STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 07/14/2022

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WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/11/22 to 7/14/22. Also reviewed in the course of the survey was complaint intake WY00003440. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) 1.) a.) On 7/13/22 "Weekly Wanderguard Battery Check" and "Check Wanderguard Placement Every Night" was added to resident #68's care plan. Documentation is reflected as ordered on the residents Treatment Administration Record (TAR). b.) Resident #32 is no longer on in-room isolation with droplet precautions. Education will be provided to all WRC staff members to address adherence to each resident's care plan related to COID-19 in-room isolation droplet precautions. c.)On 7/14/2022 "OXYGEN SETTINGS: O2 via nasal cannula @ 2L to keep sats above 90%" was added to resident #29's care plan.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		

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

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.

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F 656	Continued From page 1 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the facility infection control line listing, and staff interview, the facility failed to develop and/or implement the care plan for 3 of 22	F 656	2.) a.)WRC has identified that all residents with a Wandergard placed could be at potential risk for this deficient practice. b.)WRC is no longer in a resident COVID-19 outbreak. All residents who may test positive for COVID-19 inthe future have the potential to be affected by this deficient practice. c.) WRC has identified that all resident with an order to receive oxygen could potentially be at risk for this deficient practice 3.) a.) WRC will complete an audit of all residents that have Wanderguard placements to ensure that "Weekly Wanderguard Battery Check" and "Check Wanderguard Placement Every Night" is ordered on the TAR and documentation is reflected as ordered on or before 9/14/2022.	

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F 656	Continued From page 2 sample residents (#29, #32, #68). The findings were: 1. Review of progress notes showed on 5/6/22 at 3:15 AM resident #68 was not in his/her room. Facility staff searched for the resident and found the resident outside of the south courtyard laying on the ground (in the grassy area). The resident stated "I was trying to get back in." Review of the care plan provided by the DON on 7/13/22 at 12:32 PM showed the resident had exited the building and was found outside by staff. Interventions included "Verify wanderguard placement daily and monitor battery function weekly." The following concerns were identified: a. Review of the medical record, including the medication administration record (MAR) and treatment administration record (TAR), showed no documentation staff were verifying wanderguard placement daily or checking the battery function weekly. b. On 7/13/22 at 5:05 PM the DON reviewed the medical record and confirmed there lacked documentation to show the wanderguard checks were done. 2. Review of current physician orders for resident #32 showed a 7/8/22 order for "In room isolation with droplet precautions every shift related to Covid-19 until 7/16/22." Review of the current care plan, last revised 7/13/22, showed a problem area as "At risk for Covid-19 infection [related to] global pandemic. Tested positive for Covid on 7/7/22" with interventions that included "Promote social distancing and mask use" as well as " ... resident has attempted to leave [his/her] room and requires redirection to return to [his/her] room until 7/17/22 ..." The following concerns were identified:	F 656	b.) Education will be provided to all WRC staff members to address adherence to each resident's care plan related to COVID-19 in-room isolation droplet precautions. This will be completed on or before 9/14/2022. c.) An audit of all residents receiving oxygen therapy will be conducted and documented to ensure that each resident's oxygen orders are reflected on their individual care plan. This will be completed on or before 9/14/2022. 4.) a.) An audit will be completed and documented by the DON or designee to ensure residents who have Wanderguards have the "Weekly Wanderguard Battery Check" and "Check Wanderguard Placement Every Night" orders in place and documentation is reflected as ordered in the TAR. This audit will be conducted weekly for one month, and then	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 3 a. Observation on 7/12/22 at 10:12 AM showed the resident was seated in the common area in a chair outside of his/her room, wearing a surgical mask; however, the mask was under his/her chin, and not covering the mouth or nasal passages. Continued observation showed CNA #1 approached the resident to take his/her meal order. She did not attempt to correct or redirect the resident to apply the mask correctly, or return to his/her room. b. Observation on 7/12/22 at 9:43 AM showed the resident outside of his/her room wandering in the common area without a mask. Further observation showed resident #67 was seated in the common area at that time; review of the current infection line listing showed resident #67 was not positive for COVID-19 at that time. Continued observation showed resident #32 continued to wander through the common area and around the pool table before sitting in a chair next to his/her room, passing within 6 feet of resident #67 on three separate occasions. CNA #2 and LPN #1 were present in the common area at that time, and did not attempt to correct or redirect the resident regarding mask application or returning to his/her room. c. Interview with the DON on 7/14/22 at 10:23 AM revealed the expectation for staff is to " ... approach and re-approach, direct and re-direct and offer a mask if [he/she] isn't wearing one." She further stated the resident " ... can come out of his/her room if no other residents are out." 3. Review of the active order list dated 4/5/22 for resident #29 showed "oxygen at 2 liters [per minute] continuously via nasal cannula at night."...Oxygen at 2 liters [per minute] during the day PRN [as required] to keep oxygen saturation greater than 90%." and "check oxygen saturation	F 656	monthly for at least 3 months or until substantial compliance is achieved. This audit will be reported to the QAPI committee monthly during the facility QAPI meeting by the DON or designee. b.) WRC is no longer in a resident COVID-19 outbreak. If WRC experiences a COVID-19 outbreak the DON or designee will conduct and document audits of adherence to residents care plans related to COVID-19 in-room isolation droplet precautions. This audit will be completed daily during the resident outbreak period. This audit will be conducted for at least three months or until substantial compliance is achieved. This audit will be reported to the QAPI committee monthly during the facility QAPI meeting by the DON or designee. c.) An audit will be completed and documented by the DON to ensure that all residents who	

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F 656	Continued From page 4 [every] shift related to chronic obstructive pulmonary disease." Review of the progress notes from 7/1/22 through 7/8/22 showed nursing staff monitored oxygen saturation every shift for resident #29. The following concerns were identified: a. Review of the current care plan (not dated) showed the resident's use of oxygen was not included in the plan. b. Interview with the DON on 7/14/22 at 11:15 AM revealed oxygen use should be identified in the care plan. Further interview confirmed resident #29 was on oxygen.	F 656	receive oxygen therapy have the orders reflected on their individual care plans. This audit will be conducted weekly for one month, and then monthly for at least 3 months or until substantial compliance is achieved. This audit will be reported to the QAPI committee monthly during the facility QAPI meeting by the DON or designee.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to	F 661	5.) The corrective actions related to this deficiency will be completed on or before 9/14/2022. F661 Discharge Summary CFR(s): 483.21(c)(2) 1.) Resident #73 no longer resides in the facility. 2.) WRC has identified that any resident that is discharging from the facility is potentially at risk for this deficient practice. 3.) WRC will develop a template that recapitulates the residents stay and summarizes the	

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F 661	Continued From page 5 adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure all components of the discharge summary were incorporated and documented for 1 of 1 sample residents (#73) reviewed for discharge. The findings were: Review of the 6/22/22 discharge MDS assessment showed resident #73 was discharged on 6/22/22. Review of a 6/22/22 discharge summary progress note timed 1:15 PM showed " ...Resident left with staff member to be taken to [an assisted living facility]. Resident left with all personal belongings, all medications (copies of bubble packs made), any money [s/he] had locked in office safe ..." The following concerns were identified: a. Review of the medical record and discharge documentation showed a post-discharge plan of care, and a reconciliation of the resident's medications. However, there was no documentation of a recapitulation of the resident's stay, or a final summary of the resident's status at the time of discharge. b. Interview on 7/14/22 at 11:29 AM with the administrator and medical records director confirmed the two components were missing. They revealed they were under the impression the post-discharge plan of care was the equivalent to the recapitulation of stay.	F 661	residents status at the time of discharge that will be completed upon each resident's discharge from the facility. This template will be created on or before 9/14/2022. 4.) An audit will be conducted by the Social Services Director or Designee to ensure that the recapitulation of stay and final summary of resident status templated is completed upon discharge. This audit will be conducted weekly for one month, and then monthly for at least 3 months or until substantial compliance is achieved. This audit will be reported to the QAPI committee monthly during the facility QAPI meeting by the DON or designee. 5.) The corrective actions related to this deficiency will be completed on or before 9/14/2022.	

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F 684 F 684 SS=D	Continued From page 6 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of facility incident reports, and policy and procedure review, the facility failed to provide appropriate assessments and monitoring for 1 of 2 sample residents (#21) reviewed for falls. The findings were: Review of the 5/7/22 quarterly MDS assessment showed resident #21 was admitted to the facility on 4/30/19, with diagnoses that included Parkinson's disease, pain, fall from non-moving wheelchair, and chronic fatigue. Review of the current care plan, last revised 5/18/22, showed "The resident has had an actual fall with no injury related to poor balance 1/24/20, 3/1/20, 4/28/22" with interventions that included "Check range of motion at time of fall," "Monitor/document/report [as needed] x 72h to MD for [signs and symptoms]: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation," "Neuro-checks per facility policy," and "Vital signs [once per shift]. Take [blood pressure] lying/sitting/standing x1 in first 24hr." Review of the incident report showed the resident suffered an unwitnessed fall on	F 684 F 684	F684 Quality of Care CFR(s): 483.25 1.) WRC staff cannot retroactively complete a neurological or related assessment on resident #21. 2.) All residents who have a fall at the facility have the potential to be affected by this deficient practice. 3.) All WRC nurses will be provided education by the DON or designee related to WRC's policy "Fall Prevention and Management" policy to include medical assessment for injuries, collection of vital signs, and completion of the facilities neuro check form. This education will be provided on or before 9/14/2022. 4.) An audit will be completed and documented by the DON or designee that ensures the facilities "Fall Prevention and Management Policy" is appropriately utilized for each	

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F 684	Continued From page 7 4/28/22 at 3:45 PM. The following concerns were identified: a. Review of the 4/28/22 incident report showed "Immediate action taken: Assessed resident head to toe and found no evidence of injury, performed initial neuros ..." However, review of the medical record showed no documented assessment related to the fall, or any documented initial or subsequent neurological checks. b. Review of the 4/28/22 nursing fall risk assessment timed 5:45 PM only showed one temperature documented, and only one seated blood pressure recorded. Review of the medical record showed a full set of complete vital signs were not documented, or any additional subsequent vital signs were documented related to the fall. c. Review of facility policy "Fall Prevention and Management," last revised March 2019, showed " ... 2. Fall Evaluations ... The nurse will document the medical assessment for injuries, including vital signs ... 3. Fall Prevention Interventions ... Staff Actions ... Check blood pressure - lying and standing, to see if the resident has orthostatic hypotension ..." d. Interview with the DON on 7/14/22 at 10:02 AM revealed the expectation is for nursing staff to document nursing progress notes related to the fall, as well as document neurological assessments on the facility neuro check form. She confirmed there had been no assessment, neuro assessment, or correlating vital signs documented related to the fall. e. Interview with the medical records director revealed the facility had high nursing turnover and the facility had struggled with training and documentation during March and April of 2022. She stated the facility " ... scrambled trying to get	F 684	fall occurrence in the facility. This audit will be conducted weekly for one month, and then monthly for at least 3 months or until substantial compliance is achieved. This audit will be reported to the QAPI committee monthly during the facility QAPI meeting by the DON or designee. 5.) The corrective actions related to this deficiency will be completed on or before 9/14/2022. F689 Free of Accidents and Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 1.)a.) On 7/13/22 "Weekly Wanderguard Battery Check " and "Check Wanderguard Placement Every Night" was added to resident #68's care plan. Documentation is reflected as ordered on the residents Treatment Administration Record (TAR).	

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F 684	Continued From page 8 interventions in place and step by step instructions to assist and encourage staff to document like they should be, and where they should be ..."	F 684	2.) WRC has identified that any resident who has a Wanderguard placed as a safety intervention could be at potential risk for this deficient practice.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to implement interventions to prevent re-occurrence for 1 of 3 sample residents (#68) who eloped from the facility. The findings were: Review of the 4/9/22 quarterly MDS assessment revealed resident #68 had a BIMS score of 0 (severe cognitive impairment), required limited assistance with ambulation, and wandered 1-3 days. Observation on 07/12/22 at 11:48 AM showed the resident ambulated to the dining room by him/herself using a walker. Review of progress notes showed on 5/6/22 at 3:15 AM the resident was not in his/her room. Facility staff searched for the resident and found the resident outside of the south courtyard laying on the ground (in the grassy area). The resident stated "I was trying to get back in." During an interview on 7/12/22 at 4:37 PM the DON stated the resident eloped out of the front doors and did not have a	F 689	3.) WRC will complete an audit of all residents that have Wanderguard placements as a safety intervention to ensure "Weekly Wanderguard Battery Check" and "Check Wanderguard Placement Every Night" is ordered correctly on the TAR and documentation is reflected as ordered on or before 9/14/2022. 4.) An audit will be completed and documented by the DON or designee to ensure residents who have Wanderguard placements as a safety intervention have the "Weekly Wanderguard Battery Check" and "Check Wanderguard Placement Every Night" orders in place correctly and documentation	

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F 689	Continued From page 9 wanderguard (bracelet worn by resident which triggers door alarm) at the time of the incident because s/he had never tried to exit the facility. Review of a 5/6/22 elopement risk assessment showed frequent monitoring and a wanderguard were added as interventions. Review of physician orders dated 5/6/22 showed staff were to check the wanderguard placement every night, and do a wanderguard battery check every Tuesday night. Review of the care plan provided by the DON on 7/13/22 at 12:32 PM showed interventions related to elopement included "Verify wanderguard placement daily and monitor battery function weekly." The following concerns were identified: a. Review of the medical record, including the medication administration record (MAR) and treatment administration record (TAR), showed no documentation staff were verifying wanderguard placement daily or checking the battery function weekly. b. On 7/13/22 at 5:05 PM the DON looked at the medical record and confirmed the MAR and TAR did not have documentation regarding the wanderguard checks. She stated the physician's orders were not put into the system the correct way, so they weren't added to the MAR/TAR.	F 689	is reflected as ordered in the TAR. This audit will be conducted weekly for one month, and then monthly for at least 3 months or until substantial compliance is achieved. This audit will be reported to the QAPI committee monthly during the facility QAPI meeting by the DON or designee. 5.) The corrective actions related to this deficiency will be completed on or before 9/14/2022.	
F 880 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	F 880		

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F 880	Continued From page 10 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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	F 880		

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	535021	A. BUILDING _____ B. WING _____	C 07/14/2022

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F 880	Continued From page 11 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 observation, medical record review, review of the facility infection control line listing, staff interview, and review of policy and procedure, the facility failed to ensure infection control practices were enforced for 1 of 6 residents (#32) reviewed who had tested positive for COVID-19. At the time of the survey, the facility had 19 residents who had tested positive for COVID-19. The findings were: Review of the 5/21/22 quarterly MDS assessment showed resident #32 was admitted to the facility on 11/23/21, with diagnoses that included hypertension, nasal congestion, wheezing, unspecified dementia without behavioral disturbance, allergic rhinitis, and shortness of breath. Review of current physician orders showed a 7/8/22 order for "In room isolation with droplet precautions every shift related to Covid-19 until 7/16/22." Review of the current care plan, last revised 7/13/22, showed a problem area as	F 880	Wyoming Retirement Center CCN:535021 Event ID: WLIZ11 Survey Date: 7/14/22 Directed Plan of Correction F880 #1Standard and Transmission-Based Precautions (TBPs) Corrective action: The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected unit identified in the deficiency. The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete	

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F 880	Continued From page 12 "At risk for Covid-19 infection [related to] global pandemic. Tested positive for Covid on 7/7/22" with interventions that included "Promote social distancing and mask use" as well as " ... resident has attempted to leave [his/her] room and requires redirection to return to [his/her] room until 7/17/22 ..." The following concerns were identified: a. Observation on 7/12/22 at 10:12 AM showed the resident seated in the common area in a chair outside of his/her room, wearing a surgical mask. The mask was under his/her chin, and not covering the mouth or nasal passages. Continued observation showed CNA #1 approached the resident to take his/her meal order. She did not attempt to correct or redirect the resident to apply his/her mask, or return to his/her room. b. Observation on 7/12/22 at 9:43 AM showed the resident outside of his/her room wandering in the common area without a mask. Further observation showed resident #67 was seated in the common area at that time; review of the current infection line listing showed resident #67 was not positive for COVID-19 at that time. Continued observation showed resident #32 continued to wander through the common area and around the pool table before sitting in a chair next to his/her room, passing within 6 feet of resident #67 on three separate occasions. CNA #2 and LPN #1 were present in the common area at that time, and did not attempt to correct or redirect the resident regarding mask application or returning to his/her room. c. Interview with the DON on 7/14/22 at 10:23 AM revealed the expectation for staff was to " ... approach and re-approach, direct and re-direct and offer a mask if [he/she] isn't wearing one." She further stated the resident " ... can come out	F 880	the following: (1) Identify and implement transmission-based precautions procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS). Identification of Others: The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID-19 nursing facility guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. Guidelines for COVID-19 can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html System Changes: On or before 8/24/22 the facility shall complete the following actions: Related to Transmission-Based Precautions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure the core principles	

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F 880	Continued From page 13 of his/her room if no other residents are out." d. Review of the facility infection control policy "Personal Protective Equipment - Using Face Masks," last revised September 2010, showed " ... Objectives ... 1. To prevent transmission of infectious agents through the air ... 3. To prevent transmission of some infections that are spread by direct contact with mucous membranes ... Miscellaneous ... 2. Be sure that face mask covers the nose and mouth ... 4. Do not hang the face mask around the neck... When to Use a Mask ... 1. When providing treatment or services to a patient who has a communicable respiratory infection; 2. When providing treatment or services to a patient and the use of a mask is indicated ..."	F 880	of infection prevention were implement. Related to Transmission-Based Precautions: a. All staff are educated on the core principles of infection prevention, and interventions for residents who are resistant to implementing the core principles. (2) The facility leadership will contact the Mountain Pacific Quality improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: (1) Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for: a. Compliance of staff with the implementation of interventions to prevent the transmission of COVID-19. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three	

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F 880	Continued From page 14	F 880	months. All Monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved by the QAPI committee and medical director. Date of compliance 8/24/22	