

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675942	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Towers Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 372 Hill Road Smithville, TX 78957	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents was provided the required assistance with eating resulted in poor intake, however, the resident met identified weight services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 6 residents (Resident # 1) reviewed for nutrition. The facility failed to provide Resident #1 with supervision and assistance during meal service on 06/11/2026. This failure could place residents at risk of dehydration and malnutrition. Findings include: Record review of Resident #1's face sheet, dated 06/11/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included unspecified severe protein-calorie nutrition (a condition caused by a deficiency of both protein and energy , leading to loss of weight , muscle mass, and fat stores it is not specified the exact clinical subtype in the medical record), cognitive communication deficit (an impairment in communication skills caused by disruptions in the brain's thinking processes, rather than a primary speech or language issue), and dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (dementia involves the damage or death of nerve cells in the brain, which prevents a person from communication properly. Symptoms includes memory loss, confusing and impaired reasoning. A doctor has diagnosed a patient with dementia, but the specific cause wasn't identified, and the patient does not have behaviors.)Record review of Resident #1's Quarterly MDS Assessment, dated 03/11/2026, reflected Resident #1 had a BIMS score of 00, which indicated Resident #1 cognition was severely impaired. Resident #1 required supervision or touching assistance with eating (helper provides cues and/or touching/steadying and/ or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or as needed). She was assessed in section I under additional active diagnosis to have a diagnosis of malnutrition.Record review of Resident #1's Comprehensive Care Plan, revised on 03/18/2026, reflected the following:*Resident # 1 had a desired weight gain related to BMI (Body Mass Index - a medical screening tool that uses your height and weight to estimate your total body fat). Intervention: Continue with interventions: Resident #1 had (on 06/05/2026) 16 pounds weight gain in the past 90 days. Give supplements as ordered by physician. Offer snacks as ordered by physician. Pureed Diet with house supplement 2.0 twice a day.*Resident #1 had an ADL Self- Care performance deficit related to generalized weakness (loss of physical strength across multiple muscle groups, such as both arms and legs, rather than just a single area of the body) secondary to unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing (when the fracture [small partial cracks to complete breaks of a bone] was healing normally and no complications are present Interventions: Functional Performance of Eating- Resident #1 required supervision or touching assistance for eating.* Resident #1 had an ADL self-care performance deficit related to generalized weakness secondary to unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing. Interventions: Eating- Resident #1 required supervision assistance by one staff to eat. Review of Resident #1's weight record reflected the following:Resident #1 weighed 67.1 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Observation on 06/11/2026 at 8:04 a.m. the ADON E entered the secure unit dining room and began to ask the residents if they needed more coffee. She spoke to Resident #1 and other residents sitting at the same table as Resident #1. ADON E did not cue Resident #1 with eating her breakfast or offer assistance with feeding Resident #1. Observation on 06/11/2026 at 8:23 a.m. LVN D asked Resident #1 if she wanted him to warm up her food. He exited the dining room and the secured unit. He returned with another meal tray for Resident #1, and he began to assist feeding Resident #1. Interview on 06/11/2026 at 8:50 a.m. CNA C stated Resident #1 sometimes does not prefer staff to feed her. She stated Resident #1 did require staff to cue her to eat her meals most of the time. CNA C stated, I was feeding another resident and did not notice Resident #1 was not eating. She stated all staff was responsible to ensure the residents were cued to eat their meals or assist the residents with feeding as needed. CNA C stated she had been in-service on feeding residents, cueing residents when they are not feeding themselves. She did not recall the date or time of the in-service. Interview on 06/11/2026 at 2:46 p.m. LVN D stated he was feeding another resident, and he was sitting across from Resident #1. He stated, I did not cue Resident #1 to eat or try to get another staff to attempt to feed Resident #1. LVN D stated he was expected to cue Resident #1 to eat or have another staff to assist her if he was busy feeding another resident. He stated ADON E could have fed or cued Resident #1 when she came into the secure unit dining room. He stated he had been in-service on dining room service, cueing residents, and feeding residents. LVN D stated he did not remember the date of the in-service. Interview on 06/11/2026 at 4:25 p.m. ADON E stated Resident #1 did require to be cue when she was eating her meals. She stated there are times Resident #1 needs assistance with feeding, however, Resident #1 sometimes will refuse assistance. LVN D stated all staff was expected to attempt to assist Resident #1 with feeding if she was not feeding herself and cue Resident #1 to eat her meals. She stated there was a possibility if a meal tray sat uncovered on the dining room table from 7:20 a.m. until 8:23 a.m. the food was cold and the resident may not eat. She stated for a resident to wait approximately one hour to eat was too long and it could affect the Resident's appetite if she was drinking all of her fluids and not eating her meals. She stated her expectation was that all residents be offered assistance and be cued to eat their meals as soon as possible. ADON E stated there was a risk of Resident #1 not getting the nourishment she needed and possibility of weight loss. In an interview on 06/11/2026 at 5:25 p.m. The Nurse Consultant stated her expectations for dining room meal service was all residents to be served and their meal tray set up for the resident. She stated the residents needed cueing and/ or assistance with feeding was expected to be fed as soon as their meal tray was set in front of the resident. She stated after the staff set up the meal tray, the staff was expected to assist the resident with eating or cue the resident to eat. The Nurse Consultant stated if a resident refused assistance with feeding, she expected the staff to observe the resident and offer to assist feeding the resident for the 2nd time if the staff observed the resident not eating or to cue the resident as many times as the resident needed to be cued to eat. She stated if a resident was not eating and no one was cueing the resident or offered to assist with feeding there was a potential the resident may not eat if the food becomes cold or the resident was drinking all the fluids at one time and not eating their meal. She stated there was a potential a resident may lose weight if the resident was high risk for weight loss. In an interview on 06/11/2026 at 5:54 p.m. The Administrator stated she expected all staff to assist resident with setting up their meals. She stated (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a resident needed assistance with eating, she expected the staff to sit with the resident and assist with feeding immediately after setting up the resident's meal tray. She stated if a resident refused the assistance, she expected the staff to attempt to assist resident again. The Administrator stated all the staff was expected to cue the residents to eat if the resident was staring at their food and not eating. She stated waiting almost an hour for a resident to eat their meal was too long and this was not acceptable. The Administrator stated the staff had been in-service and trained on dining room service and this training will be continued. She did not recall the date or time of the in-service. The Administrator stated there was a possibility a resident may not eat their meal after it becomes cold and if they were drinking all their fluids especially if they had a health supplement. She stated there was a potential for weight loss if a resident was not eating their meals and needed cueing to eat. Record review of the Facility's Policy on Meal Service, dated 10/01/2018, reflected The facility believes that all residents should be treated with dignity and respect at all times. A respectful, positive dining experience is essential to the residents' quality of life and helps to identify residents' needs and improve their overall nutritional status. Residents will be properly groomed, and their needs attended to during the meal service. Procedure: Residents who require dining assistance will not have their trays delivered until a staff member is available to assist with dining.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to 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 in response to one (Resident #1) of three Residents with unknown COVID 19 status. The facility failed to appropriately screen and test Resident #1 for signs, symptoms, and exposure of COVID-19. This failure placed residents at risk of exposure to COVID-19, which could result in illness, and hospitalization. Findings included: Record review of Resident #1's face sheet, dated 06/11/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included COVID-19 with onset 01/11/2026 (an infectious respiratory illness). Record review of Resident #1's admission MDS Assessment, dated 02/25/2026, reflected Resident #1 had a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. She was assessed to have poor short- and long-term memory recall. Her decision-making abilities was severely impaired. She was assessed in section I under additional active diagnosis to have a diagnosis of COVID-19. Record review of Resident #1's Quarterly MDS Assessment, dated 03/11/2026, reflected Resident #1 had a BIMS score of 00, which indicated Resident #1 cognition was severely impaired. Resident #1 was dependent on staff for showers, and toileting hygiene. She required substantial/maximal assistance (helper does more than half the effort) with the following: Personal Hygiene Upper and Lower Body dressing Oral hygiene Putting on /taking off footwear She was assessed in section I under additional active diagnosis to have a diagnosis of COVID-19. Record review of Resident #1's Comprehensive Care Plan, revised on 03/18/2026, reflected the following: *Resident #1 had high risk for communicable respiratory infections- influenza/pneumonia (influenza- a highly contagious respiratory illness) , (pneumonia- an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid). Interventions: Monitor facility for trends in respiratory infections, Administer flu/pneumonia vaccines in accordance to CDC guidelines after consent received from resident or responsible party. *Resident #1 was at risk for deterioration of medical condition due to positive results of COVID-19 test. *Resident #1 was at risk for psychosocial well-being related to medically imposed restrictions related to COVID -19 precautions (date initiated on 1/11/2026 and revised on 1/13/2026). Interventions: Contact/droplet precautions in place due to positive COVID-19 test (date initiated on 1/13/2026). Educate staff, resident, family, and visitors of COVID -19 signs, symptoms and precautions (date initiated on 1/13/2026), and maintain in private room or cohort with other COVID-19 positive residents if applicable (date initiated 01/13/2026). Record review of Resident #1's Nurses Notes, dated 01/07/2026 at 5:38 p.m. reflected Resident continues being monitored for meal intake, Breakfast - 0 Percent, Lunch- less than 25 percent, dinner - less than 25 percent. Resident encouraged to increase PO intake for nutritional support, encouraged to increase hydration for overall health. Signed by LVN A. Record review of Resident #1' Nurses Note, dated 01/08/2026 R/P called and requested to add Vitamin C (an essential water-soluble nutrient that the body cannot produce itself), Vitamin K (a group of fat-soluble vitamins that are essential for blood clotting, wound healing, and building healthy bones), Zinc (an essential trace mineral and a bluish-white metallic chemical element), and Elderberry (it is a nutrient-dense fruit packed with antioxidants, vitamin c, and dietary fiber) to resident's Medication Administration Record NP ok'd. Notified R/P that we did not carry elderberry and R/P stated she would bring some in. MAR updated. Charge nurse notified. Signed by DON. Review of Resident #1's R/P text messages with the Director of Nurses, dated 01/08/2026 at 1:54 p.m. reflected Hi (DON) being that [Resident #1] can't be tested and can't be moved, thank you for putting a mask on her at my request. Can you see if you can get the doctor to prescribe vitamin c , k and Elderberry. Review of Resident #1's R/p text messages with the Director of Nurses, dated was not on the text sent to surveyor, reflected New (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders for [Resident #1] : Zinc 50 mg daily , Vitamin C 500 mg daily , and Vitamin K 100 mg. We don't care Elderberry. Doctor said it would be fin if family wanted to bring it in and we can add it to her [Resident #1] MAR. Record Review of Resident #1's Nurses Note, dated 01/11/2026 at 4:19 p.m., reflected Resident #1 had a cough (signs and symptoms was not described when the note stated describe S/S (signs and symptoms). Notified Responsible Party on n 01/11/2026 at 5:18 p.m. Signed by RN B.Record Review of Resident #1's Change of Condition Nurses Note, dated 01/11/2026 at 6:50 p.m., reflected Resident #1 tested positive for COVID, started on 01/11/2026. Things that make the condition worse: (this was documented in the note but did not specify). Things that make the condition better: (this was documented in the note but did not specify). History: Primary Diagnosis (did not specify). Vitals:Blood Pressure: 108/64 lying down 01/11/2026Pulse: 71 Regular 01/11/2026Resp (Respiratory) : 16 on 01/11/2026Temp (Temperature): 99 on 01/11/2026O2 SAT : 97 on 01/11/2026Functional Status: Functional Status Changes : 1 (she had changes)Mental Status Changes: 1 (she had changes). Signed by RN BRecord Review of Resident #1's Nurses Notes dated 01/12/2026 at 12:38 p.m. , reflected Resident #1 had poor PO (orally - by mouth) for nutritional support, current COVID infection diagnosis, physical decline, new order received:Start - Lactated Ringers Intravenous Solution (used to replace lost fluids and to help correct acid-base imbalances in the body) use 1 liter intravenously one time only for 1 day Administer 1,000 ml at 65 ml/hr until complete, related to poor intake PO intake/ COVID infection, may administer via IV(intravenous) or hypodermoclysis (the administration of fluids or medications directly int the layer of fat just beneath the skin) to LUE (left upper extremity), resident tolerated procedure without complications. Family notification at 8:21 p.m. Called and spoke with Responsible Party provided update of Resident #1 current condition and new MDS order, R/P thanked charge Nurse. Signed by LVN A.Record review of the facility's COVID positive log, dated January 2026, reflected the following:Resident #2 tested positive for COVID-19 on 01/06/2026.Resident #3 tested positive for COVID -19 on 01/07/2026.Resident #4 tested positive for COVID -19 on 01/07/2026.Resident #5 tested positive for COVID-19 on 01/08/2026.Resident #6 tested positive for COVID-19 on 01/08/2026.Resident #7 tested positive for COVID-19 on 01/08/2026.Resident #8 tested positive for COVID -19 on 01/09/2026.Resident #1 tested positive for COVID -19 on 01/11/2026.Resident #9 tested positive for COVID-19 on 01/11/2026.Resident #10 tested positive for COVID-19 on 01/11/2026.Resident #11 tested positive for COVID-19 on 01/11/2026.Resident #12 tested positive for COVID -19 on 01/12/2026.Review of Resident #1's R/P text message dated 01/20/2026 at 10:12 a.m., reflected Good morning [Director of Nurses] I hope you're well. Is there a specific policy governing why [Resident #1] was denied a COVID test when I requested one due to us initially not being aware of COVID because there was no sign on the door to memory care until I said something. [Resident #1] and I were exposed so I need to know why she was denied testing. Also, with my request to keep her [Resident #1] in her room and keep other residents out of her room during this COVID time, also requested her door be kept closed. Why was a resident sitting in her room with the door opened but the resident was sitting in the chair in the same corner and side of [Resident #1's] room. I would like an explanation. Thank you.Interview on 06/11/2026 at 7:52 a.m. Resident #1 was not interview able. She did not respond to questions or conversation. Interview on 06/10/2026 at 4:10 pm Resident #1's R/P stated she contacted the Director of Nurses via phone on 01/07/2026 with a concern of Resident #1 having some symptoms of COVID-19. She stated I explained to the DON (Resident #1) had been exposed to COVID-19 from Resident #2 on the hall where Resident #1lives on 01/6/2026. She stated Resident #2 was sitting by her and Resident #1in the dining room. I asked if (Resident #1) could be moved to another hall and was explained Resident #1could not be moved related to being exposed to COVID and Resident #1could impact others health if she was moved. The DON told me that COVID should not be tested because only residents with symptoms could be tested. She stated Resident #1had a running nose and this was not her normal for her. The Director of Nurses stated Resident #1 could not be tested. I sent a text on 01/08/2026 at 1:54 p.m. and asked since that my mother cannot (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be tested and cannot be moved, I thanked the Director of Nurses for placing a mask on my mother at my request. In the text I asked if the Director of Nurses could get the doctor to prescribe the following: vitamin C, Vitamin K, and elderberry . I received a text from the Director of Nurses, and the text stated Resident #1received new orders of zinc 50 mg daily, Vitamin C 500 mg daily and Vitamin K 100 mg. I was told in the text from the Director of Nurses that the facility did not carry Elderberry, but the Physician was fine if the family wanted to bring Elderberry to the facility and the staff could add it to her MAR (Medical Administration Record) . I sent a text to the Director of Nurses on 01/20/2026 at 10:20 a.m. requesting information about a specific policy governing why my mother [Resident #1] was denied a COVID test when I requested one due to us initially not being aware of COVID because there was not sign on the door to memory care unit until I mentioned it to the staff. I stated Resident #1and I were exposed to COVID, and I needed to know why Resident #1was denied testing. I also asked if my Resident #1could be kept in her room during covid and keep other residents out of her room during the COVID time. I also requested for Resident #1's door to her room be kept closed due to there was another resident in Resident #1's room sitting in a chair near her. I never received a response from the Director of Nurses via Phone or text. I sent the Director of Nurses another text on 01/30/2026 at 9:26 a.m. requesting a response from my 01/20/2026 text. I explained in the text a concern of Resident #1's health had been severely impacted due to COVID and among other things. I asked the Director of Nurses to respond. I finally received a response from the Director of Nurses stating that the Director of Nurses was in the facility Monday- Friday 9 am to 5 pm and she could also schedule a meeting anytime during the week. I responded to the Director of Nurses it was not possible at this time for her to come to the facility due to having to go to hospital every day . I asked her if she was available for a phone appointment or even on electronic face to face meeting. The Director of Nurses stopped communicating with me via text or phone. I am not going to ever meet with the Director of Nurses in person I do not trust her, and she has lied about a lot of things. I will meet with the Nurse Consultant and the Administrator. I am fine if the Director of Nurses is in the meeting, but I will not meet with the Director of Nurses alone and this is why I prefer to communicate with her via text or email due to not trusting her and she has lied to me so many times. She stated she had a meeting last week of May with the Nurse Consultant and the DON. R/P stated the Nurse Consultant stated in their meeting she would have given my mother a COVID test. In an interview on 06/11/2026 at 12:28 p.m. The Director of Nurses stated Resident #1 did not have symptoms until 01/11/2026. Her symptoms on this date was a cough. She stated Resident #1 was tested for COVID on 01/11/2026 and she tested positive for COVID. The Director of Nurses stated Resident #1 was placed on precautions (she did not specify what type of precautions), isolation and her R/P and Medical Doctor was notified. She stated Resident #1's R/P communicated with her via text messages. She stated Resident #1's R/P asked about the facilities policy on COVID testing, and I explained to her the facility followed the CDC guidelines. The Director of Nurses stated she did receive a text from Resident #1's R/P asking why was her mother denied a COVID test. She stated I did not respond via text. I attempted to call her, and she did not answer the phone. The Director of Nurses stated, I did not attempt to call her any more except that one time. She stated she did not have any documentation of her communicating with Resident #1's R/P about testing for COVID. She stated she did respond via text referring R/P [Resident #1's R/P] requested for Resident #1 receive Vitamin C, Vitamin K, Zinc, and Elderberry. She stated she contacted the physician and he approved for the vitamins and stated it was ok for the family to bring in the Elderberry due to the facility did not have Elderberry in the facility. She stated she communicated via text with this information. The Director of Nurses stated it was difficult to document everything a family requested from the staff. The Director of Nurses stated she did speak with Resident #1's R/P about CDC guidelines and she did not document this conversation. The Director of Nurses became annoyed and a little agitated with the questioning about the situation and the interviewed was stopped. In an interview with a former employee on 06/11/2026 at 1:40 p.m. She stated I did work at the facility during the month of January 2026. I do recall when (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was on the secure unit at the facility. She stated Resident #1 was having a runny nose and did not feel very well. She stated Resident #1's R/P voiced concern about Resident #1 and was worried she had COVID. She stated Resident #1's R/P, wanted her to be tested for COVID and Resident #1 was not tested when the R/P requested the test. She stated she knew she had requested the test due to hearing R/P talking to the ADON (no longer works at the facility) with her concerns of the resident having COVID and refusing to test her for COVID. She stated Resident #1 was around the first resident who tested positive for COVID. She stated I do not recall the dates of when any of the conversations occurred or when the first Resident on the secure unit tested positive for COVID. In an interview on 06/11/2026 at 5:25 p.m. The Nurse Consultant stated anytime there was telephone correspondence with a family member concerning the medical condition of the resident, she expected for the nurse to document the conversation in medical records. She stated if there was not any documentation of any correspondence with a family member about anything there was no proof the conversation had occurred with the family. She stated if Resident #1's R/P requested a covid test for her mother, she stated she would have called the physician and received an order for the COVID test. The Nurse Consultant stated Resident #1's R/P was in the facility every day for several hours. If she was attempting to call the family and was unable to reach R/P via phone she would have talked to the R/P in the facility. She stated her expectations was all communication with families concerning a resident's health to be documented and to follow-up with the family of any request a family may have asked or needs information. The Nurse Consultant stated she did have a meeting with the DON and the R/P at the end of May 2026, and she did inform the R/P if she had of asked her for the COVID test she would have given to Resident #1. She stated if Resident #1 had a runny nose this was a symptom of COVID. In an interview on 06/11/2026 at 5:54 p.m. The Administrator stated her expectations whenever a family member had requested a COVID test the Director of Nurses was expected to call the physician and get an order for the COVID test. She stated the facility staff should not deny a resident a COVID test if the family requests one and the resident has some symptoms of COVID. She stated the facility followed CDC guidelines now and during the month of January 2026 as well as their own infection control protocol. The Administrator stated anytime a family member was calling staff about concerns of their family she did expect the nursing staff to document it in the electronic medical records under nurses notes, especially if it pertained to anything related to the residents medical condition. She stated anytime a family member voiced concern about COVID the nursing staff was expected to document this in the residents electronic medical record. The Administrator stated unless the staff documents any conversations about a residents medical care voiced by a family member or by anyone there was no proof the conversations occurred between the staff and the family member or others. Record review of the most recent CDC guidelines of COVID -19 symptoms , dated 3/10/2025,the following list does not include all possible symptoms of COVID-19. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. Possible symptoms include the following:1. Fever or chills2. Cough3. Shortness of breath or difficulty breathing4. Sore throat5. Congestion or runny nose6. New loss of taste or smell7. Fatigue8. Muscle or body aches9. Headache10. Nausea or vomiting11. Diarrhea Record review of the Facilities Infection Prevention and Control Program, dated 05/13/2023 reflected, This facility has established and maintains 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 as per accepted national standards and guidelines. COVID-19 testing:Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS -CoV-2 (the highly contagion coronavirus responsible for causing COVID-19) as soon as possible.Asymptomatic residents with close contact with someone with SARS- CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 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 (where day of exposure is day 0), day 3 , and day 5.		