STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING AND REHABILITATION	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/22/2022 through 03/24/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 03/22/2022 through 03/24/2022. Two complaints were investigated during the survey. VA00050419 was substantiated with no deficiencies. VA00053267 was unsubstantiated. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 96 certified bed facility was 82 at the time of the survey. The survey sample consisted of 20 current resident reviews and 3 closed record reviews.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655	F655 **Corrective Action(s):** Resident #54's attending physician and RP were notified that the facility failed to provide a written summary of their base line care plan to the RP's upon its development. Resident #71's attending physician and RP were notified that the facility failed to provide a written summary of their base line care plan to the RP's upon its development. RECEIVED APR 12 2022	

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

Walker Chumley, LNHA — Administrator VDH/OLC 4/7/2022

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

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F 655	Continued From page 1 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide the resident and/or their representative, a written summary of their baseline CP (care plan) for 2 of 20 residents, Residents #54 and #71. The findings included:	F 655	**Identification of Deficient Practices & Corrective Action(s):** All newly admitted residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON and/or designee to identify residents whose RP's did not receive a written summary of their baseline comprehensive care plan All residents and RP's identified that did not received a written summary of their baseline comprehensive care plan will have their care plan reviewed and updated and a written summary of their resident centered care plan will be reviewed and given to the Residents and RP's identified. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility and a written summary will be given to the Resident and RP. The RCC and IDT will be inserviced by the regional nurse consultant on the development and review of the baseline as well as the process for reviewing the base line care plan with residents and RP's.	

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F 655	Continued From page 2 1. Resident #54's clinical record included the diagnoses stage 4 pressure ulcer of left buttock and left ankle, abdominal aortic aneurysm, and paraplegia. Section C (cognitive patterns) of Resident #54's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/21/22 included a BIMS (brief interview for mental status) summary score of 15, indicating the resident was alert and orientated. On 03/23/22 at 3:32 p.m., MDS nurse #1 was interviewed and stated she was new to the facility as of December 2021. She stated the baseline CP was given to the residents within 48 hours of their admission, and thought the floor nurses provided the baseline CP to the residents. On 03/24/22 at 2:15 p.m., Resident #54 was interviewed and asked if they received a copy of their CP. Resident #54 stated they never saw it. On 03/24/22 at 2:50 p.m., LPN (licensed practical nurse) #2 stated they did not give a copy of the baseline CP to the residents but the MDS staff probably did when they had their meetings. On 03/24/22 at 3:10 p.m., the administrator, administrator in training and DON (director of nursing) were notified that Resident #54 had not received a summary and/or copy of their baseline CP. No further information was provided to the survey team regarding Resident #54's baseline CP prior to the exit conference. 2. Resident #71's clinical record included the	F 655	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed timely and that a written summary has been completed and reviewed with the resident and/or RP. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	

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F 655	Continued From page 3 diagnoses systolic congestive heart failure, essential hypertension, obstructive reflux uropathy, and post-traumatic stress disorder. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/25/22 included a BIMS (brief interview for mental status) summary score of 12 of 15, indicating moderately impaired in cognitive skills for daily-decision making. On 03/23/22 at 3:32 p.m., MDS nurse #1 was interviewed and stated she was new to the facility as of December 2021. She stated the baseline CP was given to the residents within 48 hours of their admission, and thought the floor nurses provided the baseline CP to the residents. On 03/24/22 at 11:38 a.m., MDS nurse #1 stated they were unable to find any evidence that Resident #71 was provided with a copy of their baseline CP. On 03/24/22 at 2:10 p.m., Resident #71 was interviewed and stated they did not remember getting a copy of their CP. On 03/24/22 at 2:50 p.m., LPN #2 stated they did not give a copy of the baseline CP to the residents but the MDS staff probably did when they had their meetings. On 03/24/22 at 3:10 p.m., the administrator, administrator in training and DON (director of nursing) were notified that Resident #71 had not received a summary and/or copy of their baseline CP.	F 655		

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F 655	Continued From page 4 No further information was provided to the survey team regarding Resident #71's baseline CP prior to the exit conference.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and clinical record review, the facility staff failed to review and revise the care plan to reflect the	F 657	**F657** **Corrective Action(s):** Resident #180's comprehensive care plan has been reviewed and revised to accurately reflect the resident's current needs and condition. Resident #54's and their attending physician have been notified that facility staff failed to invite the resident to the care plan meeting on 2/16/22. **Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all care plans to identify residents at risk of having inaccurate care plans and not being invited to attend care plan meetings will be completed. Residents identified at risk will be corrected at time of discovery.	

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F 657	Continued From page 5 resident's current status for one of 20 residents, Resident #180; and and failed to invite the resident to the care plan meeting for one of 20 residents in the survey sample, Resident #54. 1. Resident #180 was admitted to the facility with diagnoses including diabetes mellitus, congestive heart failure, generalized muscle weakness, end stage chronic renal insufficiency, and thrombocytopenia. On the minimum data set (MDS) assessment with assessment reference date 11/24/2021, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. Resident #180's clinical record included physician orders dated 2/24/2022 and 3/7/2022 to weigh the resident on Monday, Wednesday, and Friday, and notify the physician of weight gain over 5 pounds. On 03/23/22 at 3:11 PM, Resident #180's comprehensive care plan was reviewed with the MDS nurse. The care plan did not address the potential for fluid weight fluctuations with congestive heart failure, or the order to weigh the resident on Monday, Wednesday, and Friday. The administrator and director of nursing were notified of the concern during a summary meeting on 3/23/2022. 2. Resident #54's was admitted to the facility with diagnoses of stage 4 pressure ulcer of left buttock and left ankle, abdominal aortic aneurysm, and paraplegia. Section C (cognitive patterns) of Resident #54's	F 657	**Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment; revisions to the comprehensive care plan as indicated with any changes in condition; and that residents be invited to attend care plan meetings **Monitoring:** The RCC is responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	

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F 657	Continued From page 6 admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/21/22 included a BIMS (brief interview for mental status) summary score of 15 indicating the resident was alert and orientated. On 03/22/22 at 11:40 a.m., Resident #54 was interviewed and stated they had not had any CP (care plan) meetings. On 03/23/22 at 2:01 p.m. MDS nurse #1 was iterviewed and stated they were unable to locate any documentation that Resident #54 was invited to their CP meeting. On 03/23/22 at 3:28 p.m., MDS nurse #1 stated they found the CP meeting schedule and confirmed the meeting with the RP (responsible party). On 03/24/22 at 8:42 a.m., MDS nurse #1 stated they were unable to find any evidence that Resident #54 had been invited to their CP meeting. On 03/24/22 at 1:15 p.m., MDS nurse #1 stated the CP meeting was held on 02/16/22 the RP attended and the resident refused to come. There was no documentation in the clinical record that a CP meeting was held on 02/16/22. There were 2 notes transcribed on 02/16/22, neither of which referenced Resident #54's CP meeting. On 03/24/22 at 3:10 p.m., the administrator, administrator in training and DON (director of nursing) were notified that the MDS nurse was unable to provide evidence that Resident #54 had been invited to their CP meeting and that the	F 657		

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F 657	Continued From page 7 resident had stated they had not had a CP meeting. No further information was provided to the survey team regarding this issue prior to the exit conference.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for a dependent resident for 1 of 20 residents, Resident #36. The findings included: Resident #36's was admitted to the facility with diagnoses that included, but were not limited to, fibromyalgia and muscle weakness. Section C (cognitive patterns) of Resident #36's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/20/22 included a BIMS (brief interview for mental status) summary score of 15, indicating the resident was cognitively intact. Section G (functional status) was coded 2/2 in the area of personal hygiene indicating Resident #36 required limited assistance of one person to perform this task.	F 677	**F 677** **Corrective Action(s):** Resident #36's attending physician has been notified that the facility staff failed provide activities of daily living related to facial hair on her chin. Resident #36 has received an electric razor and her facial hair has been trimmed. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have potentially been affected. The DON/designee will complete a 100% review of residents to identify resident in need of facial hair trimming. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide inservice training to the CNA's to address the importance of providing good grooming and hygiene to include bathing care to all residents. The DON/designee will conduct twice weekly resident care rounds at differing times throughout the day to observe the grooming and hygiene status of all residents. Residents found with improper ADL care will be corrected at time of discovery and the CNA staff assigned to the resident will receive additional training and/or disciplinary action as appropriate.	

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F 677	Continued From page 8 Resident #36's comprehensive care plan included the problem area of ADL self-care performance deficit related to fibromyalgia/pain with little to no motivation. Approaches included to provide assistance with ADL tasks. On 03/22/22 at 3:11 p.m., Resident #36 was observed in their room and was observed to have facial hair on the chin. Resident #36 stated the hair bothered them and that they needed a new razor. On 03/23/22 at 2:31 p.m., Resident #36 was stated they had trimmed their own facial hair using clippers and again stated they needed a new razor. On 03/23/22 at 5:45 p.m., during an end of the day meeting with the administrator, administrator in training, and DON (director of nursing) these staff were notified that Resident #36 was observed with facial hair and they stated it did bother them. On 03/24/22 at 9:00 a.m., the director of nursing (DON) stated they were buying Resident #36 an electric razor. No further information regarding this issue was provided prior to the exit conference.	F 677	**Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform ADL/grooming audits weekly coinciding with the care plan calendar to insure that their current hygiene needs are addressed. Any/all negative findings will be reported to the DON and/or Designee for immediate correction. Detail findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684	**F684** **Corrective Action(s):** Residents #9's attending physician was notified that the facility failed to administer a medication (cephalexin) as ordered by the physician.	

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F 684	Continued From page 9 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to follow physicians orders for 3 of 20 residents in the survey sample, Residents #9, #71, and #180. For Resident #9, the facility failed to administer the full course of the antibiotic cephalexin ordered by the physician. For Resident #71, the facility failed to follow physician's orders for the administration of the medication cephalexin. For Resident #180, facility staff failed to obtain weights as ordered. 1. Resident #9 was admitted to the facility with diagnoses including chronic respiratory failure with hypoxia, history of falls, muscle weakness, chronic obstructive pulmonary disease, dependence on oxygen, and essential hypertension. Clinical record review revealed Resident #9 returned from a hospitalization with orders including: 12/2/2021 cephalexin 500 mg tablet 1 tablet PO (by mouth) QID (4 times per day) X (times) 5 days diagnosis UTI (urinary tract infection). The total course would be 20 doses. The medication administration record (MAR) documented doses administered at 9:00 AM on 12/3, 12/4, 12/5, 12/6, 12/7; 1:00 PM on 12/3,	F 684	Residents #71's attending physician was notified that the facility failed to administer a medication (cephalexin) as ordered by the physician. Residents #180's attending physician was notified that the facility failed to obtain the resident's weight as ordered by the physician for 2/25/22, 2/28/22, 3/2/22, 3/4/22, and 3/7/22. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON/designee will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments to include weights and medications. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders.	

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F 684	Continued From page 10 12/4, 12/5, 12/6; 5:00 PM on 12/2, 12/3, 12/4, 12/5, 12/6; and 9:00 PM on 12/2, 12/3, 12/4, 12/5, 12/6. There were no blanks on the MAR. The MAR evidenced Resident #9 received 19 doses from 12/2/2021 through 12/7/2021. A telephone order dated 12/8/2021 documented, "continue Cephalexin 500 mg 1 tablet PO four times a day dx (diagnosis) UTI (per physician name) X 5 days. The MAR for the second order read cephalexin 500 mg tablet take 1 tablet PO four times a day DX: UTI Stop date 12/14/21. The telephone order specified four times a day times five days. The MAR documented doses administered at 9:00 AM on 12/9, 12/10, 12/11, 12/12, 12/13, 12/14; 1:00 PM on 12/8, 12/9, 12/10, 12/11, 12/12, 12/13, 12/14; 5:00 PM on 12/8, 12/9, 12/10, 12/11, 12/12, 12/13; and 9:00 PM on 12/8, 12/9, 12/10, 12/12, 12/13. The MAR evidenced #9 received 24 doses from 12/8/2021 through 12/14/2021. On 3/23/2022 at approximately 2:00 PM, Resident #9's nurse was interviewed. The nurse was asked if they entered antibiotic orders for the number of doses or if they used calendar dates. The nurse said they used number of doses because they did not want to wait to start the medication on the next full calendar day. On 3/23/2022 at 4:00 PM, the corporate clinical consultant confirmed that both courses of antibiotic were ordered for 20 doses. The concern was reported to the administrator and director of nursing during a summary	F 684	**Monitoring:** The DON will be responsible for maintaining compliance. The DON/designee will perform weekly MAR and chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	

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	495002	A. BUILDING _____ B. WING _____	C 03/24/2022

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F 684	Continued From page 11 meeting on 3/24/2022. 2. Resident #71's clinical record included the diagnoses obstructive reflux uropathy and history of malignant neoplasm of renal pelvis. Section C (cognitive patterns) of Resident #71's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/25/22 included a BIMS (brief interview for mental status) summary score of 12 of 15, indicating moderate impairment. Section H (bowel/bladder) was coded to indicate Resident #71 had a foley catheter in place. Resident #71's comprehensive care plan included the problems/needs: Indwelling foley catheter related to obstructive uropathy, urinary retention, history of UTI (urinary tract infection)/obstruction, and history of malignant neoplasm renal pelvis. Approaches and interventions included antibiotic-UTI as ordered see MAR (medication administration record). Resident #71's clinical record included documentation that Resident #71 was seen in a local ED (emergency department) on 02/24/22 to replace their foley catheter. Resident #71 was prescribed the antibiotic cephalexin (keflex) 500 mg take 1 capsule in the morning, 1 capsule at noon, 1 capsule in the evening, and 1 capsule before bedtime by mouth. Do all of this for 7 days. Dispense 28 capsules. A review of Resident #71's medication admininstration record (MAR) revealed that the nursing staff had transcribed the order to read cephalexin 500 mg administer 1 capsule in the morning, one at noon, and 1 capsule at bedtime	F 684		

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F 684	Continued From page 12	F 684		

for 7 days. The stop date was documented as 03/03/22. The nursing staff documented they had administered this medication beginning on 02/25/22 at 9:00 a.m. three times a day at 9:00 a.m., 1:00 p.m., and 9:00 p.m.

Resident #71 received 12 doses in February and 8 doses in March for a total of 20 doses. The last dose was documented as being administered on 03/03/22 at 1:00 p.m.

03/23/22 5:45 p.m., during a meeting with the administrator, administrator in training, and the DON (director of nursing) the issue with Resident #71 not receiving all of their physician ordered antibiotic was reviewed.

The administrative staff provided a copy of their policy titled, Administering Medications. This policy read in part, "...Medications shall be administered in a safe timely manner, and as prescribed...Medications must be administered in accordance with the orders, including any required time frame..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. Resident #180 was admitted to the facility with diagnoses including diabetes mellitus, congestive heart failure, generalized muscle weakness, end stage chronic renal insufficiency, and thrombocytopenia.

On the minimum data set (MDS) assessment with assessment reference date 11/24/2021, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs

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F 684	Continued From page 13 of delirium, psychosis, or behaviors affecting care. Resident #180's clinical record included physician orders dated 2/24/2022 and 3/7/2022 to weigh the resident on Monday, Wednesday, and Friday, and notify the physician of weight gain over 5 pounds. No weights were documented on 2/25, 2/28, 3/2, 3/4, or 3/7/22. On 03/23/22 at 3:11 PM, Resident #180's comprehensive care plan was reviewed with the MDS nurse. The care plan failed to address the potential for fluid weight fluctuations with congestive heart failure, or the order to weigh the resident on Monday, Wednesday, and Friday. On 3/22/2022, the list of missing weights was given to the director of nursing (DON) to find. On 3/24/22 at 10:32 AM, the DON stated that there were no additional weights. The administrator and director of nursing were notified of the concern during a summary meeting on 3/23/2022.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761	**F761** **Corrective Action(s):** The facility medical director has been notified that the facility staff failed to ensure a physician ordered supplement was kept under observation by the nursing staff until it was consumed by resident #54.	

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F 761	Continued From page 14 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a physician ordered supplement was kept under direct observation by the nursing staff until consumed by the resident for 1 of 20 residents, Resident #54. The findings included: Resident #54's clinical record included the diagnoses stage 4 pressure ulcer of left buttock and left ankle, abdominal aortic aneurysm, and paraplegia. Section C (cognitive patterns) of Resident #54's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/21/22 included a BIMS (brief interview for mental status) summary score of 15. Indicating the resident was alert and orientated.	F 761	**Identification of Deficient Practices & Corrective Action(s):** All residents receiving physician ordered supplements may have been affected. The DON/designee will complete physician ordered supplement administration observations with all licensed staff to identify staff members who do not keep supplements under observation until they are consumed by residents. Negative findings will be corrected at the time of discovery and corrective action completed if warranted. **Systemic Change(s):** Facility policy and procedure for the administration of physician ordered supplements has been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for administering physician ordered supplements **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform twice weekly supplement administration observations to monitor for compliance. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	

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F 761	Continued From page 15 03/23/22 9:51 a.m., Resident #54 was observed with a brown liquid substance in a medication cup on their over the bed table. LPN (licensed practical nurse) #1 was observed outside Resident #54's room and was not in direct line of sight of this physician ordered supplement. LPN #1 identified this substance as Proheal and stated they should not have left the Proheal in the residents' room. Resident #54's clinical record included a physicians order for Protein supplement give 30 ml PO (by mouth) BID (twice a day). 03/24/22 3:10 p.m., during a meeting with the administrator, administrator in training, and DON (director of nursing) the DON stated they would have expected the nurse to stay in the room until the Proheal had been consumed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812	**F 812** **Corrective Action(s):** The diced potatos and tofu were discarded at the time of the survey. The 3 cups of orange juice and 4 cups of grape juice were discarded at the time of the survey. The half of honeydew melon was discarded at the time of the survey. The peanut butter pies and filling were discarded at the time of survey.	

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F 812	Continued From page 16 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document reviews, the facility staff failed to store and/or prepare food in a sanitary manor in the main kitchen and failed to ensure a clean and sanitary food service area. The findings include: The initial tour of the kitchen/food service area was conducted on 3/22/22 at 9:53 a.m. Two (2) dietary staff members (SM) #26 and SM #27 participated in the tour. The following was observed: An open bag diced potatoes were observed in the reach-in freezer. The diced potatoes were uncovered. A bag of chicken flavored tofu was in contact with the diced potatoes. The refrigerator contained three (3) cups of orange juice and four (4) cups of grape juice that had been poured from a container into individual cups. These seven (7) cups of juice were not labeled with a date. Half a honeydew melon was found in a refrigerator. This melon was covered with plastic wrap but not labeled and dated.	F 812	The counter section of the steam table was cleaned after the water pitcher was removed during the survey. The facility medical director has been notified of the deficient practices cited during the survey. The facility's registered dietitian has been notified of the deficient practices cited during the survey. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will randomly monitor the kitchen preparation and food storage area to identify any negative findings. All items identified to be out of compliance will be discarded and any negative findings may result in disciplinary action if warranted **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the Food Service Manager and dietary staff on the preparing, storing, and serving foods in a sanitary manner	

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F 812	Continued From page 17 Three (3) trays of individual sized peanut butter pies were observed in a refrigerator. These trays of pies were not labeled and dated. A bowl of the peanut butter pie filling was also observed and was not labeled and dated. SM #26 confirmed the aforementioned items should have been labeled with a dated. On 3/23/22 at 4:20 p.m., observations were made of food being prepared and placed on the steam table. SM #26 was observed knocking a plastic water pitcher onto the floor. SM #27 was observed picking up the water pitcher and placing it on the counter section of the steam table prior to cleaning-up the spilled water. The water pitcher was not cleaned prior to being placed on the steam table counter. SM #28 was observed handling the water pitcher with gloved hands while placing trays of food on the steam table. The following information was found in a facility policy titled "Food Receiving and Storage" (with a revised date of October 2017): "Foods shall be received and stored in a manner that complies with safe food handling practices...All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)." The following information was found in a facility policy titled "Covering, Labeling, Dating Food" (sic) (with an updated date of 12/1/2018): "Refrigeration Storage: ... Read to eat, TCS food can be stored for only 7 days if held at 41 degrees or below. The count begins on the day the food was prepared or the container or package was opened." (TCS = Time/Temperature Control for Safety)...Freezer Storage: ... All foods must be covered, labeled and dated with a date label."	F 812	**Monitoring:** The Food Service Manager is responsible for maintaining compliance. The Food Service manager or Cook in charge will monitor the refrigerators and food storage areas twice weekly for proper labeling and dating of food and beverage items and disposal of those items per policy to monitor and maintain compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	

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F 812	Continued From page 18 The following information was found in a facility policy titled "Sanitization" (with a revised date of October 2008): "The food service area shall be maintained in a clean and sanitary manner....All utensils, counters, shelves and equipment shall be kept clean ..." On 3/23/22 at 5:43 p.m. a meeting was held with the facility's Administrator, Director of Nursing, and Administrator-in-Training. The above observations were discussed during this meeting.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide a quality assurance and performance improvement (QAPI)	F 865	**F865** **Corrective Action(s)** The facility medical director has been notified that the facility staff failed to provide a quality assurance and performance improvement (QAPI) plan for the facility. A documented QAPI meeting has been held by the facility. **Identification of Deficient Practices & Corrective Action(s):** All residents have the potential to be affected by the inconsistent monitoring of company policies and procedures. All resident concerns will be addressed by the QA Committee via ongoing audits and action plans. A QA Action Plan will be implemented to address and resolve identified concerns. **Systemic Change(s):** The QA Committee will take a more visible role in the day-to-day operations of the facility. Routine weekly QA audits of the medical records focusing on areas of concern identified through the Quality Assurance process. They will monitor all aspects of resident care and services for continuous quality improvements.	

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F 865	Continued From page 19 plan for the facility. The findings were: The administrative team provided a policy titled, "Quality Assurance and Performance Improvement;" however, no evidence related to the development, implementation, or evaluation of corrective actions or performance improvement activities was provided. The Regional Director of Clinical Services (RDCS) and the facility's Administrator were interviewed on 03/24/2022 at 2:13 p.m. about the facility's QAPI plan. The RDCS said that although the current administrative team had searched everywhere, they were not able to provide any documentation to evidence their QAPI plan. No further information was provided prior to the exit conference.	F 865	The QA Committee has been inserviced by the regional nurse consultant on the requirements for documentation of proof of quality assurance and performance improvement meetings. **Monitoring:** The administrator is responsible for maintaining compliance. The V.P. of Operations and/or Regional Nurse Consultant will visit the facility at least monthly to provide management and operational oversight per corporate direction. The V.P. of Operations will provide detail reports of negative findings to Corporate Office for immediate corrections. These findings will be forwarded to Corporate for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide evidence they had developed and implemented appropriate plans of action to identify or correct quality deficiencies for the facility.	F 867	F867 **Corrective Action(s)** The facility medical director has been notified that the facility staff failed to provide a quality assurance and performance improvement (QAPI) plan for the facility. A documented QAPI meeting has been held by the facility. **Identification of Deficient Practices & Corrective Action(s):** All residents have the potential to be affected by the inconsistent monitoring of company policies and procedures. All resident concerns will be addressed by the QA Committee via ongoing audits and action plans. A QA Action Plan will be implemented to address and resolve identified concerns. **Systemic Change(s):** The QA Committee will take a more visible role in the day-to-day operations of the facility.	

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F 867	Continued From page 20 The findings were: On 03/24/2022 at 2:13 p.m.,during review of the facility Quality Assessment and Perfomance Improvement Prgram, the Regional Director of Clinical Services (RDCS) and the facility's Administrator were interviewed. The RDCS said that although the current administrative team had searched everywhere, they were not able to provide any documentation to evidence their QAPI plans of action for quality deficiencies. No further information was provided prior to the exit conference.	F 867	Routine weekly QA audits of the medical records focusing on areas of concern identified through the Quality Assurance process. They will monitor all aspects of resident care and services for continuous quality improvements. The QA Committee has been inserviced by the regional nurse consultant on the requirements for documentation of proof of quality assurance and performance improvement meetings. **Monitoring:** The administrator is responsible for maintaining compliance. The V.P. of Operations and/or Regional Nurse Consultant will visit the facility at least monthly to provide management and operational oversight per corporate direction. The V.P. of Operations will provide detail reports of negative findings to Corporate Office for immediate corrections. These findings will be forward to Corporate for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	F 868	**F868** **Corrective Action(s)** The facility medical director has been notified that the facility staff failed to provide a quality assurance and performance improvement (QAPI) plan for the facility. A documented QAPI meeting has been held by the facility. **Identification of Deficient Practices & Corrective Action(s):** All residents have the potential to be affected by the inconsistent monitoring of company policies and procedures. All resident concerns will be addressed by the QA Committee via ongoing audits and action plans. A QA Action Plan will be implemented to address and resolve identified concerns. **Systemic Change(s):** The QA Committee will take a more visible role in the day-to-day operations of the facility. Routine weekly QA audits of the medical records focusing on areas of concern identified through the Quality Assurance process. They will monitor all aspects of resident care and services for continuous quality improvements.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 21 review, the facility staff failed to provide evidence of quarterly quality assessment and assurance (QAA) committee meetings for the facility. The findings were: The Regional Director of Clinical Services (RDCS) and the Administrator were interviewed on 03/24/2022 at 2:13 p.m. The RDCS provided signature sheets for a QAA committee meeting dated Oct 28, 2021. The RDCS said that although the current administrative team had searched everywhere, they were not able to locate the signature sheets from other quarterly QAA committee meetings. Later the same day, the administrator provided a QAA meeting signature sheet dated January 23, 2020. No further information was provided prior to the exit conference.	F 868	The QA Committee has been inserviced by the regional nurse consultant on the requirements for documentation of proof of quality assurance and performance improvement meetings. **Monitoring:** The administrator is responsible for maintaining compliance. The V.P. of Operations and/or Regional Nurse Consultant will visit the facility at least monthly to provide management and operational oversight per corporate direction. The V.P. of Operations will provide detail reports of negative findings to Corporate Office for immediate corrections. These findings will be forward to Corporate for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 8, 2022**	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	**F880** **Corrective Action(s):** Attending physicians of residents on Wing 2 and the facility medical director have been notified that facility staff failed to implement infection control practices to prevent the spread of infection when a staff member failed to sanitize their hands during a medication administration observation. LPN #1 has received one on one education regarding handwashing.	

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F 880	Continued From page 22 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 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	F 880	**Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected by improper infection control practices related to handwashing. The infection preventionist will complete a review of all nursing staff for handwashing. Any negative findings will be addressed immediately, and disciplinary action taken as needed. **Systemic Change(s):** The facility Infection Control policy and medication administration policy and procedure have been reviewed and no changes are warranted at this time. The infection preventionist has inserviced all staff on handwashing. **Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete QA audits no less than 3 times weekly monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: May 8, 2022**	

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F 880	Continued From page 23 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 interview, and facility document review, the facility staff failed to perform hand hygiene during a medication pass and pour onservation on 1 of 2 resident care units, Wing 2. The findings included: On 3/23/22 at 8:15 am during a medication pass and pour observation, LPN (licensed practical nurse) #1 administered nasal spray to a resident while wearing gloves, exited the room, returned to the medication cart and placed the nasal spray back into a medicine bottle prior to removing gloves. LPN #1 then removed gloves and placed the medicine bottle into the medication cart and proceeded down the hall to another area without performing hand hygiene. On 3/24/22 at 11:54 am, surveyor informed the DON (director of nursing) of the observation of LPN #1 exiting a resident's room following nasal spray administration without removing gloves or performing hand hygiene. The DON acknowledged LPN #1 should have removed gloves and performed hand hygiene following the medication administration.	F 880		

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F 880	Continued From page 24 The facility policy entitled "Handwashing/Hand Hygiene" documented in part: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. On 3/24/22 at 3:08 pm, during a meeting with the administrator, AIT (administrator in training), and the DON, the lack of hand hygiene during the medication pass and pour observation was discussed. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/24/22.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883	F883 **Corrective Action(s):** Documentation of Resident #8's Pneumococcal Vaccine status has been added to the resident's clinical record.	

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F 883	Continued From page 25 §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 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883	Documentation of Resident #40's Pneumococcal Vaccine status has been added to the resident's clinical record. Documentation of Resident #55's refusal of the influenza vaccine has been added to the resident's clinical record. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have been affected. A 100% review of all resident records for proof of pneumococcal vaccine status and proof of influenza vaccine declination/consent will be completed. Negative findings will be addressed at the time of discovery. **Systemic Change(s):** The facility Pneumococcal and Influenza Vaccine policy and procedure have been reviewed and no changes are warranted at this time. All licensed nurses have been inserviced by the DON regarding documentation of influenza/pneumococcal vaccine status and proof of declination/consent for the administration of the vaccines.	

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F 883	Continued From page 26 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 and clinical record review, the facility staff failed to determine flu and pneumonia status for 3 of 5 residents reviewed for vaccines, Resident's #8, #40, and #55. The facility staff was unable to provide evidence of consent or refusal in regards to the flu and/or pneumonia vaccines. The findings included: 1. Resident #8's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/15/21 included a BIMS (brief interview for mental status) summary score of 3 indicating severe cognitive impairment. Section O (special treatments/procedures/programs) was coded with a "1" indicating the resident had received the pneumonia vaccine. During clinical record review there was no consent for the pneumonia vaccine found nor any information to indicate when the resident received the vaccine.	F 883	**Monitoring:** The infection preventionist is responsible for maintaining compliance. Following the MDS calendar, the infection preventionist will review each resident's record for proof of Influenza and Pneumococcal declination/consent and proof of administration of influenza pneumococcal vaccines. Any negative findings will be corrected at the time of discovery. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: May 8, 2022**	

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F 883	Continued From page 27 On 03/23/22 at 12:29 p.m., the DON (director of nursing) was asked for documentation in regards to Resident #8's pneumonia vaccine. On 03/23/22 at 5:45 p.m., during an end of the day meeting with the administrator, administrator in training, and DON the issue with the missing documentation regarding Resident #8' pneumonia vaccine was reviewed. The DON stated they had nothing further on Resident #8's vaccine status. No further information was provided to the survey team prior to the exit conference regarding Resident #8's vaccination status. 2. Resident #40's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/25/22 included a BIMS (brief interview of mental status) summary score of 8 indicating moderate impairment in cognitive skills. Section O (special treatments/procedures/programs) was coded with a "0" indicating the resident had been offered the pneumonia vaccination and declined. During clinical record review there was no information found to indicate Resident #40 had been offered or refused the pneumonia vaccine. On 03/23/22 at 12:29 p.m., the DON (director of nursing) was asked for documentation of Resident #40's pneumonia vaccine refusal. On 03/23/22 at 5:45 p.m., during an end of the day meeting with the administrator, administrator in training, and DON the issue with the missing information regarding Resident #40's pneumonia vaccine was reviewed.	F 883		

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F 883	Continued From page 28 On 03/24/22 at 4:47 p.m., Resident #40 was interviewed and stated they did not want the pneumonia vaccine. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. Section C (cognitive patterns) of Resident 55's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/10/22 included a BIMS (brief interview for mental status) summary score of 15, indicating the resident was alert and orientated. Section O (special treatments/procedures/programs) was coded with a "0" indicating the resident did not receive the flu (influenza) vaccine in this facility. The reason marked on this MDS was offered and declined. On 03/23/22 at 12:29 p.m., the DON (director of nursing) was asked for documentation of Resident 55's refusal of the flu vaccine. The facility staff provided a copy of a vaccination record. For the flu vaccine someone had transcribed refused '21. No other documentation was provided. On 03/23/22 at 5:45 p.m., the administrator, administrator in training, and DON were made aware of the missing information in regards to Resident #55's flu vaccine. On 03/24/22 4:45 p.m., Resident #55 was interviewed and stated they did not want the flu vaccine. No further information was provided to the survey	F 883		

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F 883	Continued From page 29 team prior to the exit conference regarding Resident #55's vaccination status.	F 883		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886	**F886** **Corrective Action(s):** The facility medical director was notified that the facility staff did not obtain a COVID-19 specimen from a staff member (SM #22) per manufacturer's instructions. SM #22 has been retested per manufacturer's instructions and the results of the test documented. The facility medical director was notified that the facility staff failed to complete required COVID-19 testing on SM#1on 5 separate occasions. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected. A 100% review of all current employee files will be completed to identify employees who did not receive required testing. Negative findings will be addressed at the time of discovery and the facility Medical Director will be notified. The facility's infection preventionist and all licensed nursing staff have been inserviced by the regional nurse consultant regarding the manufactuer's instructions for obtaining specimens for COVID-19 tests for all brands of test in use at the facility.	

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F 886	Continued From page 30 §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 observation, interviews, and document reviews, the facility staff failed to properly implement COVID-19 testing processes and/or procedures. The specimen collection was not obtained according to manufacturers instructions for one staff member (SM) #22; and the facility staff failed to conduct required COVID-19 testing on five separate occasions for for 1 of 2 staff members, SM #1. The findings include:	F 886	**Systemic Change(s):** The facility COVID-19 testing policy has been reviewed and no changes are warranted at this time. All facility staff have been re-inserviced on the current COVID-19 testing policy. **Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete monthly QA audits to monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: May 8, 2022**	

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F 886	Continued From page 31 1. On 3/22/22 at 3:05 p.m., SM #21 was observed conducting a COVID-19 test on SM #22. SM #21 was observed inserting a swab into one of SM #22's nostrils. SM #21 rotated the swab 5 times prior to removing the swab and repeated the process in SM #22's other nostril. SM #21 was observed to have the swab inserted into each of SM #22 nostrils for less than 10 seconds per each nostril. SM #21 confirmed they rotated the swab 5 times in each nostril but reported they were not aware of a minimum time requirement for the COVID-19 specimen/sample collection. The following information was found in the manufacturer's instructions for use: "Anterior Nasal (Nares) Swab...Only the swab provided in the kit is to be used for nasal swab collection. To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually ½ to ¾ of an inch (1 to 1.5 cm) into the nostril. Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril." A survey team meeting, with the facility's Administrator, Director of Nursing, and Administrator-in-Training, occurred on 3/22/22 at 4:34 p.m. The COVID-19 specimen/sample collection observation was discussed during this meeting. 2. During the entrance interview on 3/22/22 at 9:30 a.m., the Administrator reported the facility's Community Transmission Level was currently at the "high" level.	F 886		

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F 886	Continued From page 32 On 3/23/22 at 2:15 pm, the DON (director of nursing) was interviewed and stated the facility's community transmission level has been red for a while. On 3/23/22, review of staff vaccination documentation revealed that SM #1 received the first COVID-19 vaccine dose of a multiple vaccine series on 3/03/22. SM #1 had not received any additional COVID-19 vaccine doses. A review of SM #1's COVID-19 testing since 2/24/22 included documentation of testing performed on 3/08/22 and 3/14/22 each with negative results. A review of SM #1's time report indicated SM #1 was working in the facility on 2/24/22, 2/25/22, 2/28/22, 3/01/22, 3/04/02, 3/05/22, 3/06/22, 3/08/22, 3/11/22, 3/14/22, 3/15/22, 3/19/22, 3/20/22, and 3/22/22. On 3/23/22 at 3:50 pm, the DON was interviewed about any additional COVID-19 testing results for SM #1. The DON stated they did not have any additional test results for SM #1. On 3/24/22 at 1:39 pm, the DON further stated they have been unable to reach SM #1 regarding the reason for their missing COVID-19 test results. On 3/24/22 at 3:08 pm, the concern of SM #1's missing COVID-19 testing results was discussed during a meeting was with the administrator, AIT (administrator in training), and the DON. The facility's policy titled "COVID-19 Testing" (with a revised date of 3/15/22) included the following	F 886		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 33 information: "Routine testing of staff who are not up to date with all recommended COVID-19 vaccines, [sic] should be based on the extent of the virus in the community." This document included a table that indicated a minimum testing frequency, of staff who are not up to date with the COVID-19 vaccinations, should be twice a week when the facility's COVID-19 Community Transmission Level is high (red). No further information regarding this concern was presented to the survey team prior to the exit conference on 3/24/22.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those	F 887	**F887** **Corrective Action(s):** Resident #40's attending physician has been notified that facility staff failed to provide evidence of COVID-19 vaccine refusal in the clinical record. Resident #40 has been offered the opportunity to accept or decline COVID-19 vaccination after the risks and benefits of the vaccine were explained to the resident. Documentation of the resident's choice has been placed in the resident's record. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected. A 100% review of all current residents will be completed to ensure proof of COVID-19 Vaccination consent/declination is present in the resident's record. Negative findings will be addressed at the time of discovery.	

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F 887	Continued From page 34 additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 887	**Systemic Change(s):** The facility COVID-19 vaccination policy has been reviewed and no changes are warranted at this time. The infection preventionist has inserviced all staff on the COVID-19 vaccination policy **Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete monthly QA audits to monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: May 8, 2022**	

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F 887	Continued From page 35 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide evidence of COVID-19 vaccination refusal for 1 of 5 residents, Resident #40. The findings included: Resident #40's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/25/22 included a BIMS (brief interview of mental status) summary score of 8 indicating moderate impairment in cognitive skills for daily decision-making. On 03/22/22, the facility provided a form titled, "Resident Vaccination Status." Under the areas for type of vaccine and the date a resident would have received the vaccine, was transcribed the word "Choice." During the clinical record review, there was no information located to indicate Resident #40 had been offered and/or refused the COVID-19 vaccine. On 03/23/22 at 12:29 p.m., the DON (director of nursing) was asked for documentation of Resident #40's COVID-19 vaccine. This documentation was not provided prior to survey exit. The current IP (infection preventionist) was new to the facility with a hire date of 03/25/22 the back-up IP had a hire date of 01/31/22. On 03/23/22 at 5:45 p.m., during an end of the day meeting with the administrator, administrator	F 887		

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F 887	Continued From page 36 in training, and DON the issue with the missing information regarding Resident #40's COVID-19 vaccine was reviewed. On 03/24/22 at 4:47 p.m., Resident #40 was interviewed and stated they did not want the COVID-19 vaccine. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 887		
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. §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.	F 888	**F888** **Corrective Action(s):** The facility medical director has been notified that the facility staff failed to implement policies and procedures for additional infection control precautions for 3 staff members (SM #1, SM #2, and SM #3) who are not fully vaccinated for COVID-19. The facility medical director has been notified that the facility staff failed to ensure a process for tracking the COVID-19 vaccination status of one staff member (SM #4). **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected. The infection preventionist will make twice weekly QA rounds to monitor for implementation of additional infection control precautions of unvaccinated staff per the facility COVID-19 Vaccination Policy.	

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F 888	Continued From page 37 §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; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;	F 888	A 100% review of COVID-19 vaccination tracking for all current staff members will be completed. Negative findings will be addressed at the time of discovery. **Systemic Change(s):** The facility COVID-19 Vaccination Policy has been reviewed and no changes are warranted at this time. All facility staff have been re-inserviced on the current COVID-19 Vaccination Policy. **Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete monthly QA audits to monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: May 8, 2022**	

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F 888	Continued From page 38 (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 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	F 888		

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F 888	Continued From page 39 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 observation, staff interview, and facility document review, the facility failed to implement policies and procedures for additional infection control precautions for staff who are not fully vaccinated for COVID-19, for 3 of 5 employees, Staff Members (SM) #1, #2, and #3. The facility staff also failed to ensure a process for tracking the COVID-19 vaccination status of staff for 1 of 7 sampled employees, SM #4. The findings included: 1. According to the COVID-19 employee vaccine tracking documentation provided by the facility on 3/22/22, SM #1 was partially vaccinated. SM #1 received their first administration of a multiple COVID-19 vaccine series on 3/03/22. SM #1's date of hire was 2/24/22.	F 888		

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F 888	Continued From page 40 SM #1 worked in the facility four days (2/24/22, 2/25/22, 2/28/22, and 3/01/22) prior to receiving their first dose of a COVID-19 vaccine. On 3/23/22 at 4:20 pm, the HRS (human resource staff) #1 was interviewed regarding SM #1's work location and duties performed on 2/24/22, 2/25/22, 2/28/22, and 3/01/22. HRS #1 stated there was no way of knowing. At 4:22 pm, SM #1's department manager was interviewed and asked the same question. The manager stated they would find out and return with the information. At the conclusion of the survey on 3/24/22, the facility had not provided evidence of SM #1's work location or duties on 2/24/22, 2/25/22, 2/28/22, and 3/01/22. On 3/24/22 at 1:39 pm, the DON (director of nursing) and HRS #1 were interviewed and stated a new employee could begin work and then had seven (7) days to make a decision regarding vaccination or requesting a vaccination exemption. On 3/23/22 at 2:15 pm, the DON was interviewed and stated the facility's community transmission level has been red for a while. A review of SM #1's COVID-19 testing since date of hire of 2/24/22, included documentation of testing performed on 3/08/22 and 3/14/22 each with negative results. A review of SM #1's time report provided by human resources indicated SM #1 was working in the facility on 2/24/22, 2/25/22, 2/28/22, 3/01/22, 3/04/02, 3/05/22, 3/06/22, 3/08/22, 3/11/22, 3/14/22, 3/15/22, 3/19/22, 3/20/22, and 3/22/22.	F 888		

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F 888	Continued From page 41 On 3/23/22 at 3:50 pm, the DON was interviewed and asked for any additional COVID-19 testing results for SM #1. The DON stated they did not have any additional test results for SM #1. On 3/24/22 at 1:39 pm, the DON stated they have been unable to reach SM #1 regarding the reason for their missing COVID-19 test results. On 3/24/22 at 3:08 pm, concern of SM #1 working in the facility four days prior to receiving the first dose of a multiple COVID-19 vaccination series and missing five out of seven required COVID-19 testing results was discussesd with the administrator, AIT (administrator in training), and the DON. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/24/22. 2. According to the COVID-19 employee vaccination tracking documentation provided by the facility on 3/22/22, SM (staff member) #2 was unvaccinated and granted a non-medical exemption. SM #2 was employed as a CNA (certified nursing assistant) and provided direct resident care. On 3/23/22 at 12:00 pm, SM #2 was interviewed regarding additional COVID-19 precautions required by the facility due to their approved vaccination exemption status. SM #2 stated they were required to have a COVID-19 test twice a week. SM #2 was asked about the type of mask they were required to wear while in the facility and SM #2 stated a disposable, blue surgical mask if there was no COVID in the building. SM #2 further stated they have their own KN95 mask	F 888		

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F 888	Continued From page 42 which they chose to wear while working. On 3/23/22 at 4:40 pm, the DON (director of nursing) and RDCS (Regional Director of Clinical Services) were interviewed and asked what additional precautions must unvaccinated staff follow. The DON stated they must be tested twice weekly. The staff were asked if there were any additional precautions regarding mask use and the RDCS reviewed the facility policy and stated "a N95". On 3/24/22 at 1:39 pm, the facility IP (infection preventionist) and the DON were interviewed regarding SM #2 stating they wear a KN95 mask while working, and are only required to wear a surgical mask if there was no active COVID-19 in the facility. The DON stated SM #2 was educated. On 3/24/22 at 3:08 pm, a meeting was held with the administrator, AIT (administrator in training), and the DON to discuss the above concerns. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/24/22. 3. According to the COVID-19 employee vaccination tracking documentation provided by the facility on 3/22/22, SM (staff member) #3 was unvaccinated and granted a non-medical exemption. SM #3 was employed as a CNA (certified nursing assistant) and provided direct resident care. On 3/23/22 at 12:38 pm, SM #3 was observed in the hall wearing two disposable surgical masks. SM #3 was asked what type of mask was	F 888		

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F 888	Continued From page 43 required by facility policy and SM #3 stated they wear two surgical masks and added that up until recently they were wearing a N95 but "it's been so hot." On 3/24/22 at 1:39 pm, the facility IP (infection preventionist) and the DON (director of nursing) were interviewed regarding the observation of SM #3 wearing two surgical masks instead of the required N95 for exempted, unvaccinated staff. The DON stated SM #3 has always worn a N95 with a surgical mask over it. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/24/22. 4. According to the COVID-19 employee vaccination tracking documentation provided by the facility on 3/22/22, SM (staff member) #4 was unvaccinated and granted a non-medical exemption. On 3/23/22 at 4:34 pm, SM #4 was observed wearing a disposable surgical mask and administering medications to residents on Wing 2. On 3/23/22 at 5:43 pm, the administrator, AIT (administrator in training), and the DON (director of nursing) were interviewed concerning the observation of SM #4 wearing only a disposable surgical mask instead of the required N95 for exempted, unvaccinated staff. The DON stated SM #4 was fully vaccinated. The administrative team was informed of the facility COVID-19 employee vaccination tracking form documenting SM #4 was unvaccinated with a non-medical exemption.	F 888		

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F 888	Continued From page 44 On 3/24/22 at 8:50 am, the administrator provided a copy of SM #4's CDC COVID-19 Vaccination Record Card indicating SM #4 received the vaccine on 1/06/21, 01/27/21, and 2/03/22. At 12:01 pm, the administrator stated the facility COVID-19 employee vaccination tracking form was coded in error and all other documentation on the form has been checked and was correct. On 3/24/22 at 3:08 pm, the concern of the inaccurate information provided for SM #4 on the facility COVID-19 employee vaccination tracking form was discussed with the administrator, AIT, and DON. The facility policy entitled, "COVID-19 Vaccine Policy & Forms" was reviewed and documented in part: Contingency Plans: Contingency plans address staff who are not fully vaccinated due to an exemption (which includes a temporary delay in vaccination). Any affected individual who obtains approval for a valid exemption (which includes a temporary delay in vaccination) will be required to wear Personal Protection Equipment (PPE) to include a N95 face mask; as an infection prevention and control measure when in the center and will be subject to routine COVID-19 testing based on the county transmission rate requirements in an effort to reduce the risks giving rise to the vaccine mandate. Guidelines: 4. Any affected individual who obtains approval for a valid exemption will be required to wear Personal Protection Equipment (PPE) to include a N95 face mask; as an infection prevention and control measure when in the center and will be	F 888		

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SOUTH ROANOKE NURSING AND REHABILITATION	3823 FRANKLIN RD, SW ROANOKE, VA 24014

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F 888	Continued From page 45 subject to routine COVID-19 testing based on the county transmission rate requirements in an effort to reduce the risks giving rise to the vaccine mandate. 5. New affected individuals are required to receive COVID-19 vaccination or provide proof of vaccination or provide adequate documentation of exemption at the time of hire or entry to the center. New applicants or affected individuals who have not provided documentation of compliance (or have failed to secure an approved exemption or immunization), will be listed as "pending" hire and will not participate in the new Team member orientation program. Newly affected individuals who have not provided documentation of compliance (or have failed to secure an approved exemption or immunization) will not be allowed to enter the facility. a. New team member applicants will be given seven (7) business days from the date of the employment health screening to provide adequate documentation of exemption or vaccination before the facility rescinds the offer of employment; during this (7) day period the new applicant will not be allowed to work without proof of vaccination status or documentation of exemption. If documentation is not received, the facility Human Resources will advise the applicant they are not cleared for hire and may result in rescinding the offer of employment. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/24/22.	F 888		