STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing & Rehabilitation	179 Combs Street Sparta, NC 28675

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** 37280 Based on record review, staff and Physician interviews, the facility failed to notify the Physician of medication unavailability for 1 of 1 resident (Resident #38) reviewed for pain. The finding included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included degenerative joint disease and chronic pain syndrome. A review of the after visit report from the emergency department dated 09/09/22 revealed Resident #38 was seen for leg pain and diagnosed with Sciatica (nerve pain) of the left side. The report also indicated Resident #38 was given the prescription of Solumedrol 4 milligram (mg) tablets with the instruction to follow the package directions. A review of a progress note written by Nurse #1 on 09/09/22 6:25 PM revealed Resident #38 returned from the emergency department with a new script for Solumedrol 4 mg tablets and to follow the package directions. On 09/11/22 a review of Resident #38's Medication Administration Record for September 2022 revealed there was no medication listed for Solumedrol. On 09/12/22 a review of Resident #38's Medication Administration Record for September 2022 revealed the first dose of Solumedrol was given on 09/12/22 at 2:00 PM. An interview was conducted with Nurse #1 on 09/13/22 at 3:18 PM who explained that Resident #38 was sent to the emergency roiagnom on [DATE] and was diagnosed with Sciatica and returned to the facility during shift change with a prescription for Solumedrol 4 mg tablets and to follow the package directions. The Nurse continued to explain that she gave the prescription to Nurse #2 to notify the pharmacy so the medication would be delivered to the facility. (continued on next page)

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 with Nurse #2 on 09/13/22 at 3:34 PM the Nurse stated on Friday 09/09/22 and received report that Resident #38 had been sent to the emergency room for leg pain and returned with a prescription for Solumedrol. The Nurse continued to explain that she attempted to input the order into the system which would have been sent directly to the pharmacy and delivered in the next pharmacy run but she could not get the system to take the prescription because the script said to follow directions on the package and she had to be specific in putting the directions in the system. She stated she faxed the prescription to the pharmacy two times. The Nurse explained that the medication did not come in the pharmacy delivery that night therefore, the steroid did not get started. On 09/14/22 at 4:38 PM during an interview with Resident #38's Physician the Physician stated he was not notified of Resident #38 not receiving his ordered medication.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45359 Based on observation, record review, resident, staff, and Nurse Practitioner interview the facility failed to perform a skin assessment upon admission and failed to initiate treatment for a rash that was itching for 1 of 4 residents reviewed with skin conditions (Resident #21). Resident #21 was admitted on [DATE] with a rash that was very itchy. The rash was not treated until 07/21/22. The finding included: Resident #21 was admitted to the facility on [DATE] with diagnoses that included: congestive heart failure, diabetes, psoriatic arthritis (inflammatory arthritis) and others. Review of Resident #21's care plan initiated on 7/8/2022 revealed a care plan in place for rash on admission to upper, inner and posterior thighs, bilateral buttocks, abdominal folds and bilateral groin with interventions of redirect from scratching, administer as needed anti-itch medication initiated 8/18/2022 and was treated for scabies initiated 7/26/2022. Review of Resident #21's medical record revealed no skin assessment completed on admission. Review of an admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #21 was cognitively intact and required extensive assistance with activities of daily living and no behaviors or rejection of care was noted during the assessment reference period. The MDS did not identify any open lesion other then ulcers, rashes, cuts. Review of a skin assessment dated [DATE] revealed that Resident #21 had a rash on her bilateral arms. Review of physician's orders for July 2022 revealed an order on 7/20/2022 that read; apply Permethrin Cream 5% (used to treat scabies) apply cream to entire body topically STAT (now) for scabies head to soles of feet, including neck, scalp, hairline, temple, forehead leave on for 14 hours then bathe. Review of a physician order dated 07/21/22 read; Permethrin Cream 5% apply to entire body topically one a day for scabies for 7 administrations head to soles of feet including neck, forehead, scalp, hairline and temple. Review of the Medication Administration dated July 2022 revealed that Resident #21 received the Permethrin cream as ordered on 07/21/22, 07/23/22, 07/24/22, 07/25/22, 07/26/22, and 07/27/22. An observation and interview were conducted with Resident #21 on 9/11/2022 at 3:47 PM. Resident #21 stated she was admitted to the facility on [DATE] with skin sores on her bilateral arms, legs, chest, bilateral legs, back and buttocks. She revealed she had scabies before but could not remember the date. Resident #21 stated she just thought she might have come in contact with something she was allergic to at the hospital, since her Cardiologist told her it was not scabies, but an allergic reaction to something. She indicated it was very itchy and she kept scratching the sores. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse Aide (NA) #5 on 9/13/2022 at 4:21 pm. NA #5 stated she was assigned to 100 hall and took care of Resident #21 upon her admission on 07/08/22. She revealed Resident #21 was admitted to the facility with a rash all over her. She stated the Nurse Practitioner was here when Resident #21 was admitted and came to assess Resident #21's rash. NA #5 revealed Resident #21 was on contact precautions because we were told she had a bad bug in her urine, so we were only wearing personal protective equipment (PPE) to empty her urinary catheter. NA #5 stated that the first time she was aware that Resident #21 was ordered a cream for her rash was on 07/23/22. The Nurse applied cream to Resident #21's entire body on Saturday, 7/23/2022, and the Nurse told me that it would need to be washed off after 24 hours. NA #5 stated she gave Resident #21 a bath on Sunday, 7/24/2022. An observation and interview of Resident #21 was made on 09/13/22 at 5:27 PM. Resident #21 was up in chair at the nursing station. She stated that this was her first time up and out of her room since admission. She was dressed in long pants and short sleeve shirt. Resident #21's bilateral arms were covered with small irregular scabs that were approximately the size of pencil eraser. They were well defined, and each area was scabbed over. There was no redness or erythema or drainage and were not crusted. Resident #21 indicated that her arms looked better than they have in a long time. The Nurse Supervisor was interviewed on 9/14/2022 at 10:16 AM. The Nurse Supervisor stated that each resident upon admission was supposed to have a head-to-toe assessment including their skin. Once the admission nurse completed the assessment then the night shift nurse was supposed to check and ensure all the components of the admission were completed then the Director of Nursing (DON) would do the final check to ensure all components of the admission were completed. The Nurse Supervisor stated she did not know who was supposed to completed Resident #21's admission assessment and could not speak to how the checks and balances were not done to ensure the admission skin assessment was completed and treatment for identified issues started. An interview was conducted with Medication Aide (MA) #2 on 09/14/22 at 2:00 PM who confirmed she was working on the hall when Resident #21 was admitted to the facility. She confirmed that she did not do treatments or any form of skin assessment that would be up the Nurse Supervisor and she could not recall who was the nurse was that day. MA #2 stated that she assisted Resident #21 on the bed pan on 07/08/22 and noted that she had open lesions all over her body that looked like bites or bug bites. MA #2 stated that she told a nurse but could not recall who that was but recalled being told it looked like something she was allergic to probably from the hospital. She stated she did not think that was right and couple of week later learned that it was scabies. The DON was interviewed on 9/14/2022 at 2:24 PM. DON stated she was on vacation when Resident #21 was admitted to the facility, from 7/8/2022 through 7/16/2022, so she was unaware that Resident #21's admission assessments, to include a skin assessment, had not been completed or why treatment to identified areas had not been initiated sooner. DON revealed she was supposed to have daily clinical meetings to talk about resident findings and concerns, this team is supposed to made up of the DON, Social Worker, MDS, Nurse Supervisor, Assistant Director of Nursing and Therapy, but right now the clinical team consisted of the DON and Nurse Supervisor and at lot of time the Nurse Supervisor was being pulled to the hall due to staffing challenges. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Nurse Practitioner was interviewed on 06/14/22 at 6:29 PM. The NP confirmed that she had seen and evaluated Resident #21 upon her admission to the facility on [DATE] and suspected scabies by the crusted lesion she had on her arms and legs. The Nurse Practitioner stated that she had ordered Triamcinolone cream for the itching and Permethrin cream for the scabies but later learned that she did not enter a date and time on the order, so the order never got carried out and the medication never got applied until it was again ordered on 07/20/22. The Nurse Practitioner also stated she was unaware until 07/20/22 that her initial order never got carried out by staff.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45359 Based on observations, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide wound treatments per the hospital discharge summary for 5 days and to complete or document a skin assessment on admission for 1 of 3 residents reviewed for pressure ulcers (Resident #21). The findings included: Resident #21 was admitted to the facility on [DATE]. Her diagnoses included combined systolic and diastolic (congestive) heart failure, and type 2 diabetes with neuropathy. Review of the hospital discharge summary dated 7/8/2022 at revealed bilateral heel wound orders: 1. Left foot: Topical dressing: wet to dry gauze with Dakin's (contains sodium hypochlorite, used as an antiseptic to cleanse wounds in order to prevent infections), to be changed 2 times a day, wash with soap and water in between dressing changes. Recommend collagenase (enzymes that break down the native collagen that holds animal tissues together) to right leg ulcer with eschar, compression therapy (edema wear), offloading of heels and non-weight bearing, calf-ankle exercises, and follow-up with wound care. 2. Right foot: twice daily dressing changes: apply barrier cream to wound border/peri-wound, then apply a dampened Dakin's kerlix to the wound bed, cover with a pad, kerlix and ace bandage (starting from below toes to below knee). 3. Follow-up appointment at Wound Care Center on 7/25/2022 at 9:15 AM. Review of the electronic record revealed the Nurse Practitioner entered the order to follow the hospital discharge wound orders on 7/8/2022 at 4:22 PM and it was confirmed by the Nurse Supervisor. An interview was conducted with the Nurse Practitioner (NP) on 9/14/2022 at 6:14 PM. NP stated she no longer worked at the facility and her last day was 8/19/2022. She stated she was familiar with Resident #21 and that she was admitted to the facility with bilateral wounds on her heels. NP revealed she had been present at the time of Resident #21's admission to the facility and had assessed her at that time. NP stated she entered the wound treatment orders and forgot to enter the time and date to start the treatments. An interview was conducted with Nurse Supervisor on 9/14/2022 at 10:17 AM. She stated on Resident #21's admission to the facility, she confirmed and entered the orders into the electronic medical record. She revealed she thought she had reviewed the orders before confirming and stated she must have made a mistake on the wound orders and did not make sure they had a time and date to start. The Nurse Supervisor stated she had no knowledge that Resident #21's pressure ulcers on her bilateral heels did not have treatment orders from 7/8/2022 through 7/13/2022. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact and required extensive to total assistance with activities of daily living (ADL). She was coded as an extensive assistance for bed mobility. Resident #21 was coded for 2 unstageable pressure ulcers. Review of Resident #21's care plan revealed she had a care plan in place for admission with bilateral heel pressure ulcers initiated on 7/8/2022, with intervention of provide wound treatments as ordered initiated on 7/15/2022. Review of Resident #21's Treatment Administration Record for July 2022 revealed there were no wound orders entered prior to 7/14/2022: 1. Order dated 7/14/2022 with a stop date of 7/22/2022: Collagenase (enzymes that break down the native collagen that holds animal tissues together) ointment 250 milligrams/unit (mg/u), apply to left heel topically every night shift, cleanse heel with normal saline, apply a nickel layer of collagenase to slough tissue, cover with a pad and wrap with kerlix every night shift. 2. Order dated 7/22/2022 with a stop date of 8/29/2022: Collagenase ointment 250mg/u apply to bilateral heels topically every night shift for wound care, cleanse heels with normal saline, apply a nickel thick layer of collagenase to slough tissue, cover with a pad and wrap with kerlix wrap every night shift and as needed. Observation of Resident #21's wound care on 9/13/2022 at 2:12 PM revealed Nurse #5 explained to Resident #21 what treatments she was going to perform to her bilateral heels. Nurse #5 followed infection control principles and completed wound treatments to bilateral heels as per medical provider orders. The bilateral heel wounds were without drainage or odor, edges of wounds clean, wound beds pink, no necrotic tissue noted. Resident stated she had been to the wound center on 9/12/2022 for wound debridement. An interview was conducted on 9/14/2022 at 1:34PM by telephone with Nurse #7. She stated she worked at the facility through an Agency and had been assigned as the Nurse on 7/22/2022 for 7 PM-7 AM shift for 100 hall. Nurse #7 revealed she had not worked at the facility for last 3 weeks. She revealed she was familiar with Resident #21 and had taken care of her since her admission to the facility. Nurse #7 revealed Resident #21 was admitted with bilateral wounds on her heels. She stated the Nurse was responsible for completing any treatments ordered for the resident and then document the completion on the Treatment Administration Record (TAR). She stated she was not aware that treatments had been missed for Resident #21. She stated Resident #21 had not voiced any concerns to her. Nurse #7 stated she documented completion of treatments as soon as she completed them, because it was very busy at night and if you didn ' t ' t take the time to document, then you might forget to document at all. She stated she would notify the Director of Nursing is she had any concerns regarding wound care and treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 9/14/2022 at 2:14 PM. The DON stated she was familiar with Resident #21 and noted she was admitted to the facility with bilateral wounds on her heels. DON revealed she had not checked on TAR completion because it was only her and one other Administrative Nurse to review and complete all the nurse administration jobs. The DON revealed she did not know why Resident #21 did not have a skin assessment completed on admission or how she did not have treatment orders. The DON indicated part of the admission process was to make sure that all orders are entered correctly into the electronic record and that all assessments are completed within 24 hours and to report to her that the admission process was completed within 24 hours and staff to notify her if unable to complete. A telephone interview was conducted with the Medical Director (MD) on 9/14/2022 at 4:16PM: He stated he was familiar with Resident #21. MD stated he was not aware that Resident #21's treatments had not been completed. MD stated he expected staff to complete orders as prescribed and if unable to complete orders, then to notify him or the Nurse Practitioner.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review, facility staff interviews, the facility failed to provide care in a safe manner for 1 of 4 residents reviewed for accidents. The resident rolled out of bed during care and sustained a laceration above his eye along with contusions to his head, skin tear to left elbow and a skin tear just above the left wrist (Resident #33). The findings included: Resident #33 was admitted to the facility on [DATE] with diagnoses that included contracture and poly-osteoarthritis. Review of Resident #33's most recent annual Minimum Data Set assessment dated [DATE] revealed him to be severely impaired with no behaviors or rejection of care. He required total assistance of 2 or more with bed mobility, transfer, dressing, personal hygiene, and bathing. He required extensive assistance of 2 or more with toilet use. A review of Resident #33's progress notes revealed a progress note dated 6/18/22 at 4:47 AM and was written by Nurse #3. The note documented at approximately 12:45 AM, the nurse was called to Resident #33's room by the Nursing Assistant (NA). Upon entering the room, the nurse observed the resident lying on the floor, face down. The resident's mouth, nose, and face were found to be actively bleeding. After checking for injuries, the resident was rolled over onto side to and the resident had an approximate 1.5 centimeter (cm) laceration just above his left eye. There was also a skin tear to left elbow and a skin tear just above his left wrist. The nurse applied pressure to left eye to control the bleeding while another nurse called 911 for emergency transport. The resident was sent to emergency room (ER) and received stitches above the left eye and steri-strips to the left elbow. The resident returned was documented as having returned to the facility in stable condition. Review of Resident #33's hospital notes dated 6/18/22 from his visit post fall revealed he was treated for a 1. 5 cm laceration above the left eye between the eyebrow and eyelid. The notes indicated 3 sutures (stitches) were completed with no complications. Other injuries noted in the hospital report included a contusion (bruise) to Resident #33's left knee and shoulder, a contusion on his head, a cervical strain, and abrasions and skin tears. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with Nurse Aide (NA) #6 on 9/13/22 at 4:00 PM, she reported she remembered the night Resident #33 fell out of bed on 6/18/22. She stated it was her first night working and on her 2nd round, she went into Resident #33's room and noticed he had vomited on himself and had some diarrhea. She reported after she changed him and had removed his dirty sheets, she rolled him on his side to put on clean sheets and when she went to apply the corner of the fitted sheet over the corner of his mattress, Resident #33 rolled out of bed towards her and face down onto the floor. She reported she believed he hit his head, elbow, and side. NA #6 verified it was just her in the room during care and that she was under the impression from the NA she received report from that Resident #33 was a one person assist. She stated she did not verify his care status with the nurse or in the electronic system. NA #6 detailed that Resident #33 was bleeding from his head, so she went and got the hall nurse immediately who assessed the resident and began first aid while another staff member contacted 911. During an interview with Nurse #3 on 9/14/22 at 4:45 PM, she reported she remembered the night Resident #33 fell on [DATE]. She stated she was on the hall when NA #6 came and got her and stated Resident #33 had fallen from the bed while she was providing care. Nurse #3 stated she went to the room and noticed he was bleeding from his head and was face down on the floor. After she assessed him, they rolled him over and she noted a laceration above Resident #33's eye that looked like it would need stitches. 911 was called and resident was sent to the emergency room for treatment and evaluation. She reported she believed he returned shortly after with stitches and other bandages from various skin tears. A review of the facility ' s fall investigation dated 6/18/22 and completed by Nurse #3, revealed Resident #33 was being cleaned up from vomiting just before incident occurred, was turned to his side to prevent aspiration if vomiting should occur again, NA (Nurse Aide) #6 was reaching for a clean sheet when resident rolled onto the floor. Per the investigation, there was only one staff member in the room at the time and attempted to change the bed sheets when Resident #33 fell from the bed. During an interview with the Director of Nursing on 09/14/22 at 5:54 PM, she reported she was aware of the incident and reported staff should verify care needs by looking at the electronic system. The DON indicated NA #6 received training to verify care status before providing care to all residents on her assignment. She stated all staff should verify care needs daily before their shift to ensure they knew how many staff members would be needed to safely provide care. She reported if Resident #33 was coded as requiring 2 or more persons to assist with bathing, dressing, toilet use, and personal hygiene, then there should have been at least two staff members in the room the night he fell out of the bed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record review, staff, Resident, Pharmacy Manager and Nurse Practitioner interviews, the facility failed to prevent a significant medication error when they failed to obtain and administrator a steroid medication as ordered by the physician for 1 of 2 residents reviewed for pain (Resident #38). The finding included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included degenerative joint disease and chronic pain syndrome. A review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and received scheduled and as needed pain medication in the last five days of the assessment reference date (ARD). The MDS also indicated the Resident received opioids 5 days of the 7 day look back period. A review of a progress note written by Nurse #1 on 09/09/22 at 2:09 PM revealed Resident #38 complained of increased throbbing pain to his left lower leg and insisted on going to the hospital. The on call service was notified and gave an order to send to the emergency room . A review of the after visit report from the emergency department dated 09/09/22 revealed Resident #38 was seen for leg pain and diagnosed with Sciatica (nerve pain) of the left side. The report indicated the Resident was given Tylenol (for pain) and Solumedrol (a steroid) while in the emergency department. The report also indicated Resident #38 was given the prescription of methylprednisolone 4 milligram (mg) tablets with the instruction to follow the package directions. A review of a progress note written by Nurse #1 on 09/09/22 6:25 PM revealed the Resident returned from the emergency room with a new script for Solumedrol 4 mg tablets and to follow the package directions. The Resident was in bed and continued to complain of pain and wanted to know when the shot of steroid would start to work. He was educated on medications and verbalized understanding. On 09/11/22 a review of Resident #38's Medication Administration Record for September 2022 revealed there was no medication listed for the steroid Solumedrol. On 09/12/22 a review of Resident #38's Medication Administration Record for September 2022 revealed an order for Solumedrol tablet 4 mg, give one tablet by mouth one time a day for moderate pain. Follow tapering dosage on package, change order to reflect. Start date 09/12/22 at 2:00 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing & Rehabilitation	179 Combs Street Sparta, NC 28675

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/22 at 3:13 PM an interview was conducted with Resident #38. The Resident explained that he went to the emergency roiagnom on Friday September 09, 2022 for pain in his left leg and was diagnosed with Sciatica. The Resident continued to explain that he was given a steroid shot and a prescription for the steroids to continue for a few days, but he had not received the steroid medication. He stated the nurse (he did not know which one) told him that they could not get the medication over the weekend because the faxes did not work. The Resident stated the steroid shot they gave him in the emergency room had worn off and they tried to give him narcotics, but he did not take narcotics. He stated the Tylenol helps a little. The Resident remarked he did not see why the facility could not get his medication when the doctor ordered it to be given to him. An interview was conducted with the Supervisor on 09/12/22 at 9:16 AM who was also the Nurse who cared for Resident #38 on 09/11/22 from 7:00 AM to 7:00 PM. The Supervisor was asked about Resident #38's visit to the emergency roiagnom on [DATE] and the order for the steroid medication. The Supervisor explained that she did not know about the emergency room visit or new medication being ordered until the Surveyor asked about it. The Supervisor looked through a stack of papers on the desk and found a prescription for Solumedrol 4 mg tablets (21 tablets) and to follow the package directions. The Supervisor also found where the prescription had been faxed to the pharmacy on 09/10/22 at 12:04 AM and 12:05 AM both with the confirmation of no answer for the faxed prescription. The Supervisor explained that the nurse who faxed the prescription to the pharmacy should have called the pharmacy and received verbal confirmation of receiving the prescription so the Resident could have been given the mediation as ordered and without delay. The Nurse continued to explain that the Resident did not complain of pain when she worked with him on 09/11/22 nor did the Resident report to her about the emergency room visit or the new medication. On 09/12/22 at 10 AM the Supervisor provided a faxed confirmation dated 09/12/22 9:45 AM of Resident #38's Solumedrol prescription being sent to the pharmacy. Attached to the confirmation was the prescription for Resident #38's Solumedrol dated 09/10/22 at 6:54 AM with the result of that no answer. On 09/13/22 at 11:07 AM an interview with the Pharmacy Manager (PM) revealed, the pharmacy delivery occurred once on Sunday and twice a day Monday through Saturday at times of approximately 4:35 PM and 1:05 AM. The PM explained that when the nurses input the orders into the system the order will directly be transmitted to the pharmacy and the medication would be delivered in the next delivery scheduled for the facility. She continued to explain that the nurses could also fax or telephone the orders directly to the pharmacy both of which would be received 24 hours a day 7 days a week. The PM continued to explain that the pharmacy closed at 5:00 PM but the phone call would roll over to an after hour service and the pharmacy had a stat service they could utilize within 4 hours so there was no reason why the Resident should have missed his medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #1 on 09/13/22 at 3:18 PM who explained that on the afternoon of Friday 09/09/22 Resident #38 complained of pain in his left leg but refused to take his prescribed Tramadol for the pain citing he did not take narcotics. The Resident insisted on being sent to the emergency room , so she notified the on call service and got an order to send him to the emergency room . The Nurse continued to explain that when the Resident returned to the facility, she learned that they diagnosed him with Sciatica and gave him a steroid injection and sent a prescription of more steroids to continue at the facility. The Nurse reported he returned from the emergency room around shift change so she gave the prescription to Nurse #2 who was relieving her from duty. Nurse #1 explained that Nurse #2 attempted to input the new prescription in the computer system which would have been immediately transmitted to the pharmacy and sent in the next pharmacy delivery but since the prescription was not specific to the dose and times she faxed the prescription to the pharmacy. The Nurse stated it was not until she came on duty the next day that she realized Resident #38's medication was not at the facility. She stated on Saturday the Resident did complain of left leg pain but stated it was not as bad as it was on Friday and was agreeable to taking the Tramadol for the pain which was effective. The Nurse stated she did not call the pharmacy about the medication because she thought the medication would be delivered during her shift but there was no pharmacy delivery during her shift that day. The Nurse explained that she did not pass on in report to Nurse #3 that Resident #38's medication had not come from the pharmacy because she was so busy that she forgot. On 09/14/22 2:01 PM Nurse #1 explained that she witnessed Nurse #2 fax Resident #38's prescription to the pharmacy on the morning of 09/10/22 during the shift change report. During an interview with Nurse #2 on 09/13/22 at 3:34 PM the Nurse stated she was an agency Nurse that worked 3-4 days a week on the 7:00 PM to 7:00 AM shift. The Nurse explained that she relieved Nurse #1 on Friday 09/09/22 and received report that Resident #38 had been sent to the emergency room for leg pain and returned with a prescription for Solumedrol. The Nurse continued to explain that she attempted to input the order into the system which would have been sent directly to the pharmacy and delivered in the next pharmacy delivery but she could not get the system to take the prescription because the script said to follow directions on the package and she had to be specific in putting the directions in the system. She stated she faxed the prescription to the pharmacy two times. The Nurse explained that the medication did not come in the pharmacy delivery that night. The Nurse continued to explain that when Nurse #1 came on duty the next morning (09/10/22) she told the Nurse that she could not complete the order in the system, so she faxed it again that morning. She stated she did not know if it went through to the pharmacy or not but did not think about calling the pharmacy directly. Numerous attempts were made to interview Nurse #3 who worked on 09/10/22 from 7:00 PM to 7:00 AM, but the attempts were unsuccessful. During an interview with Nurse #4 on 09/13/22 at 4:30 PM the Nurse explained that when the nurse inputs the order into the medication system it automatically informed the pharmacy of the order and the medication was sent in the next pharmacy delivery to the facility. The Nurse continued to explain that if they had a prescription, it could be faxed to the pharmacy and the medication would come in the next delivery run as well. The Nurse stated they could always call the pharmacy and the facility would deliver the medication stat if needed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/13/22 at 5:00 PM during an interview with the Director of Nursing (DON) the DON stated that she had already been made aware of Resident #38's medication situation. The DON explained that it was unacceptable for the Resident to not receive the newly prescribed medication for three days. The DON stated Nurse #1 should have faxed the new medication order to the pharmacy and also made the follow up telephone call to the pharmacy to ensure the pharmacy had received the order. An interview was conducted with the previous Nurse Practitioner (NP) on 09/14/22 at 6:42 PM who stated she was familiar with Resident #38. The NP explained that she would have expected the prescription was successfully faxed and received by the pharmacy so that the medication could have been started on the next pharmacy delivery. The NP stated it was unacceptable for Resident #38 to not receive his medication all weekend.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to follow the Center for Disease Control and Prevention (CDC) guidelines and facility policy when they did not identify Covid 19 positive residents and failed to place them on transmission-based precautions, therefore the staff (Nurse Aide (NA) #3, NA #4, and Housekeeper #1) failed to don/doff personal protective equipment (PPE) when entering and exiting a Covid 19 positive room and before interacting with other residents (Resident#35, Resident #41, and Resident #44) this affected 3 of 24 residents on 1 of 4 units (memory care unit.) The facility failed to have personal protective equipment available for the staff to use when caring for Covid 19 positive residents that resided on the memory care unit. The facility was in outbreak status that started on 08/26/22 and affected 10 of 24 residents on the memory care unit. There were 5 residents that had not had Covid 19 in the last 90 days and of those 5 residents 1 was unvaccinated against Covid 19. The facility further failed to identify and prevent the spread of scabies (a very contagious skin condition caused by a tiny burrowing mite). This affected 3 of 4 residents (Resident #21, Resident #17, and Resident #61 that resided on 2 of 4 units in the facility (100 and 300 units). Immediate jeopardy began on 09/11/22 when the facility direct care staff and housekeeping staff were unable to identify the Covid 19 positive residents or rooms on the memory care unit. The staff were observed caring for Covid 19 positive residents without personal protective equipment and then caring for and/or interacting with Covid 19 negative residents. The immediate jeopardy was removed on 09/13/22 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity Level G (actual harm that is not immediate jeopardy) to implement a plan of correction for the second example. The findings included: Review of a facility document titled, Hand Hygiene dated 12/01/06 read in part, wash hand with soap and water in the following situations: when visibly soiled or contaminated, before any direct contact with residents, before putting on gloves, after contact with residents ' intact skin, after contact with inanimate objects in the immediate vicinity of the resident and after removing gloves. Review of a facility document titled, Suspected Covid 19 Facility Checklist revised on 07/30/21 read; for all suspected or confirmed patients: close door to affected patients' room and wear appropriate PPE when entering the room(s) of affected patients (gown, gloves, full face shield, N95 respirator). Review of the Center for Disease Control and Prevention (CDC) guidelines dated 02/02/22 read in part, Manage Residents with Suspected or confirmed SARS-CoV-2 (Covid 19) infection: Healthcare personnel caring for residents with suspected or confirmed SARS-CoV-2 infection should use full personal protective equipment (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator). 1a. Upon entrance to the facility on [DATE] at 10:32 AM the Nurse Supervisor stated that the facility had 5 of 24 residents that were Covid positive, and all resided on the 400 hall that was the facility's memory care unit. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation of the door to the memory care unit was made on 09/11/22 at 10:44 AM, the door contained a sign that read: Patient Specific: Contact Plus Airborne Precautions: STOP: Perform hand hygiene before and after patient contact with environment and after removal of PPE, Wear a N95 respirator, Gown, Face shield and gloves upon entering the room. Change gown after each patient contact, keep room door closed. There was no PPE available at the entrance to the unit. Nurse #6 was interviewed on 09/11/22 at 11:15 AM and confirmed that he was working on the memory care unit of the facility, and he was unable to confirm who the Covid 19 positive residents were but stated he had a list at the station. After Nurse #6 retrieved his list, he was able to report that the follow rooms were Covid positive rooms: room [ROOM NUMBER] A and B, room [ROOM NUMBER] B, room [ROOM NUMBER] A, room [ROOM NUMBER] A, room [ROOM NUMBER] B, and room [ROOM NUMBER] B. Observation of the memory care unit was made on 09/11/22 at 11:45 AM and revealed that room [ROOM NUMBER] room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] contained no sign on the door indicating that either resident in the room were Covid positive. The observation further revealed that there were 2 PPE containers sitting on the hallway of the unit. One at the far end of the hallway and one near the upper end of the hallway. Neither PPE cart contained any gowns for the staff to wear. Each PPE cart contained a box of gloves and a few N95 mask but no other PPE. The residents in room [ROOM NUMBER], 405, 406, 408, and 409 were all in their rooms in their bed. The resident in room [ROOM NUMBER] which had a transmission-based precaution sign on their door was ambulating and wandering in/out of other resident rooms on the unit. A follow up interview was conducted with Nurse #6 on 09/11/22 at 3:03 PM who confirmed he only worked the memory care unit when he worked at the facility through an agency and had worked on 09/10/22 and 09/11/22 twelve-hour shifts. Nurse #6 stated that they kept a list of the Covid positive residents and room numbers at the nurse's station and he would always verify the information with the off going nurse in report. He stated that the Nurse Aides (NAs) would get report from the off going NAs about which residents who were Covid positive and if they did not get that information, they could always ask the nurse on the unit. Nurse #6 stated I treat the whole hall as a Covid unit. He stated we are supposed to have gowns, gloves masks and goggles on the unit but he could not say why they did not have personal protective equipment on both 09/10/22 and 09/11/22. Nurse #6 stated they were not supposed to leave the hall to get supplies and was not aware if the facility had supplies in other areas of the facility or not. He indicated that he wore his N95 mask for the duration of his 12-hour shift and was not aware of what the protocol was for changing his N95 mask. Nurse #6 confirmed that during the weekend of 09/10/22 and 09/11/22 he had not called the other side of the facility or the Director of Nursing (DON) to obtain the personal protective equipment and stated, in the past they have brought it to us. He further added that when a resident tested positive for Covid the PPE container did not always get put out for use by the staff on the unit. 1b. Resident #13 admitted to the facility on [DATE] and resided in room [ROOM NUMBER] B and tested positive for Covid 19 on 09/05/22. Resident #24 was readmitted to the facility on [DATE] and resided in room [ROOM NUMBER] A and tested positive for Covid 19 on 09/08/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NA #3 and NA #4 were observed to enter room [ROOM NUMBER] (both Covid positive) on 09/11/22 at 11:45 AM wearing a N95 mask and eye protection. They were observed to interact with both residents and their environment. They adjusted covers on bed, moved bedside tables and touched Resident #13's hand. NA #3 and NA #4 exited the room and neither changed their N95 mask or cleaned or disinfected their eye protection and did not perform hand hygiene. They exited into the hallway and entered the common area on the unit where other residents were located. NA #3 and NA #4 were interviewed on 09/11/22 at 11:48 AM. Neither NA #3 nor NA #4 could verbalize who the Covid positive residents were on the unit. They both confirmed that this was their weekend to work and during report no one gave them the names or room numbers of the Covid positive residents. Both NAs stated that sometimes they had a Covid positive and Covid negative in the same room and it was so confusing on what they should do with their PPE. NA #3 stated that if she was aware that a resident was Covid positive then she would put on a gown before entering the room but stated we don't have any right now and we did not have any yesterday either and of course we already have on goggles and N95 mask. NA #3 stated that when they came out of a Covid positive room they would remove their gown and gloves but did not change their N95 mask or clean/disinfect their goggles. NA #4 confirmed that they wore their N95 mask for the duration of their 12-hour shift on the memory care unit. Both NAs stated that none of the residents had any symptoms of Covid 19 and added we treat everyone like their positive. NA #3 stated that they had not received any education since their Nurse Educator that was here temporarily left a few weeks ago but added that they used to get education on Covid and PPE pretty often. A subsequent observation of NA #3 was made on 09/11/22 at 3:14 PM. There was a sign on the door of room [ROOM NUMBER] that read; Contact Plus Airborne Precautions: STOP Perform hand hygiene before and after patient contact with environment and after removal of PPE, Wear a N95 respirator, Gown, Face shield and gloves upon entering the room. Change gown after each patient contact, keep room door closed. NA #3 entered room [ROOM NUMBER] (both resident Covid positive) wearing a N95 mask and goggles. She reapplied Resident #24 ' s oxygen cannula in his nose and moved his bedside table back within his reach. She exited the room without performing hand hygiene or changing her N95 mask and she did not clean/disinfect her eye protection. Once in the hallway NA #3 was observed to approach two wandering residents (Resident #35 (who was currently Covid negative but had Covid 07/19/22) and Resident #41 (who was currently Covid negative but had Covid 08/03/22) and grab their hand and walk them down the hallway to the common area again without performing hand hygiene. NA #3 was interviewed on 09/11/22 at 3:16 PM. NA #3 stated that if she was aware that a resident was Covid positive then she would put on a gown before entering the room but stated we don't have any right now and we did not have any yesterday either and of course I already have on goggles and N95 mask. NA #3 stated that when she came out of a Covid positive room she would remove her gown and gloves but did not change her N95 mask or clean/disinfect her goggles. She stated she had not noticed the sign on the door when she entered room [ROOM NUMBER] but also there was no gowns for her to apply anyway when she entered the room. NA #3 also stated that she forgot about using hand sanitizer because when she walked out of room [ROOM NUMBER] there were 2 residents in the hallway that she needed to redirect. 1c. Resident #36 was admitted to the facility on [DATE] and resided in room [ROOM NUMBER] B and tested positive for Covid 19 on 09/06/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation of Resident #36 was made on 09/11/22 at 11:59 AM. Resident #36 was observed wandering on the memory care unit. She was observed to enter room [ROOM NUMBER] (Resident#44 who resided in 408 B was Covid Negative) and shut the door behind her. Nurse Aide (NA) #3 was notified that Resident #36 had gone into room [ROOM NUMBER] and shut the door on 09/11/22 at 12:03 PM. NA #3 replied she is hiding in that room she will be ok and continued up with the hallway without redirecting Resident #36 out of the room. An observation of Housekeeper #1 was made on 09/11/22 at 3:17 PM. Housekeeper #1 was observed in the hallway wearing a N95 mask and a face shield he was observed to enter Resident #36's room that had a sign on the door that read: Contact Plus Airborne Precautions: STOP Perform hand hygiene before and after patient contact with environment and after removal of PPE, Wear a N95 respirator, Gown, Face shield and gloves upon entering the room. Change gown after each patient contact, keep room door closed. Housekeeper #1 was observed to enter the room and place a trash bag in the trash can and then enter the bathroom and exit out of the adjoining room which was room [ROOM NUMBER] (Covid negative) room. He returned to the housekeeping cart in the hallway and proceed to empty the trash and clean the trash can. Housekeeper #1 did not change his N95 mask, clean/disinfect his eye protection or perform hand hygiene in between a Covid positive room and a Covid negative room. Housekeeper #1 was interviewed on 09/11/22 at 4:36 PM. He stated that he did not see the sign on the door of room [ROOM NUMBER], so he did not apply his gown or gloves and did not change his N95 mask when he exited the room. Housekeeper #1 stated that generally if he was entering a Covid positive room he would follow the instructions on the door as to what personal protective equipment he needed to apply but because he had not seen the sign posted on the door, he had not done that earlier in the day. An observation of NA #4 was made on 09/12/22 at 8:32 PM. NA #4 was observed to enter Resident #36's room wearing gown, gloves, N95 mask and eye protection and provided morning care to Resident #36 and assisted her with meal set up. Prior to exiting Resident #36's room NA #4 removed her gown and gloves and bagged them in a trash bag and exited the room she did not clean/disinfect her eye protection and did not change her N95 mask. NA #4 was interviewed on 09/12/22 at 8:33 AM and confirmed that she had removed her gown and gloves but had not changed her N95 mask or clean/disinfected her goggles and she should have. NA #4 could not provide a reason why she did not change her N95 mask or clean/disinfect her goggles. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The former Nurse Practice Educator was interviewed via phone on 09/13/22 at 2:52 PM via phone. The former Nurse Practice Educator stated that she had worked at the facility through an agency and a couple of weeks into her contract the Director of Nursing (DON) informed her that she would also be responsible for maintaining the infection control program at the facility. She stated she was responsible for ensuring appropriate signage was on the door if we had Covid 19 positive resident in the facility, ensuring PPE was available, ensure staff were wearing the PPE correctly, provide education on donning/doffing PPE, hand washing, Covid testing, keeping line listing of infections and tracking resident quarantine days. The Nurse Practice Educator stated the biggest issue she had was the staff was not compliant at all no one wanted to apply the PPE correctly. The Nurse Practice Educator explained that she was on vacation when the memory care unit had its first initial outbreak on 08/05/22, she stated when she returned to work on Monday 08/08/22 and found out that they had 7 residents that tested positive on 08/05/22 and nothing had been done. She stated that on 08/08/22 in the afternoon the former Administrator had asked her to round with him to ensure that all the pieces had been implemented for the outbreak on the memory care unit, she stated when they rounded, she discovered that there was no signage posted on door, no PPE on the unit, and staff were not wearing the appropriate PPE to be caring for Covid positive residents. The former Nurse Practice Educator stated that she immediately began implementing the appropriate measures, she placed signs on the doors, obtained PPE carts and filled them and put them outside of the resident rooms and she educated the staff on appropriate PPE use. She stated that when she would say to the staff in the facility pull your mask up, they would respond we have already had covid and would not follow directions. She stated that she made the DON aware of the issues and questioned her why the measures were not implemented when the residents tested positive but received no answer. When a resident tested positive for Covid the staff were taught and expected to wear full PPE including N95 mask, eye protection, gown, and gloves. They were also taught and expected to remove the PPE when they exited the Covid positive room perform hand hygiene and reapply a new N95 mask and new face shield. Again, compliance was always the biggest issue with infection control in the facility. The Nurse Practice Educator stated she had specific concerns with NA #3 and NA #4 that she had spoken to them several times and educated them several times during the first outbreak on the memory care unit and they just would not wear the PPE correctly. She added the DON was informed numerous times of my concerns with the staff noncompliance and the only response she would get if any at all was that we have to cover the building. The former Administrator was interviewed via phone on 09/13/22 at 5:14 PM and confirmed that his last day at the facility was 08/26/22. He stated that at the time the Nurse Practice Educator was handling infection control and reporting to the health department as needed. He stated that when he left the faciity on [DATE] there was no positive cases of Covid 19. When asked if he had any issue with infection control the former Administrator replied, we had error of opportunity and I constantly harped on staff to put goggles on and pull your mask up. He further stated he had the department managers responsible for stocking PPE carts each day and the biggest issue was the off-hour times like early morning, late evening, and weekends when management staff was not always present. The former Administrator stated that they did a lot of coaching in the moment to ensure mask were properly worn but to his knowledge he had no egregious issues with compliance. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Nurse Supervisor was interviewed on 09/14/22 at 10:16 AM and confirmed that she had seen staff not being compliant with PPE all the time. She stated she believed staff noncompliance with PPE contributed to the facility's Covid outbreaks. The Nurse Supervisor stated that when the residents that resided on the memory care unit test positive everyone should have been isolated but the staff noncompliance contributed to the continued outbreak. She stated night shift on the memory care unit was the worst for compliance with PPE but added NA #3 and NA #4 were also very non-compliant more so than the other staff. The Nurse Supervisor stated she would address her immediate concerns with the staff member at the time but could not say if the DON was aware of the staff noncompliance or not as she just assumed the Nurse Supervisor role and was not sure what previous conversations had been had. The Nurse Practitioner (NP) was interviewed via phone on 09/14/22 at 6:29 PM who stated she worked at the facility from January 2022 to August 2022 and treated the residents as they tested positive for Covid. She stated if staff were not wearing PPE as they were supposed to then it would have caught her attention. She stated she had no infection control concerns that she could recall. The DON was interviewed on 09/11/22 at 12:54 PM who confirmed she was the acting infection preventionist because the former Nurse Practice Educator who was responsible for infection control left 2 weeks ago. The DON stated she had been at the facility since January 2022 and the facility had been in outbreak status the entire time except for one week. The DON explained that the outbreak on the 400 hall or memory care unit started in August 2022 and currently all but 5 of the residents have had Covid in the last 90 days. The DON stated that of the 5 residents who had not had Covid in the last 90 days two were fully vaccinated and boosted/ up to date, one was only partially vaccinated, one was vaccinated without booster and one resident vaccination status was unknown. The DON stated that she worked Friday 09/09/22 until 11:00 PM and when she left the facility the memory care unit had a good supply of PPE, in addition there was more PPE on the other side of the building and even more in storage building outback that was not locked so it was accessible by all staff. She confirmed that she had not received any calls from the facility on 09/10/22 or 09/11/22 stating they needed or did not have PPE. The DON stated that each resident room that had a Covid 19 positive resident in it should have a sign on the door indicating Contact/Airborne precautions and tell staff to don eye protection, gloves, gown, and N95 mask before entering the room. There should be PPE carts outside of each of the resident rooms that were fully stocked with PPE for staff to use. She continued to say that education on Covid 19 and PPE use had been a constant revolving door and indicated the facility had done full PPE and hand hygiene competencies twice recently but could not recall the exact dates. Periodic emails were sent out to staff updating them on any changes with guidance and they also continued to have staff meetings to keep staff aware of the Covid status and changes. The DON stated that the local health department had made a visit less than a month ago and had no recommendations related to Covid 19. The Administrator was interviewed on 09/14/22 at 3:45 PM and stated that he expected the staff to follow the CDC guidance on infection control and for all staff to be compliant with PPE use to prevent the spread of infection. The Medical Director (MD) was interviewed on 09/14/22 at 4:10 PM and confirmed that he had been the MD at the facility since the summer of 2022. He stated that when he came to the facility, they were in the middle of a Covid outbreak. He also confirmed that staff made him aware of the recent outbreak on the memory care unit. The MD stated that he expected the staff to wear PPE appropriately, they should be performing frequent hand hygiene, and they should certainly be aware of who the Covid positive residents were all in attempt to prevent the spread of the Covid 19 within the facility. (continued on next page)

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	345261	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing & Rehabilitation	179 Combs Street Sparta, NC 28675

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON was notified of the immediate jeopardy on 09/11/22 at 8:02 PM via phone. The facility provided the following immediate jeopardy removal plan: Identify those residents who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance: Facility failed to follow transmission-based precautions and use of personal protective equipment (PPE) per CDC Guidance on the Memory Support Unit on 9/11/22. All residents on the Memory Support Unit have potential to be affected. As of 9/11/22 there were 24 residents on the Memory Support Unit, with 7 of them being Covid Positive, 12 Covid Recovered in the last 90 days, leaving 5 residents at risk for exposure to Covid due to this deficient practice. Testing was completed in the morning of 9/12/22 by 8:30 a.m., with no new positive residents. The 5 residents at risk have the following vaccination status: two fully vaccinated and boosted/ up to date, one with only initial dose of a 2 dose vaccination (partially vaccinated), refused the second dose/ partially vaccinated, one vaccinated without booster- booster declined/ fully vaccinated, and one status unknown. On 9/11/22 at approximately 7 p.m. the Director of Nursing responded to the Memory Support Unit and provided education for NA # 1 and # 2. The Director of Nursing assigned the RN Supervisor to the unit to monitor for compliance with immediate action taken for any discrepancies noted. Director of Nursing stayed at center and educated night shift staff on the Memory Support/Covid Positive unit on 9/11/22. Director of Nursing restocked the PPE supplies on the Memory Support Unit/Covid Positive Unit, on day shift on 9/11/22 and again on evening shift on 9/11/22. Specify action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when action will be complete: Director of Nursing began education for all staff in all departments on 9/11/22 and continues on 9/12/22, regarding CDC Guidance for use of PPE/ Transmission Based precautions during an outbreak and hand hygiene. Education also included the location of PPE Supplies in the event that they are needed during off shifts/weekends to restock units, located in the Biohazard Room and in the storage building in back parking lot, this is unlocked and available to all staff. Education included that staff should monitor each other, peer to peer for PPE compliance and report noncompliance to management. Education included disinfecting of eye protection and changing of N95s between Covid positive and Covid negative residents and the use of gloves and gowns (don and doff gloves and gowns on entry to a room with a resident on Transmission Based Precautions and to change gloves and gowns between roommates). Education included following the precaution signage on resident rooms and the location of a list of residents on precautions maintained at the nurse's station. Signage will designate if precautions are indicated for Bed A, Bed B or both, this was initiated on 9/12/22. This education included Full Time, Part Time, PRN (as needed) and Agency Staff. Across all departments. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A credible allegation of infection control was conducted in the facility on 09/14/22. Observations of the memory care unit on 09/14/22 revealed that all Covid positive rooms had a sign on the door indicating which resident was positive. Each Covid 19 positive resident room was observed to have a PPE cart outside of the room that was fully stocked with gowns, gloves, N95, and face shields. Each staff member was observed to have disinfecting wipes available to clean/disinfect their eye protection. The Nurse Supervisor was observed on the unit monitoring the infection control practices of the staff on the unit. Further observations revealed supplies of additional PPE to be located across from the main nurse ' s station, in the facility break room, and in a unlocked storage container out back of the facility. Interviews were conducted with staff members that worked in administration, nursing department, dietary department, maintenance department revealed that they had all received recent education on Covid 19, and appropriate PPE use along with hand hygiene. The managers at the facility verbalized understanding of their walking infection control rounds that they were to complete, and the supporting documentation required on the Covid 19 Walking Infection Control Round audit form. The facility's IJ removal date of 09/13/22 was validated. 45359 2. Review of the facility policy and procedure for scabies with an effective date of 9/1/2004 and review on 11/15/2021 revealed: Definition: Crusted (Norwegian) Scabies- single or multiple cases: an infestation characterized by thick crusts of skin that contain large numbers of scabies mites and eggs. It is a severe form of scabies. 1.Identify signs and symptoms of scabies: 1.1: intense itching, especially at night, 1.2: maculopapular rash, 1.3: tiny, irregular reddish lines (burrows), 2.1 Document daily patient skin checks for 8 weeks, 2.2 Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; suspected cases should be evaluated and confirmed by obtaining skin scrapings. 2.5 Maintain accurate line listings with patient name, age, sex, room number, roommate name, skin scraping status and result and name of all staff who provided hands on care to the patient before implementation of infection control measures. 2.10 Follow contact precautions until 24 hours after treatment. (continued on next page)

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