STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	08/10/2022

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DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/7/22 to 8/10/22. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		9/15/22

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

Electronically Signed | 09/01/2022

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the physician or mid-level practitioner was notified concerning a change in condition regarding swallowing issues for 1 of 1 sample residents (#22) reviewed for that issue. The findings were: 1. Review of the 5/13/22 quarterly MDS	F 580	F580 Douglas Care Center will ensure resident safety by strictly enforcing that the facility staff will notify and address any resident changes (decline/injury/room/etc.) immediately with resident, facility physician and/or mid-level practitioner, and appropriate resident representative.	

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F 580	Continued From page 2 assessment showed resident #22 had diagnoses which included Alzheimer's dementia and depression. The review showed the resident had a BIMS score of 3 (severe cognitive impairment). The review showed the following regarding swallowing, "Holding food in mouth/cheeks or residual food in mouth after meals." Observation of the resident on 8/7/22 at 12:17 PM in the secure unit dining area showed the resident was having difficulty drinking tea and a protein supplement shake, and was intermittently coughing while being assisted by staff. The staff were prompting the resident to swallow. The liquids did not appear to be thickened. Observations on 8/7/22 at 4:28 PM and 4:31 PM showed the resident was in the secure unit dining area, and [s/he] had difficulty with swallowing tea and hot chocolate, coughing intermittently. Staff were observed prompting the resident to swallow. Observation on 8/9/22 at 8:18 AM in the secure unit dining area showed the resident was intermittently coughing while drinking hot chocolate, and staff were again prompting the resident to swallow. During each of the observations the resident utilized a straw to drink. The following concerns were identified: a. Interview on 8/9/22 at 8:18 AM with RN #1 revealed she was aware the resident had swallowing issues. She stated she believed the resident might have a "waiver" regarding food texture and choking risk, but was not sure. Interview with CNA #2 on 8/9/22 at 11:17 AM revealed she was aware the resident would sometimes choke because [s/he] would forget to swallow, and staff would remind the resident to swallow. The aide stated this had been a chronic issue for the resident. b. Interview with the administrator on 8/9/22 at 9:15 AM revealed she believed the resident	F 580	1. Nurse practitioner was notified and provided with specific information related to resident # 22's difficulty in swallowing. 2. AGNP-C provided order for swallow evaluation as well as a 3-day trial of mechanical soft diet until evaluation was completed. 3. Resident #22's family representative was notified via email. 4. Resident #22 was given a swallow study and diet was changed to mechanical soft with nectar thick liquids per recommendation. 5. AGNP-C, MD, and family representative were notified of evaluation results and changes in diet. 6. All staff were educated on resident #22's changes in diet. 7. IDT team performed a resident chart audit and reviewed progress notes, events, and care plans for all residents within facility to assess any resident needs that may not be being met and/or identified appropriately. 8. DON interviewed facility's nurses regarding any resident needs that may need to be addressed. 9. Resident chart audits and DON interviews did not produce any findings regarding resident needs to be addressed. 10. Douglas Care Center staff were educated on identifying resident changes/needs and addressing/reporting procedure to prevent any further unidentified resident changes. 11. Douglas Care center staff have been educated on staff responsibility/requirement of knowing	

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F 580	Continued From page 3 had a mechanically-altered diet, but had not been ordered a swallow study. She revealed the resident did not have a waiver concerning food textures and choking risk. She stated her expectation was for staff to make nursing administration aware of any swallowing issues, and staff would then notify the physician or mid-level practitioner. She stated the nursing staff would contact the mid-level practitioner and obtain an order for a swallow study. Review of the medical record after the interview showed a mechanical soft diet with pureed meat was ordered on 8/9/22 at 10:43 AM. c. Interview with the certified dietary manager on 8/9/22 at 4:47 PM revealed the resident was started that day on a 3-day trial for thickened liquids, and had a new order for a swallow evaluation. d. Interview with family nurse practitioner (FNP) #1 on 8/9/22 at 11:05 AM revealed the resident was on comfort care and had a diagnosis of end stage dementia. The FNP confirmed she was not aware the resident was having a swallowing issue, and her expectation was for staff to notify her for that issue. She stated she would order a swallow study as soon as the DON or administrator sent the request, but since the resident was at the stage of comfort care, she did not consider it to be urgent. She further stated it was her expectation the facility staff would contact her in a timely manner for all changes in condition. e. Interview with the administrator on 8/10/22 at 8:54 AM confirmed the bedside staff should have made it clear to the administrative staff that the resident was having a swallowing issue, and the expectation for administrative staff would be to contact the physician or mid-level practitioner at that time.	F 580	resident's care plans and orders as well as where to find pertinent information to assist with identifying potential needs requiring attention or further evaluation. 12. All residents with observed concerns and/or changes will be addressed promptly and reported to the DON who will notify the MD/AGNP-C, and resident representative and update resident charts and care plans to reflect any changes as needed. 13. DON or assigned administrative RN will continue to host "nursing briefing" daily, in addition a CNA "briefing" has been implemented Monday-Friday to ensure effective communication and prompt notification of all resident changes to MD, AGNP-C, and family representative as appropriate. 14. All staff will be updated on resident changes and updated care plans as they occur. 15. IDT team will audit resident care plans and ensure all evaluations, waivers, changes, etc. are in place weekly. 16. All audits related to this subject will be brought to QAPI for 90 days or until resolved.	

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F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on employee record review, staff interview, staffing schedule review, and policy and procedure review, the facility failed to ensure the CNA registry was checked prior to resident contact for 1 of 2 CNA records (CNA #1) reviewed. The findings were: 1. Review of the employee record for CNA #1 showed a hire date of 4/15/22. The review showed the CNA registry was not checked for the CNA's status until 8/10/22 (the date the record review took place). Review of staffing schedules showed the CNA had been working independently	F 606	F606 The hiring personnel at DCC have been educated, on Douglas Care Center's policy that the CNA Registry will be checked prior to allowing any new CNA to work on the floor with residents and the report will be placed in the employee's file to reflect the date it was checked. 1. An audit of all current CNAs has been done to ensure compliance on all current CNAs. 2. A weekly audit of new CNA records will be completed for all new staff prior to	9/15/22

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F 606	Continued From page 5 prior to 8/10/22. Interview with the administrator on 8/10/22 at 10:28 AM confirmed the facility failed to check the CNA registry in a timely manner for CNA #1. 2. Review of the policy titled, "Policy on Detecting, Preventing, and Reporting Abuse, Neglect, Mistreatment of Residents or Misappropriation of Resident Property", dated March 2018, showed the following under 'Handout for Abuse Policy', "Procedure: 1. All potential employees will be screened to avoid hiring those with a history of abuse..."	F 606	starting their training on the floor with residents. 3. Audits will be brought to QAPI for 90 days or until resolved.	
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 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	F 656		9/15/22

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F 656	Continued From page 6 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, resident and staff interview, and policy and procedure review, the facility failed to ensure resident-specific care plans were implemented for 3 of 16 (#34, #38, #100) residents reviewed. The findings were: 1. Review of the 6/5/22 admission MDS assessment showed resident #34 was admitted with diagnoses that included Alzheimer's disease, altered mental status, weakness, and repeated falls. Review of the current care plan, last revised 6/5/22, showed a problem area related to the resident being " ... at risk for falls [related to] weakness and history of frequent falls." The following concerns were identified: a. Observation on 8/7/22 at 4:19 PM showed a recliner in the resident's room. It was noted the recliner was elevated off the floor, sitting on top of	F 656	F656 Development/Implement Comprehensive Care Plans Douglas Care Center will establish and maintain comprehensive care plans on all residents that are relevant and individualized. 1. Care Plan Team has been educated that safety evaluations need to be done on all furniture that has an alteration to the manufactures original design. Maintenance staff will assess the furniture stability after alterations. Restorative Aid will evaluate for proper height. 2. Resident #34 had a safety evaluation done for the modified recliner and was found safe to have the modification. 3. All residents who have alterations to furniture will have the assessment added to their individualized care plan.	

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F 656	Continued From page 7 two 2x4's stacked on top of one another. The boards were screwed into the base of the chair, making it approximately three inches higher off of the floor. Interview with the resident at that time revealed s/he had tipped the chair over (due to its elevated nature) while attempting to lower the footrest. S/he further stated s/he had asked for a new chair, but a new one had yet to be provided. b. Review of the current care plan, last revised 6/5/22, showed no documentation related to a modified or elevated recliner as an intervention for the resident. c. Interview on 8/10/22 at 11:20 AM with the DON and administrator revealed their expectation was for the resident to be assessed for use of a modified recliner, and for that intervention to be added to the care plan. 2. Review of the 6/8/22 quarterly MDS assessment showed resident #38 was admitted to the facility on 5/8/22 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypoxemia, and tobacco use. Review of the Resident Safe Smoking Assessment showed the resident was evaluated and passed the safety assessment on 1/21/22. Observations on 8/8/22 at 1:30 PM and 8/9/22 at 9:03 AM showed the resident in his/her mechanical wheelchair seated in the common area near the main facility entrance. It was noted the resident had a carton of cigarettes in his/her shirt pocket during both observations. The following concerns were identified: a. Review of the current care plan, last revised 6/9/22, showed a problem area identified as "[the resident] use chewing tobaccos." Further review showed no documentation related to	F 656	4. Restorative Aid will do monthly audits on all altered furniture and check that there has been a safety evaluation done and is Care Planned. 5. Care Plan Team has been educated to include smoking evaluations to Care Plans as well as chewing tobacco use. Care plans will be individualized for each substance and not be grouped together as tobacco products. 6. Resident #38 has had a safe smoking assessment done and passed. Resident #38 had his care plan updated to reflect he is also a smoker. 7. Care Plan Team has been educated to include Elopement Assessment in Care Plans on all residents. Residents at high risk for elopement will have individualized interventions put into their care plans. 8. Resident #100 ‘s Care Plan was updated to address his/her elopement risk. 9. Staff have been educated to notify DON and/or Administrator of changes to a resident’s condition when exit seeking behaviors are new to the resident or increasing for a resident already at high risk for elopement. A new elopement assessment will be done at that time and updated in the Care Plan. 10. All Care Plans will be audited by IDT team to ensure that they have resident-specific interventions in place. 11. F656 will be brought to QAPI for 90 days or until resolved.	

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F 656	Continued From page 8	F 656		

cigarettes, smoking, or the safe smoking assessment.

b. Interview with the DON on 8/10/22 at 11:34 AM confirmed the care plan did not address the resident's smoking.

c. Review of facility policy "Smoke Free Facility - Employees and Residents," last revised 3/9/22, showed "Policy Explanation and Compliance Guidelines: ... 16 ... care plan revisions shall be documented and implemented to promote safety ..."

3. Review of the diagnosis list showed resident #100 was admitted to the facility on 7/11/22 with diagnoses which included vascular dementia with behavioral disturbances, personal history of traumatic brain injury, and alcohol abuse. Review of the 8/1/22 Elopement Evaluation showed the resident was ambulatory, made statements about being unsure why [s/he] was at the facility, had poor decision making skills due to diagnosis, had made statements that [s/he] was leaving, and displayed behaviors that may indicate an attempt to leave. The review indicated an elopement care plan would be initiated. Observation on 8/7/22 at 5:04 PM showed the resident in the secure unit hallway without staff in the area, and at that time the resident stated that [s/he] had attempted to leave in the past. Observation on 8/9/22 at 1:40 PM and at 1:56 PM showed the resident was in the secure hallway without staff present. Observation on 8/9/22 at 2:16 PM showed the resident unsuccessfully attempted to elope out of the main doorway when the surveyor exited the area. The following concerns were identified:

a. Interview on 8/9/22 at 2:13 PM with CNA #2 on the secure unit revealed staff every 2 hour rounds on residents, and no residents on the unit at that time were on 1 to 1 care, or increased

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F 656	Continued From page 9 surveillance. b. Further review of the care plan showed no plan to address the resident's elopement risk. c. Interview with the administrator on 8/10/22 at 8:54 AM confirmed the resident was aggressive and was an elopement risk. She further confirmed the care plan was not individualized regarding elopement. 4. Review of facility policy "Baseline Care Plan," last revised 3/29/18, showed "Policy Explanation and Compliance Guidelines: ... 5. In the event that the comprehensive assessment and comprehensive care plan identified a change ... those changes shall be incorporated into an updated summary ..."	F 656		
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, resident and staff interview, and policy and procedure review, the facility failed to ensure residents were evaluated for potential safety concerns for 1 of 6 (#34) residents reviewed. The findings were: 1. Review of the 6/5/22 admission MDS	F 689	F689 Free of Accident Hazards/Supervision/Devices Douglas Care Center will ensure residents are evaluated for potential safety concerns. 1. Resident #34 requested a new recliner. PT/OT evaluated resident for new recliner without a riser and was approved for safe	9/15/22

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F 689	Continued From page 10 assessment showed resident #34 was admitted with diagnoses that included Alzheimer's disease, altered mental status, weakness, and repeated falls. Review of the current care plan, last revised 6/5/22, showed a problem area indicating the resident was " ... at risk for falls [related to] weakness and history of frequent falls." The following concerns were identified: a. Observation on 8/7/22 at 4:19 PM showed a recliner in the resident's room. It was noted the recliner was elevated off the floor, sitting on top of two 2x4's stacked on top of one another. The boards were screwed into the base of the recliner, making it approximately three inches higher off of the floor. The resident stated at that time the chair had been in his/her room since admission. Further, s/he had tipped the chair over due to its elevated nature, while attempting to lower the footrest. S/he further stated s/he had asked for a new chair, but a new one had yet to be provided. b. Review of physician orders showed no order for an evaluation related to the elevated recliner. Review of the medical record showed no documentation related to an assessment performed encompassing the resident and the modified chair. c. Review of the current care plan, last revised 6/5/22, showed no documentation related to a modified or elevated recliner as an intervention for the resident. d. Interview on 8/10/22 at 11:20 AM with the DON and administrator revealed their expectation was for the resident to be assessed for use of a modified recliner, and for that intervention to be added to their care plan. Further interview confirmed the resident had not had a safety assessment performed related to the recliner. e. Review of physician orders showed an	F 689	usage. 2. An audit of all residents with elevated/modified furniture has been done to ensure that safety evaluations have been performed for resident's that have or sit in elevated/modified recliners. 3. DON or designee will do monthly audits reviewing presence of elevated/modified recliners will be performed to ensure that safety evaluations have been completed and documented. 5. IDT team will update resident care plans to reflect elevated/modified recliners as an intervention as applicable following completion of safety evaluations. 6. All staff have been educated on the expectations of residents with elevated/modified recliners and requirement of safety evaluation prior to use. 7. Douglas Care Center's fall program will be updated to identify elevated/modified recliners as potential fall risks. 8. All audits related to this subject will be brought to QAPI for 90 days or until resolved.	

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	535040	A. BUILDING _____ B. WING _____	08/10/2022

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F 689	Continued From page 11 8/9/22 order for "[Physical Therapy/Occupational Therapy]: Safety [evaluation] for high rise chair." Review of resident progress notes showed an 8/9/22 note timed 9:41 AM showing an evaluation had been completed. f. Review of the undated facility Fall Program documentation showed the program addressed fall risks to include inappropriate bed heights and interventions, but did not address elevated recliners.	F 689		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and	F 886		9/15/22

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F 886	Continued From page 12 (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff vaccination data review, CDC COVID-19 data review, staff COVID-19 testing documentation review, CMS	F 886	F886 COVID-19 Testing- Residents and Staff Douglas Care Center will ensure testing of	

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F 886	Continued From page 13 guidance review, staff interview, policy review, and performance improvement plan review, the facility failed to ensure testing of staff for COVID-19 met requirements for 6 of 6 sample staff members (CNA #2, #3, #4, #5; LPN #1; RN #2) with vaccine exemptions. The census was 55. The findings were: Observation upon entrance to the facility on 8/7/22 at 10:41 AM showed a posted sign indicating the COVID-19 positivity rate for the community was high. At that time the DON confirmed there were no active COVID-19 cases in the facility. She further stated that one CNA had tested positive on 7/31/22, had been assigned to work exclusively in the secured unit, and the CNA left the facility upon testing positive. She stated the CNA had not been to any other area of the facility that day. Review of staff COVID-19 vaccine data provided by the facility on 8/7/22 showed 28 staff members out of 68 with vaccine exemptions, all of which were non-medical exemptions. Review of the facility policy titled, "Coronovirus Testing" last revised on 3/15/22, showed staff who were not up to date with COVID-19 vaccination should test twice a week when the the community transmission level was high. The following concerns were identified: a. Review of the CDC COVID data tracker showed the county transmission rate from 6/1/22 to 6/30/22, 7/1/22 through 7/31/22, and 8/1/22 to the survey entrance of 8/7/22 was at a "high" level. b. Review of the COVID-19 testing results for 6 sample vaccine-exempt staff members for the last 2 months showed they tested as follows: RN #2 tested on 6/9/22, 6/23/22, 6/30/22, 7/22/22, 7/28/22, and 8/4/22 (less than weekly); LPN #1 tested on 6/10/22, 6/16/22, 6/29/22, 7/1/22,	F 886	staff for Covid-19 per requirements. 1. The facilities staff has been educated on the requirements for weekly COVID-19 testing, weekly and bi-weekly 2. Infection Preventionist will notify department managers when an employee in their department has failed to test on designated testing day. Department manager will contact staff member to test either personally when employee is at work or through text message. If a second reminder is need it will be given by Administrator and testing will be conducted at that time. 3. IP Nurse has moved testing site to a central area where she has better access to staff. 4. Weekly audits will be completed by IP and results brought to QAPI for 90 days or until resolved.	

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F 886	Continued From page 14	F 886		

7/5/22, 7/7/22, 7/10/22, 7/14/22, 7/22/22, 7/24/22, 7/30/22, and 8/6/22 (less than weekly); CNA #3 tested on 6/1/22, 6/9/22, 6/10/22, 6/17/22, 6/23/22, 7/14/22, 7/19/22, 7/22/22, 7/28/22, 8/2/22, and 8/4/22 (less than weekly); CNA #4 tested on 6/9/22, 6/20/22, 6/28/22, 7/1/22, 7/11/22, 7/18/22, 7/21/22, 7/28/22, 8/1/22, and 8/5/22 (less than weekly); CNA #2 tested on 6/16/22, 6/23/22, 7/1/22, 7/3/22, 7/14/22, 7/21/22, 7/25/22, and 8/5/22 (less than weekly); and CNA #5 tested on 6/9/22, 6/20/22, 6/30/22, 7/28/22, and 8/5/22 (less than weekly).

c. Interview with the administrator on 8/10/22 at 8:54 AM confirmed staff were not always testing twice a week. She stated the facility had failed to have in place a monitoring process to ensure staff compliance with twice a week testing. She provided a performance improvement project, started after the survey process had begun, for review.

d. Review of CMS QSO-20-38-NH, revised 3/10/22, showed the routine testing interval for staff who are not up-to-date on their COVID-19 vaccinations in a county with a high level of COVID-19 community transmission is twice weekly.

e. Review of the Performance Improvement Project Guide dated 8/9/22 showed an 'Area for Improvement'. The documentation for that area showed, "Weekly employee testing is complete and accurate." The goal was, "Have a system in place to track weekly employee COVID testing to ensure completion and accuracy each week." The 'root causes' were shown to be: 1. Using "good faith" system, 2. No tracking system, 3. Staff not understanding ramifications, 4. Lack of communication, and 5. Timing." The following was documented under 'Brainstorm', Weekly review of schedules for each department,

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F 886	Continued From page 15 tracking sheet with who needs tested and dates of tests completed/how many times a week are required, Simple Text, designated testing area, watch webinar for designated testing area, self-testing competencies & policy."	F 886		