STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345393	A. BUILDING _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

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E 000	Initial Comments A recertification and complaint investigation survey was conducted from 03/23/25 through 03/26/25. The survey team went back to the facility on 04/01/25 to investigate a new complaint and validate the facility's credible allegation. Therefore, the exit date was changed to 04/01/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #N5KR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/23/25 through 03/26/25. The survey team went back to the facility on 04/01/25 to investigate a new complaint and validate the facility's credible allegation. Therefore, the exit date was changed to 04/01/25. The following intakes were investigated: NC00212169, NC00215239, NC00217369, NC00217810, NC00223170, NC00222591, NC00226069, NC00227096, NC00227710 and NC00228807. 35 of the 35 complaint allegations did not result in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (L) Immediate Jeopardy began on 03/11/25 and was removed on 03/27/25.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		4/2/25

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

Electronically Signed | 04/22/2025

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F 812	Continued From page 1 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date and seal leftover frozen food stored in 1 of 1 walk-in freezer. This practice had the potential to affect foods served to the residents. The findings included: On 3/23/2025 at 10:05 AM the initial kitchen observation was conducted with the Dietary Director and revealed the following: a. Walk-in freezer - A clear plastic bag open to air which was a quarter full of breaded fish filets with no date on the bag, edges of breaded fish filets were observed with a thin white layer around the edges.	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F812__ Food Procurement, Store, Prepare, Serve-Sanitary Corrective action for affected residents: On 3/23/2025, Food opened and undated was discarded from walk in cooler by	

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F 812	Continued From page 2 During an interview on 3/23/2025 at 10:11 AM the Dietary Director stated that all opened foods should be dated and sealed. During an interview on 3/25/2025 at 11:55 AM the Registered Dietitian stated opened food should be dated and sealed. During an interview on 3/25/2025 at 4:22 PM the Administrator stated the Registered Dietitian completed rounds every Monday morning and the breaded fish filets would have been thrown away on 3/24/2025 after rounds were completed. The Administrator provided a menu that showed baked fish had been served on 3/21/2025. The Administrator stated that opened food should have a date on it when put back in the refrigerator or freezer, but she was not sure if it needed to be sealed.	F 812	Dietary Manager. Corrective Action for Potentially Affected Residents: All current residents have the potential to be affected by the alleged deficient practice. On 3/24/2025, the Dietary Manager completed inspection of all walk-in coolers and all food items were properly stored. Any food items noted opened or without a date were removed and discarded. Systemic Changes: On 3/25/2025, the Dietary Manager began In-service education to all full time, part time, and as needed dietary staff on checking for and discarding all food items noted opened and not dated and all food must be stored, dated and discarded per NC State Regulations and Food Safety, Food Storage Policy reviewed. The Administrator will ensure that any of the above identified staff who does not receive scheduled in-service training by 3/27/2025 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance: The Dietary Manager will monitor food storage weekly x 4 weeks then monthly x 2 months using the Dietary QA Audit Tool.	

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F 812	Continued From page 3	F 812	Monitoring will include auditing kitchen reach-in and walk-in refrigerators and freezers in which food is stored to ensure all items are stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager Date of Compliance: 4/02/2025	
F 880 SS=L	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:	F 880		4/2/25

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F 880	Continued From page 4 §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 §483.71 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 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	F 880		

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F 880	Continued From page 5 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 observations, record review, and staff, Medical Director, and Health Department (HD) Nurse interviews, the facility failed to operationalize infection control policy and procedures in accordance with current Centers for Disease Control and Prevention (CDC) guidance. A) The facility failed to implement a broad-based approach to COVID testing for staff and residents when contact tracing testing failed to stop the transmission of COVID. Broad-based COVID testing per the (CDC) guidance was not implemented until 3/25/25. Before broad-based testing was implemented on 3/25/25, a total of 7 staff members and 14 residents tested positive for COVID. Results of the broad-based testing from 3/25/25 to 3/31/25 yielded one (1) staff member and 8 additional residents positive for COVID. B) In addition, the facility failed to implement staff source control to help prevent transmission while working in the facility during the COVID outbreak. C) The facility also failed to restrict staff from returning to work after testing positive for COVID in accordance with current CDC guidance. D) The facility failed to have updated COVID policies and procedures that aligned with current CDC guidance for source	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880__ Infection Prevention and Control Corrective action for affected residents: The facility failed to operationalize an infection control policy to manage a COVID-19 outbreak per the Center for Disease Control and Prevention (CDC). The facility failed to ensure its infection control policy and procedures were up to date with the most recent CDC recommendations. The facility failed to implement broad based testing when contract tracing failed	

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F 880	Continued From page 6	F 880		

control and work restriction guidance for healthcare personnel. The resident census at the time of the survey was 106; there were 59 residents whose COVID vaccinations were up to date. The facility provided a list of 128 staff members and reported there were 11 staff members whose COVID vaccinations were up to date. These cumulative practices and system failures occurred during a COVID outbreak and had the high likelihood of continued transmission of COVID to residents and staff and a serious adverse outcome.

Immediate Jeopardy began on 3/11/25 when 3 staff members and 5 residents on three different resident halls tested positive for COVID and the facility failed to implement a broad-based approach COVID testing for staff and residents. Immediate jeopardy was removed on 3/27/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of F (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings included:

A. A facility policy entitled COVID response program dated as last approved on 2/2025 read in part:
"Perform COVID viral testing: Anyone with even mild symptoms of COVID, regardless of vaccination status, should receive a viral test for COVID as soon as possible. Asymptomatic residents with close contact with someone with COVID infection should have a series of three viral tests for COVID infection. Testing is recommended immediately (but not earlier than

to stop the transmission of COVID-19.
The facility also failed to implement source control during a COVID-19 outbreak that started on 03/11/25 and continues through present 03/25/25. The COVID-19 outbreak has currently affected 7 staff members and 19 residents.
The facility also failed to implement the current CDC guidelines for staff returning to work after COVID-19.
On 3/12/2025, Resident #42 tested positive for COVID-19. Resident #42 was noted with a change of condition following a fall and noted with shortness of breath and sent to the hospital for evaluation and treatment per Medical Doctor (MD) order. Resident was admitted to hospital with diagnosis of Mechanical Fall, Acute Hypoxic Respiratory Failure secondary to Covid and Paroxysmal A-Fib with RVR. Resident #42 received appropriate medical care and was discharged back to the facility on 3/18/2025 in stable condition and continues to be monitored for complications related to COVID-19 infection.
Since 3/11/2025 of COVID-19 outbreak, all current residents who have tested positive for COVID-19 were seen and/or treated by facility Medical Director or Nurse Practitioner on day positive test noted or the following day post positive test result. Additionally, any resident who was symptomatic with a negative COVID-19 test was seen within 24 hours of onset of symptoms. Staff continue to monitor residents for any change of condition.
On 3/25/2025, Facility contacted local

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F 880	Continued From page 7 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5." "Create a process to respond to COVID exposures among health care personnel (HCP) and others: Exposures will be investigated by the infection control practitioner and other team members. Decisions to test all contacts will depend on the ability to identify all of the contacts. In cases where contacts are not identified then broad based of facility wide testing for resident and HCP will be initiated. Initial testing will be completed as a three series test. This process is described above. After the three series, testing is finished then the testing group will continue to be tested every 3-7 days until there are no new cases for 14 days." "Responding to a newly identified COVID infected HCP or resident: When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdictions' public health authority. A single new case of COVID infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach is preferred if all contacts cannot be identified or managed with contact tracing or if contract tracing fails to halt transmission. Perform testing for all resident and HCP identified as close contacts or on the affected units if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than	F 880	Health Department and implemented source control measures to include wearing surgical face mask while in the facility for all staff, encouraging residents and visitors to wear mask and initiated broad-based bi-weekly COVID-19 testing for all staff and residents until facility has completed 14 days without any new COVID-19 positive residents or staff. Corrective Action for Potentially Affected Residents: The Director of Nursing completed an audit on 3/25/25 of all current employees that were working. The audit revealed that no employees were currently working where at least 7 days had not passed since their first symptoms, that they had been 24 hours without fever without the use of fever reducing medications, and symptoms had improved. There is a total of 7 staff which have tested positive COVID-19 between 3/11/2025 and 3/17/2025. No other COVID-19 positive staff has been identified since testing began on 3/25/2025. On 3/25/2025, Facility contacted local Health Department and implemented source control measures to include wearing surgical face mask while in the facility for all staff, encouraging residents and visitors to wear mask and initiated broad-based bi-weekly COVID-19 testing for all staff and residents. The results of testing were: 7 additional residents tested positive for COVID 19. On 3/25/2025 the Director of Nursing implemented corrective action for those residents which includes: implementing	

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F 880	Continued From page 8 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5. If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility as part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days) should be considered." A review of the facility's COVID testing logs and list of COVID positive residents and staff revealed the facility's COVID outbreak started on 3/11/25 when Nurse #1, Nurse #2, and the Speech Therapist tested positive for COVID and two residents on K hall, two residents on F hall, and one resident on S hall tested positive for COVID. Additional residents on halls F, K, and S tested positive from 3/11/25 through 3/16/25. Facility testing logs indicated all Residents on F and K hall were tested and most of the residents on S hall were tested; the log indicated rooms S18, S19, and S20 were not tested. The COVID testing log indicated a resident on C hall tested positive on 3/15/25 and a resident on W hall tested positive on 3/17/25. The COVID testing logs revealed no additional residents were tested from C hall or W hall until 3/25/25. Broad-based testing was not conducted until 3/25/25. - On 3/11/25 Nurse #1 tested positive for COVID.	F 880	transmission-based precautions along with personal protective equipment to include N-95 mask for use during patient care for staff, notifying medical director and resident representative, implementing source control measures to include staff wearing surgical mask while in facility. All current residents who have tested positive for COVID-19 since outbreak began on 3/11/2025 were seen and/or treated by facility Medical Director or Nurse Practitioner on day positive test noted or the following day post positive test result. Additionally, any resident who was symptomatic with a negative COVID-19 test was seen within 24 hours of onset of symptoms. Systemic Changes: On March 25, 2025, the Director of Nursing initiated broad-based COVID-19 testing for all residents and staff to identify and isolate positive cases after the Administrator and Director of Nursing consulted with the local health department. All residents who tested positive were placed on transmission-based precautions with personal protective equipment in place to include N-95 masking by the Director of Nursing immediately following identification of positive test result. The results of COVID-19 testing on 03/25/25 identified an additional 7 residents and 0 staff. On March 26, 2025, the Quality Assurance Nurse Consultant updated the COVID-19 Response Program policy based on current CDC guidance provided	

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F 880	Continued From page 9 - On 3/11/25 Nurse #2 tested positive for COVID. - On 3/11/25 the Speech Therapist tested positive for COVID. - On 3/11/25 Resident #8 in room F10 was positive for COVID. - On 3/11/25 Resident #92 in room K1 was positive for COVID. - On 3/11/25 Resident #95 in room F9 was positive for COVID. - On 3/11/25 Resident #38 in room S3 was positive for COVID. - On 3/11/25 Resident #92 in room K9 was positive for COVID. - On 3/12/25 the Physician Assistant (PA) tested positive for COVID. - On 3/12/25 Resident #42 in room S16 tested positive for COVID. - On 3/13/25 Nurse Aide (NA) #1 tested positive for COVID. - On 3/13/25 Resident #52 in room K10 was COVID positive. - On 3/14/25 Resident #74 in room S15 was COVID positive. - On 3/14/25 Resident #106 in room F1 was COVID positive. - On 3/15/25 Resident #15 in room C10B was COVID positive. - On 3/16/25 Resident #363 in room F3 was COVID positive. - On 3/16/25 NA #2 tested positive for COVID. - On 3/17/25 Resident #93 in room W4 was COVID positive. - On 3/17/25 the Minimum Data Assessment (MDS) Nurse tested positive for COVID. - On 3/22/25 Resident #99 in room C1A was COVID positive. - On 3/24/25 Resident #39 in room C1B was COVID positive.	F 880	by the local health department. Changes included: updating masking recommendations during an outbreak to reflect CDC recommendation to say masking recommended and removing not required, completing broad-based testing if staff are shared between units, requiring KN95, N95, or surgical masks for staff while in the facility throughout the outbreak, continued the use of N95 when in a resident room who is suspected or confirmed to have COVID-19, and encouraging residents to wear masks outside their rooms. The Return-to-Work policy for healthcare personnel was also revised: return is allowed after 7 days with a negative viral test (taken within 48 hours before return), or after 10 days without testing. If the employee returns on day 7 they must also be 24 hours fever-free without medications, and symptoms must be improving. Beginning March 25, 2025, no COVID 19 positive staff will be permitted to work without a negative COVID-19 test or until they have completed the requirements for return to work. Staff members who test positive may not return to work until they meet the return-to-work criteria: at least 7 days have passed since symptom onset (or date of positive test if asymptomatic), a negative viral test was obtained within 48 hours of returning to work, and at least 24 hours fever-free without the use of fever-reducing medications, and symptoms have improved. If a negative test is not obtained, staff may not return to	

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F 880	Continued From page 10 The following were the results of COVID-19 testing after broad-based testing was initiated: - On 3/25/25 Resident #91 in room C3A was COVID positive. - On 3/25/25 Resident #43 in room C3B was COVID positive. - On 3/25/25 Resident #9 in room C5A was COVID positive. - On 3/25/25 Resident #45 in room C5B was COVID positive. - On 3/25/25 Resident #16 in room W2 was COVID positive. - On 3/25/25 Resident #70 in room W3 was COVID positive. - On 3/25/25 Resident #364 in room F5 was COVID positive. - On 3/31/25Resident #36 in room C4A was COVID positive. - On 3/31/25 Nurse #8 tested positive for COVID. Review of Resident #42's electronic medical record revealed on 3/12/25 she had a fall, generalized weakness, altered mental status, and a positive COVID test at the facility. Her blood pressure was 94/63, pulse was 137, temperature was 97.6, and her oxygen saturation level was 93% on room air. The electronic medical indicated the provider was notified and ordered for her to be transferred to the hospital. Resident #42's hospital discharge summary dated 3/18/25 revealed she was hospitalized from 3/12/25 to 3/18/25 with acute hypoxic respiratory failure secondary to COVID and atrial fibrillation. The hospital history and physical dated 3/12/25 read in part: "patient stated she started feeling poorly for 2-3 days with a productive cough, sore throat, and increased thirst. Endorses, normal PO (oral) intake, fever/chills, shortness of breath, mild swelling in both legs, dizziness when standing,	F 880	work until 10 days have passed since symptom onset or the positive test. Any staff that tested positive must undergo a mandatory screening by the Infection Control Nurse and review by the Director of Nursing to confirm return to work criteria have been met. This will be completed prior to their return to work. The local health department was updated on the outbreak by the Director of Nursing and Administrator on March 25, 2025. Based on recommendations by the health department twice-weekly COVID-19 testing will be conducted for all residents and staff who have not tested positive in the past 30 days. Testing will continue until 14 days pass with no new cases. As of March 25, all staff are required to wear surgical masks as source control when in the facility. Staff will continue to be required to use N95 masks when caring for suspected or confirmed COVID-19 positive residents. On March 26, 2025, the updated policies were reviewed with the Infection Preventionalist, Director of Nursing, and Administrator by the Quality Assurance Nurse Consultant Staff Education began March 25, 2025. The Director of Nursing began staff training on the use of mask in the facility throughout the duration of the outbreak, the need for ongoing testing, and return-to-work protocols and Infection Control Response Policies This education is mandatory for all staff, including agency	

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F 880	Continued From page 11 diarrhea." Resident #42 was re-admitted to the facility on 3/18/25. Review of Resident #363's electronic medical record revealed that on 3/16/25 he had anxiety and was complaining of pain and shortness of breath. The medical record indicated Resident #363 requested to go to the hospital. The on-call provider was notified and specified Resident #363 could be transferred to the hospital. The medical record indicated Resident #363 was transferred to the hospital on 3/16/25. Resident #363 did not return to the facility. An interview was conducted with the Administrator on 3/31/25 at 2:15 PM. The Administrator stated Resident #363 was transferred to the hospital on 3/16/25 and tested positive for COVID at the hospital on 3/16/25. She said Resident #363 had been admitted to the hospital and then discharged home after his hospitalization. An interview was conducted with Nurse #10 on 3/24/25 at 9:15 AM. Nurse #10 said she was assigned to halls W, S, and C hall (rooms C1-C6). She reported the facility had recently had several residents and staff who were positive for COVID. She stated staff were not being tested for COVID on a routine schedule. Nurse #10 said she was tested for COVID one time earlier this month, after the first COVID case was identified at the facility but that not all staff got tested to her knowledge. She explained staff were only tested for COVID if they had symptoms or if they requested to be tested. Nurse #10 reported she had tested herself at the facility, she thought on 3/16/25 but was not entirely sure of the date. Nurse #10 stated she had tested herself because	F 880	personnel. The Director of Nursing will ensure that any staff who does not complete education by 3/31/2025 will be allowed to work without completing this training. This education will be incorporated into new hire orientation for all staff. The Administrator will continue to contact the local health department at least weekly during outbreak to review testing results and receive updated guidance. Quality Assurance: Beginning 3/30/2025, the Director of Nursing or designee will be utilizing the QA Tool F880 for Infection Control to monitor Covid outbreak status, source control measures and testing per CDC recommendations if in outbreak. Also, Covid Response Policy to be reviewed to ensure updates are made per CDC recommendations. This will be completed weekly x 4 weeks then monthly x 2 months to ensure that facility is adhering to Infection Control policy per CDC guidelines. QA Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services	

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she had worked with the residents who had tested positive prior to them being identified as COVID positive. She said she had tested herself as a precaution. She reported she had not been tested for COVID since she had tested herself on 3/16/25. Nurse #10 explained the facility had COVID tests available in the provider office and at the nursing station that staff could use to self-test. She said if staff tested positive, they were supposed to let their supervisor know but otherwise the facility did not log the test results to her knowledge. She reported staff COVID testing was done per staff discretion, if they started showing symptoms, or they felt they needed to take one.

An interview was conducted with Housekeeper #1 on 3/24/25 at 10:09 AM. She reported that the facility tested residents but did not test staff unless they had symptoms. She reported she had not been tested for COVID because she had not had any symptoms.

An interview was conducted on 3/24/25 at 1:35 PM with NA #13. She reported staff were only tested for COVID if they had symptoms or if they had exposure from a family member. She explained she had been tested 2 weeks ago because she had an exposure to a family member outside of her home who had COVID. She stated there had been no facility wide testing of staff since the COVID outbreak began.

An interview was conducted with NA #8 on 3/24/25 at 1:45 PM. She reported she had not been tested for COVID. NA #8 said individuals were only tested if they had symptoms.

An interview was conducted with Physical

Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Di/rector.
Date of Compliance: 4/2/2025

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Therapy Assistant (PTA) #1 on 3/25/25 at 8:54 AM. PTA #1 reported she had worked with the residents on the rehab unit before it was known they were COVID positive. She stated she had not been tested for COVID because she did not have any symptoms. She explained if she did not have any symptoms then she did not need to be tested.

An interview was conducted on 3/25/25 at 8:55 AM with Occupational Therapy Assistant (OTA) #1. She reported she had worked with the residents on the rehab unit who had tested positive for COVID. She explained she had been tested for COVID around 3/11/25 when the first residents had tested positive because she had symptoms. OTA #1 said her COVID test had been negative. She stated she had not been tested for COVID since then.

An interview was conducted with the Rehab Director on 4/1/25 at 11:27 AM. The Rehab Director reported that the Speech Therapist had started not feeling well and had tested positive for COVID on 3/11/25. She recalled OTA #1 had a scratchy throat on 3/11/25 and had been tested for COVID as a precaution, and her test was negative. The Rehab Director reported no other staff in the therapy department were asked to get tested.

An interview was conducted with the Director of Nursing (DON) who also served as the Infection Preventionist (IP) with the Staff Development Coordinator (SDC) present on 3/24/25 at 3:52 PM. The DON said the facility's SDC was going to eventually assume the role of IP but had not yet attended the North Carolina State Program for Infection Control and Epidemiology (SPICE). The

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DON indicated she had completed the SPICE training. The DON explained that the SDC assisted with infection control but that she oversaw the facility's infection control program. The DON explained that the facility's COVID outbreak began on 3/11/25 when 5 residents and 3 staff members tested positive for COVID. The DON said since the outbreak had begun the facility had 12 residents who had tested positive for COVID. She reported that the residents who had tested positive for COVID were located on F hall, K hall, S hall, W hall, and C hall. The DON said when Nurse #1 tested positive for COVID on 3/11/25 the residents on Nurse #1's work assignment was tested. She explained Nurse #1's assignment included F hall, K hall, and the top of S hall (S1-S14). The DON stated testing was initiated for those residents due to exposure to Nurse #1 and they were tested on days 1 (3/11/25), 3 (3/13/25), and 5 (3/15/25). During the initial day 1 testing on 3/11/25, the DON reported 5 residents (Resident #8, Resident #92, Resident #95, Resident #38, and Resident #105) on halls F, K, S were identified as being positive for COVID. On day 3 testing (3/13/25) an additional resident (Resident #52) on K hall tested positive for COVID. The DON reported, Resident #74 in room S15 was not part of the initial COVID exposure testing group but was tested on 3/14/25 due to symptoms and was positive for COVID. The DON explained, Resident #42 in room S16 was also not part of the initial COVID exposure testing group but was tested on 3/12/25 due to falls. Resident #42 was COVID positive on 3/12/25, was transferred to the emergency room for evaluation, and admitted to the hospital. The DON reported, Resident #15 residing in room C10B and Resident #93 in room W4 were tested due exposure from the PA and had tested positive

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for COVID. The DON said residents were placed on transmission-based precautions for 10 days when they tested positive for COVID. She verbalized the Administrator had notified the local Health Department (HD) of the facility's COVID outbreak on 3/11/25 and had not been given any recommendations from the HD. The DON stated the facility advised staff after residents tested positive for COVID that maybe they should be tested for COVID if they had worked on the halls where the COVID residents were located and if they had symptoms. The DON stated the facility had not done any official contact tracing of staff to see if they needed to be tested. She said the facility did not have a system for tracking and logging staff test results to identify when and who were tested. The DON indicated staff tests were logged if, they were positive.

An interview was conducted on 3/25/25 at 2:43 PM with the HD Nurse. The HD Nurse said facilities were supposed to call and report to the HD if there were two or more confirmed cases of COVID with 72 hours of each other. She said the HD used an outbreak reporting email system. The HD nurse reported she went through all her emails, logs, and phone call records and she did not have any information or contact from the facility. The HD further reported the last contact with the facility had been after a large storm in September 2024 when the HD reached out to the facility to see if they needed anything. The HD nurse explained that the HD also held quarterly calls with the local facilities and had a call last week, and the facility had not been present on the call. The HD nurse reported that she had received an email from the Administrator this morning (3/25/25). She reported the email content from the Administrator had said she was

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following up on an email she had sent last week. The HD said the email from this morning (3/25/25) had a forwarded email attached that looked like it had been sent on 3/17/25. The HD Nurse said she had double checked and could not find anything in the HD email that had been sent on 3/17/25 from the facility. The HD nurse stated the email she had received from the facility today had said 2 employees were positive for COVID. The HD Nurse explained if the facility had gotten in touch with the HD on 3/11/25 she would have asked if the staff were symptomatic, where they had worked, and who they had taken care of on those shifts. She reported that if the positive staff had worked on several hallways or if residents had tested positive on several hallways, she would have recommended testing all residents and staff in the facility and would have also recommended wearing masks for source control. The HD Nurse said if staff were not wearing a mask there could be more exposure. She stated as soon as the facility had additional positive staff or residents on the initial serial testing, they should have moved up to broad-based facility wide testing of residents and staff. She indicated it was hard to contact trace and identify all the potential contacts when there were that many positive cases on multiple units. The HD nurse said after the initial 1-, 3-, and 5-day testing the facility should have continued testing residents and staff every 3 days or two times a week until they had no new cases for 14 days. She further stated the facility should have also implemented face masks for source control on 3/11/25 when multiple residents and staff had tested positive for COVID because the facility would have been in outbreak status. The HD Nurse stated the facility would not have continued to see more cases typically after 5 days if they

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were doing everything right and wearing masks. She reported the facility should have notified the HD on 3/11/25 or at least within a few days. The HD Nurse explained if for some reason the facility was not able to get in touch with the HD or she was not available the information was available on the CDC website. The HD Nurse reported there was a packet that she sent via email to all facilities in outbreak status that had specific infection control practices to implement and follow to help mitigate the outbreak.

An additional interview was conducted with the DON on 3/25/25 at 3:58 PM. She reported that the facility had received a phone call from Resident #99's son on 3/24/25 who communicated Resident #99 had tested positive for COVID at the hospital on 3/22/25. The DON stated Resident #99 had been transferred to the hospital on 3/21/25 for evaluation due to a fall. The DON explained the facility tested Resident #99's roommate (Resident #39) on 3/24/25 and she had also been positive for COVID. She said the facility decided to branch out and do more testing today (3/25/25) because they did not have a known source of COVID exposure for Resident #99. The DON reported they had decided to test all of the residents on C hall. She said when additional residents on C hall (Residents #91, #43, #9, and #45) tested positive, they decided to test the NA assignment from yesterday (3/24/25), which was split between C and W hall. She said the residents at the top of W hall were tested and 2 residents (Resident #16 and #70) were positive. She was not sure if they had tested all the residents on W hall.
An interview was conducted with the Administrator on 3/25/25 at 5:44 PM. The Administrator said she felt like what the facility

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was doing was working to mitigate the facility's COVID outbreak. Even though there was a positive COVID resident located on C hall (C10B) and W hall (W4), the Administrator reported she thought the new COVID cases on C hall and W hall were a separate outbreak from the original outbreak because there had been 5 days since the last COVID case had been identified. She said they had more staff who had been tested but did not have an official log of who. The Administrator said she had spoken with the HD Nurse by phone this afternoon but had not spoken to anyone at the HD before today. The Administrator indicated she had emailed the HD Nurse on 3/11/25 that the facility had COVID cases and then she had followed back up with her today. The Administrator reported that she was not sure what happened that the HD Nurse had not received the email on 3/11/25. The Administrator indicated that when she spoke with the HD Nurse today, she gave the HD Nurse all the information and discussed the facility's thought process for contact tracing. She reported she explained the facility rational with how they had identified and tracked the positive COVID cases and had explained what they had been doing. The Administrator reported the HD Nurse was comfortable with what the facility was doing and what they were doing for staff.

A report dated 3/26/25 from the HD Nurse was provided after she had talked to the facility on 3/25/25. The report indicated the facility's positive COVID cases from 3/11/25 through 3/16/25 on halls F, K, S had been discussed and the cases from 3/22/25 through 3/25/25 on halls W and C had been discussed. The report did not include the positive case that occurred on C hall on 3/15/25 or W hall on 3/17/25. The report indicated

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corrective actions identified were facility masking and testing staff. The HD nurse indicated that the facility Administrator had contacted her on the morning of 3/26/25 with updated information that additional C hall residents and one resident on F hall had tested positive. The HD nurse indicated the facility was conducting facility wide testing of all staff and residents going forward. The HD nurse reported that the facility planned to test all residents and staff twice weekly going forward, until there were no new cases for 14 days.

An interview was conducted on 3/31/25 at 1:49 PM with the Medical Director. The Medical Director indicated that since the end of the pandemic the CDC guidance was not as clear and not as distinct. He stated the CDC tried to establish the standard of practice. He said who to test, when to test, and how long to test afterwards was not clear cut. He reported the CDC was not as clear as they could be and that it was hard to keep up with the guidance for a little while with all the changes and there was a lot of confusion about the requirements and standard of care and what that should be. He said the facility was following its policy whether it was correct or not he was not sure, but it was a corporate policy. He thought broad based testing should be used if there was a significant outbreak. He said for him a significant outbreak would be 2 or more cases and indicated the facility outbreak that started on 3/11/25 was significant. He explained the only way to find asymptomatic people that were COVID positive would be to test the asymptomatic people. The Medical Director stated asymptomatic individuals could still be infectious and pass the virus. The Medical Director further stated, if there was a significant outbreak the facility should follow their testing

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policy to identify individuals who were COVID positive and isolate people. He reported there was not a lot of testing that had been going on since 3/11/25 and that the broad-based COVID testing was not being done. The Medical Director said there were a few residents who had gone to the hospital due to COVID symptoms. He reported Resident #99 had gone to the hospital for evaluation on 3/21/25 after a fall and had tested positive for COVID at the hospital on 3/22/25. The Medical Director indicated the residents were okay, there were no deaths, and the residents were treated with antivirals.

Additional COVID testing logs for residents and staff were provided on 3/31/25 by the Administrator. The Administrator indicated the COVID testing logs included staff and Residents who were tested due to possible exposure. The COVID testing log and daily staff schedules were reviewed. There were no therapy staff, except for the Speech Therapist listed on the COVID testing log.

Nurse #3 worked on:
3/11/25, 3/15/25, 3/17/25 on F hall, K hall, S hall
3/16/25 and 3/20/25 on B hall
A negative COVID test was documented on 3/11/25 and 3/13/25. There was no additional testing for exposure documented for Nurse #3.

NA #3 worked on:
3/9/25 on halls B, W, and S
3/11/25 on halls K and S
3/18/25 on halls C, W, and S
There was no documentation of COVID testing for NA #3

Medication Aide #1 worked on:

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F 880	Continued From page 21 3/11/25, 3/15/25, 3/16/25, 3/17/25 on halls F, K, and S 3/14/25 on halls F and K 3/19/25 on halls B and W A negative COVID test was documented on 3/20/25 but no prior testing was documented for Medication Aide #1. Nurse #4 worked on: 3/11/25 and 3/13/25 on halls F, K, and S There was no documentation of COVID testing for Nurse #4 NA #4 worked on: 3/11/25, 3/12/25, and 3/13/25 on halls F and K There was no documentation of COVID testing for NA #4 Medication Aide #2 was also an NA and worked on: 3/11/25 and 3/15/25 on halls F, K, and S (Medication Aide) 3/12/25 on halls B and W (NA) 3/13/25 and 3/16/25 on halls W and S (NA) 3/17/25 on hall S (NA) There was no documentation of COVID testing for Medication Aide #4 Nurse #5 worked on: 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, 3/17/25 on halls W, C, and S. There was no documentation of COVID testing for Nurse #5 Medication Aide #3 worked on: 3/9/25, 3/13/25, 3/14/25, 3/17/25 on halls F, K, and S. There was no documentation of COVID testing for Medication Aide #3	F 880		

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F 880	Continued From page 22 NA #5 worked on: 3/12/25 on hall S 3/17/25 on halls F and K There was no documentation of COVID testing for NA #5 Medication Aide # 4 also worked as a NA and worked on: 3/9/25 and 3/16/25 on halls F, K, and S (Medication Aide) 3/10/25 on halls C and E (NA) 3/11/25 on halls B and W 3/13/25 on halls C and W A negative COVID test was documented on 3/11/25 but no additional testing was documented for Medication Aide #4. NA #6 worked on: 3/10/25 and 3/15/25 on halls F, K, and S 3/9/25 on halls F and K There was no documentation of COVID testing for NA #6 NA #7 worked on: 3/10/25 on halls F and K 3/12/25 on hall B 3/15/25 on halls C, W, and S. There was no documentation of COVID testing for NA #7 Nurse #10 worked on: 3/10/25 on halls F and K 3/11/25, 3/12/25, and 3/16/25 on halls W, C, and S 3/13/25 on halls F, K, and S A negative COVID test was documented on 3/16/25 but no prior testing was documented for Nurse #10	F 880		

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F 880	Continued From page 23 NA # 8 worked on: 3/10/25 on hall S 3/11/25 on halls A and E 3/12/25 on hall C 3/14/25 on halls F and K 3/15/25 on halls W and S 3/16/25 and 3/17/25 on halls A and E And 3/18/25 on halls K and S There was no documentation of COVID testing for NA #8 NA #9 worked on: 3/12/25 on halls W and S 3/14/25 on halls S, W, And C 3/15/25 on halls C and E 3/16/25 on halls A, E, and C There was no documentation of COVID testing for NA #9 A follow-up interview with the Administrator was conducted on 3/31/25 at 11:04 AM. The Administrator said the original resident COVID testing log provided on 3/24/25 was for the initial exposure testing. She explained the facility had also tested the residents on halls F, K, and S two more times after the initial 1, 3, and 5-day testing. She reported the original testing log provided was not clear, she said there were a couple different formats people were using, and they were tracking things differently and that needed to be merged. She said the residents were tested again on 3/18/25 and 3/20/25. When asked why the testing was not included in the log originally provided, she said the information had been kept in different places by several different staff. The Administrator said the facility had a transition of management roles and that was why they did not have a clear and concise list of who was tested	F 880		

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and how things were monitored. The Administrator stated historically she had kept up the COVID testing log but that as things progressed the DON and SDC had started tag teaming that. She reported they had to sit down and get everything on one comprehensive list. The Administrator indicated the facility had tested staff due to symptoms and exposure from working on units that had COVID positive residents because they were not masked. She said most staff who worked on halls F, K, and S were tested. She stated the facility tested staff for exposure on days 1, 3, and 5. The Administrator said some staff had not been tested and had not had repeat testing depending on their work schedule, such as if it was a part time or as needed staff member that did not work again for a while. She said some staff were not tested because they were beyond the exposure risk time frame when they returned to work. The Administrator reported she wanted to do what was best and felt like they had been following their systems and processes for doing that.

An interview was conducted with the PA on 3/31/25 at 4:46 PM. She reported her symptoms had started on 3/8/25 and she had tested positive on 3/12/25. The PA said she had last been at the facility on 3/7/25. The PA stated the facility had not asked her what residents she had seen on 3/7/25 but that they could determine that. The PA explained she always emailed a list of all the residents she saw every day she was at the facility and said the facility would have the list of who she saw from 3/7/25. The PA said she notified the facility when she tested positive on 3/12/25.

A follow-up interview was conducted with the

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DON on 4/1/25 at 3:30 PM. The DON explained the testing for staff had not been logged because several individuals were involved in testing and the information had not been compiled. She reported some of the staff had not been tested who had worked on the exposed units because they had been following their policy and had only been testing staff who had symptoms. She explained the policy was a corporate policy and she had assumed it aligned with the CDC recommendation. The DON had not been aware that NA #2 who tested positive for COVID on 3/16/25 had worked on 3/15/25 on halls S and W. She agreed that the residents residing on W hall should have been tested due to exposure if NA#2 had worked on the hall.

B. A facility policy entitled COVID response program dated as last approved on 2/2025 read in part:

"Source control is recommended: Universal source control is not required but is recommended when a person has suspected or confirmed COVID infection or other respiratory infection; or had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with COVID infection, for 10 days after their exposure; or resides or works on a unit or area of the facility experiencing a COVID outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or has otherwise had source control recommended by public health authorities."

On 3/23/25 at 9:45 AM upon entry to the facility an observation was conducted of the reception desk and lobby area. There was visual signage at

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the entrance that said masks were encouraged. The receptionist greeted the survey team and was not wearing a mask.

An observationon 3/23/ 25 at 11:03AM was conducted of the central nursing station. There was an opened box of surgical masks available on the nursing station desk.

An observation was conducted on 3/23/25 at 11:05 AM of F hall. Room F1 was observed to have a transmission-based precautions sign on the outside of the room door. There was a cart located outside of the room with N95 masks, gowns, gloves, and eye protection. NA #10 was observed on the hall she was not wearing a mask.
An interview was conducted with NA #10 on 3/23/25 at 11:07 AM. She explained Resident #106 in room F1 was on transmission-based precautions for COVID. NA #10 said staff did not have to wear a face mask unless they were going into a COVID positive room. She said staff had to wear an N95 mask if they went into a COVID positive room.

An interview and observation were conducted on 3/25/25 at 9:03-9:05 AM of Nurse #11 at the medication cart on F hall preparing medications. She was observed entering and exiting room F8. Nurse #11 was not wearing a mask. She stated she was the assigned nurse for halls F, K, and S. Nurse #11 explained face masks were optional for staff and were not required. There was not a known COVID positive resident on her halls today but Resident #364 on F hall tested positive for COVID on 3/25/25.

An observation was conducted on 3/23/25 at

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11:30 AM of K hall. Resident #52 in room K10 was observed to have a transmission-based precautions sign on the outside of the room door. There was a cart located outside of the room with N95 masks, gowns, gloves, and eye protection.

An observation was conducted on 3/24/25 at 9:10 AM for C hall. Resident #15 in room C10B was observed to have a transmission-based precautions sign on the outside of the room door. There was a cart located outside of the room with N95 masks, gowns, gloves, and eye protection. Nurse #10 was observed in the hallway at the medication cart preparing medications. Nurse #10 was not wearing a face mask.

An interview and observation were conducted with Nurse #10 on 3/24/25 at 9:15 AM. Nurse #10 said she was assigned to halls W, S, and C hall (rooms C1-C6). She explained Resident #15 in room C10 B was on transmission-based precautions for COVID. Nurse #10 said staff were not required to wear a mask, except for when they went into a COVID positive room. She reported staff needed to wear an N95 when going into COVID positive rooms. Nurse #10 stated no one had mentioned that since there was a COVID outbreak in the facility staff needed to wear a mask, she said masks were optional at staff discretion.

An interview and observation were conducted with Housekeeper #1on 3/24/25 at 10:09 AM. She was not wearing a face mask and was exiting room C8 (a non-transmission-based precaution room). Housekeeper #1 said she had not been told by anyone at the facility to wear a facemask. She explained if you wanted to wear one you could but that it was optional as far as

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she knew. Housekeeper #1 said if you went into a COVID positive room you had to wear a N95 mask. There was a known COVID positive resident on C hall.

An observation and interview were conducted on 3/24/25 at 10:35 AM of NA #12. She was observed on the C hall entering room C6 (a non-transmission-based precautions room). NA #12 was not wearing a face mask. She explained she was assigned NA for C hall today, including C10 which was the COVID positive room. NA #12 reported she was aware of the COVID outbreak in the building but said no one at the facility had told her she needed to wear a face mask. NA #12 said she had not seen that many people wearing face masks and had assumed face masks were optional unless she was going into a COVID positive room. She reported an N95 mask was required when you went into a COVID positive room.

An observation was conducted on 3/25/25 at 8:36 AM of the Activity Director entering room C2 delivering a breakfast tray, she was not wearing a mask. There were COVID positive residents on the C hall.

An observation was conducted on 3/24/25 at 9:41 AM of W hall. Resident #93 in room W4 was observed to have a transmission-based precautions sign on the outside of the room door. There was a cart located outside of the room with N95 masks, gowns, gloves, and eye protection.

An interview and observation were conducted with NA #11 on 3/24/25 at 10:27 AM. NA #11 was observed on W hall and was not wearing a mask. NA #11 stated she was assigned to halls W and S

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today. She thought if COVID was in the building then staff should wear a mask but said no one had told her she needed to wear a face mask. NA #11 reported if she went into a COVID positive room she would need to wear an N95. There was a known COVID positive resident on W hall.

An interview and observation were conducted on 3/24/25 at 10:30 AM with NA #15. She was observed on W hall but said she was assigned to halls S and K today. NA #15 was observed wearing an N95 mask. She explained she was wearing an N95 mask because residents sometimes coughed in her face and COVID was going around. She said she preferred to wear the N95 mask for extra protection to keep from getting sick because of her kids. NA #15 stated no one at the facility had told her to wear a mask, she said it was optional to wear a mask unless you went into a COVID positive room. She said an N95 mask was required if going into a COVID positive room. There was a COVID positive resident on W hall.

An observation and interview were conducted on 3/25/25 from 9:55 AM to 10:02 AM with Care Assistant #1. She was observed on the W hall passing ice water to residents. She was observed entering rooms W1, W2, and W3 to provide ice water. Care Assistant #1 was not wearing a mask. She reported masks were not required unless they went into a COVID positive room. There was a known COVID positive resident on W hall.

An observation was conducted on 3/24/25 at 10:20 AM of the central nursing station. The central nursing station was located at the center of the facility connecting halls W, C, F, and B.

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The Unit Clerk was observed sitting at the nursing stations not wearing a mask. Nurse #10 was also, observed sitting at the nursing station not wearing a mask.

An interview was conducted on 3/24/25 at 10:21 AM with the Unit Clerk at the central nursing station. The Unit Clerk said staff had to wear an N95 mask if going into a COVID positive room but otherwise face masks were optional.

An observation was conducted on 3/24/25 at 10:41 AM of NA #13 entering room E6 (a non-transmission-based precautions room). NA #13 was not wearing a face mask. There were not COVD positive residents on E hall.
An interview was conducted on 3/24/25 at 1:35 PM with NA #13. She reported no one from the facility had told her she needed to wear a face mask and that masks were optional unless they went into a COVID positive room.

An interview was conducted with NA #14 on 3/24/25 at 3:24 PM. She was observed in Room E1 (a non-transmission-based precautions room) she was not wearing a mask. NA #14 stated she had asked specifically if she needed to wear a face mask and was told it was optional. She could not remember the name of who she had asked but said it was another NA.

An interview and observation were conducted with NA #8 on 3/24/25 at 1:45 PM. She was observed on the A hall. NA #8 was not wearing a face mask. NA #8 said no one had told her she needed to wear a face mask. She reported masks were only required if going into a COVID positive room. There were not COVID positive residents on her hall today.

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An interview was conducted on 3/24/25 3:52 PM with the Director of Nursing (DON). The DON reported there was not a requirement for staff to wear a face mask during the outbreak. She reported staff only had to wear a mask if going into a room that was COVID positive. The DON explained the facility was following their COVID policy and the policy said face masks were not required.

An interview was conducted on 3/25/25 at 2:43 PM with the HD Nurse. The HD Nurse stated everyone needed to be wearing a face mask for source control because the facility was in outbreak status. She reported that if masks were not being used for source control there could be more exposures. The HD Nurse said as soon as the facility had additional positive cases on serial testing, they should have implemented wearing masks for source control. The HD Nurse explained if the facility was doing everything right and wearing masks after 5 days, they most likely would not continue to see more cases.

An interview was conducted on 3/25/25 at 5:44 PM with the Administrator. She explained staff were not required to wear face masks for source control during an outbreak. She reported that the facility was following their COVID policy and that the policy said face masks were recommended but not required for source control during an outbreak.

An interview was conducted with the Medical Director on 3/31/25 at 1:49 PM. The Medical Director said he thought the employee's wearing masks for source control was a good concept to do. He said if he developed the policy, employee

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masks should be required. The Medical Director said when the outbreak had first begun, he had asked about masks and was told it was company policy that masks were recommended but not required. He did not say who he had talked to about the masks. He reported there was a fine line between required and recommended and his normal practice would be to mask everyone for a certain amount of time. The Medical Director reported he wore a mask in the facility and when he saw patients and he was surprised to see everyone was not wearing a mask. He said he wore a mask because he did not want to get COVID, and he thought it was reasonable. The Medical Director said the facility was living up to its policy whether it was correct or not he was unsure, but it was a corporate policy.

A follow up interview was conducted on 3/25/25 at 5:44 PM with the Administrator and she reported she had just spoken to the HD Nurse today about the facility's outbreak prior to the interview. She reported the HD had been fine with everything the facility had been doing once she had explained it all to them. She said the only recommendation the HD really had was if the facility continued to have positive cases they should consider implementing universal masking for source control.

A report dated 3/26/25 from the HD Nurse was provided after she had talked to the facility on 3/25/25. The report indicated corrective actions identified were facility masking and testing staff.

A follow-up interview was conducted on 4/1/25 at 3:30 PM with the DON. She reported she was sure she had spoken to the Medical Director about the facility COVID outbreak. She stated she

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did not remember the details of what was said. The DON did not recall any recommendations that may have been given by the Medical Director for the COVID outbreak.

C. A facility policy entitled "COVID Evaluating Health Care Personnel for Return to Work" dated as last approved on 12/2024 read in part: "Healthcare personnel (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
-Symptomatic persons: Isolation can be discontinued at least 5 days after symptom onset (day 0 is the day symptoms appear, and day 1 is the next full day thereafter) if fever has resolved for at least 24 hours (without taking fever reducing medications) and other symptoms are improving. Loss of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation.
-Asymptomatic persons: Isolation can be discontinued at least 5 days after the first positive viral test (day 0 is the date the specimen was collected for the positive test, and day 1 is the next full day thereafter)
-A surgical mask should be worn around resident, staff, visitors and vendors through day 10.
-According to the CDC a test-based strategy may be used to remove a mask sooner, however, it is our policy for staff to wear a mask for the full 10 days.
- if symptoms recur or worsen, the isolation period should restart at day 0.
-In certain high-risk congregate settings that have high risk of secondary transmission, CDC recommends a 10-day isolation period for residents. Isolation may be shortened to 7 days under certain conditions."

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"HCP who are moderately ill and not moderately or severely immunocompromised:
-Isolation and precautions can be discontinued 10 days after symptom onset (day 0 is the day symptoms appeared, and day 1 is the next full day thereafter."

"HCP who are severely ill and not moderately or severely immunocompromised:
- Isolation should continue for at least 10 days after symptom onset (day 0 is the day symptoms appeared, and day 1 is the next full day thereafter.
- Some people with severe illness may remain infectious beyond 10 days. This may warrant extending the duration of isolation and precautions for up to 20 days after symptom onset and after resolution of fever for at least 24 hours (without taking fever-reducing mediations) and improvement of other symptoms.
-Serial testing prior to ending isolation can be considered in consultation with infectious disease experts."

"HCP who are moderately or severely immunocompromised regardless of COVD symptoms:
- May remain infectious beyond 20 days. For these people, CDC recommends an isolation period of at least 20 days and ending isolation in conjunction with serial testing and consultation with an infectious disease specialist to determine the appropriate duration of isolation and precautions."

"Contingency capacity strategies to mitigate staffing shortages:
-When staffing shortages are anticipated,

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healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. Hiring new staff, agency use, bonus incentives, and adjusting work schedules should be attempted prior to implementing contingency or crisis staffing."

"Allowing HCP with COVID infection who are well enough and willing to work to return to work as follows:
-HCP with mild to moderate illness who are not moderately to severely immunocompromised: At least 5 days have passed since symptoms first appeared (day 0), and at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms have improved.
-HCP who were asymptomatic throughout their infection and area not moderately to severely immunocompromised: At least 5 days have passed since the date of their first positive viral test (day 0)."

"Crisis capacity strategies to mitigate staffing shortages staffing:
-When staffing shortages occur, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care: implement regional plans to transfer patients with COVID to designated healthcare facilities, or alternate care sites with adequate staffing. If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have

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COVID infection, if they are well enough and willing to work."

The CDC guidance for "Interim Guidance for Managing Healthcare Personnel (HCP) with COVID (SARS-CoV-2) Infection or Exposure to SARS-CoV-2" last updated March 18, 2024, read in part:
"Return to Work Criteria for HCP with SARS-CoV-2 Infection
The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immuno-compromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and
-At least 24 hours have passed since last fever without the use of fever-reducing medications, and
-Symptoms (e.g., cough, shortness of breath) have improved.

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*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:
- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).
*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
-At least 10 days and up to 20 days have passed since symptoms first appeared, and
-At least 24 hours have passed since last fever without the use of fever-reducing medications, and
-Symptoms (e.g., cough, shortness of breath) have improved.
-The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.
The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immuno-compromising conditions should be considered when

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determining the appropriate duration for specific HCP.

HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.
-Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work."

The facility's list of COVID positive staff was reviewed with the DON during an interview on 3/24/25 at 3:52 PM and revealed: There were no documented negative COVID tests on day 5 and day 7 prior to the staff members returning to work.

- On 3/11/25 Nurse #1 tested positive for COVID. Nurse #1 was working on F hall, K hall, S hall (S1-S14) 3/11/25 and was sent home when she tested positive. The DON reported Nurse #1 symptoms started on 3/8/25 and she returned to work on 3/14/25 which was 6 days after the onset of her COVID symptoms. She worked on F hall, K hall, and S hall when she returned to work on 3/14/25.

-On 3/11/25 Nurse #2 tested positive for COVID. Nurse #2 last worked on 3/10/25 on F hall, K hall, and S hall. The DON reported Nurse #2's symptoms started on 3/10/25 and she returned to work on 3/16/25 which was 6 days after the onset of her COVID symptoms. She worked on F hall, K hall, and S hall when she returned to work on

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3/16/25.

- On 3/11/25 the Speech Therapist tested positive for COVID. The Speech Therapist was working on 3/11/25 and was sent home when she tested positive. The DON reported the Speech Therapist symptoms started on 3/9/25. The Speech Therapist last worked on 3/7/25 and saw residents on F hall, K hall, S hall, and B hall. She returned to work on 3/14/25 which was 5 days after the onset of her COVID symptoms. She worked with Residents residing on F hall, K hall, S hall, and B hall when she returned to work on 3/14/25.

-On 3/12/15 the PA tested positive for COVID. The PA saw residents last at the facility on 3/7/25. The DON reported the PA's symptoms began on 3/8/25. The PA returned to the facility to see residents on 3/14/25 which was 6 days after the onset of her COVID symptoms.

On 3/13/25 NA #1 tested positive for COVID. NA #1 last worked on 3/7/25 on F hall and K hall. The DON reported NA #1's symptoms started on 3/10/25 and he returned to work on 3/18/25 which was 8 days after the onset of his COVID symptoms. He worked on F hall and K hall when he returned to work on 3/18/25.

-On 3/16/25 NA #2 tested positive for COVID. NA #2 last worked on 3/14/25 on F hall and K halls. Additionally, she worked 3/15/25 on S hall and W hall. The Administrator reported NA #2's symptoms started on 3/16/25. She returned to work on 3/23/25, which was 7 days after the onset of her COVID symptoms. She worked on C hall, W hall, and S hall when she returned to work on 3/23/25.

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-On 3/17/25 the MDS Nurse tested positive for COVID. The DON reported the MDS Nurse last worked on 3/16/25 and her symptoms started on 3/16/25. The DON reported the MDS Nurse returned to work on 3/23/25 which was 7 days after the onset of her COVID symptoms.

An interview was conducted with the HD Nurse on 3/24/25 at 2:43 PM. The HD Nurse reported typically the earliest COVID positive staff could return to work was after day 7, if they had a negative COVID test on day 5 and 7. She said for crisis staffing there was something where staff could come back earlier at 5 days but usually the facility would have a discussion with the HD about that if they had crisis staffing. She reported if it was a clinical staff member they should only be assigned to take care of COVID positive residents, would need to break alone, and wear an N95 for the entire shift. She said if a facility was going to bring staff back early a conversation was usually had. She said she would have asked the facility about agency staffing if the facility had reached out and provided resources if the facility was having staffing issues. She reported a facility may let "a person" back early but not a lot of people. She said staff who were COVID positive coming back early could increase the spread.

An interview was conducted with the DON on 3/24/25 at 3:52 PM. The DON explained staff were allowed to return to work 5 days after testing positive for COVID or the onset of symptoms. She said staff who returned to work after COVID had to wear a mask through day 10. The DON said the facility did not test staff again for COVID to see if they had a negative test before they returned to work. The DON reported that the

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facility policy said staff could return to work after 5 days and that was what they were following. The DON said the facility was using the contingency plan for staff to return to work listed under contingency staffing in the facility's return to work policy. The DON said the facility did not have a specific contingency staffing plan she was aware of except what was listed in the return-to-work policy.

A follow up interview was conducted with the DON on 4/1/25 at 3:30 PM. The DON stated the facility followed had been following their return-to-work policy for staff who were COVID positive, and the policy had said they could return after 5 days. The DON explained the policies were corporate policies and she had assumed they were correct and followed CDC recommendations.

An interview with the Administrator was conducted on 3/24/25 at 5:44 PM. The Administrator said the facility was following its return-to-work policy for COVID positive staff. She reported under contingency staffing in the policy the facility allowed COVID positive staff to return to work after 5 days and wear a mask through day 10. The Administrator indicated the facility needed the two nurses and three NAs who had tested positive to return to work even though the facility used agency nurses and NAs to supplement their staffing. The Administrator said the Speech Therapist was also considered critical staff and needed to return to work because she was the only Speech Therapist. The Administrator did not provide a copy of the contingency staffing plan the facility was using.

An interview was conducted with the Corporate

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Nurse on 3/25/27 at 6:25 PM. She reported she was not aware the facility had been doing contingency staffing to allow COVID positive staff to return to work. She stated the facility had not reached out to her and let her know they had been using contingency staffing. She stated no one was using crisis or contingency staffing anymore.

An interview was conducted with the Medical Director on 3/31/25 at 1:49 PM. The Medical Director said the CDC tried to establish a standard of care. He reported the facility should follow their policy. He said the facility policies were corporate policies, but they should align with the CDC guidance.

D. On 3/24/25 the facility was asked to provide the infection control policies used by the facility for the management of the facility's COVID outbreak. The facility provided a policy entitled "COVID evaluating healthcare personnel for return-to-work" dated as last approved on 12/2024 and a "COVID response program" policy dated as last approved on 2/2025.

A facility policy entitled "COVID Evaluating Health Care Personnel for Return to Work" dated as last approved on 12/2024 read in part:
"Healthcare personnel (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
-Symptomatic persons: Isolation can be discontinued at least 5 days after symptom onset (day 0 is the day symptoms appear, and day 1 is the next full day thereafter) if fever has resolved for at least 24 hours (without taking fever reducing medications) and other symptoms are

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improving. Loss of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation.
-Asymptomatic persons: Isolation can be discontinued at least 5 days after the first positive viral test (day 0 is the date the specimen was collected for the positive test, and day 1 is the next full day thereafter)
-A surgical mask should be worn around resident, staff, visitors and vendors through day 10.
-According to the CDC a test-based strategy may be used to remove a mask sooner, however, it is our policy for staff to wear a mask for the full 10 days.
- if symptoms recur or worsen, the isolation period should restart at day 0.
-In certain high-risk congregate settings that have high risk of secondary transmission, CDC recommends a 10-day isolation period for residents. Isolation may be shortened to 7 days under certain conditions."

"HCP who are moderately ill and not moderately or severely immunocompromised:
-Isolation and precautions can be discontinued 10 days after symptom onset (day 0 is the day symptoms appeared, and day 1 is the next full day thereafter."

"HCP who are severely ill and not moderately or severely immunocompromised:
- Isolation should continue for at least 10 days after symptom onset (day 0 is the day symptoms appeared, and day 1 is the next full day thereafter.
- Some people with severe illness may remain infectious beyond 10 days. This may warrant extending the duration of isolation and precautions for up to 20 days after symptom

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onset and after resolution of fever for at least 24 hours (without taking fever-reducing mediations) and improvement of other symptoms.
-Serial testing prior to ending isolation can be considered in consultation with infectious disease experts."

"HCP who are moderately or severely immunocompromised regardless of COVD symptoms:
- May remain infectious beyond 20 days. For these people, CDC recommends an isolation period of at least 20 days and ending isolation in conjunction with serial testing and consultation with an infectious disease specialist to determine the appropriate duration of isolation and precautions."

"Contingency capacity strategies to mitigate staffing shortages:
-When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. Hiring new staff, agency use, bonus incentives, and adjusting work schedules should be attempted prior to implementing contingency or crisis staffing."

"Allowing HCP with COVID infection who are well enough and willing to work to return to work as follows:
-HCP with mild to moderate illness who are not moderately to severely immunocompromised: At least 5 days have passed since symptoms first appeared (day 0), and at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms have

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improved.
-HCP who were asymptomatic throughout their infection and area not moderately to severely immunocompromised: At least 5 days have passed since the date of their first positive viral test (day 0)."

"Crisis capacity strategies to mitigate staffing shortages staffing:
-When staffing shortages occur, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care: implement regional plans to transfer patients with COVID to designated healthcare facilities, or alternate care sites with adequate staffing. If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have COVID infection, if they are well enough and willing to work."

The CDC guidance for "Interim Guidance for Managing Healthcare Personnel (HCP) with COVID (SARS-CoV-2) Infection or Exposure to SARS-CoV-2" last updated March 18, 2024, read in part:
"Return to Work Criteria for HCP with SARS-CoV-2 Infection
The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immuno-compromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP

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should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and
-At least 24 hours have passed since last fever without the use of fever-reducing medications, and
-Symptoms (e.g., cough, shortness of breath) have improved.
*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:
- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).
*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

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F 880	Continued From page 47 HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: -At least 10 days and up to 20 days have passed since symptoms first appeared, and -At least 24 hours have passed since last fever without the use of fever-reducing medications, and -Symptoms (e.g., cough, shortness of breath) have improved. -The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction. The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immuno-compromising conditions should be considered when determining the appropriate duration for specific HCP. HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. -Use of a test-based strategy (as described below) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work." A facility policy entitled COVID response program dated as last approved on 2/2025 read in part: "Source control is recommended: Universal source control is not required but is	F 880		

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recommended when a person has suspected or confirmed COVID infection or other respiratory infection; or had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with COVID infection, for 10 days after their exposure; or resides or works on a unit or area of the facility experiencing a COVID outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or has otherwise had source control recommended by public health authorities."

The CDC guidance for "Infection Control Guidance: COVID (SARS-CoV-2)" last updated June 24, 2024, read in part:
Source control is recommended for individuals in healthcare settings who:
-Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
-Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure
Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances:
-By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
-Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients

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with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission (See Appendix)
-Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high)

An interview was conducted with the DON on 4/1/25 at 3:30 PM. The DON stated the facility followed the return-to-work policy for staff who were COVID positive, and the policy had said they could return after 5 days. She reported the facility followed its COVID response policy and the policy said masks were recommended but not required during an outbreak for source control. The DON explained the policies were corporate policies and she had assumed they were correct and followed CDC recommendations.

An interview was conducted with the Administrator on 1/8/25 at 12:24 PM. The Administrator said the facility's COVID policies were reviewed, updated, and provided by corporate. She explained that the facility followed their COVID policies from corporate for the management of the COVID outbreak.

An interview was conducted with the Medical Director on 3/31/25 at 1:49 PM. The Medical Director said the CDC tried to establish a standard of care. He reported the facility should follow their policies. He said the facility policies were corporate policies, but they should align with CDC.

The facility's Administrator was informed of the immediate jeopardy on 3/25/25 at 6:10 PM.

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F 880	Continued From page 50 The facility submitted the following credible allegation of immediate jeopardy removal. 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The facility failed to operationalize an infection control policy to manage a COVID-19 outbreak per the Center for Disease Control and Prevention (CDC). The facility failed to ensure its infection control policy and procedures were up to date with the most recent CDC recommendations. The facility failed to implement broad based testing when contract tracing failed to stop the transmission of COVID-19. The facility also failed to implement source control during a COVID-19 outbreak that started on 03/11/25 and continues through present 03/25/25. The COVID-19 outbreak has currently affected 7 staff members and 19 residents. The facility also failed to implement the current CDC guidelines for staff returning to work after COVID-19. All current residents and staff have the potential to be affected by alleged deficient infection control practices. On 3/12/2025, Resident #42 tested positive for COVID-19. Resident #42 was noted with a change of condition following a fall and noted with shortness of breath and sent to the hospital for evaluation and treatment per Medical Doctor (MD) order. Resident #42 was admitted to	F 880		

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hospital with diagnosis of Mechanical Fall, Acute Hypoxic Respiratory Failure secondary to Covid and Paroxysmal A-Fib with RVR. Resident #42 received appropriate medical care and was discharged back to the facility on 3/18/2025 in stable condition and continues to be monitored for complications related to COVID-19 infection.

On 3/16/2025, an additional resident (Resident #363) was sent to the hospital related to abdominal pain and shortness of breath per MD order which tested positive for COVID-19 while at hospital. Resident #363 had negative COVID-19 test on 3/14/2025 and 3/15/2025. Resident #363 was admitted to hospital and treated for COVID-19 infection and Colon Cancer. Resident #363 was discharged to home from hospital on 3/22/2025.

The Director of Nursing completed an audit on 3/25/25 of all current employees that were working. The audit revealed that no employees were currently working where at least 7 days had not passed since their first symptoms, that they had been 24 hours without fever without the use of fever reducing medications, and symptoms had improved.

There is a total of 7 staff which have tested positive COVID-19 between 3/11/2025 and 3/17/2025. There are 19 total residents which have tested positive for COVID-19 since testing began on 3/11/2025 including 7 additional residents who tested positive for COVID 19 on 3/25/2025. No other COVID-19 positive staff has been identified since from testing on 3/25/2025. 3 of 7 staff who tested positive for COVID-19 are up to date with current COVID-19 vaccination. 6 of 19 residents which tested positive for COVID-19

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are up to date with current COVID-19 vaccination.

There are a total of 11 staff members currently up to date with COVID-19 vaccinations and 59 residents currently up to date with COVID-19 vaccinations.

All current residents who have tested positive for COVID-19 were seen and/or treated by facility Medical Director or Nurse Practitioner on day positive test noted or the following day post positive test result. Additionally, any resident who was symptomatic with a negative COVID-19 test was seen within 24 hours of the onset of symptoms.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On March 25, 2025, the Director of Nursing initiated broad-based COVID-19 testing for all residents and staff to identify and isolate positive cases after the Administrator and Director of Nursing consulted with the local health department.

All residents who tested positive were placed on transmission-based precautions with personal protective equipment in place to include N-95 masking by the Director of Nursing immediately following identification of positive test result. The results of COVID-19 testing on 03/25/25 identified an additional 7 residents and 0 staff.

On March 26, 2025, the Quality Assurance Nurse Consultant updated the COVID-19 Response Program policy based on current CDC guidance

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provided by the local health department. Changes included: updating masking recommendations during an outbreak to reflect CDC recommendation to say masking recommended and removing " not required", defining an outbreak as two or more cases in a 14-day period, completing broad-based testing if staff are shared between units, requiring KN95, N95, or surgical masks for staff while in the facility throughout the outbreak, continued the use of N95 when in a resident room who is suspected or confirmed to have COVID-19, and encouraging residents to wear masks outside their rooms.

The Return-to-Work policy for healthcare personnel was also revised: return is allowed after 7 days with a negative viral test (taken within 48 hours before return), or after 10 days without testing. If the employee returns on day 7 they must also be 24 hours fever-free without medications, and symptoms must be improving.

Beginning March 25, 2025, no staff will be permitted to work without a negative COVID-19 test or until they have completed the requirements for return to work. Staff members who test positive may not return to work until they meet the return-to-work criteria: at least 7 days have passed since symptom onset (or date of positive test if asymptomatic), a negative viral test was obtained within 48 hours of returning to work, and at least 24 hours fever-free without the use of fever-reducing medications, and symptoms have improved. If a negative test is not obtained, staff may not return to work until 10 days have passed since symptom onset or the positive test. Any staff that tested positive must undergo a mandatory screening by the Infection Control Nurse and review by the Director of Nursing to

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confirm return to work criteria have been met. This will be completed prior to their return to work.

The local health department was updated on the outbreak by the Director of Nursing and Administrator on March 25, 2025. Based on recommendations by the health department twice-weekly COVID-19 testing will be conducted for all residents and staff who have not tested positive in the past 30 days. Testing will continue until 14 days pass with no new cases.

As of March 25, all staff are required to wear surgical masks as source control when in the facility. Staff will continue to be required to use N95 masks when caring for suspected or confirmed COVID- 19 positive residents.
On March 26, 2025, the updated policies were reviewed with the Infection Preventionist, Director of Nursing, and Administrator by the Quality Assurance Nurse Consultant

Staff Education began March 25, 2025. The Director of Nursing began staff training on the use of mask in the facility throughout the duration of the outbreak, the need for ongoing testing, and return-to-work protocols and Infection Control Response Policies. This education is mandatory for all staff, including agency personnel. The Director of Nursing will ensure that any staff who does not complete education by 3/26/2025 will be allowed to work without completing this training. This education will be incorporated into new hire orientation for all staff.

The Administrator will contact the local health department weekly to review testing results and receive updated guidance.

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F 880	Continued From page 55 The DON will be responsible for ensuring the removal plan is implemented. Immediate Jeopardy Removal Date: 03/27/2025 On 4/1/25 the facility's credible allegation of immediate jeopardy removal was validated by the following: An interview with the DON was conducted on 4/1/25, and revealed all residents in the facility and all staff members at the facility were being tested for COVID. The facility identified one more COVID positive staff member and resident on 3/31/25. The DON stated that all staff had been educated on wearing a mask for source control, signed in-service logs were reviewed. She also stated that she will continue to report any new COVID positive cases to the health department. Staff on multiple hallways were observed on 4/1/25 wearing a surgical mask for source control, there were no staff members observed without a surgical mask. Interviews with staff revealed they were being tested for COVID and had received education on wearing a mask for source control. Review of staff COVID positive logs revealed the facility was following return to work policy and procedures for the staff who were COVID positive. The facility's infection control policy and procedures: "COVID evaluating healthcare personnel for return-to-work" and "COVID response program" were reviewed and were up to date with current CDC recommendations.	F 880		

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F 880	Continued From page 56 The IJ removal date of 3/27/25 was validated.	F 880		