STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted 01/07/21 throuugh 01/12/21. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey and abbreviated complaint survey was conducted 1/7/21 through 1/12/21. One complaint was investigated during the survey: VA00050418 was substantiated with a deficiency at past non-compliance. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 209 certified bed facility was 158 at the time of survey. One Hundred Thirty-seven (137) residents tested positive for the COVID-19 infection, 73 recovered. Seventy-five (75) facility staff tested positive for COVID-19, 61 recovered.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, clinical record reviews, staff interviews and facility documentation, the facility	F 677	Past noncompliance: no plan of correction required.	1/26/21

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

Electronically Signed | 01/29/2021

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 677	Continued From page 1	F 677		

staff failed to ensure Activities of Daily Living (ADL) included cleaning and trimming/filing fingernails to attain and or maintain safe and sanitary hand hygiene for 1 of 21 residents (Resident # 11) in the survey sample.

The findings included:

Resident #11 was admitted to the nursing facility on 7/16/19 with diagnoses that included total knee replacement in 2013, paraplegia, dysphagia, diabetes mellitus and cognitive communication deficits.

The most recent Minimum Data Set (MDS) assessment was a quarterly dated 10/27/20. The MDS coded Resident #11 with short and long memory problems and severely impaired in the cognitive skills for daily decision making. The resident was assessed totally dependent on one staff for personal hygiene and bathing, and did not resist ADL assistance. Resident #11 was not coded to have mood or behavior symptoms.

The current care plan dated 7/16/19 identified Resident #11 was at risk for decline in ADLs complicated by ability to understand or follow instructions and medical conditions. The goal set by the staff for the resident was that he would be clean and dressed appropriately daily. Some of the approaches the staff would implement to accomplish this goal included provision of personal hygiene in a consistent manner, keep nails clean and trimmed.

On 1/7/21 at approximately 11:15 a.m., during an interview with the Administrator and Director of Nursing (DON), they stated upon return from a medical procedure, the Resident Representative

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(RR) called the Unit Manager to complain of Resident #11's fingernails being long and full of feces. They stated the RR accompanied the resident for the medical procedure and also sent a picture of his hands. They stated it was determined that some of the fingernails were long and jagged, but no feces under the fingernails as indicated by the RR. They stated they cleaned and trimmed the fingernails and created a fingernail audit to ensure adequate hand hygiene that included all residents.

On 1/7/21 at 1:15 p.m., Resident #11 was observed in bed, lying on his right side. His fingernails were observed clean, short, and filed smooth.

On 1/7/21 at 2:00 p.m., a face to face interview was conducted with the Unit Manager where Resident #11 resided. She stated that on 12/15/20, the Resident Representative (RR) accompanied and was present during the resident's medical appointment, after which the RR called to complain about the staff not having the resident's fingernails cleaned and trimmed. It was thought by the RR that the exudates under the resident's fingernails was feces. She said the RR sent a picture of the resident's nails. According to the Unit Manager, some of the resident's fingernails were long, jagged and had dark debris under them. She stated the debris was determined to be dried blood from a recurrent open wound on the resident's left knee. She said, "He has a habit of scratching and digging the area which causes it to reopen and the knee prosthesis is now showing, we provide wound care." She said they soaked, cleaned, cut and filed all of the resident's fingernails and instituted a fingernail audit to ensure fingernail

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F 677	Continued From page 3 care was provided for Resident #11, as well as all the residents of the unit. On 1/12/21 at 4:28 p.m., a final debriefing was conducted with the Administrator, DON, ADON (Assistant Director of Nursing), Corporate Quality Management and Administrator in Training (AIT). No further information was provided prior to the survey's exit. The facility presented the following Corrective Action Plan (CAP) with actions to be initiated on 12/22/20: 1. Resident #11's nails were assessed by the nurse manager on 12/15/20 after a call from the RR and an emailed picture of the resident's hand. The fingernails were cleaned and trimmed. 2. Social worker will conduct random interviews with 6 residents in regard to nail care for 4 weeks. 3. Education was provided at unit huddles regarding expectations for nail care. 4. Social worker or designee will conduct observational hygiene assessments for 4 weeks. Results will be shared with the DON and reported to the QAPI Committee. Based on review and validation of the aforementioned Corrective Action Plan (CAP), review of the resident fingernail audits, assessment of Resident #11's fingernails, as well as observations of randomly selected resident fingernails observed clean, trimmed and smooth, the facility this deficient practice is cited as Past Non-Compliance (PNC).	F 677		
F 880 SS=E	Complaint deficiency-PNC Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/31/21

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F 880	Continued From page 4 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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:	F 880		

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F 880	Continued From page 5 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility documentation, the facility staff failed to ensure infection control standards were followed to prevent the transmission of COVID-19 infection. The facility staff failed to apply Personal Protective Equipment (PPE) (procedural facemask and N95-Respirator) to attain and maintain its intended effectiveness. The facility staff failed to ensure transmission based precautions were in place to prevent the possible transmission of COVID-19 infection on 1 of 4	F 880	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in statement of deficiency. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. 1. 1. Food and nutrition team member was re-educated same day of	

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F 880	Continued From page 6 units (Chesapeake Unit). The findings included: 1. Prior to tour of the facility's units, on 1/7/21 at approximately 11:15 a.m., the Administrator and DON provided typed PPE guidelines for each unit and stated it was his expectation that the survey team followed the same guidelines on each unit, as his staff. The Chesapeake Unit PPE guidelines dated 12/31/20 indicated the following: PPE included N95, full face shield, and gown. You will need to wear this until the facility has been cleared and that it is communicated to you by your leadership team. Wear PPE correctly (wearing 2 masks at the same time can change the filtration properties of your mask and put you and others at risk). The Chesapeake Unit housed both COVID positive and negative residents; however, it was the unit with the most COVID-19 positive residents. On 1/7/21 at 12:45 p.m., a dietary employee was observed wearing a procedural face mask under an N95-Respirator. She delivered a dietary cart to the Piedmont Unit. She stated she wore the procedural facemask in the kitchen and placed the N95-Respirator over top when she was on any of the 4 units. She said she recently returned to work after a week out and would be officially fit tested for an N95-Respirator sometime during the day when the person to conduct the fit testing was available. On 1/7/21 at approximately 3:30 p.m., the same dietary employee was observed with a procedural facemask under her chin and an N95-Respirator over her nose and mouth with the lower elastic band hanging down, not around her head like the top elastic band. She stated	F 880	observation, 1/7/2021, regarding proper wearing of N95 respirator. Social worker was immediately re-educated within 1 hour of observation on 1/7/2021 regarding proper wearing of N95 respirator. Hospitality Aide #1 and #2 were re-educated on the unit same day of observation, 1/7/2021, regarding proper donning and doffing of PPE. 2. The DON/designee will review with team members the facility policy entitled Infection Control Policy & Procedure: Novel Coronaviruses as it specifically related to donning and doffing of PPE and the proper use of N95 respirators. The screening log has been updated as of 12/30/2019 asking team members if they have been tested two times weekly with specific instructions to the screener if they have not. 3. The DON/designee will educate new team members on the process of proper use of PPE regarding donning and doffing and proper use of N95 respirators. Team members including agency will be educated on following testing schedules weekly according to local positivity rates. 4. The Nurse Manager/designee will observe 5 clinicians weekly x 4 weeks, then two clinicians weekly x 8 weeks to ensure they are donning and doffing PPE appropriately. Administration will audit screening logs weekly for 8 weeks ensuring that team members including agency that have worked have been tested per positivity rate. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing	

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F 880	Continued From page 7 she was fit tested for the N95 shortly after she was interviewed earlier and could not wear it with both bands around her head because it hurt her face. She further stated she would pull the procedural mask up under the N95 for comfort. According to the dietary employee, she was not told that the N95 had to be next to skin on her face. On 1/7/21 at 1:30 p.m., the Social Worker (SW) was observed wearing a procedural face mask under her N95-Respirator on the Chesapeake Unit. She was involved in care planning at the bedside of several residents. The SW was observed in an out of the resident's rooms and throughout the hallways on the unit wearing both facemasks in the same fashion. None of her colleagues on the unit attempted to correct the improper donning of her N95. At 2:00 p.m., the SW stated she had been fit tested for the N95-Respirator that she was wearing. When asked the way she wore both of them was routine for her she responded, "Yes, I have always worn my N95 this way, it is very comfortable like this. No one has told me anything else otherwise." On 1/7/21 at approximately 4:20 p.m., an interview was conducted with the Administrator, DON and ADON. They were informed that the facility staff failed to follow their 12/31/20 PPE guidelines. The DON stated it was the culture in the facility to approach their peers to maintain a check and balance to keep each other and the residents safe. The ADON stated she saw the SW in the hall outside of the Chesapeake Unit an hour earlier and corrected how she was wearing the procedural face mask under the N95 to reflect just the N95 directly on her face. The DON stated it was important to wear the N95 appropriately to	F 880	monitoring for continuous improvement.	

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F 880	Continued From page 8 ensure a proper seal protecting themselves and others. On 1/12/21 at 4:28 p.m., a final debriefing was conducted with the Administrator, DON, ADON (Assistant Director of Nursing), Corporate Quality Management and Administrator in Training (AIT). No further information was provided prior to the survey's exit. DHHS (NIOSH) Publication No. 2018-129 (April 2018) The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires a respirator fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace. Re fit tested to be annually. This ensures that users are receiving the expected level of protection by minimizing any contaminant leakage into the face piece (https://www.cdc.gov/niosh/npptl/hospresptoolkit/fittesting.html). https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (accessed 1/12/21, dated 11/20/20): Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing...While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents...Residents with known or suspected COVID-19 should be cared for using	F 880		

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F 880	Continued From page 9 all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html (accessed 1/12/21, dated 12/14/20): HCP (health care providers) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred... 2. On 1/7/21 at approximately 11:15 a.m., the Administrator and the Director of Nursing (DON) shared PPE guidelines with the survey team for the Chesapeake Unit. They stressed that the staff followed strict isolation procedures and that surveyors were to follow the same procedures on the unit. It was shared that scrubs, extra PPE was required for going in and out of resident rooms in order to ensure COVID-19 was not transmitted to the non COVID-19 residents. The Chesapeake PPE guidelines dated 12/31/20 indicated the following: Due to the number of rooms and the location of positives, your unit will be moving to reverse isolation immediately. This is similar to normal isolation, but we are trying to stop the infection	F 880		

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F 880	Continued From page 10 from getting into the room (somewhat the reverse of normal isolation). For every negative resident, you must take every precaution to keep them safe (we do not want to give them COVID). When entering a negative resident's area, this is a critical time for PPE! Change your gown, disinfect your face shield, perform hand hygiene, and don gloves. On 1/7/21 from 1:00 p.m. to 2:45 p.m., Hospitality Aide #1 was observed in and out of COVID-19 resident rooms, as well as COVID-19 negative rooms without changing her isolation gown or wearing gloves. The HA #1 wore an N95-Respirator, face shield and isolation gown. She used hand sanitizer in between each room, but wore the same isolation gown in and out of each room regardless of their COVID-19 status. She stated she started work at 7:00 a.m. and among many of her duties, she was observed delivering and picking up meal trays, setting up meal trays for the residents, assisting to reposition residents, answering call bells to give fluids and other miscellaneous resident centered requests. Although HA#1 and Certified Nursing Assistant (CNA) #1 were observed at 1:40 p.m. going into Resident #11's room to help reposition him so HA#1 could feed him. At 1:45 p.m., she asked CNA #1 should she go into the resident's room to feed him, at which time she proceeded to feed the resident at his bedside. HA#1 did not change out her isolation gown. HA #1 exited the room at 2:05 p.m. Resident #11 was assessed totally dependent on staff to eat and a COVID-19 negative resident.	F 880		

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F 880	Continued From page 11 Prior to assisting this resident to eat, HA#1 entered many of the COVID-19 positive resident rooms and COVID-19 negative resident rooms to either deliver their meal trays or pick them up, and answer call bells, without changing her gown. She did not exercise a system to group the positives then proceed to the negatives, or if not able, change her gown and don gloves before entering the negative resident rooms. She did not use gloves, but used hand sanitizer in between resident rooms. HA#1 entered the rooms of the following residents without regard to their positive or negative COVID-19 status: Resident #6 COVID-19 positive on 12/15/20. Resident #11 COVID-19 negative. Resident #12 COVID-19 positive on 12/19/20. Resident #13 COVID-19 positive on 12/28/20. Resident #14 COVID-19 positive on 12/10/20. Resident #16 COVID-19 negative. Resident #17 COVID-19 positive on 12/28/20. Resident #18 COVID-19 negative. Resident #19 COVID-19 negative. Resident #20 COVID-19 negative. Resident #21 COVID-19 negative. HA#1 was also observed leaving the unit three times without doffing (removal) of gown, cleaning face shield, and upon reentry re-donning a new gown and gloves. Once on 1/7/21 at 1:20 p.m. to deliver a tray of gingerale to the breakroom, second on 1/7/21 at 1:27 p.m. to deliver a tray of cola, and third on 1/7/21 at 2:30 p.m. to retrieve a glass of ice water for Resident #10. HA#2 was also observed leaving on 1/7/21 at 2:24 p.m. and returning to the unit without doffing and donning the appropriate PPE. HA#2's straps	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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F 880	Continued From page 12 to her gown were not tied and were dragging on the floor. On 1/7/21 at 3:50 p.m., HA#1 was interviewed in the Chesapeake Unit Manager's (UM) office with the UM present. The UM stated all staff should change out gown, gloves and disinfect face shield prior to entering a COVID-19 resident room. The UM stated all staff should doff and don the same when leaving the unit and that was the purpose of the isolation equipment station and large receptacle to dispose of used gowns and gloves at the double doors. HA#1 stated 1/7/21 was her first day on the unit and she was only told to wear a gown, answer call bells, deliver and pick up trays and feed residents. She stated, "I had online training for COVID-19, but I was never told which residents were positive or negative for COVID-19 or that I should change my gown, clean face shield before I entered a COVID-19 negative resident room. I was not told to change my gown if I left the unit. I wore the same gown all shift. I was not sure when to wear gloves. I knew once my shift was over everything came off." The UM stated it was her fault that she did not take time to orient her more to the unit or explain negative isolation during morning huddle. The UM said, "A lot was going on." On 1/7/21 at 4:22 p.m., the aforementioned observations on the Chesapeake Unit were shared with the Administrator, DON and the ADON. The DON stated all staff were to follow reverse isolation procedures when entering a negative resident's area per their 12/31/20 PPE guidelines, and to remove PPE to enter another unit to include the break room. On 1/12/21 at 4:28 p.m., a final debriefing was	F 880		

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F 880	Continued From page 13 conducted with the Administrator, DON, ADON (Assistant Director of Nursing), Corporate Quality Management and Administrator in Training (AIT). No further information was provided prior to the survey's exit.	F 880		
F 886 SS=E	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 (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	F 886		1/31/21

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F 886	Continued From page 14 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 staff interviews and facility documentation, the facility staff failed to conduct testing according the positivity rate of COVID-19 in their county for 9 out of 11 agency nursing staff. The findings included: On 01/08/21, at approximately 10:00 a.m., a	F 886	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or of any conclusion set forth in statement of deficiency. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	

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F 886	Continued From page 15 phone interview was conducted with the Assistant Director of Nursing (ADON.) The ADON stated, "The agency staff is treated just like our own staff, they are to be tested twice a week." The ADON stated "if an agency staff member is not working on our scheduled testing day which is every Monday and Thursday, they are to be tested on the next day (upon entry into the facility)." She said at the screening station, the staff will complete a team member screening for COVID-19 that indicates if the staff have not received COVID-19 testing per the facility testing schedule (twice a week) then they must speak with the supervisor prior going on the unit. A phone interview was conducted with the Director of Nursing (DON), ADON and Cooperate staff on 01/12/21 at approximately 11:00 a.m. The ADON said all staff were being tested for COVID-19 (Rapid Testing) twice a week including agency staff. The as-worked agency nursing schedules were reviewed which included the following: Certified Nursing Assistant (CNA) #1 worked the following days: 11/27, 12/08, 12/10, 12/11, 12/14, 12/15, 12/16, 12/17, 12/18, 12/23, 12/24, 12/28/20, 01/04, and 01/07/21 CNA #1 was tested for COVID-19 (Rapid Testing) by the facility on 12/10, 12/17, 12/24, 12/30/20 and 01/06/21. CNA #2 worked the following days: 12/01, 2/02, 12/09, 12/14, 12/15, 12/17, 12/22, 12/24, 12/28, 12/29, 12/30 and 12/31/20. CNA #2 was only tested once for COVID-19 (Rapid Testing) by the facility on 12/10/20.	F 886	1. Agency partners were re-notified (date) of the testing requirements for all of their contracted workers. RN #3, CNA #1, CNA #2 and CNA #3 were each tested prior to, or on the day of their next day worked following the survey. 2. All staff including agency staff will be screened prior to beginning their shift to ensure frequency is in accordance with company policy. The screening log was updated on 12/30/2020 asking new team members if they have been tested twice weekly with specific instructions to the screener if they have not been tested. 3. Same day testing will be completed for any staff including agency staff that have not previously been tested according to frequency outlined by company policy at the time of their entry. Team members including agency staff will be re-educated regarding weekly testing schedules according to the county positivity rates by the DON or designee. 4. The Director of Nursing or designee will audit the as-worked schedule weekly x 8 weeks to ensure compliance by all staff including agency personnel with required COVID-19 testing. The results of these audits will be reported at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement.	

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F 886	Continued From page 16 (CNA) #3 worked the following days: 11/26, 11/27, 11/28, 12/06, 12/07, 12/12, 12/17, 12/18 and 12/19/20. CNA #3 was tested by the facility for COVID-19 (Rapid Testing) on 12/21/20, and 12/24/20 for COVID-19 (Rapid Testing) with positive results. CNA #5 worked the following days: 11/26, 11/28 and 12/19/20. The facility was unable to provide evidence that CNA #5 was tested for COVID-19 during the time she worked in the facility. License Practical Nurse (LPN) #9 worked the following days: 11/21, 11/22, 11/25, 11/26, 11/27, 12/06, 12/08, 12/11, 12/30 and 12/31/20. LPN #9 was tested by the facility for COVID-19 (Rapid Testing) on 12/11/20. LPN #10 worked on 12/08/20. The facility was unable to provide evidence that LPN #10 was ever tested for COVID-19 during the time she worked in the facility. LPN #11 worked on 11/24, 12/30/20 and 01/05/21. The facility was unable to provide evidence that LPN #10 was ever tested for COVID-19 during the time she worked in the facility. Registered Nurse (RN) #2 worked the following days: 12/01, 12/02, 12/08, 12/11, 12/12, 12/15, 12/16, 12/17, 12/18, 12/21, 12/23, 12/24, 12/25	F 886		

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F 886	Continued From page 17 and 12/26/20. RN #2 was tested for COVID-19 by the facility on 11/25/20, 12/10/20, 12/17/20, 12/21/20 and 12/24/20. RN #3 worked the following days: 11/24, 12/16, 12/17, 12/22/20 and 01/04/21. RN #3 was tested for COVID-19 by the facility on 12/17/20, 12/29/20, and 01/05/21. According to the county positivity rate, the facility staff required twice a week COVID-19 testing starting on 11/26/20 through the current date of the survey (01/12/21). The Administrative staff was asked if the agency nursing staff mentioned above were tested according to the county positivity rate (twice a week), the ADON replied, "No." On 01/12/21 at approximately 4:45 p.m., the above information was shared with the Administrator and Team. The the Administrator stated, "We are still trying to contact the Agencies to see if they have documentation of any of their staff testing (COVID-19) but do not have anything to add at this time." No further information was presented prior to exit.	F 886		