STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	C 03/30/2022

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ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/27/22 through 03/30/22. 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 standard survey was conducted 03/27/22 through 03/30/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints, VA00054547- Substantiated with deficiency and VA00054187- Substantiated with deficiency, were investigated during the survey. The census in this 130 certified bed facility was 62 at the time of the survey. The survey sample consisted of 32 resident reviews and 14 staff record reviews.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600	**F600- Free from Abuse and Neglect** 1. Resident #316 was discharged from facility on 1/17/2022 LPN F & LPN G are no longer employee at the facility RN B- re-educated on 3/31/2022 2. Quality review conducted by the Director of Clinical Services/designee of current residents to ensure that residents are free from abuse, neglect, misappropriation of resident property, and exploitation	4/22/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 4-21-22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff neglected to provide goods and services to one Resident (Resident #316) in a sample size of 32 Residents. For Resident #316, the facility staff failed to provide adequate hydration for over 24 hours after a registered nurse assessed that Resident #316 was dehydrated. Resident #316 was hospitalized and treated for significant dehydration on 01/17/2022. This is harm.

The findings included:

On 03/27/2022 and 03/28/2022, Resident #316's clinical record was reviewed. Resident #316's most recent Minimum Data Set with an Assessment Reference Date of 12/16/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Resident #316's medical diagnoses included but were not limited to status-post cerebrovascular accident and aphasia.

A physician's order dated 11/11/2021 documented, "Full code."

A review of the progress noted from October 2021 through January 2022 included but were not limited to the following:

Excerpts of a nurse's skilled note dated 01/12/2022 at 00:00 A.M. documented the

3. All facility and contracted staff educated by the Director of Clinical Services/designee by regarding Abuse & Neglect

4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure that residents are free from abuse, neglect, misappropriation of resident property, and exploitation, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, then weekly x 4 weeks

   The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.

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F 600	Continued From page 2 following: "Current vital signs are: Temperature: T 98.0 - Route: Forehead (non-contact) Pulse: P 82 Pulse Type: Regular Respirations: R 18 Blood pressure: BP 128/72 Position: Lying r/arm [right arm] Pain level: 0 Pain scale: Numerical. Level of consciousness noted as oriented to person Hx [history] Aphasia. Skin is warm dry. Swallowing problems are not noted [no punctuation] refusing all offers of fluids. Mood status is flat affect." There was not a skilled note written on 01/13/2022 through 01/17/2022. A Medication Administration note dated 01/14/2022 at 9:18 P.M. documented, "Resident not eating or taking medications." A Medication Administration note dated 01/14/2022 at 9:19 P.M. documented, "Insulin not given as resident is not eating and BS [blood sugar] 150 [milligrams per deciliter]." A Medication Administration note dated 01/15/2022 at 10:31 A.M. documented, "Resident would not open her mouth to take her medicine and turns head whenever offered to her, resident educated." A nurse's note written by Licensed Practical Nurse F (LPN F), agency nurse, dated 01/16/2022 at 6:14 A.M. documented, "Note Text: Resident laying bed not responding to verbal stimuli. Resident has some response to physical stimuli VS [vital signs] [blood pressure] 89/64 [respirations] 18 [pulse] 68 [temperature] 97.5 BS [blood sugar] 147. Call placed to on call. Awaiting response. RN [registered nurse] on duty called to unit to assess resident. Pushing fluids. Report to oncoming shift when MD returns call to request IV to be started. Will continue to attempt oral fluid intake until further instructed."	F 600		

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A nurse's note dated 01/16/2022 at 6:47 A.M. documented, "Note Text: Continue to push fluid with minimal success. Resident able to swallow only a few times. Will continue to monitor."

A Medication Administration note dated 01/16/2022 at 10:23 A.M. documented, "res [resident] not swallowing md [medical doctor] made aware rp [responsible party] made aware."

A nurse's note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. documented, "Note Text: res [resident] not swallowing holding food and meds crushed in pudding in mouth when offered fluid via spoon res [resident] holding fluid in mouth not swallowing res awake with eyes open waving hand at times vital signs at this time 96/52 [blood pressure] 114 [pulse] 96.8 [temperature] 16 [respirations] 97% [oxygen saturation] MD [medical doctor] made aware gave orders to hold meds and insulin until 1/17/22 res [resident] is to be seen by MD [medical doctor] in the AM [morning]."

A nurse's note written by Registered Nurse B (RN B) dated 01/16/2022 at 5:00 P.M. documented, "Note Text: This nurse spoke with resident's [responsible party] and informed that resident was not eating, she was pocketing food and not drinking much. Her [responsible party] suggested we try ice chips to get fluid in her."

A nurse's note dated 01/17/2022 at 10:09 A.M. documented, "Note Text: Writer called RP [responsible party] and made aware that resident was being sent out to ED for eval [emergency department for evaluation] and treatment. Voiced understanding."

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Resident #316's Emergency Department (ED) medical records dated 01/17/2022 at 12:52 P.M. under the header "ED Course" documented, "Patient presents with hypotension initial hypoxia hypoxia [sic] is improved now on 4 liters of oxygen blood pressure is normalized after 2 liters of fluid is COVID positive severe dehydration case discussed with the hospitalist soft plan will be medical admission." Under the header "Clinical Impression" it was documented, "1. COVID 2. Dehydration." An excerpt under the header "Physical Exam" documented, "Unresponsive, occasional grimace due to pain."

On 03/29/2022 at 9:40 A.M., Certified Nursing Assistant F (CNA F) was interviewed. CNA F confirmed she had taken care of Resident #316. When asked about Resident #316's eating and drinking, CNA F stated that Resident #316 was "eating and drinking at first." CNA F then stated that at one point Resident #316 wouldn't eat but would hold a cup and drink fluids. CNA F stated that then [at some point] Resident #316 "wouldn't take anything [food or fluids]."

On 03/29/2022 at 10:20 A.M., Registered Nurse B (RN B) was interviewed. When asked about Resident #316's eating and drinking, RN B stated that Resident #316 refused to eat and "often refused her drinks, too." When asked about the process if a Resident refuses to eat and drink fluids, RN B stated "We inform the doctor." RN B also stated that [Resident #316] "would drink some but not enough and that's why she went to the hospital." When asked how fluid intake is monitored, RN B stated "We don't track I and O [meaning intake and output] unless there is a doctor's order." When asked about the process if

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a Resident is not drinking adequate amount of fluids, RN B indicated she would notify the physician because of the "need to send them out [to the hospital]." RN B also stated that she would obtain vital signs. RN B did not mention assessment for dehydration.

On 03/29/2022 at 11:50 A.M., the Director of Nursing (DON) was interviewed. This surveyor and the DON reviewed the nurse's note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the expectation of the nurse at that time, the DON stated they have a policy that if the nurse cannot get in touch with the physician, they are to call the administrator or the nurse on call. When asked who the RN was referencing in the note, the DON stated she would find out. When asked about the expectation of the RN, the DON stated she would expect the RN to assess and document findings. The DON also stated that based on the RN's assessment findings, she could've sent [Resident #316] out [to the hospital]. This surveyor and the DON reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked about the expectation of the nurse at that time, the DON stated the nurse should ask the physician if [Resident #316] can be sent out [to the hospital]. When asked about monitoring for adequate hydration, the DON stated the nurse should check skin turgor [elasticity] and mucous membranes. The DON also stated that the nurse should ask the aides how many cc's [cubic centimeters meaning milliliters] intake the Resident has had. The DON also stated that output should also be measured.

On 03/29/2022 at 2:25 P.M., LPN G was interviewed. The surveyor and LPN G reviewed

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the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked why she called the physician about [Resident #316], LPN G stated that [Resident #316 was not swallowing and "was concerned because her blood pressure was low and her pulse was up." LPN G stated that [Resident #316] "I know she was dehydrated because she wasn't drinking anything or swallowing." LPN G also stated that she thought the physician would send her out but he didn't [send her out]. When asked if she felt she had other options, LPN G stated, "I did not." LPN G verified the on-call physician was [Employee L].

On 03/29/2022 at approximately 3:00 P.M., the DON provided the name of the RN referenced in the note dated 01/16/2022 at 6:14 A.M. as (RN C).

On 03/29/2022 at 4:00 P.M., Employee L, the on-call physician, was interviewed. When asked about the process of being the on-call physician, the on-call physician indicated he does not take notes on the calls he receives and he does not have access to the clinical record. The on-call physician stated he relies on the nurse's report. When asked about [Resident #316]'s status on 01/16/2022, the on-call physician stated he did not remember [Resident #316]. This surveyor and the on-call physician reviewed the nurse's note written by LPN G dated 01/16/2022 at 12:49 P.M. When asked if he would want to send [Resident #316] to the emergency department for evaluation based on the note, the on-call physician stated "No" because it sounded like a chronic problem. The on-call physician indicated that unless the Resident was lethargic or choking on food or aspirating, he would not send the

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Resident out but have the primary provider address it in the morning. When asked about the hydration status, the on-call physician stated that "It could've been dehydration; I might have thought about that." The on-call physician stated that he sent a message to the nurse practitioner to evaluate [Resident #316] the following day [Monday morning]. This surveyor and the on-call physician reviewed the note written on 01/16/2022 at 6:14 A.M. The on-call physician stated he wasn't aware [Resident #316] "not responding to verbal stimuli." The on-call physician indicated that [LPN G] did not convey that information.

On 03/29/2022 at 4:55 P.M., an interview with RN C was conducted. RN C verified she was the RN referenced in the note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the events indicated in the note, RN C stated that [LPN F] asked her to look at [Resident #316] at approximately 6:30 A.M. [on 01/16/2022]. RN C stated that [Resident #316] had dry lips, dry mucous membranes, and poor skin turgor. RN C stated that Resident #316 "looked dehydrated to me." RN C stated she told [LPN F] she was unsure he would even be able to get an IV [intravenous catheter] in her because "she was dehydrated." RN C stated she told LPN F that if he couldn't get an IV into her, they would have to send her out [to the hospital]. RN C stated that LPN F called the physician and left a message. When asked if she had documented her assessment findings, RN C stated "no." RN C indicated that she had her own assignment and was not working as a supervisor.

On 03/30/2022 at 9:30 A.M., a follow-up interview with RN C was conducted. When asked about

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F 600	Continued From page 8 Resident #316's level of consciousness at the time of her assessment on the early morning of 01/16/2022, RN C stated that Resident #316 was at her [level of consciousness] baseline "but she definitely needed an intervention because she was dehydrated." RN C also stated that she wished she had gone back to check on [Resident #316] and followed up. A review of the Physician orders for January 2022 revealed there were no orders for an IV to be started. The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Exploitation & Misappropriation." An excerpt under the header "Definitions" documented the following: "Neglect is the failure of the center and its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to: Failure to provide adequate nutrition and fluids." On 03/30/2022 at approximately 3:30 P.M., the administrator and DON were notified of findings. The administrator stated they had no further information or documentation to submit.	F 600		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637	**F637- Comprehensive Assessment after Significant Change** 1. Resident #15 Significant Change Minimum Data Set (MDS) was completed on 3/29/2022	4/22/2022

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F 637	Continued From page 9 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct a Significant Change Minimum Data Set (MDS) for Resident (R)15's clinical status following the discontinuation of Hospice services. This failure of conducting an updated MDS could have an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both. The deficient practice effected one of two residents reviewed for hospice services, in the sample of 32 residents. Findings include: Review of R15's undated "Face Sheet" located in the electronic medical record (EMR), under the profile tab, revealed R15 was admitted on 06/09/15 with diagnoses of dementia with behavioral disturbance, schizoaffective disorder, and history of repeated falls. Review of a letter (on [name redacted] Hospice letterhead) found in the R15's EMR, under the "progress notes" tab, revealed R15 had been admitted to [name redacted] Hospice services on 04/28/21. The document indicated R15 had been seen by the hospice physician on 02/09/22. The physician deemed R15's condition had stabilized, and that she no longer met the hospice criteria and was discontinued from hospice services on 02/21/22.	F 637	2. Quality review conducted by the Director of Clinical Services/designee of other Residents receiving Hospice Services to ensure a significant change Minimum Data Set (MDS) for starting and discontinuing hospice services. 3. Minimum Data Set Staff will be educated by the Regional Case Mix Coordinator/Designee regarding when to determine that a significant change occurred and to conduct a Significant Change Minimum Data Set (MDS) using the Resident Assessment Instrument (RAI) guidance 4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure that significant change in resident status is complete within 14 days after facility determines or should have determined, that there is a change in residents' physical or mental condition, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

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F 637	Continued From page 10 Review of R15's EMR revealed a Significant Change MDS had not been completed to identify the care needs that were provided by the hospice agency, and that the facility would need to resume to maintain R15's current and/or baseline functional status. In an interview with MDS Coordinator on 03/30/22 at 8:05 AM, the MDS Coordinator indicated that the discontinuation of hospices services would prompt a Significant Change MDS. The MDS Coordinator confirmed that a Significant Change MDS had not been completed. In an interview with the Director of Nurses (DON) on 03/30/22 at 10:20 AM, the DON confirmed a Significant Change MDS was not completed.	F 637		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care according to professional standards of practice for one Resident (Resident #316) in a sample size of 32 Residents. For Resident #316, the facility staff failed to: 1) convey Resident #316's dehydration status to the on-call physician	F 658	**F658- Services Provided Meet Professional Standards** 1. Resident #316 was discharged from facility on 1/17/2022 LPN F & LPN G are no longer employee at the facility RN B- re-educated on 3/31/2022 2. Quality review conducted by the Director of Clinical Services/designee of residents with a change in condition to determine if facility response met standards of practice.	4/22/2022

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F 658	Continued From page 11 2) document assessment findings 3) address the dehydration status in a timely fashion after a registered nurse assessed that Resident #316 was dehydrated which resulted in hospitalization and treatment for significant dehydration. This is harm. The findings included: On 03/27/2022 and 03/28/2022, Resident #316's clinical record was reviewed. Resident #316's most recent Minimum Data Set with an Assessment Reference Date of 12/16/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Resident #316's medical diagnoses included but were not limited to status-post cerebrovascular accident and aphasia. A physician's order dated 11/11/2021 documented, "Full code." A review of the progress noted from October 2021 through January 2022 included but were not limited to the following: Excerpts of a nurse's skilled note dated 01/12/2022 at 00:00 A.M. documented the following: "Current vital signs are: Temperature: T 98.0 - Route: Forehead (non-contact) Pulse: P 82 Pulse Type: Regular Respirations: R 18 Blood pressure: BP 128/72 Position: Lying r/arm [right arm] Pain level: 0 Pain scale: Numerical. Level of consciousness noted as oriented to person Hx [history] Aphasia. Skin is warm dry. Swallowing problems are not noted [no punctuation] refusing all offers of fluids. Mood status is flat affect." There was not a skilled note written on	F 658	3. All Nurses educated by the Director of Clinical Services/designee regarding Resident change in condition and notification to include; the nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the Medical Director may be contacted. If the Medical Director does not respond, call 911 and document in the medical record. 4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure that residents' identified with a change in condition are provided with care according to professional standards of practice and Medical Director made aware of findings and nurse assessment completed and documented related to findings, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

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01/13/2022 through 01/17/2022. A Medication Administration note dated 01/14/2022 at 9:18 P.M. documented, "Resident not eating or taking medications." A Medication Administration note dated 01/14/2022 at 9:19 P.M. documented, "Insulin not given as resident is not eating and BS [blood sugar] 150 [milligrams per deciliter]." A Medication Administration note dated 01/15/2022 at 10:31 A.M. documented, "Resident would not open her mouth to take her medicine and turns head whenever offered to her, resident educated."

A nurse's note written by Licensed Practical Nurse F (LPN F), agency nurse, dated 01/16/2022 at 6:14 A.M. documented, "Note Text: Resident laying bed not responding to verbal stimuli. Resident has some response to physical stimuli VS [vital signs] [blood pressure] 89/64 [respirations] 18 [pulse] 68 [temperature] 97.5 BS [blood sugar] 147. Call placed to on call. Awaiting response. RN [registered nurse] on duty called to unit to assess resident. Pushing fluids. Report to oncoming shift when MD returns call to request IV to be started. Will continue to attempt oral fluid intake until further instructed."

A nurse's note dated 01/16/2022 at 6:47 A.M. documented, "Note Text: Continue to push fluid with minimal success. Resident able to swallow only a few times. Will continue to monitor."

A Medication Administration note dated 01/16/2022 at 10:23 A.M. documented, "res [resident] not swallowing md [medical doctor] made aware rp [responsible party] made aware."

A nurse's note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M.

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documented, "Note Text: res [resident] not swallowing holding food and meds crushed in pudding in mouth when offered fluid via spoon res [resident] holding fluid in mouth not swallowing res awake with eyes open waving hand at times vital signs at this time 96/52 [blood pressure] 114 [pulse] 96.8 [temperature] 16 [respirations] 97% [oxygen saturation] MD [medical doctor] made aware gave orders to hold meds and insulin until 1/17/22 res [resident] is to be seen by MD [medical doctor] in the AM [morning]."

A nurse's note written by Registered Nurse B (RN B) dated 01/16/2022 at 5:00 P.M. documented, "Note Text: This nurse spoke with resident's [responsible party] and informed that resident was not eating, she was pocketing food and not drinking much. Her [responsible party] suggested we try ice chips to get fluid in her."

A nurse's note dated 01/17/2022 at 10:09 A.M. documented, "Note Text: Writer called RP [responsible party] and made aware that resident was being sent out to ED for eval [emergency department for evaluation] and treatment. Voiced understanding."

Resident #316's Emergency Department (ED) medical records dated 01/17/2022 at 12:52 P.M. under the header "ED Course" documented, "Patient presents with hypotension initial hypoxia hypoxia [sic] is improved now on 4 liters of oxygen blood pressure is normalized after 2 liters of fluid is COVID positive severe dehydration case discussed with the hospitalist soft plan will be medical admission." Under the header "Clinical Impression" it was documented, "1. COVID 2. Dehydration." An excerpt under the header "Physical Exam" documented,

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"Unresponsive, occasional grimace due to pain."

On 03/29/2022 at 9:40 A.M., Certified Nursing Assistant F (CNA F) was interviewed. CNA F confirmed she had taken care of Resident #316. When asked about Resident #316's eating and drinking, CNA F stated that Resident #316 was "eating and drinking at first." CNA F then stated that at one point Resident #316 wouldn't eat but would hold a cup and drink fluids. CNA F stated that then [at some point] Resident #316 "wouldn't take anything [food or fluids]."

On 03/29/2022 at 10:20 A.M., Registered Nurse B (RN B) was interviewed. When asked about Resident #316's eating and drinking, RN B stated that Resident #316 refused to eat and "often refused her drinks, too." When asked about the process if a Resident refuses to eat and drink fluids, RN B stated "We inform the doctor." RN B also stated that [Resident #316] "would drink some but not enough and that's why she went to the hospital." When asked how fluid intake is monitored, RN B stated "We don't track I and O [meaning intake and output] unless there is a doctor's order." When asked about the process if a Resident is not drinking adequate amount of fluids, RN B indicated she would notify the physician because of the "need to send them out [to the hospital]." RN B also stated that she would obtain vital signs. RN B did not mention assessment for dehydration.

On 03/29/2022 at 11:50 A.M., the Director of Nursing (DON) was interviewed. This surveyor and the DON reviewed the nurse's note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the expectation of the nurse at that time, the DON stated they have a policy that if the

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nurse cannot get in touch with the physician, they are to call the administrator or the nurse on call. When asked who the RN was referencing in the note, the DON stated she would find out. When asked about the expectation of the RN, the DON stated she would expect the RN to assess and document findings. The DON also stated that based on the RN's assessment findings, she could've sent [Resident #316] out [to the hospital]. This surveyor and the DON reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked about the expectation of the nurse at that time, the DON stated the nurse should ask the physician if [Resident #316] can be sent out [to the hospital]. When asked about monitoring for adequate hydration, the DON stated the nurse should check skin turgor [elasticity] and mucous membranes. The DON also stated that the nurse should ask the aides how many cc's [cubic centimeters meaning milliliters] intake the Resident has had. The DON also stated that output should also be measured.

On 03/29/2022 at 2:25 P.M., LPN G was interviewed. The surveyor and LPN G reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked why she called the physician about [Resident #316], LPN G stated that she was told in report that [Resident #316 was not swallowing and she observed herself that [Resident #316 was not swallowing and "was concerned because her blood pressure was low and her pulse was up." LPN G stated that [Resident #316] "I know she was dehydrated because she wasn't drinking anything or swallowing." LPN G also stated that she thought the physician would send her out but he didn't [send her out]. When asked if she felt

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she had other options, LPN G stated, "I did not." LPN G verified the on-call physician was [Employee L].

On 03/29/2022 at approximately 3:00 P.M., the DON provided the name of the RN referenced in the note dated 01/16/2022 at 6:14 A.M. as (RN C).

On 03/29/2022 at 4:00 P.M., Employee L, the on-call physician, was interviewed. When asked about the process of being the on-call physician, the on-call physician indicated he does not take notes on the calls he receives and he does not have access to the clinical record. The on-call physician stated he relies on the nurse's report. When asked about [Resident #316]'s status on 01/16/2022, the on-call physician stated he did not remember [Resident #316]. This surveyor and the on-call physician reviewed the nurse's note written by LPN G dated 01/16/2022 at 12:49 P.M. When asked if he would want to send [Resident #316] to the emergency department for evaluation based on the note, the on-call physician stated "No" because it sounded like a chronic problem. The on-call physician indicated that unless the Resident was lethargic or choking on food or aspirating, he would not send the Resident out but have the primary provider address it in the morning. When asked about the hydration status, the on-call physician stated that "It could've been dehydration; I might have thought about that." The on-call physician stated that he sent a message to the nurse practitioner to evaluate [Resident #316] the following day [Monday morning]. This surveyor and the on-call physician reviewed the note written on 01/16/2022 at 6:14 A.M. The on-call physician stated he wasn't aware [Resident #316] "not

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responding to verbal stimuli." The on-call physician indicated that the nurse did not convey that information.

On 03/29/2022 at 4:55 P.M., an interview with RN C was conducted. RN C verified she was the RN referenced in the note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the events indicated in the note, RN C stated that [LPN F] asked her to look at [Resident #316] at approximately 6:30 A.M. [on 01/16/2022]. RN C stated that [Resident #316] had dry lips, dry mucous membranes, and poor skin turgor. RN C stated that Resident #316 "looked dehydrated to me." RN C stated she told [LPN F] she was unsure he would even be able to get an IV [intravenous catheter] in her because "she was dehydrated." RN C stated she told LPN F that if he couldn't get an IV into her, they would have to send her out [to the hospital]. RN C stated that LPN F called the physician and left a message. When asked if she had documented her assessment findings, RN C stated "no." RN C indicated that she had her own assignment and was not working as a supervisor.

On 03/30/2022 at 9:30 A.M., a follow-up interview with RN C was conducted. When asked about Resident #316's level of consciousness at the time of her assessment on the early morning of 01/16/2022, RN C stated that Resident #316 was at her [level of consciousness] baseline "but she definitely needed an intervention because she was dehydrated." RN C also stated that she wished she had gone back to check on [Resident #316] and followed up.

A review of the Physician orders for January 2022 revealed there were no orders for an IV to be

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F 658	Continued From page 18 started. According to "Fundamentals of Nursing" by Perry & Potter, Eighth Edition, 2013, page 217 under the header, "Documentation Data", it was documented, "Data documentation is the last part of a complete assessment. The timely, thorough, and accurate documentation of facts is required in recording patient data. If you do not record an assessment finding or problem interpretation, it is lost and unavailable to anyone else caring for the patient. If information is not specific, the reader is left with only general impressions. Observing and recording patient status are legal and professional responsibilities. The Nurse Practice Acts in all states and the American Nurses Association Nursing's Social Policy Statement (2010) require accurate data collection and recording as independent functions essential to the role of the professional nurse." In Chapter 34 entitled, "Communication" on page 316, an excerpt documented, "Research indicates that effective communication between health care providers and other members of the health care team ensures patient safety and promotes optimal patient outcomes." On 03/30/2022 at approximately 3:30 P.M., the administrator and DON were notified of findings. The administrator stated they had no further information or documentation to submit.	F 658		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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	F 842		

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F 842	Continued From page 19 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, 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.	F 842	**F842- Resident Records- Identifiable Information** 1. Resident #28 and Resident #39 interviewed regarding incident that occurred on 1/18/22, a minor physical altercation, without injuries. Resident #39 Brief Interview for Mental Status (BIMS) score is 99 unable to be interviewed. Resident #28 BIMS score is 15, interview conducted and denies any psychosocial issues and feels safe at this time. Resident #28 and Resident #39 medical records was updated as indicated. 2. Quality review conducted by the Director of Clinical Services/designee of all current residents' clinical record to ensure any incidents, occurrences or changes in their status have complete documentation in the clinical record 3. All Nurses re-educated by the Director of Clinical Services/designee regarding documentation with change in condition. 4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure that residents' identified will have complete documentation in their clinical record for incidents, occurrences or changes in their status, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks.	4/22/2022

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F 842	Continued From page 20 §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 clinical record review, staff interview, and facility documentation review, the facility staff failed to maintain an accurate clinical record for 1 resident, Resident #28, in a sample size of 32 residents. The Findings included: For Resident #28, there was incomplete documentation in the clinical record for a resident to resident altercation which involved Resident #28 on 1/18/22. On 3/29/22, a review of Resident #28's clinical record was performed and revealed a progress noted dated 1/18/22 at approximately 2:45 PM	F 842	The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

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F 842	Continued From page 21 that read, "[name redacted, Resident #28's Responsible Party] notified of incident that happened this am". There was no previous documentation on 1/18/22 in Resident #28's clinical record related to any "incidents". On 3/29/22, an interview was conducted with the Director of Nursing (DON), who stated there was a minor physical altercation, without injuries, that involved Resident #28 and Resident #39. The DON accessed the clinical record for Resident #28 and confirmed that there was no documentation of the incident nor any documented clinical assessment for injuries. The DON stated that documentation would be an expectation in order to provide accurate detail for the healthcare team. On 3/30/22, the Facility Administrator was notified of these findings. No further information was provided.	F 842		
F 883 SS=D	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	F 883	**F883- Influenza and Pneumococcal Immunizations** 1. Resident #4 received the Pneumococcal Vaccine on 4/8/2022 2. Quality review conducted by the Director of Clinical Services/designee of residents who are eligible or want the Pneumococcal Immunizations. Influenza Immunization is currently out of season and not offered. 3. All Nurses educated by the Director of Clinical Services/designee regarding Vaccinations of Residents (Pneumococcal Vaccine/ Influenza Vaccine), Provide Immunizations as ordered by Physician	4/22/2022

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F 883	Continued From page 22 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 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.	F 883	4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure that residents' identified will have vaccine administered as per order with documentation or refusal documented, and consent and education to responsible party or resident with documentation, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

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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 a pneumococcal vaccine for 1 resident out of 5 residents reviewed for pneumococcal immunization.

The findings included:

The facility staff failed to provide pneumococcal immunization for Resident #4.

On 3/28/22, clinical record review was performed for Resident #4's and revealed an active physician's order dated 9/10/16 for "Pneumovax" and a document entitled, "Informed Consent for Pneumococcal Vaccine", dated 11/1/21, signed by Resident #4's Responsible Party, with a check mark placed next to the statement which read, "I accept and GIVE the facility permission to administer the pneumococcal vaccine". There was no further documentation that indicated whether or not Resident #4 had received a pneumococcal vaccine.

On 3/28/22, Surveyor B conducted an interview with the facility Infection Preventionist who accessed the clinical record for Resident #4 and verified the findings. A facility policy on pneumococcal immunization was requested and received.

Review of the facility policy entitled, "Pneumococcal Vaccine", revised October 2019, read: "Policy Statement...All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections".

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F 883	Continued From page 24 On 3/29/22 at 5:09 PM, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No additional information was submitted prior to the survey exit conference held on 3/30/22.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 886	**F886- COVID-19 Testing-Residents & Staff** 1. Facility is currently not in an active COVID-19 outbreak. The current community rate of transmission is low. Staff who are not up to date with COVID-19 vaccination or have medical/religious waiver are tested at least weekly. 2. Quality review conducted by the Director of Clinical Services/designee of all current staff to identify who is not up to date with their vaccination status or with exemption to determine who is subject to testing. 3. The Vice President of Operations has educated the Executive Director and Director of Clinical Services on the Centers for Medicare/Medicaid Services (CMS) process on COVID testing as of 3/31/2022 to include; testing of all staff and residents in response to an outbreak-any single new infection in staff or resident. Facility will monitor the county positivity rate every other week and adjust the frequency of performing staff testing accordingly. All Facility and contracted Staff educated by the Director of Clinical Services/designee regarding The Facility COIVD-19 Pandemic Plan as it relates to COVID-19 Testing for Residents and Staff	4/22/2022

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F 886	Continued From page 25 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review, the facility staff failed to conduct routine COVID testing of facility staff who were not up-to-date with COVID vaccinations for 5 Employees (Employee P, CNA B, CNA D, CNA H, and LPN C) in a survey sample of 14 employees.	F 886	4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure testing is conducted based on parameters and factors specified by the Secretary to identify and prevent transmission of COVID-19, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

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The findings included:

On 3/27/22, upon survey team entry to the facility and during the entrance conference, the facility Administrator was asked to provide the survey team with a Staff vaccination Matrix. At this time, the facility confirmed that their last COVID-19 positive case was January 25, 2022. Therefore, they were not in an active COVID outbreak status.

On 3/28/21 at 10:31 AM, the facility staff provided evidence of where they have been tracking the COVID community rate of transmission. The information submitted revealed the following:
* On 2/27/22, the community rate of transmission was "high"
* On 3/6/22, the community rate of transmission was "substantial"
* On 3/6/22, [sic, typographical error, should have been 3/13/22] was recorded as "moderate"
* On 3/20/22, the community rate of transmission was "moderate"

Centers for Medicare & Medicaid Services (CMS) directs facilities in QSO Memo Ref: QSO-20-38-NH, with a revision date of 3/10/22, with "Facility Testing Requirements". This document read, "...Routine Testing Intervals by County COVID-19 Level of Community Transmission: Low: testing not recommended, Moderate (yellow): testing once a week, Substantial (orange) testing twice a week, High (red) testing twice a week... Staff who are up-to-date do not need to be routinely tested".

This document from CMS further stated, "...If the level of community transmission decreases to a

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lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission as remained at the lower activity level for at least two week before reducing testing frequency".

On 3/29/22 at 6:55 PM, the facility submitted a corrected/revised version of the staff vaccination matrix on the CMS form. From this form, a sample of 14 employees was selected for review with regards to COVID-19 testing.

On 3/30/22 at 11:55 AM, a group interview was conducted with the facility Administrator, Director of Nursing, Employee N the scheduler, Employee O the Regional Director of Clinical Services, and Employee E, the Vice President of Operations.

During the interview, the Director of Nursing (DON) stated, she oversees the testing for COVID-19 within the facility. The DON stated that routine testing is based on the community transmissibility rate and for the month of March they have tested twice weekly, until this week [week of March 27-April 2], they will "start testing once a week". This was consistent with the level of community transmission rates previously submitted by the facility.

Review of the employees sampled to review testing, compared to the facility submitted testing logs, the following deficient practices were noted:

1. Certified Nursing Assistant (CNA) B, was noted on the vaccination matrix to be granted a religious exemption and not vaccinated for COVID-19. Therefore, CNA B was not up-to-date on COVID immunizations and should have routine testing. Her testing dates were as follows for the month of

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March: 3/1/22, 3/15/22, and 3/24/22. This information was reviewed with the facility staff who confirmed the findings.

On 3/28/22 at 8:39 PM, a telephone interview was conducted with CNA B, who was on duty at the facility at the time of the call. CNA B confirmed that she is not vaccinated for COVID-19 and has a religious exemption. CNA B stated her last COVID test was conducted on 3/23 or 3/24. When asked if she had been tested this week, CNA B said, "No".

2. CNA H was noted on the vaccination matrix to be granted a religious exemption and not vaccinated for COVID-19. Therefore, CNA H was not up-to-date on COVID immunizations and should have routine testing. Per the testing log, CNA H's test dates were: 3/8/22, 3/15/22, and 3/22/22. The facility confirmed these findings.

3. Employee P, a dietary aide was noted on the vaccination matrix to be completely vaccinated but not boosted. The facility Administrator confirmed that Employee P had declined the administration of a COVID-19 booster. Therefore, Employee P, was not up-to-date on COVID immunizations and should have routine testing. Employee P's test dates were noted as: 3/1/22, 3/7/22, 3/11/22, and 3/15/22.

4. CNA D was noted on the immunization matrix to be a contracted agency staff person who is completely vaccinated but not boosted. The facility Administrator confirmed that CNA D had declined the booster immunization. Therefore, CNA D was not up-to-date on COVID immunizations and should have routine testing. CNA D was not noted to have any test dates for

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March.

5. LPN C was noted on the immunization matrix to be fully vaccinated but not boosted. The facility Administrator confirmed that LPN C was eligible to receive a booster immunization but had not done so. Therefore, LPN C was not up-to-date on COVID immunizations and should have routine testing. Her test dates were noted as: 3/1/22, 3/4/22, 3/7/22, 3/10/22, 3/15/22, 3/18/22, and 3/21/22.

On 3/30/22 at approximately 3:15 PM, the facility Administrator and Surveyor B reviewed the above findings. The facility Administrator stated that he had the following information in addition to what was provided to Surveyor B and copies were provided.
* CNA B had a test date of 3/10/22.
* CNA H had a test date of 3/29/22.
* Employee P had a test date of 3/28/22.
During this conversation the facility Administrator stated that he did not think the community transmission rate had required twice weekly testing throughout the month.

On 3/30/22 at 3:32 PM, the facility Administrator presented a document which logged the community transmission rate as: 3/3/22- low, 3/10/22- low, 3/17/22- low, 3/24/22- low.

The facility policy titled, "COVID-19 Pandemic Plan" having a revision date of 2/8/22, was reviewed. This policy read, "...Expanded Screening Testing of Asymptomatic Staff: Test all staff who are not up to date with the recommended COVID-19 vaccine doses based on the extent of the virus in the community, using the community transmission level available from

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F 886	Continued From page 30 the CDC. i. Centers should begin testing based on the community transmission level reported for the past week. ii. Center should monitor their community transmission level every other week and adjust the frequency of testing accordingly....If the community transmission level decreases to a lower level of activity, the center should continue testing staff at the higher frequency level until the community transmission level has remained at the lower activity level for at least two weeks before reducing testing frequency". No additional information was provided prior to the survey team exit at 4:45 PM.	F 886		
F 888 SS=E	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. §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;	F 888	**F888- COVID-19 Vaccination of Facility Staff** 1. The Employee Vaccination Matrix has been updated to reflect current employees and their current vaccination status. 2. Quality review conducted by the Director of Clinical Services/designee of F888 Employee Vaccination Matrix to ensure the matrix is current with employees and their current vaccination status 3. The Vice President of Operations has educated the Executive Director and Director of Clinical Services on F888 Employee Vaccination Matrix All Facility and contracted Staff re-educated by the Director of Nursing/designee regarding Employee COVID-19 Vaccinations	4/22/2022

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F 888	Continued From page 31 (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 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;	F 888	4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring to ensure that all staff members are included on the vaccination tracking system, staff will be listed on the Vaccination Matrix. Matrix will include Proof of Vaccination or Exemption provided to Infection Preventist, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	

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(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 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

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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 1) have an accurate system to track the immunization status of all facility employees, and 2) failed to ensure 100% of facility staff were vaccinated, the facility vaccination rate was 98.6%.

1. The facility failed to include all staff members of the vaccination tracking and their tracking system was not accurate with regards to the COVID-19 vaccination status of all employees.

2. The facility staff vaccination rate for COVID-19 was 98.6%.

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The findings included:
1. The facility failed to include all staff members of the vaccination tracking and their tracking system was not accurate with regards to the COVID-19 vaccination status of all employees.

On 3/27/22, at approximately 12 Noon, during an entrance conference held with the facility Administrator the facility staff were notified of the need to provide the staff vaccination matrix.

On 3/28/22 at 2:27 PM, the facility staff submitted a staff vaccination matrix. Review of this matrix revealed none of the housekeeping or dietary employees were listed. Comparing to the "as worked" schedule for 3/27 and 3/28, and a few clinical staff were noted as having worked but were not listed on the vaccination matrix. The facility was notified of the missing staff and asked to provide a complete staff vaccination matrix, to include the CMS required information, including columns listing employee title, vaccination status, booster status, exemptions, etc.

*The matrix listed LPN B as having had only 1 dose of the COVID vaccine.
On 3/28/22 at 8:19 PM, a phone interview was conducted with LPN B, who was actively working a shift at the facility. LPN B stated she had received her second COVID-19 vaccine to complete her primary vaccination series about 3 weeks ago.

* The matrix did not list LPN C.
On 3/28/22 at 8:30 PM, a telephone interview was conducted LPN C, who was currently working a shift at the facility. LPN C stated that she

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	495235	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

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received the one-dose COVID vaccine on 4/1/21.

* The Matrix listed CNA B as having declined the COVID vaccine.
On 3/28/22 at 8:39 PM, a telephone interview was conducted CNA B, who was currently working a shift at the facility. CNA B stated that she has an approved religious exemption on-file with the facility.

On 3/29/22 at 10:23 AM, the facility staff submitted a revised staff vaccination matrix. This matrix was reviewed and compared to the facility submitted "as worked" schedule. The as worked schedule for the days of the survey were compared to the staff vaccination matrix and revealed 6 employees (CNA C, CNA D, LPN D, LPN E, and CNA E) were still not listed on the staff vaccination matrix.

On 3/29/22 at 1:26 PM, an interview was conducted with Employee F, the human resources manager. Employee F confirmed that each of the 6 employees were working in direct Resident care capacities and verified their work/time punches over the past week. They were as follows:
CNA C had worked a double shift on 3/27/22, and worked a full shift on 3/28.
CNA D had worked an entire shift on 3/27/22.
LPN D had worked an entire shift on 3/28/22, and was working a current shift at the time of the interview.
LPN E had worked an entire shift on 3/27/22 and had worked a double shift on 3/28/22.
CNA E had worked an entire shift on 3/28/22 and was currently working a shift at the time of the interview.

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On 3/29/22 at 1:45 PM, a video call was conducted with Employee C, the facility infection preventionist and Employee N, the medical records manager. Employee N confirmed that she maintains the information with regards to employee vaccination status. During this call Employee C and Employee N were asked to show COVID vaccination status of several employees. These finds are as follows:
* CNA J was listed on the staff vaccination list as having not received any COVID vaccines. During this video call, Employee N was able to provide evidence of CNA J having received one dose of the vaccine on 2/10/22.
* LPN B was listed on the staff vaccination matrix as having had only one dose of the COVID vaccine. Employee N was able to provide evidence of LPN B having received both doses of her primary COVID vaccination series.
* Employee P was noted on the staff vaccination matrix as having received only one dose of the COVID vaccine. During the video call, Employee N was able to provide copies of Employee P's immunization card which indicated Employee P had received a first dose on 1/29/21, which was not noted in the vaccine matrix.
* LPN J was listed on the vaccine matrix as having had a non-medical exemption noted as "other", with no doses of the vaccine recorded. During the video call, Employee N had a copy of LPN J's vaccination card which revealed she was fully vaccinated.

On 3/29/22 at 2:41 PM, a group meeting was held with the survey team, facility Administrator, Vice President of Operations, facility director of nursing, infection preventionist and corporate clinical consultants. The facility staff were made aware that the staff vaccination matrix reveals

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that the facility does not have a accurate system to track the COVID immunization status of facility staff. This was determined based upon inaccurate information being noted on the matrix such as employees working that were not listed at all, as well as employees whose immunization status was not correct. The above noted staff CNA J, LPN B, LPN J, CNA C, CNA D, LPN D, LPN E, and CNA E, were discussed.

Review of the facility's policy titled, "Pandemic Plan" read, "... COVID-19 Vaccine... Staff: 1. Document on the immunization record".

Review of the facility policy titled, "Employee COVID-19 Vaccinations", was reviewed. This policy read, "...3. Proof of Vaccination or Exemption: a. Care Center employees and other eligible personnel...will submit appropriate proof of vaccination, or proof of an approved exemption, to the Infection Preventionist, or their designee, by the regulatory deadline. b. All other eligible personnel subject to the CMS vaccine mandate, may present proof of vaccination or exemption to the Infection Preventionist, or their designee, to be retained by the Care Center, or may choose to present proof upon each entry into the Care Center that will not be retained by the Care Center. c. If an individual's proof of vaccination or exemption is retained by the Care Center, additional requests for documentation will not be made unless required because of a change in the individual's circumstances or due to an update to regulatory requirements. d. All documentation will be maintained confidentially and in compliance with applicable record keeping requirements".

On 3/29/22 at 6:55 PM, the facility submitted a

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revised staff vaccination matrix that they had completed using the CMS provided form, supplied on survey entrance.

No further information was provided.

2. The facility staff vaccination rate for COVID-19 was 98.6%.

On 3/28/22 at 2:41 PM, during a meeting with the facility Administrator, Vice President of Operations, Director of Nursing and facility Infection Preventionist, the facility was asked about their expectation with regards to employee immunization for COVID-19. The Vice President of Operations stated, "The expectation is 100%, unless they have a legitimate exemption".

On 3/29/22 at 6:55 PM, the facility provided the survey team with a final staff vaccination matrix that they indicated was accurate following being notified their previous tracking system was not accurate.

Review of this revised matrix revealed the facility had a total of 74 employees. Of the 74 employees, 68 were completely vaccinated and five (5) had been granted religious exemptions.

CNA K was noted to be listed as "partially vaccinated". On the facility documents submitted by the facility, CNA K was noted with a hire date of 7/22/21.

On 3/30/22 at 11:55 AM, an interview was conducted with the facility Administrator, Director of Nursing (DON) and Employee N, the medical records manager. During this interview, Surveyor

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B asked for details with regards to CNA K. The DON said, "She has gotten one shot, she received Pfizer on 3/8/22".

Review of the facility policy titled, "Employee COVID-19 Vaccinations" was reviewed. This policy read, "The Company requires that all eligible staff be fully vaccinated against COVID-19 in compliance with applicable laws, rules and regulations...."

The facility Administrator, Director of Nursing and Vice President of Operations were made aware that based on the information submitted, the facility's staff vaccination rate is: 98.6%.

No further information was submitted prior to the survey team's exit.