STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING ______ B. WING ______	C 06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 06/14/2022 and continued with offsite review through 06/15/2022. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 94 certified bed facility was 84 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid COVID-19 Focused Infection Control Survey and Abbreviated complaint survey was conducted 06/14/2022 and through 06/15/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The survey sample consisted of 11 residents and 12 staff. One complaint was investigated during the survey (VA00054186- Substantiated with deficient practice).	F 000		
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;	F 677		7/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/07/2022

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 677	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interviews, facility documentation review, clinical record review and during the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) assistance to Residents who were dependent on staff to maintain personal hygiene, for two Residents (Resident #10 & #12) in a survey sample of 11 Residents. The findings included: 1. For Resident #10, who was dependent upon facility staff for ADL assistance, the facility failed to provide hair care and nail care, and failed to ensure the Resident's clothing was clean. On 6/14/22 at 10:21 AM, Resident #10 was visited in her room by Surveyor C. Surveyor C observed Resident #10's hair to have three braids, which had a lot of fraying and appeared untended and uncombed. Resident #10 stated, "No one does my hair anymore". Resident #10 was observed to have right arm contractures and stated, "I can't comb it or do that" [referring to braiding] and pointed to her right arm. Resident #10 said she would "love it" if someone would do her hair. Resident #10 was also observed to have a small crusty substance on the right collar of her shirt, her fingernails were long, with chipped nail polish, and some dirt was noted under the nails. Resident #10 said she would like her nails trimmed and reported to Surveyor C that it has been about 2 weeks since anyone provided any nail care.	F 677	F677 Corrective Action(s): Resident #10 declined shower on 6/14/2022. Per resident preference bed bath provided by staff as well as hair cleansed and re-braided. Nails cleaned under and trimmed to appropriate length. Resident #12 was showered and hair washed on 6/14/2022 7p-7am shift. Identification of Deficient Practices & Corrective Action(s): A 100% audit will be conducted on resident preferences regarding shower/tub or bed bath by 7/22/2022. A 100% audit of residents' hair and nails to be conducted by 7/22/2022. Any hair and nail care will be provided immediately of needed. Twice weekly bathing schedule will be created and residents care plan will be updated to reflect resident preference. Systemic Changes: Facility policy and procedures have been reviewed. No revisions are warranted at this time. In-service will be provided to nursing staff regarding ADL care, bathing, showering, nail and hair care by DON, ADON, or unit managers. New hires will be educated as part of orientation. Monitoring: DON/ADON or Unit Managers will	

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F 677	Continued From page 2	F 677		

Review of Resident #10's electronic health record revealed on the ADL sheets that she required extensive assistance to being totally dependent on facility staff. The ADL sheets also noted that Resident #10 frequently refused baths. For the month of May and to date in June, Resident #10 was not noted as having received any baths other than bed baths.

On 6/14/22 at 12 PM, an interview was conducted with CNA B. CNA B stated that Resident's hair is "washed twice a week". When asked about nail care and the frequency, CNA B stated, "I am not sure if we trim nails, I just got here a month ago".

On 6/14/22 at 12:26 PM, an interview was conducted with CNA J. CNA J was asked about nail care and she said, "CNA's do nail care except for diabetes. [Resident #10's name redacted] refuses for us to cut her nails". CNA J was told Resident #10 was observed to have chipped nail polish, CNA J said, "Activities will remove and put on polish a few times a week". When asked who cleans the nails, she said, "The CNA's are supposed to be doing that with ADL care".

On 6/14/22 at 12:28 PM, an interview was conducted with CNA C. CNA C was told Resident #10's nails are very long, CNA C said, "I wiped her up this morning, there was food under her nails when I first went in, I cleaned her with soap and washcloth, they look better than they did".

2. For Resident #12, the facility staff failed to provide ADL assistance to maintain personal

conduct audits of 5 residents Monday through Friday x 4 weeks, then 5 residents weekly x 8 weeks as well as a visual inspection of residents to ensure hair/nails and bathing of resident.

Results of such audits will be taken to QAPI committee monthly for 3 months for review and revision as needed

Compliance Date: 7/29/2022

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F 677	Continued From page 3 hygiene of hair care. On 6/14/22 at approximately 12 Noon, Resident #12 was visited in her room by Surveyor C. Resident #12 was asked about showers and baths. Resident #12 said she doesn't get showers often but gets a bed bath daily. Resident #12 said, "My hair needs to be washed, it has been about a month since it's been washed". Resident #12's hair was observed to appear very oily and in need of washing. Review of Resident #12's electronic health record revealed he/she was dependent on facility staff for personal hygiene and bathing. Resident #12 was noted to not have had a shower or tub bath for the month of May, nor to date in June. Resident #12 was noted to only receive bed baths. There was no further information in the clinical record with regards to hair washing. On 6/14/22 at 12 PM, an interview was conducted with CNA B. CNA B stated that Resident's hair is "washed twice a week". On 6/14/22 at 2:30 PM, an interview was conducted with the Director of Nursing (DON). She was asked to explain when nail care and hair care is provided. She said, "CNA's or nurses provide nail care, cleaning and trimming, they check nails everyday with ADL care and if it is needed they provide it". The DON said they have a shower room where showers are given and they "Should be given twice a week". The DON said hair washing is done with showers, but some people prefer to go to the beauty salon". The DON confirmed that the beauty salon is a service Residents have to pay for and she added, "Hair washing should be provided when they do	F 677		

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F 677	Continued From page 4	F 677		

showers or a bath in the room".

A review was conducted of the facility policy titled, "Resident Bath/Showering/Scheduling Policy". This policy read, "...Residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin condition... (G) If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the charge nurse. (H) The charge nurse will speak with the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse the charge nurse will inform the DON and document the resident's refusal in the nursing notes and on the 24-hour report. Further attempts and interventions will be documented in the nursing notes and on the 24-hour report..."

The facility policy titled, "Morning Care/AM Care" was reviewed. This policy read, "Morning care will be offered each day to promote resident comfort, cleanliness, grooming, and general wellbeing...3. Perform hand hygiene... 6. Provide bath/shower as indicated...9. Provide fingernail care...13. Brush/comb hair..."

On 6/14/22, during an end of day meeting Surveyor C shared her observations of Resident #10 and #12.

On 6/15/22, during an end of day meeting the above findings were discussed with the facility Administrator, Director of Nursing and Assistant Director of Nursing/Infection Preventionist.

No further information was provided.

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F 677	Continued From page 5 Complaint related deficiency.	F 677		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		7/29/22

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F 880	Continued From page 6 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to implement infection control practices as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements to prevent the spread of COVID-19 within the facility by 3 nursing staff members, LPN B, CNA C, and	F 880	F880 Corrective Action(s): All staff in facility were provided protective eye protection to wear during patient encounters.	

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F 880

Continued From page 7

CNA F, out of 3 nursing staff observed providing resident care.

The facility nursing staff, LPN B, CNA C, and CNA F, failed to implement proper use of PPE (personal protective equipment) while providing direct resident care for Resident #10.

The findings included:

On 6/14/22 at approximately 10:30 AM, an Entrance Conference was conducted with the Facility Administrator and the Infection Preventionist (IP) who confirmed the facility was in a COVID-19 Outbreak status and the last positive COVID case in the facility occurred on 6/2/22.

The IP also verified that the facility was located in a county with a high (Red) level of COVID transmission. She stated that all staff in the facility were expected to be wearing an N95 level facemask due to the facility Outbreak status as well as the high community COVID transmission levels.

The IP confirmed that CDC and CMS requirements were the foundation for the development and implementation of the facility's policies and decisions in the management of COVID-19. A copy of the facility's policies related to general infection prevention and control as well as the facility's policies specific to COVID-19 management were requested and received.

On 6/14/22 at approximately 11:00, Surveyor C observed CNA C and CNA F providing incontinence care for Resident #10, during which LPN B also arrived to empty Resident #10's

F 880

Identification of Deficient Practices & Corrective Action(s):

All staff to be provided eye protection to be worn during patient encounters while on duty at facility while in outbreak status or county transmission rates high or substantial.

Systemic Changes:

Facility policy and procedures have been reviewed. No revisions are warranted at this time. In-service to be provided to all staff by DON/ADON/ or unit Managers regarding recommended use of PPE for Health Care Settings by 7/22/2022. New hires will be educated as part of orientation.

Monitoring:

DON/ADON or Unit Managers will conduct an audit of five staff members five times weekly x 4 weeks, 4 staff members five times weekly x 4 weeks, then 3 staff members five times weekly x 4 weeks to ensure compliance of correct PPE as per policy.

Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed.

Compliance Date: 7/29/2022.

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F 880	Continued From page 8	F 880		

Continued From page 8

colostomy bag. Surveyor C noted that all 3 staff members were not wearing any eye protection while performing direct resident care for Resident #10 and when queried, the staff members were unaware of the need for eye protection.

On 6/14/22 at approximately 2:30, a second interview was conducted with the IP regarding the expectations of personal protective equipment (PPE) usage for source control and she stated, "I expect everyone [facility staff] to be wearing an N95 while in the facility, I do not require any eye protection at this time".

On 6/15/22, a review of the facility's document entitled, "Recommended use of personal protective equipment (PPE) for Health care settings for Coronavirus Disease", update 2/2/2022, read, "Facilities in Outbreak Status or Community Transmission Level is Red/High or Orange/Substantial: N95 and Eye Protection for patient care encounters".

Per CDC guidance, updated on February 2, 2022, entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel [HCP] During the Coronavirus Disease 2019 (COVID-19) Pandemic", page 4, subtitle, "Implement Universal Use of Personal Protective Equipment for HCP", read, "Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: ...*Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters". Accessed online at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

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F 880	Continued From page 9 The Facility Administrator and Director of Nursing were informed of the findings on 6/15/22 at approximately 12:15. No further information was provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative 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	F 883		7/29/22

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F 883	Continued From page 10 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to implement their immunization policy and ensure each Resident is offered influenza and pneumococcal immunization, for 1 Resident (Resident #20), in a sample of 6 Residents reviewed for immunizations. The findings included: On 6/14/22, during the survey entrance conference the facility, the Administrator identified Employee C as the infection preventionist and stated she was responsible for the vaccination effort within the facility.	F 883	F883 Corrective Action: Pneumonia vaccine was offered and declined by Resident #20 on 6/20/2022. Not eligible for flu vaccine at this time. Identification of Deficient Practices & Corrective Action(s): A 100% audit will be completed on all residents by 7/29/2022. Any missing vaccinations will be educated and offered to Resident/ or RP if appropriate to determine their wishes to receive these	

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F 883	Continued From page 11 On 6/14/22 and 6/15/22, clinical record reviews were conducted for the sampled Residents with regards to immunization for flu and pneumonia. This review revealed the following: Resident #20 had been admitted to the facility on 5/27/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the pneumonia or flu vaccine status of Resident #20. Review of the misc. (miscellaneous) tab, assessment tab, and progress notes revealed no evidence of vaccine administration or offering of such. Review of the Medication Administration Records (MAR) revealed no evidence of the flu or pneumonia immunization being provided to Resident #20. There was an admission alert scanned in the misc. tab, which indicated COVID vaccination status of Resident #20, but no information was noted with regards to flu or pneumonia immunization status. On 6/15/22 at 9:45 AM, an interview was conducted with Employee C, the Infection Preventionist (IP). The IP was asked to explain the process when a Resident is admitted, with regards to immunizations. The IP said, "We offer the flu shot if it is flu season, if they have had it we try to find that information and we offer it to them. If they refuse, we let the doctor know, the doctor will encourage them to take it and sometimes the family will try to encourage them". When asked if any declination or acceptance forms are signed, the IP said, "Usually we just put a note in and document in the immunization tab". During the interview with the IP, she accessed the EHR for Resident #20. She observed and confirmed the immunization tab only had a TB	F 883	vaccinations. Flu vaccines to be offered at beginning of flu season when available. Systemic Changes: Facility policy and procedures have been reviewed. No revisions are warranted at this time. In-service to be provided to licensed nurses in regards to Vaccination Policy by DON/ ADON/ or Unit Managers by 7/22/2022. New hires will be educated as part of orientation. Monitoring: DON/ or designee to conduct vaccine audits of 10 residents weekly x 4 weeks, 5 residents weekly x 4 weeks, and 3 residents every week x 4 weeks to ensure vaccine statuses are up to date or educated/offered and declined. ICP to conduct an audit within 48 hours of admission to ensure vaccine status with appropriate vaccinations being offered to patient. EHR to be updated as vaccination given or educated and declined. Results of such audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. Compliance Date: 7/29/2022	

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F 883	Continued From page 12	F 883		

(tuberculosis) skin test and no other data was recorded. She reviewed the misc. tab and nursing notes and confirmed there was no information in the EHR. She stated, "We usually go down and talk to admissions, I will have to look at my papers". The IP confirmed that based on the EHR she did not know Resident #20's immunization status with regards to flu or pneumonia immunization and had no evidence of it being offered to the Resident. She was asked to provide her papers if she found them. No further information was provided.

Review of the facility policy titled, "Infection Prevention and Control Program Policy" was conducted. This policy read, "...All residents are given the influenza vaccination unless they refuse or have medical contraindications. All residents, meeting criteria, are given the pneumococcal vaccine unless they refuse or medical contraindications."

The facility policy titled, "Resident Vaccination Policy" was reviewed. This policy was noted to read, "...The date of historical vaccination(s) will be documented in the health record immunization portal on admission and as information becomes available. Vaccination information may be obtained from the resident/responsible party, past medical records, VIIS documentation, etc. If specific historical vaccination information is not known the resident/representative will provide their best estimate of dates of prior vaccinations and where received. The infection preventionist will track resident immunizations and holds the responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered...Consents/refusals/medical ineligibility

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F 883	Continued From page 13 will be documented in the immunization portal in the electronic health record..." On 6/15/22 at 12:51 PM, an end of day meeting was held with the facility Administrator, Director of Nursing and Infection Preventionist. They were made aware of the above findings. The Administrator reported during this meeting that Resident #20 was cognitively impaired and they had been unable to reach his/her responsible party for consent. The clinical record indicated on the profile tab that Resident #20 was their own responsible party and the family member was noted as an "emergency contact". Also, there was documentation in the miscellaneous tab of the chart for Resident #20 which indicated Resident #20 had signed other documents, which included but were not limited to, Resident handbook and an advance beneficiary notice. No further information was provided.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in	F 886		7/29/22

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this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

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F 886	Continued From page 15 §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 clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 3 Residents, Residents #16, #17, and #19, in a sample of 3 Residents reviewed for resident COVID-19 testing and for contracted agency nursing staff in 2 out of 2 months reviewed for facility staff COVID-19 testing. The findings included: 1. For Residents #16, #17, and #19, facility staff failed to conduct COVID-19 testing for admission/re-admission to the facility and did not document the results of COVID-19 testing in their clinical record. 1a. For Resident #16, the facility staff failed to conduct COVID-19 testing upon her admission to the facility on 5/19/22 and failed to document the results of a COVID-19 test performed on 5/26/22. On 6/14/22, a clinical record review was conducted and revealed that Resident #16 was admitted to the facility on 5/19/22, however there was no evidence of any COVID-19 testing until 5/26/22. There was no documented result for the	F 886	F886 Corrective Action(s): Residents #16,17 and 19 were all swabbed on 6/13/2022, 6/16/2022 and 6/20/2022 with negative results. All staff scheduled to work were swabbed on 6/16-6/18/2022. Identification of Deficient Practices & Corrective Action(s): Any new admissions will be tested within 24 hours of admission and 5-7 days later per policy. Residents and staff to be COVID tested per CMS/CDC guidelines. Systemic Changes: Facility policy and procedures have been reviewed. No revisions are warranted at this time. In-service to be provided to all staff by DON/ ADON/ Or unit managers regarding CMS/CDC Covid testing guidelines for LTC facilities by 7/22/2022. New hires will be educated as part of orientation. Monitoring:	

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F 886	Continued From page 16 COVID-19 test performed on 5/26/22 in her medical record. 1b. For Resident #17, the facility staff failed to conduct COVID-19 testing upon his readmission to the facility on 6/10/22 and failed to document the results of a COVID-19 test performed on 6/13/22. On 6/14/22, a clinical record review was conducted and revealed that Resident #17 was readmitted to the facility on 6/10/22 following his admission to the local hospital on 5/24/22. There was no evidence of any COVID-19 testing until 6/13/22. There was no documented result for the COVID-19 test performed on 6/13/22 in his medical record. 1c. For Resident #19, the facility staff failed to conduct a second COVID-19 test following her admission to the facility on 5/19/22 and failed to document the result of a COVID-19 test performed on 5/20/22. On 6/14/22, a clinical record review was conducted and revealed facility staff performed a COVID-19 test for Resident #19 on 5/20/22, however failed to document the result of that test in her medical record. There was no evidence of any additional COVID-19 testing for Resident #19 within 5-7 days of her admission. On 6/14/22 at approximately 2:30 PM, an interview was conducted with the facility Infection Preventionist (IP) who confirmed the facility conducts COVID-19 testing for all residents in accordance with CDC (Centers for Disease Control and Prevention) recommendations. The IP was asked about the facility's protocol for	F 886	An audit to be conducted twice weekly for new admission COVID testing as well as outbreak testing if applicable x 12 weeks. DON or designee will conduct an audit five times a week x 4 weeks, 3 times a week x 4 weeks, and one time a week x 4 weeks of all staff working in facility to ensure COVID testing is being completed per CMS/CDC guidelines. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. Compliance Date: 7/29/2022	

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testing newly admitted residents for COVID-19 and she stated, "we test all new admits within a day of their arrival, after that then only if there is a reason to....testing and results are documented in their [medical] record". A copy of the facility's COVID-19 testing policy was requested and received.

Review of the facility policy titled, "COVID Testing Guidance", updated 6/14/2022, page 2, subheading, "Tracking, Reporting and Documentation", read, "Documentation of resident test results will be retained in the resident health record" and on page 4, subheading, "COVID-19 Testing Algorithm", read, "Newly admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection: approximately 24 hours after admission/readmission and, if negative, again 5-7 days after their admission or return".

The CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, page 4, subheading, "Testing", item 3, read, "Newly-admitted residents and residents who have left the facility for (greater than) 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV2 infection; immediately and, if negative, again 5-7 days after their admission".

Review of the CMS (Centers for Medicare & Medicaid Services) Memo Ref: QSO-20-38-NH, revision date 3/10/2022, page 11, revealed, "....the results of tests must be done in accordance with standards for protected health

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information. For residents, the facility must document [COVID-19] testing results in the medical record".

On 6/15/22, the Facility Administrator, Director of Nursing, and IP were made aware of the findings. No further information was provided.

2. For the months of May and June 2022, facility staff failed to conduct COVID-19 testing for 42 contracted agency nursing staff.

On 6/14/22 at approximately 10:30 AM, an Entrance Conference was conducted with the Facility Administrator and the Infection Preventionist (IP) who confirmed the facility was in a COVID-19 Outbreak status which began on 5/30/22 and the last positive COVID case occurred on 6/2/22.

The IP also verified that COVID-19 testing was currently being performed twice per week for all staff and residents while the facility remained in Outbreak status.

The IP confirmed that CDC and CMS requirements were the foundation for the development and implementation of the facility's policies and decisions in the management of COVID-19. A copy of the facility's COVID-19 testing policy was requested and received. The facility COVID-19 staff testing logs and nursing staff work schedules beginning on May 1, 2022 to present were requested and received.

On 6/15/22, a review of the facility's staff COVID-19 testing logs and nursing staff work schedules revealed a total of 42 contracted

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F 886	Continued From page 19 agency nursing staff, to include RNs, LPNs, and CNAs, worked in the month of May 2022 with no documented COVID-19 testing occurrences. From 6/1/22 through 6/14/22, a total of 41 agency nursing staff worked with no documented COVID-19 occurrences. Review of the facility policy titled, "COVID Testing Guidance", updated 6/14/2022, page 1, Table 1 titled, "Testing Summary", read, "Testing Trigger... [COVID-19] Outbreak...Test all staff within 24 hours of first case and then every 3-7 days until no new cases are identified for 14 days". Review of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated on February 2, 2022, page 8 read, "Perform testing for all residents and HCP [Health Care Personnel]...regardless of vaccination status, immediately...and, if negative, again 5-7 days later...if additional cases are identified, testing should continue...every 3-7 days...until there are no new cases for 14 days". On 6/15/22, the Facility Administrator, Director of Nursing, and IP were made aware of the findings. No further information was provided.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the	F 887		7/29/22

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F 887	Continued From page 20 immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident 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	F 887		

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F 887	Continued From page 21 (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: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to offer COVID vaccination(s) to one Resident (Resident #20), in a sample of 6 Residents reviewed for immunizations and the facility staff failed to obtain and maintain record of the COVID-19 vaccination status for 57 out of 57 contracted nursing agency staff members who worked during the months of May and June. The findings included: 1. For Resident #20, who was not up to date with COVID immunizations, the facility staff failed to provide evidence that he/she was offered, educated and provided/or declined COVID vaccination. On 6/14/22 and 6/15/22, a clinical record review for Resident #20 was conducted. This review revealed the following: Resident #20 had been admitted to the facility on	F 887	F887 Corrective Action(s): Resident #20 received COVID booster on 6/22/2022. All current staff/agency vaccine cards were obtained by 6/24/2022. Identification of Deficient Practices & Corrective Action(s): A 100% audit of COVID vaccines of residents/agency to be completed by 7/22/2022. Systemic Changes: Facility policy and procedures have been reviewed. No revisions are warranted at this time. In-service to be conducted with all staff regarding vaccine policies by	

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F 887	Continued From page 22 5/27/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #20. Review of the misc. (miscellaneous) tab a document was noted that indicated "COVID vac info". This document indicated Resident #20 had received doses of the Pfizer vaccine on 3/3/21 and 3/24/21. There was no information with regards to a booster dose. There was also a document titled, "Admission Notification" that indicated the same dates of administration for the COVID vaccine. Review of the Medication Administration Records (MAR) revealed no evidence of a COVID booster dose being provided to Resident #20. The progress notes were read in their entirety and no information was noted of a conversation, offer, education or refusal for a COVID booster. On 6/14/22, during an interview with Surveyor D and Employee C, the Infection Preventionist, the IP confirmed the facility follows all CDC (Centers for Disease Control and Prevention) guidance. On 6/15/22 at 9:45 AM, an interview was conducted with Employee C, the Infection Preventionist (IP). The IP was asked to explain the process when a Resident is admitted, with regards to immunizations. The IP said, "We offer immunizations, if they have had it we try to find that information and we offer it to them. If they refuse, we let the doctor know, the doctor will encourage them to take it and sometimes the family will try to encourage them". When asked if any declination or acceptance forms are signed, the IP said, "Usually we just put a note in and document in the immunization tab".	F 887	DON/ADON/or unit managers to be conducted by 7/22/2022. New hires will be educated as part of orientation. Monitoring: Any resident not up to date on COVID vaccine will be offered COVID vaccine by 7/29/2022. Any agency staff prior to working will provide proof of COVID vaccine prior to working a shift at the facility. DON or designee will conduct an audit of the of the agency staff utilized at the facility and ensure vaccination status five times a week x 4 weeks, 3 times a week x 4 weeks, and weekly x 4 weeks. DON or designee will audit 5 residents weekly x 6 weeks, 3 residents weekly x 6 weeks to ensure vaccination status is up to date or educated/offered and declined. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. Compliance Date: 7/29/2022	

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F 887	Continued From page 23 During the interview with the IP, she accessed the EHR for Resident #20. She observed and confirmed the immunization tab only had a TB (tuberculosis) skin test and no other data was recorded. She reviewed the misc. tab and nursing notes and confirmed there was no information in the EHR to indicate Resident #20 had been offered a COVID booster, she also confirmed that Resident #20 was eligible for a COVID booster dose. The IP stated, "We usually go down and talk to admissions, I will have to look at my papers". She [the IP] was asked to provide her papers if she found them. No further information was provided. Review of the facility policy titled, "Infection Prevention and Control Program Policy" was conducted. This policy read, "...All residents are given the influenza vaccination unless they refuse or have medical contraindications. All residents, meeting criteria, are given the pneumococcal vaccine unless they refuse or medical contraindications." The facility policy titled, "Resident Vaccination Policy" was reviewed. This policy was noted to read, "...COVID vaccination will be offered to all residents and administered per provider orders...The date of historical vaccination(s) will be documented in the health record immunization portal on admission and as information becomes available. Vaccination information may be obtained from the resident/responsible party, past medical records, VIIS documentation, etc. If specific historical vaccination information is not known the resident/representative will provide their best estimate of dates of prior vaccinations and where received. The infection preventionist will track resident immunizations and holds the	F 887		

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responsibility for ensuring resident's vaccination history is reviewed with/by their providers and that vaccines are administered timely when ordered...Consents/refusals/medical ineligibility will be documented in the immunization portal in the electronic health record..."

CDC provides the following guidance to nursing facilities in their document titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes". This document read, "...New Admissions and Residents who Leave the Facility: Create a Plan for Managing New Admissions and Readmissions....In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine...COVID-19 vaccination should also be offered". Accessed online 6/15/22, at web address:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030153017

On 6/15/22 at 12:51 PM, an end of day meeting was held with the facility Administrator, Director of Nursing and Infection Preventionist. They were made aware of the above findings. The Administrator reported during this meeting that Resident #20 was cognitively impaired and they had been unable to reach his/her responsible party for consent. The clinical record indicated on the profile tab that Resident #20 was their own responsible party and the family member was noted as an "emergency contact". Also, there was documentation in the miscellaneous tab of the chart for Resident #20 which indicated Resident #20 had signed other documents, which included but were not limited to, Resident

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handbook and an advance beneficiary notice.

No further information was provided.

2. The facility staff failed to obtain the COVID-19 vaccination status for 57 contracted nursing agency staff members who provided direct resident care during the months of May and June 2022.

On 6/14/22, an interview was conducted with the Facility Administrator and the Infection Preventionist (IP) who stated that the facility had a 100% COVID-19 staff vaccination rate. A staff COVID-19 vaccination list was requested and received. A list of all facility staff members, including contracted agency staff, scheduled to work on 6/14/22 was requested and received.

The IP stated that the Human Resources (HR) Director was responsible for obtaining and maintaining the COVID-19 vaccination status for all contracted nursing agency staff.

On 6/14/22 at approximately 1:00, Surveyor C conducted an interview with the HR Director to obtain the COVID-19 vaccination status for LPN D and CNA C, both of whom were contracted agency staff working on 6/14/22. The HR Director stated, "No one told me how to handle agency [nursing staff], I'm guessing [name redacted, Infection Preventionist] does that [obtain COVID-19 vaccination status]".

At approximately 1:15, Surveyor C conducted a group interview with the HR Director and the IP

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who stated, "the agency staff person sends their information to their agency, once they [the agency] complete the [staff] packet, then [name redacted, HR Director] gets the packet which includes abuse and residents rights, HIPPA information, and COVID vaccination--they have to be vaccinated in order to work with us...there is no nursing oversight, we rely on [name redacted, HR Director] with agency staff packets".

The HR Director responded, "I have never seen anything from agency since I've worked here on March 14th [2022]". The IP stated, "I will have to call agency to get their vaccination cards...everyone who works here must be vaccinated".

On 6/14/22 at approximately 3:15 PM, the IP stated that she was able to obtain the COVID vaccination status for LPN D and CNA C. The IP submitted a copy of an email sent to her by the Agency liason which revealed that LPN D was fully vaccinated, however CNA C was not vaccinated but had a non-medical exemption that had been submitted to the Agency.

The IP confirmed that the COVID vaccination status had not been obtained for any contracted staff that had been employed by the facility except for the recently received status for LPN D and CNA C that was just submitted. The agency nursing staff work schedules beginning on 5/1/22 was requested and received.

Review of the agency nursing staff work schedules for 5/1/22-6/14/22 revealed a total of 57 agency nursing staff, 27 RNs/LPNs and 30 CNAs, with unknown COVID-19 vaccination status were permitted by the facility to provide

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F 887	Continued From page 27 direct care to residents. Review of the facility policy titled, "Employee COVID-19 Vaccination Policy", last revision date 4/5/22, read, "...All employees are required to receive a FDA authorized and/or approved COVID-19 vaccination...". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, page 3, subtitle, "Vaccinations", read, "Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and residents against SARS-CoV-2 infection". The Facility Administrator, Director of Nursing, and IP were updated. No further information was received.	F 887		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility	F 888		7/29/22

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or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care,

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F 888	Continued From page 29 treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and	F 888		

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F 888	Continued From page 30 (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their COVID policy and procedures and were unaware of the COVID vaccination status of 57 contracted nursing agency staff who worked on all nursing units within the facility during the months of May and June. The facility staff failed to obtain the COVID-19	F 888	F888 Corrective Action(s): All agency staff COVID vaccine cards were obtained by 6/24/2022. Identification of Deficient Practices & Corrective Action(s): All agencies were informed of Employee	

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vaccination status for 57 contracted nursing agency staff members who provided direct resident care during the months of May and June 2022.

The findings included:

On 6/14/22, an interview was conducted with the Facility Administrator and the Infection Preventionist (IP) who stated that the facility had a 100% COVID-19 staff vaccination rate. A staff COVID-19 vaccination list was requested and received. A list of all facility staff members, including contracted agency staff, scheduled to work on 6/14/22 was requested and received.

The IP stated that the Human Resources (HR) Director was responsible for obtaining and maintaining the COVID-19 vaccination status for all contracted nursing agency staff.

On 6/14/22 at approximately 1:00, Surveyor C conducted an interview with the HR Director to obtain the COVID-19 vaccination status for LPN D and CNA C, both of whom were contracted agency staff working on 6/14/22. The HR Director stated, "No one told me how to handle agency [nursing staff], I'm guessing [name redacted, Infection Preventionist] does that [obtain COVID-19 vaccination status]".

At approximately 1:15, Surveyor C conducted a group interview with the HR Director and the IP who stated, "the agency staff person sends their information to their agency, once they [the agency] complete the [staff] packet, then [name redacted, HR Director] gets the packet which includes abuse and residents rights, HIPAA information, and COVID vaccination--they have to

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Vaccine policy on 6/22/2022. Any new agency staff vaccination status should be sent to HR/IP prior to their scheduled shift.

Systemic Changes:
Facility policy and procedures have been reviewed. No revisions are warranted at this time. In-service provided to HR/ICP and Staffing Coordinator by 7/15/2022 regarding employee vaccination policy by DON/ADON. New hires will be educated as part of orientation if in those three positions.

Monitoring:
DON or designee will conduct audits 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, then weekly x 4 weeks to ensure agency staff have a vaccination card on file prior to working at facility.

Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed.

Compliance Date: 7/29/2022

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be vaccinated in order to work with us...there is no nursing oversight, we rely on [name redacted, HR Director] with agency staff packets".

The HR Director responded, "I have never seen anything from agency since I've worked here on March 14th [2022]". The IP stated, "I will have to call agency to get their vaccination cards...everyone who works here must be vaccinated".

On 6/14/22 at approximately 3:15 PM, the IP stated that she was able to obtain the COVID vaccination status for LPN D and CNA C. The IP submitted a copy of an email sent to her by the Agency liaison which revealed that LPN D was fully vaccinated, however CNA C was not vaccinated but had a non-medical exemption that had been submitted to the Agency.

The IP confirmed that the COVID vaccination status had not been obtained for any contracted staff that had been employed by the facility except for the recently received status for LPN D and CNA C that was just submitted. The agency nursing staff work schedules beginning on 5/1/22 was requested and received.

Review of the agency nursing staff work schedules for 5/1/22-6/14/22 revealed a total of 57 agency nursing staff, 27 RNs/LPNs and 30 CNAs, with unknown COVID-19 vaccination status were permitted by the facility to provide direct care to residents.

Review of the facility policy titled, "Employee COVID-19 Vaccination Policy", last revision date 4/5/22, read, "...All employees are required to receive a FDA authorized and/or approved

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F 888	Continued From page 33 COVID-19 vaccination...". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, page 3, subtitle, "Vaccinations", read, "Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and residents against SARS-CoV-2 infection". The Facility Administrator, Director of Nursing, and IP were updated. No further information was received.	F 888		