STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 08/21/2024

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WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/18/24 through 08/21/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #X2J711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/18/24 through 08/21/24. Event ID# X2J711. The following intakes were investigated NC00207135, NC00210765, and NC00220919. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		9/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/13/2024

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a residents (Resident #92) code status election was accurate throughout the medical record for 1 of 1 residents reviewed for advance directives. The findings included: Resident #92 was admitted to the facility on 06/06/23. A significant change Minimum Data Set (MDS) dated 07/04/24 revealed that Resident #92 was severely cognitively impaired. A care plan last revised on 07/16/24 read: End of Life/Advance Directive and contained the	F 578	Westwood Hills Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.	

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F 578	Continued From page 2 following interventions Cardio-pulmonary resuscitation/Full Code. A physician order dated 08/12/24 read: Do Not Resuscitate (DNR). Nurse #1 was interviewed on 08/21/24 at 9:17 AM. She stated that code status election was done upon admission with the resident and family and then discussed at each care plan meeting. If the resident or family wished to change the advance directive then she would get help from the Unit Manager (UM) at getting the new forms completed, obtaining the physician order, and updating the care plan. She stated that when she completed the quarterly care plan review, she always made sure the care plan matched what the residents/family wishes were. Nurse #1 stated that if a resident changed their code status and once the order was signed off and paperwork completed then the care plan would be updated. UM was interviewed on 08/21/24 at 3:33 PM. The UM stated that she had taken the order for Resident #92 to be a DNR on 08/12/24 and forgot to update the care plan. She stated that she must have gotten busy because normally she would update the care plan when she took the order from the provider. The Director of Nursing (DON) was interviewed on 08/21/24 at 4:14 PM. She stated that Resident #92 recently changed his code status and there was several nurses that updated care plans. Generally, when the UM put the order in the system, she would update the care plan or let Nurse #1 know that the care plan needed to be updated but Resident #92 "fell through the crack." The DON added that they also reviewed all new	F 578	Further, Westwood Hills Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F578 Request/Refuse/Advance Directive Based on a review of the resident□s medical record, it was alleged that the facility failed to correctly document Resident #92□s code status election on the care plan. The Licensed Nursing Home Administrator is responsible for ensuring the plan of correction is implemented and followed by the staff at Westwood Hills Nursing and Rehabilitation Center. On 8/21/24, Resident #92□s Care Plan was updated to reflect the change in order to Do No Resuscitate (DNR) by the licensed nurse. On 8/21/2024, a 100% audit of all resident□s advanced directive orders was completed by the Director of Nursing/Assistant Director of Nursing/Quality Assurance Nurse to ensure the resident□s medical record correctly reflected the residents preferred Advanced Directives in the plan of care, the physician order and the medical chart both physically and electronically. On 8/21/24, the Director of Nursing	

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F 578	Continued From page 3 orders in the daily morning meeting but again Resident #92 "fell through the crack."	F 578	conducted 100% education with the admission director and the unit manager which included ensuring the resident□s medical record correctly reflected the resident□s preferred Advanced Directives in the plan of care, the physician order and the medical chart both physically and electronically. On 9/13/2024, a 100% inservice was initiated to include all licensed nurses to ensure the resident's medical record correctly reflects the resident's preferred Advanced Directives in the plan of care, the physician order, and the medical chart both physically and electronically. An audit will be completed weekly x 4, then monthly x 1, for 10% of the residents to ensure the advance directives are documented correctly in the electronic medical record. This will be completed by the Director of Nursing or Assistant Director of Nursing. Any issues will be corrected immediately with retraining. The Director of Nursing will present the findings of the Advance Directives Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The committee will determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The Director of Nursing is responsible for the Plan or Correction and the Administrator is responsible for sustained compliance. Date of Alleged Compliance: 9/18/2024	

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F 690	Continued From page 4	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		9/18/24

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F 690	Continued From page 5 Based on record review, family, staff, and Nurse Practitioner interviews the facility failed to prescribe an antibiotic that would effectively treat a urinary tract infection (Resident #29) for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #29 was admitted to the facility on 08/23/23 with diagnoses that included vascular dementia. A quarterly Minimum Data Set (MDS) dated 05/19/24 revealed that Resident #29 was severely cognitively impaired and was frequently incontinent of bowel and bladder. A urinalysis laboratory report dated 08/17/24 indicated that Resident #29 was positive for greater than 100,000 bacteria and the culture report attached indicated that it was resistant to Ciprofloxacin (Cipro is an antibiotic). The report was signed by the Nurse Practitioner. Resident #29's family member was interviewed on 08/18/24 at 11:55 AM. The family member stated that Resident #29 had recently had 2 falls and the staff thought she may have a urinary tract infection and the medical provider over the weekend was going to order a test to determine if she did or did not have a urinary tract infection. A physician order dated 08/19/24 read, Cipro 500 milligrams (mg) by mouth twice a day for urinary tract infection proteus for five days. Review of the Medication Administration Record (MAR) dated August 2024 revealed that Resident #29 had received the Cipro one time on 08/19/24	F 690	F690 Bowel/Bladder Incontinence UTI/Catheter It was alleged that the facility Nurse Practitioner failed to treat Resident #29 with the appropriate antibiotic based on a urinalysis obtained with culture and sensitivity report that was obtained on 8/17/24. The Licensed Nursing Home Administrator is responsible for ensuring the plan of correction is implemented and followed by the staff at Westwood Hills Nursing and Rehabilitation Center. On 8/21/2024, Resident #29□s lab report culture and sensitivity was reviewed by the Family Nurse Practitioner. The current antibiotic was discontinued and another antibiotic that was susceptible per the report was started. On 8/21/2024, the Staff Development Coordinator/Infection Control Preventionist conducted a 100% audit of all residents for the previous 30 days who had been on antibiotics or were currently being treated with antibiotics for an infection to ensure the correct antibiotics were ordered as compared to the culture and sensitivity report performed if indicated. No further concerns were identified. On 8/21/24, the Director of Nursing initiated training to all licensed nurses to include comparing the lab report to include the culture and sensitivity if	

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F 690	Continued From page 6 and twice on 08/20/24. The Unit Manager (UM) was interviewed on 08/21/24 at 8:42 AM. The UM stated that generally lab reports were automatically uploaded into the system from the lab company and the medical providers would go in and review them and then write any orders that were needed. The UM stated if she saw a lab report that had not been addressed, she would say something to the provider and have them review and address it. The UM stated that if the providers were in the facility she generally did not review the lab reports because she assumed the providers would take care of them. However, if she was aware the provider was off or not going to be in the facility then she would review them and call anything urgent to the on-call provider. The Nurse Practitioner (NP) was interviewed on 08/21/24 at 8:50 AM. The NP stated she had reviewed Resident #29's urinalysis and started her on antibiotic because the urinalysis revealed she did have a urinary tract infection, and she was symptomatic. The NP was asked to review the culture again and draw her attention to the Cipro that indicated it was resistant to the bacteria that Resident #29 had, the NP stated, "that was faux pas (error or mistake) on me" and "I will have to change it right now" because the Cipro will not help her. The Director of Nursing (DON) was interviewed on 08/21/24 at 4:17 PM. The DON stated that the NP had reported to her that she had prescribed the wrong antibiotic. She stated the NP had already switched Resident #29 to the correct antibiotic. The DON stated that infection preventionist checked the urinalysis reports to	F 690	indicated, that reveals an infection to the antibiotic that is ordered by the provider to ensure the correct medication has been ordered. Any concerns identified will be called to the provider immediately. All new licensed nurses will be trained on this process during inital orientation. The Director of Nursing and the Staff Development Coordinator/Infection Control Preventionist will conduct an audit 5 times weekly x 4 weeks during the facility□s daily quality assurance and performance improvement meeting to review all new antibiotic orders to ensure the correct medication has been ordered as compared to the lab/culture and sensitivity report as indicated. Any concerns identified will be corrected immediately and the provider will be notified. The Director of Nursing will review the results of the Antibiotic Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 1 month. The committee will determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Compliance: 9/18/2024	

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F 690	Continued From page 7 ensure that the correct antibiotic had been ordered and she was very meticulous and would have probably caught the error in another day or two.	F 690		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		9/18/24

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F 880	Continued From page 8 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility policy, Center for Disease Control guidance, Statewide Program for Infection Control and Epidemiology (SPICE) representative, local health department, and staff interviews the facility failed to identify the need for	F 880	F880 Infection Prevention and Control It was alleged that the facility failed to implement broad based testing to identify and further prevent the spread of COVID	

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F 880	Continued From page 9 and implement broad based testing during a Covid-19 outbreak when the interventions implemented failed to halt transmission of Covid-19 which spread to 2 of 5 hallways (100 and 200) and affected 11 residents on the 100 hall and 1 resident on the 200 hall (Resident #97). The findings included: Guidance from the Center for Disease Control (CDC) website updated 03/18/24 read in part, "Responding to a newly identified SARS-CoV-2 infected health care personnel or resident: the approach to an outbreak investigation could involve either contract tracing or a broad-based approach; however a broad based (e.g., unit, floor, or other specific area (s) of the facility) approach is preferred if all potential contracts cannot be identified or managed with contract tracing or if contact tracing fails to halt transmission." "If no additional cases are identified during contract tracing or the broad-based testing, no further testing is indicated." "If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit (s) or facility wide every 3-7 days until there are no new cases for 14 days." Review of a facility policy titled, "Infection Control Manual" "Appendix A: Covid 19 Infection Prevention & Control Program Guidelines" last	F 880	19 when the virus had spread to 2 halls (100 and 200) which affected 11 residents on 100 hall and 1 resident on 200 which was identified as Resident #97. The facility believes that during this outbreak, we were following the guidance in F880 of the CDC recommendations and our local health department. The Licensed Nursing Home Administrator is responsible for ensuring the plan of correction is implemented and followed by the staff at Westwood Hills Nursing and Rehabilitation Center. • Residents #11, 14, 20, 39, 54, 60, 64, 65, 75, 80, and 104 were all placed on enhanced droplet precautions. The physician and responsible parties were notified by the licensed nurse timely following their positive test results. • Resident #97 was sent to the hospital for evaluation and treatment. He tested positive for COVID 19 while in the hospital Emergency Room, however, did not complain of symptoms at the facility. Upon returning, resident #97 was placed on enhanced droplet precautions. The physician was made aware of his COVID 19 infection upon readmission and the family was notified while in the hospital. • On 8/26/24, the Director of Nursing/Staff Development Director conducted a 100% audit of all halls occupied by residents who were positive for COVID 19 to determine if broad based testing for COVID 19 was warranted. • On 8/26/24, broad based testing was	

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F 880	Continued From page 10 revised on 09/25/23 read in part, "facilities have the option to perform outbreak testing through two approaches, contract tracing or broad-based testing. Contract tracing is the recommended method as it more definitively identifies the source and provides best quality of life; although the Administrator, Director of Nursing, and Medical Director reserve the right to utilize broad based approach." "If no additional cases are identified after completion of initial serial contact tracing or the broad-based testing, no further testing is indicated. "If additional cases continue to be identified and facility assesses ongoing uncontrolled transmission, strong consideration should be given to shifting to the broad-based approach if not already being performed and implement additional precautions as indicated for residents in affected areas of the facility. As a part of the broad-based approach, testing should continue on affected unit(s) or facility wide every 3-7 days until there are no new cases for 14 days. Review of a list of residents that resided on the 100 hall of the facility revealed that Resident #11, #14, #20, #39, #54, #60, #64, #65, #75, 80, and #104 all actively had COVID-19 or had recently recovered from COVID-19. Review of the facility's COVID-19 Outbreak testing log revealed that on 07/31/24 a newly hired Activity Employee #1 tested positive for COVID-19. The log listed the residents and staff that Activity employee #1 had close contact with which included Activity Employee #2 and #3 and Resident #22, 95, and 102. The log revealed that	F 880	completed by the licensed nurses providing care to the residents on all hallways where new positives had occurred based on the facility testing schedule. All concerns were addressed immediately according to facility policy and procedure, CDC guidance and the county health department's recommendations. All care plans were updated, the Medical Director and Responsible Party was notified for any resident that tested positive during this testing period. • On 9/13/24, the Nurse Consultant provided 100 % education to the Licensed Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, and the Assistant Director of Nursing on the Centers for Disease Control (CDC) guidance for COVID 19 to include testing as well as the facility policy and procedure for COVID 19. • On 9/13/24 the Director of Nursing/Staff Development Coordinator conducted 100% education to all nurses on the CDC guidance for COVID 19 to include testing as well as the facility policy and procedure for COVID 19. Any nurse that is hired after 9/13/24 will receive education during orientation prior to the start of their first shift. • The licensed nurse will notify the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator of any new positive residents and any residents who are symptomatic for COVID 19. The health department will be notified, and a collaborative decision will be made	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 through frequent testing Activity Employee #1, #2, and #3 all tested positive for COVID-19. Resident #22, #95, and #102 through testing tested negative for COVID-19. Further review of the Outbreak testing log revealed that through contact tracing testing Resident #11 and #65 tested positive for COVID-19 on 08/07/24, Resident #14, and #80 tested positive on 08/09/24, Resident #64 and #104 tested positive on 08/10/24, Resident #26 and #54 tested positive on 08/12/24, Resident #60 and #75 tested positive on 08/14/24, and Resident #39 tested positive on 08/15/24. Review of a list of residents that resided on the 200-hall revealed none of the residents had or recently had Covid-19 including Resident #97. Resident #97 was readmitted to the facility on 07/25/24 and was sent to the Emergency Room (ER) on 08/19/24. He resided on the 200-hall in the facility. Review of Resident #97's ER record dated 08/19/24 read in part, SARS-CoV-2 Nucleic Acid Test was performed on 08/19/24 at 10:34 AM and was "detected" (positive Covid-19 test). The report further read; "patient states he feels fine and people at his care facility are sick with COVID and he had some mild nasal congestion and cough with some clear sputum however that resolved." "Initial blood pressure was 93/59, he was given IV fluids and increase his blood pressure to low normal and slightly tachycardic with no hypoxia on room air and a fever of 101.2 however that was prior to his blood transfusion." The Infection Preventionist (IP) and the Director of Nursing (DON) were interviewed on 08/20/24	F 880	to determine if contact tracing or broad-based testing is sufficient. • The Director of Nursing, the Assistant Director of Nursing, or the nursing supervisor will review the infection control log 5 times per week for 4 weeks in the facilities morning quality assurance and performance improvement (QAPI) meeting to determine if the appropriate testing schedule was implemented (broad based or contact tracing). Any identified concerns will be addressed immediately. • All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of Compliance: 9/18/24	

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	345205	A. BUILDING _____ B. WING _____	C 08/21/2024

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at 1:55 PM. The DON explained that the facility's recent Covid-19 outbreak started on 07/31/24 when Activity Employee #1 tested positive for Covid-19. She explained that they obtained a list of residents and staff that were in close contact with Activity Employee #1 and began testing those individuals every other day for 3 tests. The DON stated that during that time they began to get calls from family members reporting that the family member had Covid-19 and had recently visited a resident in the facility. With each call that they received they added that resident to the list of residents to be tested. So, all the residents that were added to the contact tracing list were tested every other day for a series of 3 tests. While those test were being performed, they continued to have residents and staff that were testing positive for Covid-19. The IP stated that on 07/31/24 when Activity Employee #1 tested positive for Covid-19 the facility initiated and required all staff to wear a surgical mask at all times when in the facility except when caring for a Covid-19 positive resident then the staff were instructed to wear a N95 respirator. She stated that they placed surgical masks at the reception desk if visitors wanted to wear a mask as well while visiting. The IP stated that the Covid-19 positive residents and staff resided and worked on the 100 hall and the 700 hall which was the assisted living hall within the facility so because it was contained to one hall, they did not perform broad based testing or test all residents and staff in the facility. The IP stated she had reported the outbreak to the local health department Nurse on 07/31/24 and again on 08/02/24 and she had no additional recommendations for the facility. The DON explained that the same staff that worked on the 100 hall also worked on the assisted living hall within in the facility. In addition, Resident #11

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and #65 who resided on 100 hall would go and visit some of their friends that resided on the assisted living hall, so they were unsure if the Covid-19 was being spread by staff or residents, but they continued to test their growing list of contract trace residents and continued to require the staff to wear mask while working in the facility. The DON stated that they also added any symptomatic residents or staff to the list for testing as well.

A phone interview was conducted with the representative from SPICE on 08/21/24 at 11:49AM who stated that the CDC guidance regarding outbreak testing was pretty clear. It stated that if contract tracing testing could not identify all individuals who had potentially been exposed or if the contract trace testing and interventions failed to halt transmission of Covid-19 then the facility should strongly consider switching to broad-based testing.

The local health department Nurse was interviewed via phone on 08/21/24 at 2:25 PM. She confirmed that she had been notified of the outbreak and she had opened the outbreak case paperwork on 08/02/24. She stated she had been made aware that the outbreak had been contained to one hall and one set of staff and she stated she had instructed them to ensure staff were wearing masks and washing their hands. The Nurse stated that if the Covid-19 outbreak spread to another unit then there may be additional recommendations and of course if a resident was symptomatic, they would recommend the facility test that resident. She added that if she saw the outbreak moving to another unit or other areas of the facility, she would recommend broad based testing. The local

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health department Nurse was not aware of Resident #97 who resided on the 200 hall and was transferred to the local ER and tested positive for Covid-19 the same day and was also not aware the outbreak affected the residents on the assisted living hall within the facility.

A follow up interview was conducted with the local health department Nurse via phone on 08/21/24 at 3:55 PM. She stated that she had spoken to the DON and her health director at the local health department and because Resident #97 was still at the hospital there was nothing, that the staff could do about that, and they continued to support the facilities contract tracing testing at this time and had no additional or new recommendations. She again stated she had been kept informed of the outbreak and had no other recommendations at this time.

A follow up interview was conducted with the DON and the Administrator on 08/21/24 at 4:21 PM. The DON stated that they had not considered broad based testing because the outbreak "seems like it is fizzing out." If the local health department Nurse would have recommended it, we would have done it. The DON stated that Resident #97 has had no symptoms and that was why he was not tested in the facility. She stated that when they tested the residents' that remained on the contact tracing list on Sunday 08/18/24 everyone that was tested was negative. The Administrator stated that they could not mandate the visitors to wear a mask but did have them available to wear if they wanted to and stated that Resident #97 could have gotten Covid-19 in the ambulance ride on the way to the hospital and had also had an outside appointment on 08/02/24. The DON added that Resident #97

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F 880	Continued From page 15 was in a private room and no staff had close contact for more than 15 minutes, so no residents or staff were added to the list for testing. The DON also added that the testing of the contact tracing was completed, and they would only be testing those residents that were symptomatic.	F 880		