STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

(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 A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 02/24/2022 through 02/25/2022. The facility was in substantial compliance with 42 CFR Part 483.475(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 196 certified bed facility was 187 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and complaint survey was conducted onsite 02/24/2022 through 02/25/2022. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The survey sample consisted of 11 residents. One complaint, VA00054421 (Unsubstantiated), was investigated during the survey. The census in this 196 certified bed facility was 187 at the time of the survey. The survey sample consisted of 11 resident reviews and 8 employee reviews.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		3/28/22

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

Electronically Signed | 03/18/2022

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F 760	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to ensure that two (2) Residents (Resident #1 and #4) were free from significant medication errors in a survey sample of 11 Residents. The findings included: 1. For Resident #1 the facility staff failed to administer Lantus (insulin) as ordered by the physician on 7 occasions from January 18, 2022, through February 24, 2022. On 2/24/22 and 2/25/22, a clinical record review of Resident #1, electronic health record was conducted. This review revealed the following physician orders: * "Lantus Solution 100 UNIT/ML (Insulin Glargine) Inject 20 unit subcutaneously at bedtime for DM [diabetes mellitus], with a start date of 1/13/2022". This order was discontinued when Resident #1 discharged on 1/31/22, and was readmitted on 2/8/22. * A physician order dated 2/11/22, read, "Lantus Solution 100 UNIT/ML (Insulin Glargine) Inject 30 unit subcutaneously at bedtime for DM Refrigerate before opening. Once opened may store at room temp. Date when opened and discard after 28 days. Do not mix other insulin". Review of the Medication Administration Record revealed that on 1/18/22, 1/27/22, 1/28/22, 2/11/22, 2/14/22, 2/19/22, and 2/24/22, the Lantus insulin had not been administered.	F 760	Colonial Heights Rehabilitation and Nursing Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence to comply with the requirements of participation and effort to provide high quality resident centered care. 1. Resident # 1 continues to reside in the facility and receives Lantus as ordered. Resident #4 continues to reside in the facility and receives phenytoin as ordered. 2. All residents prescribed Lantus have the potential to be affected by this alleged deficient practice. An audit of current residents receiving Lantus was conducted to verify they have received as ordered. All residents prescribed phenytoin have the potential to be affected by this alleged deficient practice. An audit of current residents receiving Phenytoin was conducted to verify they have received as ordered. 3. All facility licensed nurses will be educated by DON or designee on ordering medications to ensure availability, checking Cubex for availability and on the process with documentation for medications not available. The MD/NP will be notified for medications not available to consider alternative or hold until available with documentation. Medications will be administered per physician order. 4. DON or designee will audit MARs of	

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F 760	Continued From page 2 Review of the progress notes for Resident #1 revealed an entry on 2/24/22, regarding the Lantus insulin that read, "Reordered". There were no other notes regarding why the Lantus had not been given as ordered. 2. For Resident #4 the facility staff failed to administer Phenytoin (medication used to prevent and control seizures (also called an anticonvulsant or antiepileptic drug) on 10 occasions in February 2022. On 2/24/22 and 2/25/22, a clinical record review was conducted for Resident #4. This review revealed a physician order dated 10/04/2021, that read, "Phenytoin Sodium Extended Capsule 30 MG Give 2 capsule by mouth three times a day for Seizures related to conversion disorder with seizures or convulsions". Review of the MAR (medication administration record) revealed in the month of February 2022, Resident #4 was not administered Phenytoin as ordered on: 2/2/22, 2/3/22, 2/5/22, 2/6/22, two occasions on 2/11/22, 2/20/22, and three missed doses on 2/21/22. Review of the nursing notes revealed the following notes: * On 2/2/22, "went on appointment", indicating Resident #4 was not given Phenytoin because she went on a medical appointment outside of the facility. * On 2/20/22 and twice on 2/21/22, a nursing note entry was made with regards to the Phenytoin that read, "Awaiting arrival from pharmacy".	F 760	residents receiving Lantus and Phenytoin weekly x 4 weeks then monthly x 2 to ensure availability and administration of Lantus and Phenytoin medications per physician order. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be March 28, 2022	

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* On 2/21/22, another nursing note read, "MEDICATION NOT AVAILABLE WAITING ON PHARMACY".

On 2/25/22, during an interview with Resident #4, the Resident stated, "I am blessed I haven't had any seizures lately even though they missed my Dilantin a whole day and half. I take 6 pills a day and they ran out of them; they shouldn't wait until the last minute to order stuff like that. I was going to bring that up in the care meeting next time". When asked if this happened recently, Resident #4 said, "Yes, this week".

On 2/25/22 at 8:20 AM, Surveyor E spoke with LPN B, the unit manager. LPN B stated that the facility has an emergency supply/box of medications and also has a Pyxis (an automated medication dispensing system). LPN B said if a medication is not available she would call the pharmacy to see when it would be delivered and then call the doctor to see if they want to hold the medication and wait for deliver or give orders for something else, and then she would document in the clinical record all of these efforts. LPN B said it is really important for Residents to receive medications because "It may be something the eye really have to have".

On 2/25/22 at 8:31 AM, Surveyor E spoke with RN D. RN D stated that if a medication is not available, she would see if it is in the emergency box, if not she would then call the pharmacy to see the estimated time of arrival. At that point RN D said she would call the doctor and let them know it is not available, the estimated time of arrival and ask if they want to substitute something else. She would document all of this in the chart. RN D was asked how important it is

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for a Resident who takes Dilantin and Lantus to receive those medications. RN D said, "It's pretty important you don't want them to have a seizure. For insulin you risk them having a diabetic coma or worse, but we have a house stock of insulin".

On 2/25/22 at 8:45 AM, the Director of Nursing (DON) was made aware of the above findings. The DON reviewed Resident #1 and #4's, clinical record and confirmed Surveyor E's observations. The DON said the pharmacy delivers to the facility twice daily.

On 2/25/22 at 10:54 AM, Surveyor E spoke with LPN D. LPN D confirmed he had not been assigned Resident #1 on all of the observed occurrences of the insulin not being administered. LPN D further confirmed that if it was not documented on the MAR there was no other way to confirm it was given.

Review of the facility supplied listing of medications maintained on hand, available for use revealed the Phenytoin Sodium was available in 100 mg capsules with a quantity of 10 on hand.

On 2/25/22 at 11:20 AM, Surveyor E spoke with Employee H, the Nurse Practitioner (NP) regarding Resident #4's missed doses of Phenytoin. The NP stated that Resident #4 risks having seizures if the medication isn't administered. When asked if she was made aware that an alternate strength of Phenytoin was available in the emergency box to see if she wanted to adjust the order she stated "No, that was never communicated". The NP went on to say, "They [the facility staff] need to be more proactive in ordering medications from the pharmacy, if she takes 6 a day, you can't wait

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F 760	Continued From page 5 until she only has a few pills to reorder it, they should be reordering when she gets down to about 21". The facility policy titled, "Medication Administration- General Guidelines" was reviewed. This policy read, "...11) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, and the medication may be removed from the emergency kit if available..." This policy also stated, "...Documentation: 6) If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. If electronic MAR is used, documentation of the un-administered dose is done as instructed by the procedures for use of the eMAR system. An explanatory note is entered on the reverse side of the record. If three (3) consecutive or multiple doses as established by facility policy of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response..." On 2/25/22, the Assistant Administrator and the DON were made aware of the above findings. No additional information was provided.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/28/22

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 7 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 observation, staff interviews, facility document review and clinical record review the facility staff failed to implement policies and CDC guidance to mitigate the spread of COVID19. The findings include: The facility staff failed to: 1) Display instructional signage throughout the facility that provided visitor education on COVID19 signs and symptoms and infection control precautions. 2) Appropriately use Personal Protective	F 880	1. The facility is no longer in Covid Outbreak. Instructional signage was placed throughout the facility for visitors referencing COVID-19 signs and symptoms and Infection Control Precautions. Employee O was re-educated on the proper use of PPE during COVID-19 source control. Employee D was re-educated on the proper use of PPE when cleaning residents' rooms. C.N.A F was re-educated on the proper wearing of PPE and physical distancing. Nurse C was	

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F 880	Continued From page 8 Equipment (PPE) 3) perform hand hygiene between residents On 2/24/22 the following observations were made: 9:30 AM, two signs were observed on the door. The first sign said "If you have any of the following symptoms please call before coming." The sign then listed symptoms of COVID 19. The second sign stated that all visitors must be screened in at the lobby kiosk, The sign further said visitors going to the COVID areas are to drive around to the back and enter through the doors in that area. 1) However, there were no signs informing the public of the outbreak status and instructing on the proper use of PPE on the main entrance door or on the "COVID Entrance doors." 2a) Upon entry Employee O was observed sitting at the Receptionist desk behind not wearing a mask while talking on the phone. 9:35 AM - The DON was asked what type of masks are being utilized for source control. The DON stated that N 95's were required in patient care areas. She elaborated "We are still technically in outbreak so we are wearing N95 on the floor but up at front offices we are wearing procedure / surgical masks." When asked what the Receptionist should wear she stated a surgical mask. When asked to look over at the Receptionist she saw that she was not wearing a mask and asked her to put one on. 10:05 AM - An interview was conducted with the Assistant Administrator and the DON who stated,	F 880	re-educated on hand hygiene during med pass. 2. All residents have the potential to be affected by this alleged deficient practice. An observation audit was conducted on 2/24/2022, the day of finding, by the Unit Manager to ensure other staff were wearing and removing PPE appropriately and use of hand sanitizer available to clean and disinfect hands on medication carts. 3. Facility staff will be re-educated by DON or designee on proper hand hygiene, PPE usage and physical distancing. All Facility Licensed Nurses will be re-educated by DON or designee on hand hygiene during medication pass and have hand sanitizer available on the medication carts. 4. DON or Department Manager will conduct observation audits on 10 facility staff for use of mask on with proper placement, hand hygiene and use of applying and removing PPE weekly x 4 weeks the monthly x 2. DON or designee will conduct observation audits on 10 Licensed Nurses conducting hand hygiene during medication pass and verify hand sanitizer available on the medication cart weekly x 4 then monthly x 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be March 28, 2022	

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"We have 2 COVID Positive patients now they were admitted positive." She stated that they did have a COVID unit but not anymore, now and they were sheltering in place.

2b) 10:38 AM - Employee D observed was observed wearing yellow procedure mask and face shield, a yellow disposable gown, and blue gloves. Employee D went into room 323 [No precautions sign on door] she was observed cleaning tables, washing floor picking emptying trash exited room 323, without changing PPE. Employee D then entered room 324 [Droplet precautions sign on door], she was observed cleaning tables sink wiping surfaces and sweeping and mopping the floor she came out of room 324 and once again did not change PPE. Employee D then went 322 [No precautions sign on the door] and using the same PPE washed the floor cleaned tables and took out trash and exited room 322 after cleaning tables, washing floor picking up trash and once again without changing PPE she entered room 321 and once again began cleaning room.

2c) 10:55 AM Employee O was observed coming out of room 321 with PPE on. She walked to the Janitors Closet and emptying the mop water once again not changing her PPE. At that time an interview was conducted with Employee O who was asked if she had received training on PPE use and the spread of COVID. She indicted that she had received training. She stated that she had been instructed to wear a gown, gloves, procedure mask and face shield. When asked if she was instructed to change them between rooms she stated no.

2d) 11:20 in the TV room CNA F was sitting within

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3 feet of a resident and visitor. CNA F had her N 95 below her chin talking to another CNA. CNA F was asked should if she should be wearing her mask she stated yes but it's difficult to talk with it on.

3) 10:45 Nurse C was observed passing medications to 4 Residents. She did not wash hands or use hand sanitizer between the first 2 Residents. Once she realized she was being observed by the surveyor, she went to the linen cart and used the hand sanitizer located in the linen cart.

At 10:45 an interview was conducted with Nurse C and she was asked if she had hand sanitizer in her pocket she said no. She was asked if it was on her cart she looked and said no. When asked if there was sanitizer in the Resident rooms she stated no. When asked how she sanitized her hands she stated well I went to the linen cart there is a bottle in there. When asked about the first 2 rooms she passed med on she stated well I just found the sanitizer in the linen cart. I don't work here. I'm an agency staff. When asked if the facility provided sanitizer she stated "I don't know I am agency staff."

10:50 Interview was conducted with LPN E who was asked if the facility provided sanitizer for the Nurses when passing meds, she stated that they did. When asked what the expectation was for cleaning hands she stated "They are expected to use it between residents when passing medications and at times when a sink is not immediately available."

1:45 PM Interview with the IP was conducted and she was asked the expectation of staff passing

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meds and hand hygiene. She stated that it is the expectation of the facility that all nurses passing meds either wash hands or use sanitizer between pulling and passing medications for residents. When asked if the facility provides the sanitizer she stated that they do.

The IP was asked about the expectation of housekeeping with regards to PPE she stated that she expected them to wear N95 eye protection and gloves and gown while in COVID positive rooms or those on isolation precautions. When asked if they were expected to change PPE between rooms she stated yes they should be changing gloves and gown and they should be wiping off the face shield. She was asked what type of mask she should be wearing and she stated she is in a patient care area and all staff in patient care areas have to wear N 95.

When asked what the expectation was for staff wearing PPE in common areas such as the TV room she stated all staff, unless actively eating or drinking (in the designated staff break areas) are to wear their mask appropriately at all times.

Per CDC and CMS guidance:
· Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
· Appropriate staff use of Personal Protective Equipment (PPE)

On 2/25/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

(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 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		3/28/22

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F 883	Continued From page 13 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide influenza vaccines for 7 residents (Residents #1, #5, #6, #7, #8, #9, and #10) out of 11 residents reviewed for influenza immunization and facility staff failed to provide a pneumococcal vaccine for 2 residents (Residents #1 and #5) out of 11 residents reviewed for pneumococcal immunization. The findings included: 1. The facility staff failed to provide influenza immunizations for Residents #1, #5, #6, #7, #8, #9, and #10. On 2/25/22, clinical record review was performed and revealed the following: Resident #1 had no documentation with regard to influenza immunization, to include the resident's current influenza vaccination status, offer to	F 883	1. Residents #1, #7, and #9 continue to reside in the facility and have received the Influenza vaccine on 3/1/22. Residents #6, #8, and #10 continue to reside in the facility but refused the Influenza vaccine. Resident #5 no longer resides in the facility. Resident #1 continues to reside in the facility but refused the pneumococcal vaccine. 2. All residents have the potential to be affected by this alleged deficient practice. An audit on current residents was conducted to verify flu vaccine and pneumococcal vaccine was received or not. Residents identified that did not receive the vaccine will be administered if meets the criteria and agrees. 3. All licensed nurses will be re-educated by DON or designee on offering and documenting in PCC for Influenza and Pneumococcal vaccines to residents upon admission and annually	

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F 883	Continued From page 14 provide immunization against influenza infection, or documentation of resident refusal or medical contraindication. Resident #5 had documentation of a confirmed consent for influenza immunization on 1/19/22, however no administration of the influenza vaccine was recorded. Resident #6 had documentation of a confirmed consent for influenza immunization on 3/30/21, however no administration of the influenza vaccine was recorded. Resident #7 had documentation of a confirmed consent for influenza immunization on 3/30/21, however no administration of the influenza vaccine was recorded. Resident #8 had no documentation with regard to current influenza immunization, to include an offer to provide immunization or documentation of resident refusal. Resident #8's last influenza vaccine was administered on 10/16/20. Resident #9 had no documentation with regard to current influenza immunization, to include an offer to provide immunization or documentation of resident refusal. Resident #9's last influenza vaccine was administered on 10/16/20. Resident #10 had no documentation with regard to current influenza immunization, to include an offer to provide immunization or documentation of resident refusal. Resident #10's last influenza vaccine was administered on 10/16/20. An interview was conducted with the Director of Nursing who accessed the clinical records for the	F 883	and administer per agreement of the resident and/or RP and meets the criteria for the administration of the flu or pneumococcal vaccine. Infection Prevention nurse will be educated by DON/Designee on offering all residents the Influenza/Pneumococcal vaccine annually and/or as recommended by CDC with administration and documentation. 4. DON or designee will audit new admissions weekly x 4 then monthly x 2 to ensure influenza and pneumococcal vaccines have been offered, documented and have been administered if accepted. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be March 28, 2022	

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previously listed residents and verified the findings. An interview was conducted with the Infection Preventionist who also confirmed the findings and stated, "There may have been a couple residents that got by me, I will be looking into it and I will get them caught up".

Review of the facility policy revised August 2016 and entitled, "Influenza Vaccine", subheading, "Policy Statement" read, "All residents...will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza". The Facility Administrator, Director of Nursing, and Infection Preventionist were all made aware of the findings. No further information was provided.

2. The facility staff failed to provide pneumococcal immunization for Resident #1 and Resident #5.

On 2/25/22, clinical record review was performed and revealed the following:

Resident #1 had no documentation with regard to pneumococcal immunization, to include the resident's current pneumonia vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication. There was a physician's order dated 2/8/22 which read, "May have Pneumovax with consent".

Resident #5 had no documentation with regard to pneumococcal immunization, to include the resident's current pneumonia vaccination status, offer to provide immunization against

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F 883	Continued From page 16 pneumococcal infection, or documentation of resident refusal or medical contraindication. There was a physician's order dated 9/21/21 which read, "May have Pneumovax with consent". An interview was conducted with the Director of Nursing who accessed the clinical records for the previously listed residents and verified the findings. An interview was conducted with the Infection Preventionist who also confirmed the findings and stated, "There may have been a couple residents that got by me, I will be looking into it and I will get them caught up". Review of the facility policy revised August 2016 and entitled, "Pneumococcal Vaccine", subheading, "Policy Statement" read, "All residents will be offered the pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections". The Facility Administrator, Director of Nursing, and Infection Preventionist were all made aware of the findings. No further information was provided.	F 883		
F 888 SS=D	COVID-19 Vaccination of Facility Staff 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.	F 888		3/28/22

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§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 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

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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;
(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

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F 888	Continued From page 19 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 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 documentation review, the facility staff failed to implement their policy and procedure with regards to tracking the vaccination status of facility employees and failed to ensure the facility had a 100% vaccination rate for COVID-19 vaccination of employees. The facility vaccination	F 888	1. All unvaccinated staff offered the Covid-19 vaccine per CDC/CMS guidelines as well provided information on exemption application process. All new hires and agency staff to show proof of COVID Vaccination Status prior to first day of employment.	

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F 888	Continued From page 20 rate of staff was 78.4%. The findings included: On 2/24/22 at 1:07 PM, the facility staff submitted a facility staff vaccination tracking log. Review of this log revealed that data was missing and the facility asked for an opportunity to submit a revised copy. On 2/24/22 at 4:43 PM, the facility submitted a revision staff COVID vaccination matrix. Review of this form revealed the following data: 181 staff were listed 11 were noted as being partially vaccinated 5 granted religious exemptions 18 staff that are not vaccinated On 2/25/22, the facility submitted "as worked" schedule for all departments listing staff that worked on 2/24/22, was reviewed and compared to the facility staff vaccination matrix. This review revealed numerous staff that were noted as having worked but were not listed as being on the vaccination matrix with a vaccination status. On 2/25/22 at 10:00 AM, the facility assistant administrator and Infection Preventionist were interviewed. During this interview they were given the list of employees that were noted as having worked on 2/24, that were not on the staff vaccination matrix. On 2/25/22 at 12:11 PM, the facility submitted a response to the employees missing on the vaccination matrix. The response revealed that there was 27 employees identified by Surveyor E that were not on the vaccination matrix. Twenty-three (23) of which the facility confirmed	F 888	2. All residents have the potential to be affected by alleged deficient practices. An audit on current staff was conducted by Human Resource or Infection Preventionist to ensure they are vaccinated and up to date or have documented approved exemption. Identified unvaccinated staff without an approved exemption will have the first series of vaccine until up to date if refuses will be unable to work. 3. Facility Scheduler, IP Nurse, and hiring managers will be educated by DON or designee on COVID-19 vaccination requirements for staff, including agency staff, per CDC/CMS guidelines. All unvaccinated staff will be educated by DON or designee on COVID-19 vaccination requirements for staff per CDC/CMS Guidelines. 4. DON or designee will audit new hires or agency vaccination status weekly x 4 then monthly x 2 to verify vaccination series has been initiated or an exemption has been granted. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be March 28, 2022	

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had worked on 2/24/22, with all but one providing direct Resident care and/or interaction with Residents.

On 2/25/22 at 1:09 PM, Surveyor E conducted an interview with the facility Assistant Administrator and Infection Preventionist. Both confirmed that there were 27 employees identified by Surveyor E that were not on the list and the facility staff did not know the vaccination status of these employees.

Upon adding the additional 27 employees to the total staff number, and that their vaccination status is unknown, this made the facility vaccination rate of staff be 78.4%. This was discussed with the facility assistant administrator and infection preventionist. They verbalized understanding and that this survey had raised their awareness that they needed to work on the tracking of staff and vaccination rate of staff.

The facility staff also confirmed that their lack of knowledge of facility employee's vaccination status and inaccurate and incomplete tracking, made their data reported to the NHSN (National Health Care Safety Network) reporting inaccurate.

The facility policy titled, "Mandatory COVID-19 Vaccinations" was reviewed. This policy read, "POLICY: The facility is committed to ensuring maximum resident protection, all staff who interact with other staff or residents in any location beyond the formal clinical setting (such as homes, clinics, other sites of care, administrative offices, off-site meetings, etc.) will be vaccinated. The facility will recognize and respect exemptions for medical conditions and

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F 888	Continued From page 22 religious beliefs to COVID-19 vaccinations as outlined in this policy and in accordance with federal and state regulations. ...4. a) The facility will maintain a current listing for each employee identifying the type of vaccination and dates that each vaccination was obtained [this may also include booster vaccinations]". On 2/25/22, the facility's assistant Administrator and Director of Nursing were made aware of the findings. No additional information was received.	F 888		