STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	R 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

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{E 000}	Initial Comments An unannounced Emergency Preparedness second revisit survey was conducted onsite 12/7/21 through 12/9/21. The first revisit survey was conducted onsite 10/26/21 through 10/28/21 and the original survey was conducted onsite 09/07/21 through 09/10/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit was conducted onsite 12/7/21 through 12/9/21. The first revisit survey was conducted onsite 10/26/21 through 10/28/21 and the original survey was conducted onsite 09/07/21 through 09/10/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long-Term Care Requirements. No complaints were investigated during the survey. The census in this 120 certified bed facility was 69 at the time of the survey. The survey sample consisted of 9 resident reviews.	{F 000}		
{F 623} SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	{F 623}		1/11/22

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

Electronically Signed | 12/27/2021

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{F 623}	Continued From page 1	{F 623}		

Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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{F 623}	Continued From page 2	{F 623}		

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure

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{F 623}	Continued From page 3 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to provide a written notice of discharge, timely, for one Resident (Resident #914) in a survey sample of 2 Residents reviewed for transfer notices. The findings included: On 12/7/21, the survey team requested that the facility provide a list of all Residents transferred or discharged from the facility from 11/30/21-12/7/21. Upon receipt of the listing, two Residents were noted to have transferred/discharged. These two Residents were placed in the Resident sample. A clinical record review of Resident #914's electronic health record was conducted. This review revealed that Resident #914 was transferred from the facility to the hospital for evaluation of a critical lab result. The clinical record review revealed an entry by Employee F on 12/6/21, that read, "DDP (Director of Discharge Planning) notified Ombudsman by fax and RP by certified mail of Pt's transfer/discharge to the hospital ON 12/03/2021". However, on 12/7/21, the facility Discharge Planner (Employee F) provided the survey team with the discharge notice for Resident #914 which	{F 623}	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F Tag 623 1. Resident #914 has been made aware of the reason for recent transfer. This has been documented in the clinical record. The office of state ombudsman has been notified in writing. 2. A review of resident□s discharge within past 14 days has been completed to validate appropriate written notification. This includes notification to the state ombudsman. 3. The Admissions Director/Discharge Planner will be educated by The Administrator/designee will educate on providing proper written notification to the resident/residents representative of the	

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{F 623}	Continued From page 4 was completed on Monday, 12/6/21, (not on 12/3/21 as stated in the clinical record) when it was mailed to the responsible representative (RR), by Employee F. On 12/8/21 at 10:30 PM, a telephone interview was conducted with LPN H, the nurse who transferred Resident #914 to the hospital on 12/3/21. LPN H was able to recall the details of the night Resident #914 went out. LPN H said, "When I came in the day before she [Resident #914] was coughing, they did an x-ray and put her on an antibiotic". LPN H went on to say that the doctor ordered a STAT [as soon as possible/urgent] lab and when she [LPN H] came in on 12/3/21, Resident #914 was very weak, alert but not her normal self. The doctor ordered to send her to the hospital. LPN H confirmed that the only notice provided to Resident #914 and/or her family was a verbal notice of transfer and a bed hold policy was sent with her. On 12/9/21 at 12:23 PM, an interview was conducted with the facility Director of Nursing (DON). The DON was shown the discharge notice for Resident #914 and confirmed it was completed 12/6/21. The DON was made aware that this notice was not sent "as soon as practicable" as required by the regulations. Review of the facility policy titled, "Notice of Transfer/Discharge" was conducted. This policy read, "...4. Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative utilizing the [Company name redacted] Notice of Transfer/Discharge form. Under federal and state law: ...ii. If a transfer/discharge is involuntary and for the following reasons, notification shall be	{F 623}	reason for the transfer/discharge. The education will include notification to the Office of the State Long Term Care Ombudsman weekly. 4. The Administrator/designee will audit transfer/discharges weekly to ensure proper written notification was completed to the resident/residents representative. The audit will also include verification of notification to the Office of the State Long Term Care Ombudsman weekly. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date 1/11/2022	

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{F 623}	Continued From page 5 made as soon as reasonably possible..." No further information was provided.	{F 623}		
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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	{F 880}		1/11/22

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{F 880}	Continued From page 6 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to maintain a system for recording incidents and ongoing surveillance, and failed to implement infection control practices as per the CDC	{F 880}	F tag 880 No action was taken since the time frame had already passed. The screening kiosk will send an alert when the temperature if	

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{F 880}	Continued From page 7 (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements to prevent the spread of COVID-19 within the facility. The findings included: 1a. The facility staff failed to implement a system for identifying staff who may have been exposed to COVID-19. On 12/7/21, during general tour, Surveyor C observed staff screening logs on a table across from the time clock. Surveyor C took photos of the documents on a secure state issued cell phone. On 12/7/21, the facility staff provided evidence of staff screening to include paper logs located across from the time clock and the electronic kiosk at the front entrance as well as visitor and staff rechecking of temperature logs. Further review of the logs revealed some entries on the paper logs that the names were not legible. Additionally, multiple entries had temperature re-checks written in the right hand margin that were not present on the original document Surveyor C had observed. During an end of day meeting on 12/7/21, the facility staff were notified that many of the entries were illegible and were asked if they could identify who the staff were. On 12/8/21, the facility staff provided revised copies of the paper screening logs to include some staff names that were not previously	{F 880}	greater than 99.5 or answers to questions indicate COVID like symptoms will ot be allowed to work and a rapid swab will be performed. Employees are being screened prior to working their scheduled shift. Surveillance logs are updated to demonstrate any positive employees or residents to include those being tracked for symptoms /exposure. Employees are wearing face mask and eye protection since the center remains in the high/substantial transmission level. Current residents in the center have the potential to be affected. Facility staff will be educated by the DON/designee on the screening process prior to working, there are no exceptions. Education also included, repeat education on COVID 19, symptoms, and who to report to if they have COVID like symptoms. In addition, facility staff will be educated on wearing face mask and eye protection while the center remains in high/substantial transmission level. The DON/IP will be educated by the Regional Director of Clinical services/designee completion of the surveillance log/line listing for employees/residents who are COVID +, demonstrating S/S COVID like symptoms or who have been exposed. The DON/IP/Administrator/designee will monitor on a daily basis the screening on the kiosk to ensure employees working,	

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{F 880}	Continued From page 8 legible. On 12/8/21 during mid-morning, an interview was held with the DON. The DON was questioned about the variation on the paper screening forms and the addition of data in the right margin that was not present on the original documents observed by Surveyor C. The DON was shown the original documents as well as the copies provided and had no answer as to who had written the additional data in. On 12/8/21 at 12:13 PM, RN D was accompanied by the facility Administrator and VPO/Employee L presented Surveyor C with a document titled "Employee Recheck" and indicated it was in response to Surveyor's C questions regarding the document changes. RN D stated that she had taken the temperatures/rechecks on the employees and this is the log she maintains on her unit. Review of this document revealed that not all of the added entries of temperature re-checks on the paper screening forms were on the log provided. Review of these logs revealed the following employees had worked and not screened in: * On 12/1/21, housekeeper, Employee O * On 12/2/21, 2 LPN's (LPN B & LPN C) * On 12/3/21, 1 LPN's (LPN F) who worked 2 shifts * On 12/4/21, 2 LPN's (LPN B and LPN E) and 2 CNA's (CNA D and CNA E) * On 12/6/21, 2 LPN's (LPN B and LPN C) * On 12/7/21, 3 CNA's (CNA B, CNA C and CNA F) On 12/9/21 at 12 Noon, during an interview with the DON, the DON was asked if there was any	{F 880}	have been screened. In addition the monitoring will include ensuring any employee showing S/S of COVID like symptoms including fever or high risk travel/exposure. Surveillance logs/line listing will be monitored 5x weekly by the Administrator/designee to ensure they are up to date and include the required information. The DON/designee via direct observation ensure facility staff is wearing both face mask and eye protection while the center is in high/substantial transmission level. The results of the monitoring and observations will be presented to the monthly QAPI Committee for review and discussion. Once the committee determines the problem no longer exists, audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date 1/11/2022	

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{F 880}	Continued From page 9	{F 880}		

reason that staff members who had worked could not be found on any of the COVID screening forms submitted. The DON stated, no and confirmed that all screening documents had been submitted to the survey team. The DON also stated that no one is double checking to ensure that all staff were screened in prior to their shift.

Review of the facility policy titled, "COVID-19" read, "...6. Surveillance- Employees. a. Screen center employees prior to beginning shift to include: * positive travel history to locations with sustained community transmission of COVID-19 within the past 14 days. * Signs or symptoms of COVID-19 (fever (temperature greater than 99.5 degrees F), chills, sore throat, cough, nasal congestion, runny nose, fatigue, myalgia, body aches, shortness of breath, difficulty breathing, headache, nausea, vomiting, diarrhea, or new loss of taste or smell). * Has had high risk/prolonged contact with someone who is suspected or positive for COVID-19".

The CDC (Centers for Disease Control and Prevention) gives the following guidance to nursing facilities in a document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic". It read, "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic. Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection. ...Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2)

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{F 880}	Continued From page 10 symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Healthcare personnel (HCP), even if fully vaccinated, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility. Recommendations for evaluation and work restriction of these HCP are in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2". 1b. On 12/8/21, review of the staff screening logs revealed that on 12/5/21 Employee P had a temperature of 99.9 degrees F. An interview was conducted with Employee P, the receptionist. Employee P stated that on 12/5/21, they were having problems with the kiosk not taking accurate temperatures so this is where she was taking her temperature to verify there was a problem. She stated she then called the DON and started using the paper log where she manually took a temporal temperature. The paper log was obtained and the recheck of her temperature revealed a temperature of 98.6. Father review of the screening logs revealed that on 12/6/21, LPN G screened in with a temperature of 99.6. On 12/7/21, Other Employee C screened in with a temperature of 99.5 there was no evidence of either employee's temperature being re-checked for accuracy, no	{F 880}		

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{F 880}	Continued From page 11	{F 880}		

log of a COVID test being performed or any other staff intervention for these 2 employees.

The facility staff was asked to provide evidence of all of the alerts they had received from the kiosk screening system. Review of the alerts from the kiosk revealed 2 instances where individuals attested to answering the questions wrong. There was no evidence of any follow-up from LPN G or Other Employee C's abnormal temperature readings.

On 12/9/21, at approximately noon, an interview was conducted with the DON. The DON was asked about the elevated temperatures of staff on the screening log and no evidence of any interventions. The DON stated that the kiosk was set to provide alerts when temperatures exceeded 100 degrees F and was just changed. When asked when this change was made, the DON stated they were not aware of it until they reviewed the screening forms provided to the survey team and it had "just been changed" within the past day to alert them for temperatures of 99.5 or greater.

Review of the facility policy titled, "COVID-19" read, "...6. Surveillance- Employees. a. Screen center employees prior to beginning shift to include: * positive travel history to locations with sustained community transmission of COVID-19 within the past 14 days. * Signs or symptoms of COVID-19 (fever (temperature greater than 99.5 degrees F), chills, sore throat, cough, nasal congestion, runny nose, fatigue, myalgia, body aches, shortness of breath, difficulty breathing, headache, nausea, vomiting, diarrhea, or new loss of taste or smell). * Has had high risk/prolonged contact with someone who is

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{F 880}	Continued From page 12 suspected or positive for COVID-19". The CDC (Centers for Disease Control and Prevention) gives the following guidance to nursing facilities in a document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic". It read, "Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility". No further information was provided. 2. The facility staff failed to implement proper use of PPE (personal protective equipment) while in an area with a high rate of COVID-19 community transmission. No eye protection was observed on staff when providing direct care to residents. On 12/7/21 at approximately 1:15 PM, Surveyors B and C conducted general facility observations within the entire facility. All staff, to include administrative staff, dietary, housekeeping, therapy, nursing and direct care staff were observed to be wearing procedure masks only. No eye protection was observed to be worn by any staff. Staff were observed in various	{F 880}		

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situations to include entering Resident rooms to provide direct care of Residents.

On 12/7/21, the survey team accessed the community rate of transmission via the Virginia Department of Health website and confirmed the facility was in an area noted as "high" transmission rate. Accessed online at: https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-in-virginia/community-transmission/

On 12/8/21, during the afternoon a group meeting was held in the DON (Director of Nursing) office with Surveyors B and C as well as facility staff to include the facility Administrator, DON, Employee D, the Corporate Nurse Consultant and Employee L, the Vice President of Operations. During this meeting Employee D stated, "I haven't checked this week, it gets sent out weekly, I don't know the exact number but I know we are red," when asked about the current rate of community transmission.

Review of the facility policy titled, "COVID-19" it read, "11. Prevention measures include, but are not limited to: a. Universal source control....*Centers in area of high community transmission will also wear eye protection (i.e. goggles or face shield) when in patient care areas".

CDC guidance document titled, "Implement Universal Use of Personal Protective Equipment for HCP". This document read, "If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission

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{F 880}	Continued From page 14 should also use PPE as described below: .... * Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html No further information was provided. 3. The facility staff failed to maintain a system for recording infection surveillance and monitoring for Employee C and Employee H. In addition, printed documents provided to the survey team contained information that was not observed on the electronic copy when viewed on a computer screen. On 12/7/21, upon entrance to the facility, Surveyors B and C observed no signage to indicate the facility was in an active COVID outbreak. During the entrance conference held with the facility DON (Director of Nursing) and Employee D, the corporate nurse consultant, they disclosed that the facility had no current Residents or staff with COVID-19. They further reported that the last COVID case in a Resident was October. The most recent staff COVID positive was the week of Thanksgiving. On 12/7/21, a copy of the facility line listing/infection tracking was requested. The facility staff provided the survey team with Resident and staff COVID testing logs. On 12/7/21 at 4:30 PM, Surveyor C conducted a telephone interview with Employee C. Employee	{F 880}		

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C reported that on Monday, 11/29/21, she called out for her scheduled shift due to coughing, blowing nose, having chills and aching. She (Employee C) then reported going to an urgent care clinic on Tuesday 11/30/21, and was tested for COVID-19. On 12/2/21, Employee C received the results indicating she had tested positive for COVID-19 and notified the facility Administrator that same day.

On 12/8/21 at 11:45 AM, Surveyor C conducted a telephone interview with the local health department Epidemiologist (Other Person B). The Epidemiologist stated that she was notified of Employee C's COVID case on Dec. 2. She stated the facility staff requested to conduct contact tracing, because they reported she was training 6 students and no Residents. She said she then received a phone call on Dec. 3, 2021, from the facility to notify her that they had identified 2 Residents with exposure. During this phone interview, the Epidemiologist stated that the facility had emailed her yesterday (12/7/21) and reported a new COVID-19 case that day. Other person B, identified the reported positive on 12/7/21, was Employee H. She (the Epidemiologist) said the facility staff said that Employee H had only been in the facility for about 20-30 minutes on 12/6/21, and had no close contacts.

On 12/8/21 at approximately 10:30 AM, the facility staff identified the DON as their Infection Preventionist. The DON was asked to provide the infection line listing/tracking logs to the survey team that had been requested on 12/7/21. Additional testing logs were provided which listed one staff member who the DON said was their only staff member who is not fully vaccinated.

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{F 880}	Continued From page 16 On 12/8/21 at approximately 12:30 PM, the DON returned to the conference room and asked for clarification on what the survey team meant by a line listing. The survey team explained that they were looking for a listing or tracking of Residents and staff that have infections or symptoms of infection that are being monitored. The DON said that the previous SDC (Staff Development Coordinator) or previous IP (Infection Preventionist) kept track of that and they severed employment in mid-November. Surveyors B and Surveyors C accompanied the DON to the SDC & IP office. The DON was not able to find any infection tracking/line listing other than from previous months prior to November 2021. The DON commented that the previous employees had destroyed a lot of documents when they left. The DON then went to the Administrator's office and they began looking in closets and binders for the requested document. Everyone (Surveyors B and C, the DON, Administrator, Employee D and Employee L) went to the DON's office. The DON began looking on her computer. During the conversation held in the DON office, Employee L said she could access it. Employee L stepped out of the office and in approximately 5-10 minutes returned and said she sent it to the DON. The DON pulled the document up and attempted to print it. Employee D then stepped out of the room and was going to print it from a different printer. While waiting, Surveyor C asked to review the document on the DON's computer screen. The document displayed on the computer screen listed 2 employees who tested positive for COVID-19 on 10/17 and 10/21. Employee D, the	{F 880}		

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Corporate Nurse Consultant then entered the room at 1:32 PM, and provided Surveyor C with printed copies. However, now that same document in printed form listed Employee C as testing positive on 11/30 with a "date resulted: 10/2/21."[SIC] Employee C was not on the DON's computer screen before the document was printed. It should be noted that according to Employee C's interview on 12/7/21, Employee received results on 12/2/21 not on 10/2/21 as indicated on the printed document.

During the group meeting/interview on 12/8/21 at 12:30 PM, the facility was questioned about an additional case of COVID-19 that the health department epidemiologist had disclosed. Employee D stated that Employee H had tested positive and they had tested the office mate, Employee M who was negative.

On 12/9/21, the facility Administrator again confirmed that all testing logs and information had been submitted and no additional records were available. The Administrator confirmed that Employee C was the last staff positive. None of the testing logs had any information regarding the testing of Employee H.

On 12/9/21 at 11:44 AM, an interview was conducted with the DON. The DON/IP was asked about the COVID status of Employee H as recent findings from an interview with the local health department as well as Employee F indicated the likelihood of another positive COVID staff member that was not previously disclosed to this survey team. The DON said Employee H had reported not feeling well and was tested for COVID-19, and was directed to get a PCR test". When asked why she is not on the surveillance

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log/line listing, the DON said, "Because she hasn't been confirmed with PCR". The DON also said, "So no, this [the line listing] is not up to date".

On 12/9/21 at 1:01 PM, an interview was conducted with Employee H. Employee H reported the following symptoms, "fever, no sense of taste and smell, it came on oddly fast, very fast, I felt a little tired on Sunday and Monday morning nothing out of the ordinary. Monday morning when I came in I was tired but thought I would get an extra cup of coffee, took my temperature and was at work maybe 20 min and suddenly felt hot and didn't feel well. I knew something wasn't right, I went back and took my temp at the kiosk, and it was 99.3. [Employee Q's name redacted] took a test and it was negative. I came home and slept several hours. Tues morning I called and told them something was wrong and asked what they wanted me to do. They told me to come to the facility and they would send someone to my car to test me. [Employee D's name redacted] came out all gowned up and did the test. [Employee D's name redacted] called me about 15-20 minutes later and said it was positive. I told her [Employee Q] I would remain in contact, they have been checking on me".

On 12/9/21 at 4:13 PM, the facility Administrator handed Surveyor B some documents that had been requested. Included in those documents were forms titled "COVID-19 Contact Tracing Guideline & Template" with a hand written note "re: [Employee H's name redacted]. Included with this was "Close Contacts" which listed, Employee M and a testing occurrence for Employee M on 12/7/21. Also included was a

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separate page of testing occurrences that listed Employee C as being tested on 11/26, Employee H being tested on 12/6 and 12/7.

Review of the facility policy titled, "COVID-19" it read, "9. Containment/Management....b. Identification of positive case in employee:* Initiate Respiratory Illness Surveillance Log".

Review of the facility policy titled, "COVID-19 Testing" was conducted. It read, "1. Routine testing of employees: ...d. Document using the COVID-19 testing log....10. Documentation of testing: a....document the date(s) and times(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the Center took based on the results. b. Identification of a new COVID-19 case in the Center- document the date the case was identified, date that all other patients and employees were tested, and the dates that all negative patients and employees were retested".

Review of the facility Infection Control Policy and Procedure titled, "Collection Methods and Monitoring", the policy statement read, "The Center routinely monitors the work environment for infection prevention and control practices, and systematically collects, records, and monitors patient data related to healthcare-acquired infections, including infections prior to and after admission, in order to establish baselines, to assess infection prevention and control measures, and to reduce the risks of transmission or acquisition of infection.". The policy also stated ..."10. Compiling surveillance information on a line listing is one of the quickest methods of organizing the data for analysis. This

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{F 880}	Continued From page 20 method arranges the essential information for one patient on a horizontal line. Common problems can be identified by scanning the vertical columns. 11. Collected data must be analyzed to make the data meaningful and documented on the PCC Infection Control dashboard. In addition, Antibiotics orders are to be attached to the case list on the PCC Infection Control dashboard and monitored on the PCC Antibiotic Stewardship dashboard. a. Line listings should be reviewed at least weekly by the Infection Preventionist or designee. The data should be analyzed by nursing units, anatomic sites, and/or organisms with similar antibiotic sensitivities. The analysis may identify infection problems and suggest common-source infections or cross-infections. With this information in mind, the Infection Preventionist may carry out special studies to try to identify the cause and prevent further infections. b. The data analyzed should be expressed in terms of epidemiologic rates so that data can be easily compared. Trends in types of infection or breaks in patient care techniques will be evident...". No further information was provided.	{F 880}		
{F 885} SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms	{F 885}		1/11/22

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{F 885}	Continued From page 21 occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to notify residents, their representatives, and families of a new positive COVID-19 infection within the facility. There were 69 residents admitted to the facility at the time of survey. The facility staff failed to provide required notification to the residents, their representatives, and families of a new COVID-19 positive staff member. The findings included: On 12/7/21, at approximately 1:30 pm, an Entrance Conference interview was conducted with the Corporate Nurse Consultant (Employee D) and the Director of Nursing (DON) in the absence of the Facility Administrator. The Corporate Nurse Consultant stated there were no current COVID positive cases within the facility	{F 885}	F Tag 885 1. Current residents/representatives /families have been notified of current Covid 19 status in the center. 2. Current residents in the center have to potential to be affected 3. The Director of nursing/designee will educate the service ambassador on appropriate notification to residents /representatives /families upon change in Covid 19 status within the center. 4. The DON/ designee will complete a weekly audit of resident records to ensure documentation of notification related to COVID positive cases, results of the audits will be presented to the QAPI Committee for review and recommendation. 5. Once the committee determines the problem no longer exists, audits will be conducted on a random basis. The	

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{F 885}	Continued From page 22 and the facility was not currently in an outbreak status. The DON stated the last COVID positive resident was in October and the facility ended the last outbreak on 11/13/21. The DON stated the last positive staff member was Employee C who left work early on 11/26/21 due to not feeling well. The DON also stated she is also the facility's Infection Preventionist (IP). On 12/8/21, at approximately 11:25 am, an interview was conducted with the Facility Administrator who confirmed the facility was not currently in an outbreak status, last facility COVID outbreak ended on 11/13/21, no COVID positive residents since then and last COVID positive staff member was Employee C. The Facility Administrator stated that she notified the local health department about Employee C as required. On 12/8/21, Surveyor C conducted an interview with Other Employee B from the Local Health Department who confirmed the facility COVID positive notification for Employee C and also stated that an additional COVID positive notification was just received on 12/7/21 for Employee H. On 12/9/21, between 10:00 am and 10:35, brief interviews were conducted with Employee J (housekeeping), Employee K (housekeeping), RN B, and RN C, all of whom confirmed the last COVID positive case in the facility was Employee C around the end of November. At approximately 10:45 am, Employee F, the discharge planner, was interviewed and stated she was notified by the Facility Administrator and the DON/IP on 12/8/21 that Employee H had	{F 885}	Administrator/DON are responsible for implementation of the plan of correction. Completion date 1/11/2022	

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tested positive for COVID-19 on Tuesday, 12/7/21.

However, on 12/9/21, at approximately 11:45 am, during an interview with the DON/IP, the DON stated again, "(Employee C) is the last staff member who tested positive in the facility" and "we notified the health department right away and notified staff, residents, and families as required". The DON/IP confirmed that facility policy and infection control practice is based on recommendations and guidance from the Centers for Disease Control and Prevention (CDC) and guidance, including regulation, by the Centers for Medicare & Medicaid Services (CMS).

The DON/IP was asked about the COVID status of Employee H as recent findings from an interview with the local health department as well as Employee F indicated the likelihood of another positive COVID staff member that was not previously disclosed to this survey team since entering the facility on 12/7/21 at 1 PM.

The DON/IP confirmed that Employee H left work early on Monday, 12/6/21, due to not feeling well. Employee H returned to the facility on Tuesday morning, 12/7/21, and was administered a rapid COVID test by the Corporate Nurse Consultant which resulted in "Positive". The DON/IP confirmed that she was present when the Corporate Nurse Consultant notified the local health department on 12/7/21 and a few staff notifications were made on 12/8/21. The DON/IP confirmed there were no notifications made to residents, responsible parties, or family members.

Review of the facility's policy entitled,

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{F 885}	Continued From page 24 "COVID-19", policy number 2202, effective date 09/30/21, subtitle, "8. Case Reporting", item d read, "Notify all patients, families/RPs [responsible parties], and employees no later than 5pm the following calendar day of any new case". Review of current CDC guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated on September 10, 2021, subheading entitled, "Infection Prevention and Control Program", section 4, item 3 read, "Notify HCP [Health Care Personnel], residents, and families promptly about identification of SARS-CoV-2 [COVID-19] in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions". CDC recommendations/guidelines accessed online 12/14/2021 at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html	{F 885}		
{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	{F 886}		1/11/22

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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 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

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{F 886}	Continued From page 26 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 interview, clinical record review, and facility documentation review, the facility staff failed to conduct COVID-19 testing for 2 out of 131 staff members and 2 out of 9 residents, (Residents #914 and #916), as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements. The findings included: 1. The facility staff failed to conduct routine COVID-19 testing for Employee R and Employee S who had not completed a second COVID vaccine. On 12/7/21, at approximately 1:30 pm, an Entrance Conference interview was conducted with the Corporate Nurse Consultant and the Director of Nursing (DON) who confirmed she (the DON) was also the facility's Infection Preventionist (IP). The Corporate Nurse Consultant stated there were no current COVID positive cases within the facility and the facility was not in an outbreak status. The DON/IP stated that COVID-19 routine testing was currently being conducted twice a week, on Tuesdays and	{F 886}	F tag 886 1. Testing date has been documented in clinical record related to residents #914 #916. Employees number 4 and 5 are no longer employed with the center. 2. Current residents in the center have the potential to be affected 3. Director of nursing/ Designee will be educated by Regional director of clinical services related to documentation of Covid 19 in Electronic medical record to include notification to patients /representatives /families 4. The DON/designee will audit COVID testing completed for the week to ensure proper notification and documentation has been completed. 5. Results of the audit will be discussed at the monthly QAPI meeting for review. Once the committee determines the problem no longer exits the audit will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date 1/11/2022	

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Fridays, for all unvaccinated residents and staff, due to the local community's high level of transmission rates. The facility's COVID-19 staff testing logs beginning on 11/30/21 were requested and received.

On 12/8/21, review of the facility documents revealed routine staff COVID-19 testing on "12/2/21" and "12/7/21" for one unvaccinated employee, RN E. During a follow-up interview with the DON/IP, she confirmed the findings stating, "[RN E] is the only staff member that has been routinely tested since 11/30/21, everyone else has been vaccinated and does not meet the routine testing criteria, we don't have to test anyone who has been vaccinated right now".

Review of previously requested staffing lists to include COVID-19 immunization status revealed the following: Employee R and Employee S who had not completed a second COVID vaccine, with first vaccines given 2/26/21, 10/27/21 and 11/18/21 respectively.

Review of the facility's policy entitled, "COVID-19 Testing", policy number 1704, effective date 09/21/21, subheading, "Procedure", item "1. Routine testing of employees:" read, "Unvaccinated employees are to be routinely tested based on the center's county level of community transmission" and item "6. Testing--Others:" read, "a. Unvaccinated consultants, contractors, volunteers, students, transportation staff and anyone else who 'provide services under arrangement and volunteers' should be tested. These individuals must be tested using the timeframe that corresponds to the centers testing frequency".

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{F 886}	Continued From page 28 Review of the CMS QSO Memo Ref: QSO-20-38-NH, with a revision date of 9/10/21, noted, "Routine testing of unvaccinated staff should be based on the extent of the virus in the community....The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week". Review of current CDC guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated on September 10, 2021, subheading entitled, "Testing", item 4 read, "...In nursing homes, unvaccinated HCP [Health Care Personnel] should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week...if unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift)". CDC recommendations/guidelines access online 12/14/2021 at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html 2. For Resident #914, who displayed symptoms consistent with COVID-19, the facility staff failed to conduct COVID-19 testing as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services)	{F 886}		

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{F 886}	Continued From page 29 guidance/requirements. On 12/9/21, review of the clinical record for Resident #914 revealed the following: * On 11/30/21, Resident #914 was seen by the physician for cough and sinus drainage. * On 11/30/21, the physician ordered a chest x-ray and medication to treat the cough. * On 12/2/21, the Nurse practitioner saw the Resident and ordered a repeat chest x-ray. * On 12/3/21, the provider indicated Resident #914 had pneumonia and started her on an antibiotic. * On 12/3/21, Resident #914 was sent to the hospital due to a critical lab value and change in condition. * No COVID-19 testing had been conducted on Resident #914 since 10/17/2021. Review of the hospital records revealed at EMS (emergency medical services) noted Resident #914's temperature to be 100.2 degrees. 3. For Resident #916, who displayed symptoms consistent with COVID-19, the facility staff failed to conduct COVID-19 testing as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements. On 12/9/21, a clinical record review was conducted of Resident #916's clinical record. This review revealed the following: * On 12/1/21, Resident #916 was administered a cough drop. * On 12/2/21, the nurse practitioner saw Resident #916 for complaints of a cough, sore throat and	{F 886}		

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congestion.
* On 12/2/21, Resident #916 was ordered cough syrup

On 12/9/21 at 10:55 AM, an interview was conducted with Resident #916. Resident #916 reported, "I've got a cold, I need cough syrup. I feel bad in my back and my throat. I didn't know if I was going to die". Resident #916 was asked about COVID testing, Resident #916 said, "They used to do it all the time but haven't done it since I've been sick".

On 12/8/21, in the afternoon, an interview was conducted with the facility Administrator, Director of Nursing (DON), Corporate Nurse Consultant and Vice President of Operations. They facility team was asked what are the events that would trigger COVID testing, the DON said, "If someone has symptoms of COVID, staff or a Resident test positive we would do testing, exposure, if in outbreak status, and community transmission rate". The DON was asked to describe symptoms of COVID-19. The DON said, "Elevated temperature, body aches, coughing, sneezing, vomiting, diarrhea, loss of taste and smell, headaches, respiratory symptoms, shortness of breath, congestion, runny nose".

On 12/8/21 at 5:52 PM, an interview was conducted with LPN J. LPN J was asked what the facility's response is if a Resident is exhibiting COVID symptoms. LPN J said, "We would do a COVID test, get vital signs and notify the doctor".

On 12/9/21 at 10:19 AM, an interview was conducted with RN D, the unit manager for South Wing. RN D stated, "All residents have a standing order for COVID test PRN [as needed] if a

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resident is symptomatic the nurse will notify the doctor and follow whatever orders they provide as far as daily monitoring for symptoms of COVID". RN D reported symptoms of COVID as being a cough, runny nose, shortness of breath, nausea, vomiting, and diarrhea.

On 12/9/21 at 10:41 AM, an interview was conducted with RN C, the unit manager for North wing. RN C confirmed none of her Residents on her wing are on any kind of precautions/isolation.

On 12/9/21 at 10:52 AM, an interview was conducted with RN F. RN F reported symptoms of COVID include: "cough, fever, nausea, vomiting, and sore throat". RN F stated that they have standing orders on all Residents for COVID testing and then would call the doctor for further instructions.

On 12/9/21, both the facility Administrator and DON confirmed that they had provided the survey team with all COVID testing logs. Review of the testing logs submitted revealed that neither Resident #914 or #916 had been tested for COVID-19 following the presentation of COVID-19 symptoms.

Review of the facility policy titled, "COVID-19 Testing" with an effective date of 9/21/21, read, "...4. Symptomatic testing for patients: a. Symptomatic testing of patients will occur at the time symptoms are identified b. POC [point of care] antigen testing may be utilized, if available. If negative, perform confirmatory PCR test. c. While test results are pending, patients with signs and symptoms are to be placed on Enhanced Droplet-Contact precautions. Once results are obtained, the Center will continue or discontinue

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{F 886}	Continued From page 32 Enhanced Droplet-Contact Precautions in accordance with CDC's Discontinuation of Transmission-based Precautions guidance. d. Document using the COVID-19 testing log". A review of the CDC document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" with a revision date of 9/10/21, was conducted. This document read, "Even as nursing homes resume normal practices, they must sustain core IPC [infection prevention and control] practices and remain vigilant for SARS-CoV-2 infection among residents and HCP [healthcare personnel] in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.... Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible". Review of the CMS QSO Memo Ref: QSO-20-38-NH, with a revision date of 9/10/21, noted, "Residents who have signs or symptoms of COVID-19, vaccinated or not vaccinated, must be tested immediately". No further information was provided to the survey team.	{F 886}		
{F 887} SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the	{F 887}		1/11/22

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immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that

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{F 887}	Continued From page 34 includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to document the COVID-19 vaccination status for 38 out of 131 staff members. The findings included: The facility staff failed to obtain and document the COVID-19 vaccination status for 38 out of 131 staff members. On 12/7/21, an interview was conducted with the Human Resources (HR) Manager and a list of all facility staff members to include their vaccination status for COVID-19 was requested. He stated that he did not have any personnel records or staff lists for Agency staff, dietary staff, or housekeeping staff as they were all contractors. He did provide a list that contained the names of 83 staff members and their vaccination status. A staff list with COVID-19 vaccination status was requested and provided from the Dietary Manager, Housekeeping Manager, and Staffing Coordinator. On 12/8/21, an interview was conducted with the Director of Nursing (DON) who confirmed she	{F 887}	F tag 887 1. The center has obtained and documented Vaccinated status for current employees 2.-An audit was conducted of current staff of the facility to ensure vaccination status is documented. 3-The DON/ designee will educate the Human Resource Director on obtaining and documenting COVID vaccine status information for staff members. 4-The Human Resources Director /designee will complete weekly audits of newly hired staff members to ensure that the COVID vaccination status is obtained and documented. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists, the audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date 1/11/2022	

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was also the facility's Infection Preventionist (IP). The DON/IP was shown the list of staff members submitted by the HR Manager and verified it was the same list that she had and current. The DON/IP stated that she did not have any lists of dietary staff, housekeeping staff, or Agency staff. She stated, "We use several agencies for staffing needs and I depend on [name redacted, Staffing Coordinator] to handle and deal with Agency staff".

Review of the staffing list submitted containing 83 staff names revealed a total of 3 staff members with unknown COVID-19 immunization status. An entry for 1 staff member, RN C, contained a note in the "1st Vaccine" and "2nd Vaccine" columns that read, "Not started yet". RN C's hire date, on the same document, was listed as 11/1/2021. RN C's time card revealed full time work to date, which began on 11/1/21. In addition, entries for 2 staff members only had a first dose date recorded, 2/26/21 and 7/19/21 respectively, with a blank spots under "2nd Vaccine" for both employees.

Review of the staffing list submitted by the Staffing Coordinator revealed a total of 35 names of nurses and certified nurse aides with their respective agency name with no COVID-19 immunization status listed.

On 12/8/21, an interview was conducted with the Staffing Coordinator who stated the list of employees represented Agency staff that have been routinely utilized since 11/30/21. The Staffing Coordinator confirmed that she did not have the COVID-19 vaccination status for any of the Agency staff and stated, "That may be coming down the road but right now we [the facility] do

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not require that Agency staff be vaccinated to work here, I just make sure they know how to use our timeclock and that they can access medical records to be able to chart".

On 12/9/21, a follow-up interview was conducted with the DON/IP who confirmed that she did not know the COVID-19 immunization status of any Agency staff members working in the facility. The DON/IP verified that knowledge of the COVID-19 immunization status for residents and staff, is an important component in the determination of COVID-19 testing.

Review of the facility's policy entitled, "COVID-19 Testing", policy number 1704, effective date 09/21/21, subheading, "Procedure", item "1. Routine testing of employees:" read, "Unvaccinated employees are to be routinely tested based on the center's county level of community transmission" and item "6. Testing--Others:" read, "a. Unvaccinated consultants, contractors, volunteers, students, transportation staff and anyone else who 'provide services under arrangement and volunteers' should be tested. These individuals must be tested using the timeframe that corresponds to the centers testing frequency".