STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165614	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Nursing Home	**1500 N Franklin Avenue , Marengo, Iowa, 52301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ OK/CP	INITIAL COMMENTS Correction date: 06/03/2026 The following deficiencies resulted from investigation of complaints #2794509-C and #2788173-C conducted May 5, 2026 to May 7, 2026. Complaints #2794509-C and #2788173-C resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but	F0880	Resident #2's clinical record, hospital discharge information, respiratory status, COVID-19 diagnosis, physician orders, and care plan were reviewed by the DON/Infection Preventionist. The resident's care plan was updated to include respiratory risk factors, monitoring requirements, and the need for Transmission-Based Precautions when COVID-19 or other communicable respiratory illness is suspected or confirmed. Resident #1 no longer resides in the facility. The facility reviewed Resident #1's clinical record, symptoms, monitoring, provider notification, hospital transfer, and COVID-19 diagnosis through QAPI to identify opportunities for improvement. Staff identified as symptomatic or COVID-19 positive will be removed from resident care and excluded from work until return to work criteria are met. All current residents were reviewed for respiratory symptoms, change in condition, oxygen changes, cough, fever, weakness, fatigue, abnormal lung sounds, or other signs of communicable respiratory illness.	06/03/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	06/03/2026

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F0880 SS = D	Continued from page 1 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 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 staff interviews, clinical record review, facility policy review, and Centers for Disease Control and Prevention (CDC) guidelines, the facility	F0880	Any resident with new or worsening symptoms will be assessed by a licensed nurse, reported to the provider, tested as indicated, placed on appropriate precautions, and monitored each shift until symptoms resolve. Any resident returning from the hospital or outside healthcare setting will be screened for infection risk before room placement and before discontinuing precautions. Residents potentially exposed to COVID-19 or another communicable respiratory illness will be monitored, tested as indicated by their provider, and placed on precautions as appropriate. The facility revised the Infection Surveillance Policy to include additional guidance for Employee Absence Notification and Return to Work Guidelines along with admission and hospital return/readmission infection screening evaluations. All staff were sent re-education message and posting in employee break room on 5/7/2026 on COVID-19 reporting requirements. Direct care staff, department managers, and HR/scheduling staff will be re-educated on Infection Surveillance Policy with emphasis on symptom reporting, resident monitoring, testing expectations, PPE, isolation precautions, contact tracing, documentation, and staff exclusion from work. A respiratory illness line list will be maintained by Infection Preventionist or designee to track resident and staff symptoms, test results, exposure status, precautions, provider notification, and return-to-work status. Infection Control Assessment (ICAR) scheduled at facility on 06/03/2026 with the Iowa HHS Health Associated Infections Nurse Clinician.	

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F0880 SS = D	Continued from page 2 failed to implement transmission based precaution procedures, monitor, and test residents with symptoms or exposure to COVID-19 virus for 2 of 4 residents reviewed for infection control. The facility failed to ensure that criteria was followed to reduce the risk of COVID-19 transmission when Resident #2 tested positive for COVID-19 on 2/19/26 at the hospital, then returned to the facility on 2/25/26 (7 days), the facility did not provide additional precautions for Resident #2 who continued to have respiratory symptoms. The facility further failed to prevent transmission of COVID-19 when 2 direct care staff reported symptoms while working of fever, body aches, cough, decreased smell/taste, and tested positive for COVID-19 at the facility on 2/24/26, both staff continued to provide direct cares and work 12 hour shifts on 3 of 3 hallways. The facility additionally failed to conduct any further testing or monitoring for additional cases of COVID-19, Resident #1 complained of excessive fatigue, anxiety and had diminished lung sounds on 2/18/26, continued with these symptoms, then was admitted to the hospital on 2/28/26 for diagnoses including COVID-19 and nursing-home acquired pneumonia. Resident #1 continued to decline and died at the hospital on 3/02/26 from chronic respiratory failure as a consequence of viral pneumonia. The facility reported a census of 50 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 2/18/26, revealed that Resident #2 had modified independence for cognitive skills in daily decision making. The list of diagnoses included acute and chronic respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), malnutrition, anxiety disorder, and history of pneumonia. Review of Resident #2's Care Plan, initiated on 2/20/24 and revised on 4/01/26, revealed a Focus area for Resident #2's risk for altered respiratory status/difficulty breathing related to COPD, history of respiratory failure, history of pneumonia, COPD exacerbation on 4/29/24, readmission following hospitalization for sepsis, acute respiratory failure, pneumonia, and recurrent hospitalization for pneumonia. Review of a Nurses Note, dated 2/18/26 at 8:32 PM, revealed the following entry: Called to resident's room by staff, resident having increased confusion, color is dusky/ashy, using accessory muscles to breath, eyes rolled back in head. Vital Signs: 144/80,	F0880	The DON/Infection Preventionist or designee will audit compliance daily for 2 weeks, three times weekly for 4 weeks, weekly for 8 weeks, and monthly for 3 months. Audits will include review of new or worsening symptomatic residents, hospital returns, admissions, new residents on precautions, new staff illness reports, contact tracing logs if indicated, precautionary PPE/isolation signage if indicated, and documentation. Audit results will be reviewed by the Administrator, DON/Infection Preventionist, Medical Director, and QAPI committee. Any concern identified will be corrected immediately through resident assessment, provider notification, initiation of precautions and staff re-education.	

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F0880 SS = D	Continued from page 3 Temperature 100.7 (degrees Fahrenheit) (normal is 98.6 to 99.6 degrees Fahrenheit), 84% oxygen saturation (normal is greater than 90%) while on 4 liters (L) of oxygen per nasal cannula, pulse 136 beats per minute (bpm), (normal is 60-100 bpm). Spoke with the physician and obtained an order to have the Resident transferred to the hospital to be evaluated. Called the family to inform them of the resident's condition and transfer. Review of a Nurses Note, dated 2/19/26 at 1:53 AM, revealed an entry that an update was received from the hospital, reporting that Resident #2 had septic shock due to respiratory illness. The Note documented that Resident #2 was COVID-19 positive and admitted to the hospital for intravenous (IV) antibiotics. Review of a Nurses Notes revealed the following entries, in part: On 2/25/26 at 11:50 AM, Resident #2 returned to the facility on 2 L of oxygen, and was noted to have a productive cough. On 2/26/26 at 12:21 AM, Resident #2 was receiving skilled care with Physical Therapy (PT) and Occupational Therapy (OT) post hospital stay for COVID-19 infection and pneumonia. Resident #2 continued taking antibiotics x3, had occasional loose cough, productive at times, and lung sounds noted with expiratory wheeze to lower right lobe. On 2/27/26 at 1:49 PM, Resident #2 up per usual self and ambulating in hallway. On 2/27/26 3:46 PM, Resident Lung sounds with expiratory wheezes. On 3/01/26 at 10:41 AM, Resident #2 continues on antibiotics for pneumonia, noted to have a loose cough that the resident reported being productive at times with green/yellow sputum. Lung sounds noted to have diminished bases, respirations were even and unlabored, nasal cannula in place, no signs of respiratory distress, and resident denying any chest pain. Review of the Hospital Discharge Summary Notes, revealed that Resident #2 was admitted on 2/18/26 and discharged on 2/25/26 from the hospital. The hospital course revealed that Resident #2 was admitted for shock in the setting of COVID-19 infection, was weaned off pressors (powerful intravenous medications used to treat life-threatening hypotension by constricting blood	F0880		

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F0880 SS = D	Continued from page 4 vessels and increasing blood pressure to ensure adequate organ perfusion) when he arrived to the Medical Intensive Care Unit (MICU). Required ongoing respiratory support with supplemental oxygen due to Acute Hypoxemic (low level of oxygen in the blood) Respiratory Failure (AHRF). Infectious Disease (ID) was consulted for assistance with antibiotic regimen and Resident #2 was medically ready to discharge back to the facility on 2/25/26 with oral antibiotics and follow up with the physician one week post-hospitalization. Physical Exam documented productive cough with moderate amounts of thick, cream colored sputum. Laboratory results documented: high white blood cell count at 18.9, Methicillin-resistant Staphylococcus aureus (MRSA) positive result, Review of the Hospital Discharge Summary, dated 2/25/26, included a problem list of the following active problems/diagnoses: Shock, suspect septic shock in the setting of COVID-19 infection (Resolved) COVID-19 Infection History of recent Methacillin Resistant Staphylococcus Aureus (MRSA) empyema (accumulation of pus containing MRSA in the pleural space- between lung and chest wall) History of recurrent pneumonia Concern for recurrent aspiration COPD exacerbation Respiratory acidosis with metabolic compensation Leukocytosis (higher than normal white blood cell count), likely secondary to COVID-19 infection and possible pneumonia Review of Resident #2's Care Plan, identified a resolved Focus area for COVID-19 infection, date resolved on 9/24/24, which instructed to follow isolation precautions per protocol. Review of the Care Plan lacked additional documentation for COVID-19 infection following resolution of Focus area on 9/24/24. During an interview on 5/06/26 at 11:50 AM, Staff E, Licensed Practical Nurse (LPN) reported that if a resident were to have COVID-19 they would be in isolation and staff would don additional Personal Protective Equipment (PPE) during resident care.	F0880		

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F0880 SS = D	Continued from page 5 Staff E stated that Resident #2 had not been on isolation precautions upon return from the hospital on 2/25/26 due to having aspiration pneumonia. During an interview on 5/06/26 at 11:55 AM, Staff F, Registered Nurse (RN) reported that no residents have been on COVID-19 transmission based precautions (TBP) within the past year. During an interview on 5/06/26 at 2:30 PM, the Director of Nursing (DON) reported also holding the role of the facility's Infection Preventionist (IP). The DON stated that for residents positive with COVID-19 infection, TBP procedures would be implemented to prevent cross-contamination of the virus. When queried how long residents would remain in TBP procedures, the DON stated she believed it was at least 10 days and if a resident was still having symptoms, might need to continue past 10 days or may depend on a negative test. The DON confirmed that Resident #2 tested positive for COVID-19 in the hospital on 2/19/26 and returned to the facility on 2/25/26 (7 days). The DON said Resident #2 was not placed on TBP procedures upon return to the facility, due to the hospital discharge indicating COVID-19 was resolved. When asked to clarify if septic shock in the setting of COVID-19 was resolved and COVID-19 infection remained, the DON stated nursing received report from the hospital that Resident #2's COVID-19 was resolved. The DON was unable to recall if Resident #2 had negative COVID-19 testing at the hospital and denied testing Resident #2 to determine a negative COVID-19 test upon readmission. When queried about Resident #2's continued occasional loose cough producing yellow/green colored sputum and adventitious lung sounds, documented in Nurses Notes following readmission on 2/25/26, the DON stated Resident #2 had this at baseline. During an interview on 5/07/26 at 12:15 PM, the Medical Director stated Resident #2 had a long history of respiratory and pulmonary issues and was at higher risk for complications related to COVID-19 infection. 2. Review of the facility provided nursing staff schedule, dated 2/24/26, revealed the following working schedule of staff, in part: Staff A worked 6:00 AM to 2:30 PM Staff D worked 6:00 AM to 2:30 PM Staff B worked 6:00 AM to 6:00 PM	F0880		

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F0880 SS = D	Continued from page 6 Staff G worked 6:30 AM to 6:30 PM Staff C worked 10:00 AM to 10:30 PM Staff H worked 6:30 PM to 10:30 PM During an interview on 5/05/26 at 4:25 PM, Staff A, Certified Nursing Assistant (CNA), confirmed working on 2/24/26, and reported working alongside Staff B and Staff C who had respiratory symptoms and tested positive for COVID-19 during their shifts on 2/24/26. Staff A denied being asked to test for COVID-19 infection following potential exposure to COVID-19. During an interview on 5/06/26 at 10:55 AM, Staff D, CNA, recalled a couple of residents and a couple of CNA staff tested positive for COVID-19 around the same time. Staff D stated she was unsure about the facility's current guidance on what to do if staff tested positive for COVID-19 as it related to wearing a mask, testing, and staying home when sick. During an interview on 5/06/26 at 9:45 AM, Staff B, CNA, confirmed working on 2/24/26 and reported working throughout the facility on 3 of 3 hallways providing direct care to residents. Staff B recalled having symptoms of sore throat, body aches, and dizziness beginning while working her shift on 2/24/26 and reported these symptoms to Staff G, RN. Staff B revealed that Staff G gave her a COVID-19 test, which showed positive results. Staff B said Staff G told her to let management know and Staff B said she then went and reported the positive test and symptoms to the Business Office Manager(BOM)/Human Resources(HR) who indicated she would call the facility Administrator for guidance. Staff B reported that approximately 10 minutes later the BOM/HR directed Staff B to continue working her scheduled 12 hour shift on 2/24/26. Staff B stated she then called in for the following shifts scheduled to work on 2/26/26 and 2/27/26 due to symptoms and positive COVID-19 test. During an interview on 5/06/26 at 10:15 AM, Staff C, CNA, confirmed working on 2/24/26 and reported working throughout the facility on 3 of 3 hallways providing direct care to residents. Staff C recalled having symptoms of cough, congestion, and change in taste/smell worsening while working her shift on 2/24/26 and reported these symptoms to Staff G, RN, at approximately 4:00 PM. Staff C revealed that Staff G gave her a COVID-19 test, which showed positive results and was instructed by Staff G to	F0880		

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F0880 SS = D	Continued from page 7 notify management staff. Staff C revealed that she then notified BOM/HR who indicated that she would call the facility Administrator for guidance. Staff C reported that approximately 10 minutes later, the BOM/HR directed Staff C to continue working a 12 hour shift on 2/24/26, as scheduled until 10:30 PM. Staff C stated she then called in for her next scheduled shift on 2/27/26 due to fever. During an interview on 5/07/26 at 10:30 AM, Staff G, RN, confirmed working on 2/24/26 and was notified by both Staff B and Staff C of respiratory symptoms that they developed while working their shifts on 2/24/26. Staff G said she assisted Staff B and Staff C with testing for COVID-19 and stated that both Staff B and Staff C tested positive for COVID-19. Staff G said she then instructed Staff B and Staff C to go tell the office and see if they want Staff B and Staff C to continue to work. Staff G said she was told by Staff B and Staff C that they were instructed to continue working by BOM/HR. Staff G recalled that shortly after, the BOM/HR approached Staff G and told her not to mention the staff's positive COVID-19 tests. Staff G reported that on 3/02/26 she then received a write up by the DON and facility Administrator for utilizing COVID-19 tests on Staff B and Staff C. Staff G denied receiving instruction for any additional testing or monitoring of residents or staff following potential exposure. During an interview on 5/07/26 at 5:00 PM, Staff H, RN, confirmed working on 2/24/26 and stated that when she came into work at 6:30 PM, Staff B and Staff C both appeared to be ill and was informed that they both tested positive for COVID-19 and were instructed to continue working 12 hour shifts on 2/24/26. Staff H stated that the guidance for nurses was to go through Human Resources/scheduling for staff to leave early and stated she had been talked to in the past for sending staff home early. Staff H reported that she also came into the facility the following day, 2/25/26 on her day off, to ask the facility Administrator about COVID-19 positive staff and usage/availability of masks and then again brought up the positive staff who worked to the facility Administrator on 2/27/26 and Staff H said she received no answers. Staff H revealed that the facility had no current COVID-19 policies or procedures and stated there was no guidance on monitoring or testing exposed residents and/or staff. During an interview on 5/06/26 at 1:18 PM, the BOM/HR reported that when staff become ill at work, the current direction is that staff need to ask the charge nurse if they could go home and not BOM/HR to direct them. The BOM/HR confirmed	F0880		

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F0880 SS = D	Continued from page 8 that Staff B and Staff C let her know about being sick and testing positive for COVID-19. The BOM/HR denied talking to the nurse about positive tests but stated she let the facility Administrator know and was instructed to tell the DON. The BOM/HR stated she could not remember if she talked to the DON and said she did not remember any guidance received. The BOM/HR reported that when she was asked by Staff C if she should wear a mask, the BOM/HR told Staff C if she hadn't worn a mask all day, it would be up to Staff C if she wanted to wear a mask for the rest of the day. The BOM/HR stated she did not remember if Staff B and Staff C continued to work their shifts on 2/24/26 after reporting respiratory symptoms and COVID-19 positive tests. During an interview on 5/06/26 at 2:30 PM, the DON reported that employees who tested positive for COVID-19 would stay home for 7 days and the facility would do contact tracing. When queried about Staff B and Staff C testing positive at the facility on 2/24/26, the DON stated no one talked to her or left any notes about this. The DON stated that on 2/25/26, she identified a used COVID-19 test in the public bathroom trash that appeared to be negative, and no one knew anything about the test. The DON reported that staff would not be tested at the facility but would refer staff to leave or not come into work if sick and visit their provider for COVID-19 testing instead. During an interview on 5/07/26 at 1:27 PM, the facility Administrator stated that she was off work on 2/24/26 and upon return to work, word of mouth got to her that Staff B and Staff C were tested for COVID-19. The facility Administrator stated that she received many calls while off, but no calls were related to COVID-19. During an interview on 5/07/26 at 1:35 PM, the DON and the facility Administrator both deny knowledge of Staff B and Staff C testing positive for COVID-19 until Saturday or Sunday (2/28/26 or 3/01/26). The DON and facility Administrator state that there was no proof/doctor note of Staff B and Staff C testing positive for COVID-19. The DON and facility Administrator revealed the expectation that the charge nurse uses discretion to send staff home who are sick. Review of an image captured on Staff B's cellular phone, dated 2/24/26 at 3:07 PM, revealed a picture of a testing device labeled for COVID-19. The results box appeared to have a line for the control test present and a line for the COVID-19 test present,	F0880		

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F0880 SS = D	Continued from page 9 indicating that the COVID-19 test showed positive results. Review of Staff G's employee file, revealed a document titled, Coaching Form, dated 3/02/26, revealed the following description of concern: On 2/25/26, the DON found COVID-19 test kits in the bathroom trash and when Staff G was asked if she knew who had tested, Staff G stated that she had no idea. Reported by staff to DON that Staff G suggested that 2 certain employees test for COVID-19 and got them the tests from the facility stock and was present for the testing. The Coaching Form instructed the following plan of correction for COVID-19 testing: COVID-19 tests are the property of the facility. Employees are expected to purchase their own at home tests or go through their physician. The Coaching Form was signed on 3/02/26 by the DON and the facility Administrator. 3. Review of the MDS assessment, dated 2/28/26, revealed that Resident #1 had modified independence for cognitive skills in daily decision making. The list of diagnoses included respiratory failure, anemia, malnutrition, and anxiety disorder. Review of the Care Plan, initiated on 5/20/25 and revised on 11/10/25, revealed a Focus area for Resident #1's altered respiratory status/difficulty breathing related to history of pneumonia and interstitial lung disease. The Care Plan identified the following intervention: Monitor for signs and symptoms of respiratory distress and report to provider as needed: Increased respirations, decreased pulse oximetry, increased heart rate (Tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis (bloody sputum), cough, pleuritic pain, accessory muscle usage, skin color changes to blue/grey. Review of Resident #1's Nursing Notes revealed the following entries documented, in part: On 2/18/26 at 2:46 PM, Resident #1's vital signs were within normal limits. Resident complained of excessive tiredness and weakness, does not want this nurse to contact anyone (family or provider) at this time. On 2/19/26 at 7:21 AM, Resident #1's provider and family aware of reports of increased fatigue.	F0880		

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F0880 SS = D	Continued from page 10 Reviewed medication use with resident and new order for as needed Lorazepam (a benzodiazepine medication used for short-term relief of severe anxiety) which may be increasing fatigue. Resident #1 reported that she would rather have less anxiety and be a little more tired. On 2/21/26 at 2:59 PM, Resident #1's vital signs noted to be within normal limits and lung sounds had diminished sounds in the bases of lungs. On 2/24/26 at 3:11 PM, the provider at the facility for a routine 60 day visit and increased Resident #1s lorazepam from 1 milligram (mg) every 12 hours as needed to lorazepam 1mg three times a day as needed. On 2/27/26 at 3:18 PM, Resident #1 endorsed head congestion and noted with lung sounds diminished in the bases. Vital signs within normal limits. On 2/28/26 at 5:00 PM, Resident #1 noted to be more tired and weaker than usual. Resident #1 requested to eat supper in her room. On 2/28/26 at 6:20 PM, Resident #1 continued with increased weakness and anxiety, family requesting for Resident #1 to be seen at the hospital Emergency Department (ED). An ambulance arrived at 6:15 PM to transport the resident. On 3/02/26 at 12:59 PM, Resident #1 not expected to be leaving the hospital, resident receiving comfort cares. On 3/02/26 at 9:40 PM, the hospital called the facility and reported that Resident #1 had expired. Review of the Hospital Emergency Department (ED) Note, dated 2/28/26, revealed that Resident #1 had complaints of not feeling well for several weeks and noted decreased appetite, fatigue, dyspnea (difficulty breathing), orthopnea (difficulty breathing while lying flat), diarrhea, chest tightness, and nausea. Resident #1 noted a productive cough for 3 days and coryza (a medical term for an acute inflammatory, contagious disease of the upper respiratory tract). Resident #1 normally on 2 liters (L) of oxygen, her residential facility increased oxygen to 4L and Emergency Medical Services (EMS) increased it to 6L. The Hospital ED Note identified the following symptoms in a physical exam: Respiratory rate: 40 breaths per minute (normal is 12-20 breaths per minute)	F0880		

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F0880 SS = D	Continued from page 11 General: She is in acute distress (mild to moderate) Breath sounds: Rhonchi (low-pitched, rattling, or snoring-like lung sounds caused by air flowing through large airways obstructed by mucus, fluid, or inflammation) present. Tachypenic (rapid shallow breathing). Lung sounds diminished in the bases. Anxious at times with panic. The Hospital ED Note documented Resident #1 positive for SARS-COV-2 (COVID-19) virus on 2/28/26. Review of the Hospital Discharge Summary, dated 3/02/26, listed the following admission diagnoses: Principle Problem: Acute on chronic respiratory failure with hypoxia (low oxygen saturation) Nursing home-acquired pneumonia Metabolic alkalosis Severe protein-calorie malnutrition Chronic bilateral pleural effusions COVID-19 Review of the Hospital Discharge Summary, revealed an admission date of 2/28/26 and a discharge date of 3/02/26. The hospital course documented that Resident #1 was admitted through the ED on 2/28/26 due to progressive chronic symptoms of fatigue, dyspnea, chest tightness, and shortness of breath and also had progressive productive cough. Resident #1 had chronically received supplemental oxygen via nasal cannula due to Congestive Heart Failure (CHF) and recurrent pneumonia and had been hospitalized multiple times in the past several months. The hospital course documented that imaging had revealed low lung volumes with moderate bilateral pleural effusions (excess fluid in the lining of lungs) and antibiotics were started empirically for pneumonia. Resident #1 was given IV albumin (plasma protein), normal saline, and lasix (diuretic medication). Resident #1 did not want a chest tube, thoracentesis, or Computed Tomography (CT) scan, only interested in comfort measures and passed away peacefully with family present. Review of the Certificate of Death, revealed Resident #1 date of death on 3/02/26 at 9:19 PM. The immediate cause of death listed as: Chronic Hypoxic Respiratory Failure, due to or as a consequence of	F0880		

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F0880 SS = D	Continued from page 12 viral pneumonia. During an interview on 5/07/26 at 2:30 PM, Staff F, RN, reported Resident #1 always had a long history of anxiety and chronic respiratory symptoms. Staff F stated there were no new or worsening signs or symptoms of a respiratory illness she recalled leading up to Resident #1's hospitalization on 2/28/26. During an interview on 5/07/26 at 3:00 PM, Staff E, LPN reported Resident #1 had a history of being anxious throughout the overnight shift and had chronic respiratory symptoms she believed were either related to CHF or COPD and denied new or worsening symptoms of respiratory illness identified leading up to Resident #1's hospitalization on 2/28/26. During an interview on 5/06/26 at 2:30 PM, the DON/Infection Preventionist, revealed that a resident's physician would be contacted with respiratory symptoms to ask if they wanted to test the resident for COVID-19. The DON reported that residents with new, worsening or positive COVID-19 tests would be charted on every shift until symptoms resolved and documentation would include vital signs, lung sounds and a respiratory assessment. The DON reported that Resident #1 was being monitored prior to hospitalization on 2/28/26 for side effects of fatigue related to new lorazepam medication and had weakness/fatigue, anxiety at Resident #1's baseline. During an interview on 5/07/26 at 1:27 PM, the DON/Infection Preventionist and facility Administrator denied having documentation related to contact tracing for potential exposure or additional COVID-19 testing when made aware of 2 residents and 2 staff testing positive for COVID-19 within a 10 day time period. The DON/Infection Preventionist and facility Administrator revealed that the facility followed guidance from the CDC. During an interview on 5/07/26 at 12:15 PM, the facility's Medical Director revealed the expectation that the facility would implement isolation with TBP procedures for a resident who tested positive for COVID-19 and would follow the CDC guidelines for how long to isolate. The Medical Director revealed the expectation of the facility to test residents for COVID-19 who were potentially exposed to the virus, if staff working tested positive, as soon as they find out, and expected staff to be home for the recommended period of time. The Medical Director stated the facility may follow standing orders to test	F0880		

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F0880 SS = D	Continued from page 13 residents for COVID-19 and notify providers of the results. Review of the facility provided document titled, Infection Surveillance Report, dated 1/01/26 through 5/06/26, lacked identification of residents who had COVID-19 infection during this time period. On 5/07/26 at 2:00 PM, the facility Administrator and DON denied having any facility policies or procedures related to COVID-19. Review of the facility policy, titled Infection Surveillance Policy, dated 2/12/26, revealed the following: A. Purpose Statement: The purpose of this policy is to establish a comprehensive Infection Surveillance Program that detects infections early, prevents transmission within the facility, monitors infection trends and outbreaks, identifies opportunities for performance improvement, supports antibiotic stewardship initiatives, and promotes resident safety and quality of care based upon the facility's unique resident population and services and care provided. B. Policy Statement: It is the policy of the facility to maintain an organized, ongoing, facility-wide Infection Surveillance Program as part of the Infection Prevention and Control Program (IPCP) to identify, investigate, monitor, track, trend, prevent, and control infections and communicable diseases among residents, staff, volunteers, visitors, and contracted service providers. C. Procedures: Surveillance Program Oversight The Infection Preventionist (IP) shall coordinate and oversee the Infection Surveillance Program, maintain specialized infection prevention training, conduct routine surveillance activities, analyze infection data and trends, initiate investigations of suspected outbreaks, collaborate with leadership, and report findings to Quality Assurance and Performance Improvement (QAPI). Surveillance Activities The facility shall maintain active surveillance for: Respiratory infections Influenza-like illness	F0880		

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F0880 SS = D	Continued from page 14 COVID-19 Pneumonia Employee Illness Surveillance Monitoring shall include employee-reported illnesses/communicable diseases, infected skin lesions, work restrictions, exposure tracking, vaccination compliance, return-to-work clearance, and outbreak-related staffing concerns. Environmental Surveillance Monitoring may include cleaning/disinfection practices, high-touch surfaces, shared equipment sanitation, water management, ice machine sanitation, linen handling, waste management, ventilation concerns, and environmental contamination risks. Infection Identification and Investigation Infection Identification Nursing reports New infections Change in condition Laboratory results/positive cultures Reportable disease concerns When a suspected infection is identified: Appropriate precautions shall be initiated; The physician/practitioner shall be notified; Diagnostic testing shall be obtained as ordered; Exposed individuals shall be assessed; and Findings shall be documented. Review of the facility policy, titled Infection Control Interventions-Precautions, revised on 3/24/26 revealed the Purpose Statement that it is the policy	F0880		

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F0880 SS = D	Continued from page 15 of this facility to implement and take appropriate precautions to prevent transmission of pathogens and multidrug-resistant organisms The Section titled, Procedure directed the following, in part: Isolation Protocol (Transmission-Based Precautions): A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines. Residents with tuberculosis are placed on airborne precautions and placed in a special room that is equipped with special air handling and ventilation capacity. If no such room is available, the resident(s) will be discharged to a facility with such capabilities. Visitors coming to visit a resident who is on transmission-based precautions or quarantine, will be informed by the facility of the potential risk of visiting and precautions necessary when visiting the resident. Review of the facility policy titled, Infection Prevention and Control Policy, revised on 8/24/25, revealed the Purpose Statement was to establish and maintain a facility-wide infection prevention and control program that is evidence-based and designed to prevent, identify, investigate, and control infections and communicable diseases among residents, staff and visitors. The Section titled Procedure directed the following,	F0880		

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F0880 SS = D	Continued from page 16 in part: The infection prevention and control program applies to all departments and staff, contracted services, volunteers, and visitors. Educate team member in regard to- When a resident requires isolation to prevent spread of infection Prohibit Team members with a communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will spread the disease/infection. Require team members to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practices. 2. Provide surveillance and monitoring to: Minimize exposure to potential source of infection Uses appropriate hand hygiene prior to and after all procedures Uses CDC, NHSN, McGeer Criteria Ensures appropriate sterile / aseptic techniques are followed as warranted Use of Personal Protective Equipment (PPE) when indicated Ensures reusable equipment is appropriately disinfected / cleaned Use single-use medication vials and other single use items appropriately and proper disposal of items. Collect data, track infections, MDROs, and outbreaks to evaluate for trends 3. Reducing the risk of spread of infection by: Following infection control practices to include (but not limited to): i. Standard Precautions ii. Enhanced Barrier Precautions iii. Isolation Procedures	F0880		

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F0880 SS = D	Continued from page 17 iv. Infection screening of new residents and team members v. Blood-borne pathogens vi. Air-borne, contact and droplet precautions b. Monitoring and documenting infections, including tracking, and analyzing outbreaks of infection as well as implementing and documenting actions to resolve any noted issue. c. Work with community, state, and federal health agencies as warranted d. Manage food safety, including team member health and hygiene, pest control, investigation of potential food-borne illnesses and wash disposal. e. Define and manage appropriate health initiatives, such as, immunization program & TB screening on admission and following discovery of a new active case consistent with State requirements. Review of the CDC Infection Control Guidance: SARS COV-2, updated 12/11/2025, revealed the following practices for COVID-19 in Long Term Care Facilities: 1. Health Care Professionals (HCP) who enter the room of a patient with suspected or confirmed COVID-19 infection should adhere to Standard Precautions and use an approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. (i.e. goggles or face shield that covers the front and sides of the face). Duration of Transmission Based Precautions for Patients with COVID-19 infection should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation as listed: i. At least 10 days have passed since symptoms first appeared, AND ii. At least 24 hours have passed since last fever without the use of fever-reducing medications, AND iii. Symptoms (e.g. cough, shortness of breath) have improved. Residents placed in Transmission Based Precautions for acute respiratory infection should primarily remain in their rooms except for medically necessary	F0880		

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F0880 SS = D	Continued from page 18 purposes. If they must leave their room, they should practice physical distancing and wear a facemask for source control. The resident should be removed from Transmission Based Precautions as soon as they are deemed no longer infectious to others. Preventing Spread of Covid-19 among residents: 1. Apply appropriate Transmission Based Precautions for symptomatic residents based on the suspected cause of their infection. 2. When available, residents can be placed in a single person room to minimize the risk of spreading to roommates. 3. Moving residents to a single room is often not practical and in the situations, resident could remain in the current location. In shared rooms: a. Consider ways to increase ventilation. b. Use of facemasks at all times by both residents while in the room may also reduce the risk of spread, but is often impractical and not routinely recommended. c. Symptomatic residents should not be placed in a room with a new roommate unless they have both been confirmed to have the same respiratory infection. d. Roommates of symptomatic residents- who have already been potentially exposed- should not be placed with new roommates, if possible. They should be considered exposed and wear a facemask for source control around others.	F0880		