. LPN, Employee E6 returned to work, without having completed the 48 hours of symptom resolution before returning to work. -NA, Employee E7 was noted to have signs and symptoms of a GI illness on 5/1/24. NA, Employee E7 returned to work on 5/2/24, at 6:53 a.m. until 3:35 p.m. NA, Employee E7 returned to work, without having completed the 48 hours of symptom resolution before returning to work. -Housekeeping Aide, Employee E8 was noted to have GI illness on 5/2/24. Housekeeping Aide, Employee E8 returned to work on 5/3/24, at 7:01 a.m. until 3:30 p.m. Housekeeping Aide, Employee E8 returned to work, without having completed the 48 hours of symptom resolution before returning to work. -Maintenance Technician, Employee E9 was noted to have GI illness on 5/2/24. Maintenance Technician, Employee E9 returned to work on 5/3/24, at 7:25 a.m. until 4:00 p.m. Maintenance Technician, Employee E9 returned to work, without having completed the 48 hours of symptom resolution before returning to work. -LPN, Employee E10 was noted to have GI illness on 5/2/24. Housekeeping Aide, Employee E10 returned to work on 5/4/24, at 6:59 a.m. until 7:23 p.m. LPN, Employee E10 returned to work, without having completed the 48 hours of symptom resolution before returning to work. -IP, Employee E5 was noted to have GI illness on 5/2/24. IP, Employee E5 returned to work on 5/3/24, at 6:53 a.m. until 9:00 p.m. IP, Employee E5 returned to work, without having completed the 48 hours of symptom resolution before returning to work. During an interview on 5/7/24, at 10:21 a.m. the DON confirmed the facility failed to obtain an order for contact precautions for Resident R4, R5, and R6 who had current symptoms of Norovirus. During an observation on 5/7/24, at 10:27 a.m. a sign that stated STOP was posted on Resident R6's door. No other signage was posted that indicated the resident was in contact isolation, or to report to nurse's station. No PPE cart was observed near the resident's door. Review of the facility's Order listing Report which included all orders that were active, completed and discontinued for all residents from 4/25/24, through 5/7/24, at 12:39 p.m. failed to include an order for contact precautions for any resident for the duration of the Norovirus outbreak. During an interview on 5/7/24, at 10:54 a.m. Resident R7's family visitor confirmed he was not notified about an outbreak when he entered the facility today. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/7/24, at 10:57 a.m. Resident R7's family visitor stated there has been a lot of residents sick with nausea, vomiting, and diarrhea. Resident R7's family member stated he was never notified of an outbreak from the facility. Resident R7's family visitor indicated he visited Resident R7 last week on Monday, Tuesday, Wednesday, and Thursday. It was indicated he helped Resident R7 with lunch last Tuesday, then Resident R7 got sick in the afternoon, and had a loss of appetite on Wednesday. Resident R7's family member indicated he did not wear any PPE when visiting last week, then he developed symptoms of GI illness over the weekend. He indicated he was running to the bathroom and had diarrhea. Resident R7's family visitor stated he was never told it was Norovirus, and Resident R7's never had signage on her door for contact isolation. Review of Resident R7's clinical record on 5/7/24, indicated Resident R7 was very upset and restless, on 4/28/24, and indicated the resident's son was not in to visit today when she thought he was coming. During an interview on 5/7/24, at 11:04 a.m. Infection Preventionist, Employee E5 indicated the first outbreak started on 4/26/24, and she was not notified until 4/29/24, three days later. IP, Employee E5 confirmed the facility does not have signage posted that indicated the facility is in a current Norovirus outbreak, and the facility failed to screen visitors for signs and symptoms of a GI illness. IP, Employee E5 stated she educated staff that hand sanitizer is an acceptable form of hand hygiene for Norovirus. It was indicated signage must be posted on resident's doors who are in isolation that indicates the type of isolation or a sign that indicated to see nurse's station. During an interview on 5/7/24, at 12:08 p.m. the Nursing Home Administrator (NHA), indicated the DON notified the County's Health Department on 4/30/24, of the Norovirus outbreak, and left a message with no response. The NHA confirmed no follow-up was completed. The NHA and the Medical Director were made aware that an Immediate Jeopardy situation existed for residents on 5/7/24, at 1:23 p.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. On 5/7/24, at 5:42 p.m. an acceptable Corrective Action Plan was received which included the following interventions: -All Residents will be assessed immediately for any s/s of norovirus, if identified the following will occur: a. Residents will be cohorted to a single unit when possible, by end of the day May 7, 2024. b. Resident will immediately be placed in contact isolation until symptom free for a minimum of 48 hours. c. RN Supervisor will notify MD for orders for contact isolation. d. Orders will be placed into the chart for contact isolation. e. Residents will remain in their rooms when possible, and educate on norovirus fact sheet. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	f. The residents who exhibit symptoms will be placed in isolation with signage on the door to indicate the appropriate PPE that is needed to provide care. g. The Registered Nurse Assessment Coordinator (RNAC) will ensure that the resident's care plan is updated with the norovirus upon identification. h. Residents will be cohorted to a single unit when possible, by end of the day May 7, 2024. -For duration of outbreak the facility will do the following. a. Residents will remain in their rooms when possible. b. Residents will be cohorted to a single unit when possible. c. Activities will be provided on each individual unit during outbreak period. d. Residents will be encouraged to have their meals in their rooms. -The IDT team will review infection control procedures and policies by end of day May 7, 2024, and update as needed. -Whole house education will be provided by DON or designees on the following: a. Hand hygiene and the use of soap and water. b. Signage on the door to indicate the appropriate PPE that is needed to provided care. c. How to protect themselves as well as other residents from being exposed to Norovirus using the Norovirus Face sheet and Tool kit. d. Initial whole house education will be completed as of today May 7, 2024 with any current employees who are working. e. Education will be provided to all current staff members before the start of their next shift including agency. A notice is placed at the time clock informing staff to report to DON or designee to complete education. -The DON, ADON, infection Preventionist, and NHA or designee will review documentation on the current residents for s/s of nausea, vomiting, and diarrhea during am clinical throughout the duration of the outbreak. a. DON, ADON, NHA, IP or designee will audit during outbreak daily, after outbreak will monitor weekly for the first month, and monthly thereafter. -Families and staff will be notified of an outbreak with the norovirus via alert media. Signs will be posted at the entrance doors indicating that there is an outbreak of the Norovirus. a. Visitor screening tool will be placed at the front desk during the outbreak. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	b. All visitors will be screened for signs and symptoms of the illness and instructed to speak to a member of the nursing team prior to visiting. c. Staff experiencing s/s of norovirus will notify manager immediately and will not be permitted to return to work until 48 hours after symptoms resolve. -The DON and/or the infection Preventionist will follow-up with the local department of health for further guidance and testing requirements for outbreak by end of day May 7, 2024. -Housekeeping will increase frequency by the minimum of twice a day of cleaning and disinfecting of residents rooms with active Norovirus symptoms and common areas, and high touch areas by end of day-May 7th, 2024. a. Ongoing infected resident rooms will have additional disinfecting using Rapid Multi Surface Disinfectant Cleaner. -The review of infection control procedures and policies will be reviewed during our monthly quality assurance meeting to ensure compliance. During staff interviews conducted on 5/8/24, between 10:15 a.m. and 11:01 a.m., 22 of 22 staff members confirmed that they received education on signs and symptoms of GI virus, handwashing with soap and water, infection control of a GI virus infection, and appropriate donning and doffing of PPE. 5 of 11 Agency staff were educated on Norovirus. Agency staff who were not educated will report to RN supervisor prior to start of their shift to be educated. A review of the documentation received from the facility on 5/8/24, at 12:56 p.m. revealed that all elements of the Corrective Action Plan were substantially completed. The Immediate Jeopardy was lifted on 5/8/24, at 1:32 p.m. when the Corrective Action Plan implementation was verified. During an interview on 5/8/24, at 1:32 p.m. the NHA and DON confirmed the facility failed to maintain an infection prevention and control program by failing to timely investigate and document surveillance, exclude ill staff from working, failed to educate staff on appropriate precautions related to GI illness, and failed to implement preventative measures to address an outbreak of gastrointestinal illness among residents for 10 of 17 residents (Residents R1, R2, R3, R4, R5, R6, R7, CR8, R9, and R14) The facility's failure created a situation in which all 100 of 100 residents were placed in Immediate Jeopardy related to a lack of proper infection control procedures. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.