STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 survey was conducted 2/8/2022 through 2/10/2022. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/8/2022 through 02/10/2022. One complaint was investigated during the survey. VA00053425 was unsubstantiated with no deficient practice identified. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this 90 certified bed facility was 72 at the time of the survey. The survey sample consisted of eighteen (18) current resident reviews, and three (3) closed record reviews.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 645		2/22/22

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

Electronically Signed | 02/21/2022

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F 645	Continued From page 1	F 645		

State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

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F 645	Continued From page 2 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to accurately complete a PASARR (Preadmission Screening and Resident Review) for one of 22 residents in the survey sample, Resident #62. Resident #62's PASARR did not accurately document the diagnosis of schizophrenia. The findings include: Resident #62 was admitted to the facility on 01/18/2022 with diagnoses that included foot fracture, hypertension, hypotension, muscle weakness, hyperlipidemia, depression, and schizophrenia. The most recent minimum data set (MDS) dated 01/25/2022 was a 5 day admission assessment and assessed Resident #62 as cognitively intact for daily decision making with a score of 14 out of 15. Under Section I - Active Diagnoses: Psychiatric/Mood Disorders, Resident #62 was assessed with depression and schizophrenia.	F 645	1. Resident #62 PASARR Level 1 was corrected with schizophrenia dx recognized. 2. All residents with qualifications for Level 2 assistance could have been affected. No residents were affected. 100% PASARR Level 1 audit completed to ensure all mental health diagnosis are accurately documented. Audit completed on 2/21/2022 by Social Services Director. 3. In-service with Social Service Director on how to accurately complete the PASARR Level 1. In-service completed on 2/17/2022 by Corporate Director of Social Services. 4. Social Services Director will audit all new admission PASARR weekly to ensure all mental health diagnosis are accurately documented. Report findings to QAPI monthly for 3 months. 5. DOC 2/22/2022	

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F 645	Continued From page 3	F 645		

Resident #62's electronic clinical record was reviewed on 02/08/22. Observed on the physician's orders was the following: "Trihexyphenidyl HCl Table 5 MG Give 0.5 tablet by mouth two times a day for schizophrenia. Start Dated 01/27/2022."

Observed on the care plans was the following focus area: "Resident is at risk for adverse effects R/T (related to) psychoactive medication use: Schizophrenia, depression, delusions. Date Initiated: 01/19/2022."

A PASARR Level I, DMAS form 95 was observed scanned into the miscellaneous documents of the clinical record. The PASARR did not identify Resident #62 has having a current mental illness. Per review of the clinical record, Resident #62 was diagnosed with schizophrenia.

On 02/09/2022 at 4:00 p.m., the facility's social service director (OS #3) was interviewed regarding the PASARR. OS #3 reviewed the PASARR and stated he was responsible for completing the Level I prior to admission. OS #3 was asked about the information on the document that was not reflective of the diagnoses listed on Resident #62's clinical record. OS #3 stated, "I must have missed the schizophrenia diagnosis when I reviewed the preadmission paperwork."

On 02/09/2022 at 4:40 p.m., the above findings were reviewed with the administrator, director of nursing, assistant director of nursing, and corporate consultant.

No other information was provided to the survey

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F 645	Continued From page 4 team prior to exit on 02/10/22 at 12:30 p.m.	F 645		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to ensure food was stored and prepared in a sanitary manner in the main kitchen of the facility. Findings include: On 2/8/22 beginning at 10:55 a.m. the kitchen was inspected with the dietary manager (DM). The refrigerator contained 4 plastic bins with approximately 50 half-pint containers of milk that were expired as of 2/7/22. Another plastic bin contained approximately 20 cartons of expired	F 812	1. All expired milk was disposed of on 2/11/2022. Cook placed her hair net on immediately on 2/8/2022. 2. All residents have potential to be affected by this practice, no ill effects noted to any resident. Refrigerators were checked for any other expired milk or foods and none observed on 2/11/2022. All dietary staff had appropriate hair coverings on 2/11/2022. 3. Dietary Manager in-serviced all dietary staff that no expired food or drink will be stored awaiting disposal in the	2/22/22

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F 812	Continued From page 5 milk for a total of approximately 220 cartons of expired milk. The DM was asked about the amount of milk, and he replied, "The delivery man used to come twice per week, he has only been coming once a week for the past month. I had this same issue last week, and I'm trying to get him back twice a week. There was no explanation as to why he has reduced the delivery schedule..." On 2/8/22 at 12:00 p.m. an employee, identified as the cook, was observed without a hair restraint covering over her hair. When asked why she did not have on a hair restraint, she stated "I've been running around here trying to get things done and just forgot." On 2/9/22 the nurse consultant was asked for a policy for food storage and hair restraint. The food storage policy "Storage of Refrigerated Foods" documented "16...Monitor daily for expiration or 'use by' dates and discard all outdated items immediately." The policy for hair restraints "Dress and Personal Hygiene" documented "2. Employees, when working in the Food and Nutrition Services Department" will wear a clean and appropriate hairnet/hair restraint. This hairnet/hair restraint will cover all hair....." The administrator, DON (director of nursing), ADON (assistant director of nursing), and corporate nurse consultant were advised of the above observations during a meeting with facility staff 2/9/22 beginning at 4:40 p.m. No further information was provided prior to the exit conference.	F 812	kitchen. If the food or drink is expired then it will disposed of immediately. When in kitchen all staff is to wear appropriate hair covering to contain their hair per our policy. Completed on 2/21/2022. 4. Administrator and/or designee will perform weekly kitchen audits to ensure that dietary staff have appropriate hair coverings and that no expired food or drink is present in the refrigerators/freezer. Audit will be discussed at QAPI monthly for 3 months. 5. DOC 2/22/2022	

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F 842	Continued From page 6	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/22/22

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,

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F 842	Continued From page 7 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 22 residents in the survey sample: Resident # 31. Resident 31 had a PASARR (Preadmission Screening and Resident Review) form in the clinical record that was incomplete and inaccurate.	F 842	1. Resident #31 PASARR Level 1 was corrected. 2. All residents could have been affected. No residents were affected. 100% PASARR Level 1 audit completed to ensure they are accurately completed. Audit completed on 2/21/2022 by Social Services Director. 3. In-service with Social Service Director	

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F 842	Continued From page 8 Findings include: Resident # 31 was admitted to the facility 6/2/13 with diagnoses to include, but were not limited to: muscle weakness, pain in right hip, heart failure, high blood pressure, and vitamin D deficiency. The most recent MDS (minimum data set) was a quarterly review dated 1/7/22 and had Resident # 31 as being cognitively intact with a summary score of 13 out of 15. The electronic medical record (EMR) was reviewed 2/9/22 at approximately 3:00 p.m. A PASARR Level I, DMAS form 95 was observed scanned into the miscellaneous documents of the clinical record. The PASARR did not identify Resident #31 has having a current mental illness. Per review of the clinical record, Resident # 31 did not have a diagnosis of a mental illness, or dementia. The PASARR form, dated 12/17/21 had the resident as "5.b. No referral for active treatment needs assessment required because individual: Has a primary diagnosis of dementia (including Alzheimer's disease)....." On 02/09/2022 at 4:00 p.m., the facility's social service director (OS #3) was interviewed regarding the PASARR. OS #3 reviewed the PASARR and stated he was responsible for completing the Level I prior to admission. Resident # 31 was admitted as a "private pay" resident, and only recently required a screening for the Medicaid services. It was pointed out to OS #3 that the information on the document was not reflective of the diagnoses listed on Resident # 31's clinical record. OS #3 stated, "I thought [name of resident] had dementia....." OS # 3 was informed the resident did not have a dementia or	F 842	on how to accurately complete the PASARR Level 1. In-service completed on 2/17/2022 by Corporate Director of Social Services. 4. Social Services Director will audit all new admission PASARR weekly to ensure the form is completed accurately. Report findings to QAPI monthly for 3 months. 5. DOC 2/22/2022	

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F 842	Continued From page 9 Alzheimer's disease diagnosis listed in the EMR. OS # 3 stated "I'll check on that to see if that was updated; I'm fairly certain I heard she had some dementia....." The DON (director of nursing) was asked if Resident # 31 had any update of her diagnoses to include dementia or Alzheimer's. She stated "No." On 02/09/2022 at 4:40 p.m., the above findings were reviewed with the administrator, director of nursing, assistant director of nursing, and corporate consultant. No other information was provided to the survey team prior to exit on 02/10/22 at 12:30 p.m.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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	F 880		2/22/22

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F 880	Continued From page 10	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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.

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F 880	Continued From page 11 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure infection control practices were followed for one of three isolation rooms on the COVID unit. Findings include: On 02/09/22 10:36 AM, the COVID unit/rooms were observed. Each room had a plastic barrier at each door and two isolation carts were in the hall. Both isolation carts had gowns, gloves and N-95 masks, but there was no eye protection in either of the isolation carts. Each of the rooms had signage attached to the door frame, which documented: "...droplet-contact precautions...perform hand hygiene, wear a mask before entering, gown before entering, gloves before entering, eye protection before entering...red room." CNA (certified nursing assistant) #3, was informed there was no eye protection/goggles on the carts and was asked where the eye protection was located. CNA #3 stated that she didn't know, but would try to find the goggles they use. CNA #3 looked in the supply room and did not find any. CNA #3 stated that she thought housekeeping restocked the isolation cart, but wasn't sure. CNA #3 then stated that CNA #2 was working down	F 880	*See attached DPOC 1. Goggles were provided to CNA #2 and she was in-serviced that day, 2/9/2022, on wearing appropriate PPE in isolation room by the DON. 2. All residents could have been affected. No ill effects to any residents for this practice. 4 other residents were on isolation and their bins were checked and filled with goggles/face shields on 2/9/2022, so staff would have readily available. 3. CNA #2 was in-serviced individually on 2/9/202 about appropriate PPE and where to find PPE if Bins are not stocked. Education provided with all staff on wearing the appropriate PPE when in isolation rooms and where supplies are located to restock the isolation bins when they are out of certain items. Staff are to notify the Admin/DON/ADON if any supplies are needed. To ensure that isolation items are restocked we have put a stocking procedure in place. In-service completed on 2/21/2022 by the ADON and DON. Stocking of isolation bins for the COVID rooms will be as followed: Central Supply staff will check the isolation bins 2 times per day 6 days per week to ensure they	

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(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
F 880	Continued From page 12 there and may know where they were. CNA #3 then walked down the hall and called for CNA #2. CNA #2 was observed through the plastic barrier, sitting in the first isolation room in a chair. CNA #3 asked CNA #2 through the plastic barrier where the goggle/eye protection was located. CNA #2 stated that she didn't know. CNA #2 was observed sitting inside of the room, behind the plastic barrier without any eye protection CNA #2 was asked why she didn't have on eye protection. CNA #2 got up from the chair and walked closer to the door and stated, "There wasn't any in there (pointing to the isolation cart)." At 10:45 AM, RN (Registered Nurse) #3 came down the hall with several pairs of goggles. CNA #2 came to the plastic barrier of the room where she was sitting and RN #3 handed her a pair of goggles. RN #3 stated that she would refill the goggles with what she had brought down. RN #3 was asked about the protocol for COVID positive rooms. RN #3 stated, "We are supposed to have N95, eye protection, gown and gloves in the red and yellow rooms." RN #3 was asked what a red room wasz. RN #3 replied a COVID positive room. RN #3 was asked if CNA #2 should have had on eye protection in that room RN #3 stated, "100 % it should have been for that room." At 11:11 AM, CNA #2 was interviewed. CNA #2 stated that she was in the COVID room, because the resident was in the bathroom and she was waiting on him to finish. CNA #2 was asked why she didn't have a pair of goggles on prior to entering in a COVID positive room, as the	F 880	are supplied with all required items (gowns, gloves, goggles/face shields, and N95 masks). When central supply person is off then extra supplies will be readily available for the nurses/aides to stock as needed. 4. DON or designee will complete random audits 3 times per week at random times of the day on isolation rooms to ensure staff are wearing appropriate PPE in rooms. Report to QAPI monthly for 3 months. 5. DOC 2/22/2022	

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	495411	A. BUILDING _____ B. WING _____	C 02/10/2022

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F 880	Continued From page 13 signage reads. CNA #2 stated, "There wasn't any in the outside cubby drawer and I didn't have any." CNA #2 was asked about the signage on the door. CNA #2 stated that the red rooms are COVID positive and you should wear a gown, gloves, mask and goggles prior to entering and stated, "Goggles for sure." CNA #2 was asked who usually stocks the carts and CNA #2 stated that staff usually do after their shift and stated, "They have some now." On 02/09/22 at 2:16 PM, the DON (director of nursing) was asked the expectation for PPE (personal protective equipment) when entering a COVID positive room. The DON stated, "The expectation is that staff will wear a gown, gloves, N95 and eye protection." The DON was made aware of the observation and was asked for a policy regarding isolation and PPE requirements. At 2:30 PM, the DON presented a policy, "Recommended use of personal protective equipment for health care settings for Coronavirus Disease...Isolation unit [RED]...anyone...N95-eye protection-gown-gloves..." On 02/09/22 4:40 PM, the Administrator, DON, ADON [assistant director of nursing] and corporate nurse were made aware of the above information. No further information and/or documentation was presented prior to the exit conference on 02/10/22.	F 880		
F 888 SS=D	COVID-19 Vaccination of Facility Staff	F 888		2/25/22

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F 888	Continued From page 14 CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in	F 888		

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F 888	Continued From page 15 paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;	F 888		

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F 888	Continued From page 16	F 888		

(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for

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F 888	Continued From page 17 those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to meet the requirement for staff COVID-19 vaccination. The facility staff's COVID-19 vaccination rate was 93.5% instead of the required 100% compliance rate as required. The findings include: On 02/08/2022 at 10:21 a.m. during the entrance conference, the administrator and director of nursing (DON) were interviewed regarding the facility's staff COVID-19 vaccination rate. The DON stated, "We're not at 100%, but we're working on it and are providing onsite COVID-19 vaccines for all staff." The facility's staff was requested to provide the current COVID-19 vaccination status for all staff members including any contract staff. A review of the NHSN (National Health Safety Network) data dated 1/23/2022 documented the facility's reported staff vaccination rate was 83.2%. A review of the facility's COVID-19 staff vaccination matrix documented the facility employed 123 staff, that included 109 staff completely vaccinated, 5 staff partially vaccinated, and 1 staff with a pending medical exemption which equaled 93.5% of staff that were vaccinated.	F 888	1. In order to achieve 100% compliance, the facility staff who have not received their Covid 19 vaccination will be placed on unpaid leave on 2/20/2022. 2. No other staff members are affected since they have had at least one or both of their Covid-19 vaccinations or otherwise have an approved exemption. 3. If these staff members have still not had their 1st Covid-19 vaccination by 2/20/2022, then they will be placed on unpaid leave until 2/25/2022 to give them a chance to change their mind about receiving the vaccine or they could bring proof of vaccination, then they will be able to continue their employment. If not, however, then they will be terminated on the 25th. These staff members are met with 1-1 weekly and they sign an education sheet stating they understand they will be terminated if they are not compliant with the vaccine mandate. Applicants will be notified of the vaccination policy. After an offer of employment has been made, but prior to the individual starting work, the individual must provide proof of vaccination, or receive the first dose of the vaccine, or request and receive an approved	

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F 888	Continued From page 18 On 02/09/2022 at 8:09 a.m., the DON was interviewed regarding the staff's vaccination rate. The DON stated that one staff member (laundry aid) had received her first vaccination on 2/8/21 and the facility had an upcoming vaccination clinic scheduled for Friday, 2/11/22 and two more staff were scheduled to receive their first vaccines. The DON was asked if the facility provided ongoing testing, education and monitoring for all staff who were not fully vaccinated. The DON stated, "Yes staff and residents are currently being tested twice per week. We educate everyone about the importance of COVID vaccination especially staff. If they choose not to get vaccinated or don't have an approved exemption then they are removed from the schedule. They either quit or are terminated. We've been offering vaccine/COVID clinics since January 2021 not only for our staff and residents, but also for family members and vendors." On 02/10/2022 at 9:15 a.m., the corporate consultant was interviewed regarding the facility's staff vaccination rate. The corporate consultant stated, "We originally had a QAPI (Quality Assessment and Performance Improvement) Plan dated 1/27/22 to meet the required 100% compliance by 3/27/22 which was within the 90 day window. However, on yesterday (02/09/22) we reviewed and updated the plan to meet the 100% compliance by 02/20/22." The corporate consultant was asked if the facility was providing education to non-vaccinated staff. The corporate consultant stated, "Yes we meet with them weekly and document our efforts. If they choose not to get vaccination and there is not an approved exemption then they will be terminated effective 2/25/22."	F 888	accommodation. The individual will not begin work until the first dose is received or an approved accommodation has been given. 4. HR/IP/Designee will review employee/applicant Covid-19 vaccination status or an approved accommodation status weekly times 12 weeks and/or as needed to maintain compliance with the vaccination mandate and/or CMS changes or amendments. HR/IP/designee will report the results of the monitoring to the QA committee for review and recommendations for the monitoring period or as it is amended by the committee. 5. DOC date 2/25/22	

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F 888	Continued From page 19 On 02/10/22 at 12:00 the above findings were reviewed with the administrator, DON, ADON, and corporate consultants. No other information was provided to the survey team prior to exit on 02/10/22 at 12:30 p.m.	F 888		