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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 08/24/2022 through 08/30/2022. 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.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted onsite 08/24/2022 through 08/30/2022. Significant corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. No complaints were investigated during the survey. The census in this 96 certified bed facility was 73 at the time of the survey. The survey sample consisted of 20 resident reviews and 14 employee reviews.	F 000		
F 880 SS=F	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	F 880		10/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/22/2022

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 880	Continued From page 1 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism 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	F 880		

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F 880	Continued From page 2 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation review, and clinical record review, the facility staff failed to implement infection control practices and failed to utilize proper PPE (personal protective equipment) as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance to prevent the spread of COVID-19 within the facility, on all 5 of the 5 Resident care halls and affecting 11 Residents (Resident #1, 5, 6, 7, 9, 10, 12, 13, 14, 16 and 20), in a survey sample of 20 Residents. The findings included: 1. The facility staff failed to don (put on) appropriate personal protective equipment (PPE), prior to entering the room of two Residents (Resident #1 and #20) who was on Transmission Based Precautions (TBP) for a confirmed COVID-19 infection.	F 880	Disclaimer: This Plan of Correction is submitted under Federal and State regulations and state application to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that surveyor□s finding or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. 1.All residents (as noted in the 2567 as all 5 resident care hallways), including the 11 affected residents identified, began being cared for with proper PPE (N95 respirators and eye protection) on	

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On 8/24/22 at approximately 12:50 PM, CNA B was observed to exit the room of Resident #1. CNA B was not wearing any eye protection. There was signage on the door to indicate Resident #1 was on TBP and a station was set-up with personal protective equipment (PPE) outside of the room. When asked, CNA B confirmed that she was feeding Resident #1. When asked about eye protection she said she usually does wear it in the rooms of COVID Residents but "I had washed it off and was waiting for it to dry". CNA B confirmed that Resident #1 has an active COVID infection.

On 8/25/22 at 9:55 AM, CNA H was observed to enter the room of Resident #20, who had signage on the exterior of the room that they were on TBP. CNA H was wearing a KN-95 only, she was observed to enter without putting on an N-95, eye protection, isolation gown or gloves. CNA H stepped back out into the hallway a moment later with gloves in her hand. When asked what PPE she is supposed to wear when entering the room she stated, gloves, gown, and eye protection. When asked why she had entered without wearing those items she stated she had gone in to get gloves. When asked what was wrong with the gloves on the cart outside of the room, she said she didn't see those. There were two boxes of gloves observed and pointed out that were on top of the cart that contained isolation gowns. CNA H then put on an isolation gown, gloves and eye protection and reentered the room.

All COVID related facility policies were requested. Review of the policies submitted/provided, did not address the use of PPE (personal protective equipment).

F 880

8/26/2022 per CDC□s recommendations for healthcare workers in counties with substantial or high transmission during resident care encounters.

Residents who were on transmission-based precautions (TBP) for confirmed COVID-19 infection (residents #1 and #20) began being cared for on 8/26/2022 with PPE that is required for TBP (gloves, gown, N95 respirator, and eye protection).

Beginning on 8/27/2022 and ongoing all team members were educated on the proper use of PPE (N95 respirators and eye protection) by the Director of Nursing (DON), Staff Development Coordinator (SDC), and other designees for both counties in substantial/high transmission and for residents who are COVID positive.

The nine residents identified (Residents #5, 6, 7, 9, 10, 12, 13, 14, and 16) who were not up to date with their COVID immunizations and had experienced a COVID exposure during an outbreak were placed on TBP on 8/26/2022.

On 8/26/2022 a broad based facility wide testing approach was initiated (and will be used when a new case of COVID-19 is identified) so that proper contact tracing could be learned and implemented appropriately by the community Infection Preventionist (IP).

2. All residents have the potential to be affected by the deficient practice. All

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Review of the CDC guidance in the document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" was conducted. This document read, "...Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection: HCP [healthcare personnel] caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator)..." Accessed online at:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031561398 1/11

During an end of day meeting on 8/24/22, the facility Administrator, DON and Infection Preventionist were made aware of the above findings. They confirmed they expect staff to wear an N-95 mask, isolation gown, eye protection and gloves prior to entering the room of a Resident on TBP.

No further information was provided.

2. The facility staff failed to wear eye protection when providing direct Resident care, while the facility was located in an area of high COVID-19 transmission and during a COVID outbreak as per the guidance from CDC (Centers for Disease Control and Prevention)

Prior to the survey team's entry to the facility the CDC COVID Data Tracker was reviewed and it noted the facility was located in an area with a "high" level of community transmission for COVID-19.

F 880

residents are at risk for transmission of COVID-19.

All residents are being cared for using the proper PPE both for substantial/high transmission rates and for TBP this began 8/26/22.

An audit of all residents vaccination status was done and all residents who were not up to date with COVID vaccination were placed on TBP this was completed by 8/29/2022. Residents TBP were discontinued after the required 10 days of isolation.

All residents were tested for COVID-19 on 8/25/22 and 8/27/2022 and proper protocol followed based on test results. (NOTE: appropriate outbreak testing was carried out per facility policy and procedure for residents and team members and the outbreak concluded on 9/12/2022).

Beginning 8/26/2022, the process of COVID testing all new admissions upon admission and 5 days after admission began. Any resident with a positive test will be placed on TBP and any resident who is not up to date with COVID vaccination will be placed on TBP.

3. Beginning on 8/27/2022 and ongoing all team members were educated on the proper use of PPE (N95 respirators and eye protection) by the Director of Nursing (DON), Staff Development Coordinator (SDC), and other designees for both

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On 8/24/22 at approximately 11:30 AM, during an entrance conference with the facility Administrator, Director of Nursing (DON), and Infection Preventionist (IP) they identified that they currently were in a COVID outbreak and staff were required to wear a KN-95 mask on the nursing units. They made no mention of eye protection being required.

The facility submitted tracking of the community's COVID transmissibility rates which indicated the facility had remained in an area of substantial or high COVID transmission since December 2021.

On 8/24/22 at approximately 12 Noon, a tour of the facility was conducted by Surveyor B. Nurses, certified nursing assistants, therapy staff, and housekeeping employees were all observed entering Resident rooms wearing no eye protection on all 5 of the Resident care hallways and entering Resident rooms to provide direct care or be within a few feet of the Residents.

The following specific observations were noted on the third floor:
a. Employee F was in a room providing care to a Resident wearing no eye protection. According to the staff vaccination matrix, Employee F was not up to date with COVID immunizations.
b. LPN C entered a room to provide medication wearing no eye protection. LPN C was not up to date with COVID immunizations.
c. CNA C was pushing a Resident in the hallway to their room, wearing no eye protection. CNA C was not up to date with COVID immunization per the staff vaccination matrix.
d. Employee E was ambulating a Resident in the hallway wearing no eye protection. Employee E

F 880

counties in substantial/high transmission and for residents who are COVID positive.

On 8/26/2022 the VP of Clinical Services re-educated the DON, IP, and SDC on the facility COVID testing policy and procedure which is based on CDC and CMS guidance.

The Infection Preventionist, Director of Nursing, Interim Administrator, and SDC were educated on 8/28/2022 on CDC and CMS guidelines for COVID using the two documents Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and Interim Infection Prevention and Control Recommendations for HC Personnel During the COVID-19 Pandemic. Also reviewed were facility policies and procedures which are based on the CDC and CMS guidance. This education included proper conduction of contact tracing when a new COVID-19 case is identified in a team member or resident.

On 8/26/2022 LifeSpire VP of Clinical Services developed a policy specific to PPE use in counties with substantial or high transmission titled Use of PPE in Facilities Located in Counties with Substantial or High Transmission. This policy was adopted by facility and incorporated into the 8/28/2022 training described above.

On 8/29/2022 LifeSpire VP of Clinical Services revised policy titled Transmission

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was not up to date with COVID immunizations.
e. CNA D was distributing meal trays to various Residents, setting up the Resident and food for the meal and had no eye protection on. CNA D was up to date with COVID immunizations.

On 8/24/22 at approximately 12:30 PM, the following specific observations were made on the second floor:
a. CNA E was distributing meal trays to Residents and was wearing no eye protection.
b. CNA F was sitting beside a Resident feeding them with no eye protection on.
c. LPN B was administering eye drops to a Resident wearing no eye protection. LPN B was not up to date with COVID immunizations.
d. CNA B was feeding a Resident and had no eye protection on.
e. CNA K entered a room to put a towel around the Resident in an effort to provide protection to the Resident's clothing while they ate, CNA K had on no eye protection.
f. CNA K entered the room of a Resident and sat beside then and started feeding them without wearing eye protection.

On 8/24/22 at 4:00 PM, observations were made on all of the Resident care halls and observations were again made on each hall of staff entering rooms to provide care without any eye protection. They included, but were not limited to, CNA G and LPN D.

On 8/25/22 at 9:10 AM, observations were made on each of the Resident care units/hallways. LPN E was observed in a Resident room administering medications and did not have any eye protection on. Eye protection was observed on top of her medication cart, which had been left in the

F 880

Based Precautions including TBP specific for COVID-19 to include more specific instructions around PPE use for COVID-19. This revised policy was adopted by facility and clinical leadership educated. On 8/29/2022 team members were educated regarding this revised policy.

Infection Preventionist has the following new processes in place:
" tracking all residents vaccination status and is maintaining a current log - this log includes resident testing, and resident isolation
" tracking all new resident admissions to ensure TBP are implemented if COVID vaccination status is not up to date
" weekly documentation of county transmission rate
" educate all new team members on proper use of PPE and COVID practices (vaccination, testing) during new employee orientation and during annual in-service sessions.
" make rounds daily to ensure team members are utilizing PPE properly and use an audit form
" contract tracing form to show proper contact tracing is being implemented for all positive cases (within a resident or team member, including agency staff)

4. DON, or designee, will review resident vaccination log, weekly documentation of transmission rate, and daily PPE round audit form every week for 4 weeks, then twice a month for two months and then quarterly for two quarters. DON, or

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F 880	Continued From page 7 hallway while she entered the Resident room. On 8/25/22 at 9:14 AM, Surveyor B knocked on the door of Resident #7 and upon opening the door observed a therapy staff member in the room providing treatment who was not wearing any eye protection. On 8/25/22 at 9:25 AM, an interview was conducted with LPN E. When asked why PPE is necessary and the purpose, LPN E said, "So you won't transmit infection". All COVID related facility policies were requested. Review of the policies submitted/provided, did not address the use of PPE (personal protective equipment). The CDC guidance document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic", with a revision date of Feb. 2, 2022, was reviewed. This document read, "Implement Universal Use of Personal Protective Equipment for HCP [health care personnel]...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 On 8/25/22, during an end of day meeting, the facility Administrator, Director of Nursing and IP were given a copy of the above referenced CDC guidance document.	F 880	designee, will review the new resident admission log daily for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. Identified areas of concern will be corrected as appropriate and feedback provided to IP. All completed contact tracing forms will be reviewed by the Administrator and VP of Clinical Services for each positive COVID case within a team member or resident. This will be done for each new case for 2 months. Identified area of concern will be corrected and IP re-educated. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	

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On 8/26/22 at approximately 9:15 AM, the facility Administrator, DON and IP confirmed that they follow CDC guidance. The above CDC guidance references were pointed out to the facility staff and they were made aware of Surveyor B's observations.

No further information was provided.

3. The facility staff failed to place 9 Residents, (Resident #5, 6, 7, 9, 10, 12, 13, 14, and 16) who were not up-to-date with COVID immunizations and had a COVID exposure, on transmission based precautions during a COVID outbreak.

On 8/24/22, the listing of Resident's COVID immunization status listing that the facility staff provided was reviewed. This review revealed that 12 current Residents are not up to date with COVID immunizations. Three of the 12 were currently on transmission based precautions for an active COVID infection. The other 9 Residents, (Resident #5, 6, 7, 9, 10, 12, 13, 14, and 16) rooms were observed and identified no signage or indication that they were on TBP.

On 8/25/22 at 9 AM, a facility tour was conducted with special attention being made to Resident #5, 6, 7, 9, 10, 12, 13, 14, and 16's rooms. There was still no indication that the Residents were on TBP.

Review of the facility submitted COVID line listing/infection report revealed that each of the nine Residents who were not up-to-date with immunizations had a possible exposure to

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COVID-19. The facility had not identified this during their contact tracing.

Resident #14 was potentially exposed to CNA M on 8/14/22 and 8/15/22. CNA M tested positive for COVID-19 on 8/16/22.

Residents #5, #6, and #16 were potentially exposed to COVID by CNA L on 8/17/22. CNA L tested positive for COVID 19 on 8/19/22. On 8/19/22, LPN G cared for Residents #5, 6, and 16. LPN G then tested positive for COVID-19 after her shift on 8/19/22.

Resident #7 and #12 were potentially exposed to CNA L on 8/16/22. CNA L tested positive for COVID-19 on 8/19/22.

Resident #13 was cared for by CNA B on 8/16/22 and 8/17/22. CNA B tested positive for COVID-19 on 8/18/22.

Residents #9 and #10, were cared for by LPN H on 8/17/22. LPN H reported having COVID symptoms on 8/17/22 and then tested positive for COVID-19 on 8/18/22.

Residents #7, #9, #10, #12, and #13 were cared for by LPN F on 8/17/22. LPN F had COVID symptoms on 8/17/22, then tested positive for COVID-19 on 8/18/22.

On 8/25/22 at 10:21 AM, an interview was conducted with the facility Infection Preventionist. The IP stated that no one had trained her on how to conduct contact tracing but she knew to look back two days for potential exposures due to COVID having an incubation period. When asked to explain this, the IP said, "That is when

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they may be infectious prior to exhibiting symptoms". When asked if she looked at who the staff had provided care to in the two days prior to a confirmed test, she said, "No".

All COVID related facility policies were requested. Review of the policies submitted/provided, did not address the use of PPE (personal protective equipment).

Review of the CDC guidance in the document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" was conducted. This document read, "...Empiric use of Transmission-Based Precautions (quarantine) is recommended for residents who ... have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses...Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection. Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).

Residents can be removed from Transmission-Based Precautions after day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, healthcare providers could consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of Transmission-Based Precautions.

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F 880	Continued From page 11	F 880		

Residents can be removed from Transmission-Based Precautions after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of Transmission-Based Precautions..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031561398 1/11

CDC also provides additional guidance when the facility is in a COVID outbreak. This guidance is found in the above referenced guidance document and read, "...New Infection in Healthcare Personnel or Residents: Respond to a Newly Identified SARS-CoV-2-infected HCP or Resident. Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak....Residents and HCP who are not up to date with all recommended COVID-19 vaccine doses:
These residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities. Close contacts, if known, should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection...."

On 8/25/22, during an end of day meeting, the

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F 880	Continued From page 12 facility Administrator, Director of Nursing and IP were given a copy of the above referenced CDC guidance document. On 8/26/22 at approximately 9:15 AM, the facility Administrator, DON and IP confirmed that they follow CDC guidance. The above CDC guidance references were pointed out to the facility staff and they were made aware of Surveyor B's observations. No further information was provided.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F 883		10/17/22

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F 883	Continued From page 13 immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. 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, failed to document influenza and pneumococcal immunization status and failed to offer immunizations to 3 Residents (Resident #2, #3, and #6), in a sample of 5 Residents reviewed for immunizations.	F 883	1. Residents #2 was offered the pneumonia vaccine on 9/21/2022 and education was mailed to the RR on 9/22/2022. Resident #4 was discharged on 9/3/2022. Residents #6 was discharged on 8/26/2022. All residents will be educated on and	

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F 883	Continued From page 14 The findings included: On 8/25/22, clinical record reviews were conducted for the sampled Residents in the presence of the Infection Preventionist (IP). The review revealed the following with regard to immunizations for flu and pneumonia: 1. Resident #2 had been admitted to the facility on 6/7/22. On the immunization tab of the electronic health record (EHR) no information with regards to pneumonia vaccination status was found. The Infection Preventionist looked throughout the clinical record and indicated there was no information available. 2. Resident #3 had been admitted to the facility on 6/6/22. The IP reviewed the clinical record of Resident #3 and noted no information was present to indicate Resident #3's immunization status with regard to flu or pneumonia. 3. Resident #6 had been admitted to the facility on 8/11/22. Review of the clinical record for Resident #6 revealed no information was available regarding Resident #6's vaccination status for flu or pneumonia. Additionally, there was no evidence that Residents #2, #3 and #6, were educated or offered vaccination for pneumonia. The Infection Preventionist stated that it is the responsibility of the admitting nurse to document all of this information and offer immunizations upon admission. During the above interview with the IP accessed	F 883	offered an influenza vaccine during the facility□s flu vaccination clinic. 2. All residents have the potential to be affected by the deficient practice. An audit of all residents□ pneumococcal vaccination status will be done by the DON or designee. Any resident found to have not been educated and offered the pneumococcal vaccine will be educated and offered the vaccine. All residents will be educated on and offered an influenza vaccine during the facility□s flu vaccination clinic. 3. Facility policies titled Vaccine □ Pneumococcal Vaccine and Influenza Vaccine Policy were reviewed with the facility Infection Preventionist on 9/16/2022 by the Administrator and VP of Clinical Services. IP, or designee, will re-educate nurses on offering the flu and pneumococcal vaccines to all newly admitted residents, education on the benefits of the vaccination and document accordingly in the resident□s medical record. Documentation will include declination if applicable. 4. IP, or designee, will audit the medical charts of all new residents on a weekly basis for the education, offering, administration and documentation of the flu and pneumococcal vaccines (including declination if applicable). This weekly	

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F 883	Continued From page 15 the EHR for Residents #2, #3 and #6. She observed and confirmed the immunization tab had no data recorded. She reviewed the remainder of the record and confirmed there was no information for the missing immunizations and that no information was available to indicate they had been educated on or offered the immunizations. On 8/25/22 at 10:37 AM, an interview was conducted with the facility's Infection Preventionist (IP). The IP was asked, "Why is it important for the immunization status to be documented?" The IP stated, "We should know their immunization status, if they don't have the immunizations we should offer it". When asked if the doctor and other providers should know the immunization status of Residents, the IP said, "Yes". When asked where the doctor would look for that information, the IP said, "In the chart". During the above interview, the IP was asked if the immunization status of a Resident affects the care that is provided to them, she said, "Yes". Review of the facility policy titled, "Vaccine-Pneumococcal Vaccine" was conducted. This policy read, "...1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission..."	F 883	audit will occur for 4 weeks, then twice a month for two months, then quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to staff nurses. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	

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F 883	Continued From page 16 The facility policy titled, "Influenza Vaccine Policy" was reviewed. This policy was noted to read, "... 1. All residents are to be offered vaccination, except those with a history of egg allergy, previous severe reaction to vaccination... 3. The Director of Nursing or designee is responsible for coordinating the administration of vaccinations...Procedure: 1. Prior to vaccination, current educations materials will be offered to residents, and explained as necessary by the nursing staff. The responsible parties of cognitively impaired residents will be contacted with this information. 2. The resident or his responsible party will be asked to sign consent before any vaccine is given. The consent or refusal will become a part of the resident's permanent medical record. 3. A physician's order will be obtained prior to the administration of a vaccine. 4. Documentation will be maintained in the resident's medical record indicating the type of vaccination given, the date given, and the name and title of the staff member administering the vaccination." On 8/25/22 and again 8/26/22, the facility interim Administrator, Director of Nursing and Infection Preventionist were made aware of the above findings. No further information was provided.	F 883		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in	F 885		10/17/22

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facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—

(i) Not include personally identifiable information;
(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on Resident and family interviews, staff interviews, and facility documentation review, the facility staff failed to notify Residents and families when new cases of COVID-19 were identified in the facility, affecting all 73 Residents residing in the facility.

The findings included:

The facility staff had no evidence of any Resident and family notifications of the facility's COVID outbreaks and mitigating strategies being implemented prior to the current outbreak.

On 8/24/22 at 11:30 A.M., evidence of Resident and family notifications of COVID cases and the weekly communication for the last 6 months,

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1. Resident□s #2, #4, #6, #8 and #15 were noted as not having email addresses on file for COVID-19 reporting. Resident #4 was discharged on 9/3/2022. Resident #6 was discharged on 8/26/2022. Families of residents 2, 8 and 15 are to be contacted via phone for COVID-19 reporting.

2. An audit was conducted on 100% of residents on 9/15/22 by Administrator and newly admitted residents since 8/30/22 had email addresses in their records and addresses were added to the email distribution list. The list will be updated when there are new admissions by the Activities Director or designee. All

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February-August, 2022, was requested.

On 8/24/22 at 3:00 PM, Employee D, the unit clerk, provided Surveyor B with letters dated 8/18/22, 8/19/22, and 8/23/22, which she stated she had emailed to Resident's families. Review of the email list she used for the notifications was reviewed and identified 9 Residents that the facility had no email address on file for. The 9 Residents with no email address on file included, but was not limited to Resident #2, #4, #6, #8 and #15, which were part of the survey sample. When asked if she placed any calls to those families, she stated, "No". Employee D was asked if she had made any notifications prior to 8/18/22, she said "No".

On 8/24/22 and 8/25/22, reviews of the electronic health record (EHR) for Residents #2, 4, 6, 8, and 15, were conducted. There was no evidence in the clinical record of the Resident or families being notified of the facilities COVID outbreak.

On 8/24/22 at approximately 1:00 PM, an interview was conducted with the spouse of Resident #19. During this interview, the spouse was asked how she is made aware of COVID cases within the facility. The spouse of Resident #19 stated, "I received an email last week". Surveyor B asked if she had received any communication prior to last week and she said, "No".

On 8/25/22, the facility interim Administrator, Director of Nursing (DON) and Infection Preventionist (IP) were made aware that there was only evidence provided of letters being sent to those whose emails were on file and that no information prior to 8/18/22, had been provided.

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residents who do not have an email address on file will be called by the Activities Director or designee. If the resident representative (RR) does not have an email address to provide, then a copy of notifications will be mailed to RR and a phone call made.

All residents have the potential to be affected by the deficient practice. The COVID-19 outbreak concluded on 9/12/2022. Residents/families were notified via email on 8/27/2022 and via email on 9/7/2022 with an update.

3. Education will be completed by the Director of Nursing or designee to nursing leadership on contacting residents and their families without email addresses via phone, and on how to document in the electronic medical record.

For all new cases of COVID-19 within a team member or resident, a notification/phone call will be provided to residents and residents responsible representatives. The notification will include information regarding the positive case/outbreak (no personally identifiable information), mitigating strategies being implemented to prevent or reduce the risk of transmission (including if normal operations of the facility will be followed), and cumulative updates at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified or whenever three or more residents or staff with new onset of

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On 8/25/22 at 5 PM, the DON provided copies of progress notes dated 8/25/22, where she attempted to call Resident families who had no email address on file.

On 8/26/22 at 9:55 AM, an interview was conducted with Resident #5 and her daughter who was at the bedside. The Resident displayed some confusion and difficulty recalling events. The daughter reported that she is made aware of COVID verbally by staff when she visits. When asked if this communication occurs routinely, she said, "No, usually I just hear them talking about it". When asked if she had received anything in writing, she stated, "No".

Review of the COVID line listing revealed that the facility had a COVID outbreak affecting Residents in May and again starting August 14. In May, June, July, and Aug., facility staff tested positive for COVID-19. The facility had no evidence of Residents and families being made aware by 5 PM, the following day as required.

Review of the facility policy titled, "COVID-19 Testing- Routine, Symptomatic and Outbreak, (Revised 3/14/22)", was conducted. This policy read, "...5. Residents, family members and team members will be notified of the outbreak promptly and advised as to the measures the community is taking to mitigate the spread of infection. 6. Communities will maintain frequent, ongoing communication with team members, residents and families for updates and facility actions..."

On 8/26/2022, the interim administrator, Director of Nursing, and Infection Preventionist, were made aware of the above findings and that no

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respiratory symptoms occur within 72 hours of each other. The Administrator, or designee, will be responsible for ensuring the notification is developed and provided.

4. The IP, or designee, will audit resident charts for documentation of COVID-19 reporting and will include auditing the records of those without email addresses on file once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified area of concern will be corrected and responsible staff re-educated.

Executive Director (ED), or designee, will review all notifications developed by the Administrator for the next 30 days. Identified areas of concern will be addressed by ED or designee.

Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated, and staff will be re-educated and/or counseled as indicated.

5. Date of Compliance: October 17, 2022

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F 885	Continued From page 20 additional information had been provided. No further information was submitted prior to the end of survey.	F 885		
F 886 SS=F	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	F 886		10/17/22

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F 886	Continued From page 21 conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident’s testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with CDC (Centers for Disease Control) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements affecting 28 staff (24 agency staff and Staff #2, #3, #6, and #8) and all Residents.	F 886	1. All residents were tested for COVID-19 on 8/25/22, 8/27/22, 8/31/22, and 9/7/22. The results of their COVID-19 test were documented in the resident□s electronic medical record. Any residents testing positive for COVID-19 had transmission-based precautions implemented based on the facilities policies and procedures and CMS	

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The findings included:

1. The facility staff failed to conduct routine and outbreak COVID-19 testing of all 24 agency/contract staff who worked in the facility June-August 2022.

On 8/25/22, Surveyor B used the as-worked schedule and staff vaccination matrix to select a staff sample, which was reviewed for COVID immunization and testing.

On 8/25/22 at approximately 10 AM, Surveyor B met with the facility's infection preventionist. The IP confirmed she was the person that maintained records of all of the staff testing. She was given the name of Staff #1 and asked to provide the dates of COVID testing. The IP stated, "I don't have her, I don't think she works here". The IP was told she was an agency staff person, and the IP stated that they do not conduct COVID-19 testing of agency staff unless they are symptomatic.

The IP was then given the name of Staff #7. The IP said, "I don't have her". She was told she was another agency staff member and the IP said, "If she was not symptomatic, they screen when they come in but if they aren't symptomatic we don't test them".

On 8/25/22 at 11:34 AM, Surveyor B met with the Human Resources Director, Employee H. Employee H was given Staff #1's name and Employee H confirmed that Employee H had worked 8/24/22.

The HR Director, Employee H confirmed that Staff #7 was agency and worked 6/29/22, 7/9/22,

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guidelines.

All staff members, including agency staff, began being tested for COVID-19 per CMS guidance. Twice a week testing began the week of 8/29/2022 and continues.

Outbreak status concluded 9/12/2022. Staff continue to be tested twice weekly due to the high county transmission rate and will continue while the county transmission rate remains substantial or high.

All testing is being recorded on a team member testing log and a resident testing log by the IP.

2. All residents have the potential to be affected by the deficient practice.

Resident testing and staff member testing was started and carried out as described above.

Since 8/29/2022 all new admissions have been COVID tested upon admission and 5 days after admission. Appropriate transmission-based precautions were implemented based on facility policy.

Residents will have appropriate physician orders to test for COVID-19.

3. On 8/26/2022 the VP of Clinical Services re-educated the DON, IP, and SDC on the facility COVID testing policy and procedure which is based on CDC

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7/24/22, 7/25/22, and 8/24/22.

Employee H, the HR Director looked and confirmed that she didn't maintain record of the COVID immunization status for agency staff, she identified that Employee G kept that information.

On 8/25/22, in the afternoon, Surveyor B met with Employee G, the scheduling coordinator. She was given the name of Staff #1 and #7 and was asked to obtain her COVID vaccination information. Employee G later provided vaccination records that confirmed both Staff #1 and #7 had received the primary vaccination series, but were not boosted, which meant they were not up-to-date, and therefore were subject to routine testing.

Employee G provided Surveyor B with a listing of agency staff that had worked at the facility. For the months of June and July, 24 agency staff had worked at the facility.

On 8/25/22, during the end of day meeting the facility Infection Preventionist again confirmed that agency staff were not tested for COVID-19 routinely and she had no records for any routing testing of the agency staff.

The facility policy titled, "COVID-19 Testing-Routine, Symptomatic, and Outbreak" with a revision date of 3/14/22, was reviewed. This policy read, "...[company name redacted] will attempt to follow the testing requirements, to the extent possible, based on the parameters set forth by the Department of Health & Human Services, CMS. This applies to resident and team member testing, including providing services under arrangement and volunteers for

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and CMS guidance.

The Infection Preventionist, Director of Nursing, Interim Administrator, and SDC were educated on August 28, 2022 on CDC and CMS guidelines for COVID using the two documents Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and Interim Infection Prevention and Control Recommendations for HC Personnel During the COVID-19 Pandemic. Also reviewed were facility policies and procedures which are based on the CDC and CMS guidance. This education included proper conduction of contact tracing when a new COVID-19 case is identified in a team member or resident.

The Infection Preventionist or designee will educate admissions and nursing on the criteria for testing newly admitted residents and on appropriate documentation in the resident□s medical record including physician□s order to test, testing results, and RR notification.

Human Resources Director will maintain a current team member vaccination status log and will include all agency staff. This log will be updated daily Monday through Friday and available to clinical leadership.

IP will document facility county transmission rate weekly on the weekly transmission rate log.

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F 886	Continued From page 24 COVID-19...Routine Testing of Team Members: 1) Routine testing of team members, who are not up-to-date, is based on the extent of the virus in the community- using the most recent community transmission level for the trigger for team member testing frequency per CMS guidelines....III. Who should be tested: Individuals included in the testing include employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in training programs or from affiliated academic institutions..." 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 7, read, "Expanded screening testing of asymptomatic HCP [Healthcare Personnel] should be as follows:...In nursing homes, HCP who are not up to date with all recommended COVID-19 doses should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week...If these HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift)". Review of the CMS (Centers for Medicare & Medicaid Services) Memo Ref: QSO-20-38-NH, revision date 3/10/2022, subheading "Documentation of Testing, page 10, item 3 read, "For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g.,	F 886	IP will maintain resident testing log daily Monday through Friday when resident outbreak testing is being conducted. IP will maintain team member testing log daily Monday through Friday. 4. The Infection Preventionist or designee will audit resident medical records for COVID-19 testing per facility policy once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be addressed and responsible staff re-educated. DON, or designee, will review resident testing log, weekly documentation of transmission rate, and team member testing log week once a week for 4 weeks, then twice a month for two months and then quarterly for two quarters. DON, or designee, will review the new resident admission log daily for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. Identified areas of concern will be corrected as appropriate and feedback provided to IP. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	

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every week), and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test" and page 11, "For staff, including individuals providing services under arrangement and volunteers, the facility must document testing results in a secure manner...".

2. The facility staff failed to conduct routine COVID-19 testing of staff who were not up to date with COVID immunizations for Staff #2, #3, #6, and #8.

Review of the staff vaccination matrix submitted revealed that Staff #2, 6 and 8, were noted to not be up to date with COVID immunizations, as they had not received a booster dose. Staff #3 had been granted an exemption from COVID immunization.

On 8/25/22, Surveyor B met with the facility Infection Preventionist (IP) to review testing occurrences of the staff sample. The following was noted during this review:

Staff #2 was not tested twice weekly based as required since Staff #2 was not up to date with COVID immunizations and the facility was located in an area of high community transmission of COVID-19. Staff #2 was tested 8/5/22, and was not tested again until 8/12/22. Review of Staff #2's time card revealed they worked

Staff #3, who had been granted an exemption from COVID immunization, was reviewed for testing occurrences. Staff #3 was tested on the following dates in the months of June-August:

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6/9/22, 6/28/22, 6/29/22, 7/27/22, 7/29/22, 8/11/22, 8/12/22, 8/18/22, and 8/19/22. Review of Staff #3's timecard revealed in June, she had worked 17 shifts, in July she worked 21 shifts. In August, Staff #3 worked 15 shifts.

Staff #6 was tested 6/9/22, and was not tested again until 6/29/22. Review of Staff #6's timecard revealed she worked 13 shifts during this time frame. When the Infection Preventionist was asked about testing during the time frame from 6/9-6/29, she said, "That's all I have for her".

Staff #8 had no testing for July. When asked, the IP said, "I don't know why I don't have any July testing, I don't know why it's missing".

Review of the facility submitted tracking of the community transmissibility rate of COVID revealed they had remained at a high level for all of June, July and August.

Review of the facility policy titled, "COVID-19 Testing- Routine, Symptomatic, and Outbreak" with a revision date of 3/14/22, was conducted. This policy read, "...1) Routine testing of team members, who are not up-to-date, is based on the extent of the virus in the community- using the most recent community transmission level for the trigger for team member testing frequency per CMS guidelines.... Table 2: Routine testing intervals by County COVID-19 Level of Community Transmission: High (red), Minimum testing frequency of staff who are not up-to-date: Twice a week".

Review of the CMS (Centers for Medicare & Medicaid Services) Memo Ref: QSO-20-38-NH, revision date 3/10/2022, subheading

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"Documentation of Testing, page 10, item 3 read, "For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g., every week), and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test" and page 11, "For staff, including individuals providing services under arrangement and volunteers, the facility must document testing results in a secure manner...".

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 7, read, "Expanded screening testing of asymptomatic HCP [Healthcare Personnel] should be as follows:...In nursing homes, HCP who are not up to date with all recommended COVID-19 doses should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week...If these HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift)".

3. The facility staff failed to maintain documentation of COVID-19 testing occurrences and results in the clinical record for all Residents.

On 8/25/22, Surveyor B met with the facility Infection Preventionist (IP) to review testing occurrences of the staff sample. The following

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was noted during this review:

Surveyor B let the IP know she was not able to find COVID-19 testing occurrences within the clinical record. The IP said that she keeps a listing of the Residents who were tested in her testing book that only positive results are documented in the clinical charts.

Review of the testing logs the IP had available revealed a Resident listing that would indicate the test date with a minus sign beside a Resident's name to indicate they tested negative. There was no indication as to who had performed the testing and no testing information was noted in the clinical charts.

The facility policy titled, "COVID-19 Testing-Routine, Symptomatic, and Outbreak" with a revision date of 3/14/22, was reviewed. This policy read, "... VII. Documentation of Testing: ...C. Resident testing will be documented in the residents' medical record..."

The CMS (Centers for Medicare and Medicaid Services) issued QSO-20-38-NH with a revision date of 03/10/2022. It read, "... (3) For each instance of testing :...(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..."

4. The facility staff failed to perform outbreak testing of Residents who were potentially exposed to COVID-19 on 4 of 5 halls/units.

Review of the testing logs for August 2022, revealed Resident testing occurred on 8/17/22, of

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the Residents on the 2nd floor third hall. There was a census sheet of the Residents residing on the third floor but no indication of any testing being conducted.

Review of the COVID line listing revealed numerous staff had tested positive for COVID-19 in August. Review of the assignment sheets revealed the following:

Residents on the second floor halls 1, 2 and 3 were exposed on 8/17/22, by LPN F who worked as the only nurse for the second floor and tested positive for COVID 19 on 8/18/22.

Residents on the second floor hall 1 had an additional possible exposure on 8/17/22, by LPN H, who worked 8/17/22, and tested positive on 8/18/22.

Residents on the second floor, hall 2 had an additional exposure on 8/16/22 by CNA L, who worked 8/16/22, and tested positive for COVID-19 on 8/18/22.

Residents on the third floor, hall 1 were exposed 8/14/22 and 8/15/22, by CNA M, who worked both days and then tested positive for COVID-19 on 8/16/22.

Residents on the third floor, hall 2 were exposed 8/17/22, by CNA L, who worked their hall and then tested positive for COVID-19 on 8/18/22.

Residents on the third floor, hall 2 also had a possible exposure on 8/18/22 and 8/19/22, by LPN G, who tested positive for COVID-19 on 8/19/22.

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On 8/25/22, during a meeting with the infection preventionist (IP), the IP confirmed that contact tracing is conducted. When asked who trained her on how to conduct contact tracing, the IP said, "No one, but I know to go back 2 days because of the incubation period of COVID". When asked to define incubation period, she indicated this is when a person could be infectious and not be symptomatic. When asked to show evidence of her contact tracing for the above noted staff members, CNA L, CNA M, LPN F, LPN G, and LPN H, she said, "I look at the assignment sheet". When asked if she went back to the two days prior to the staff testing positive she said she did not.

The facility policy titled, "COVID-19 Testing- Routine, Symptomatic, and Outbreak" with a revision date of 3/14/22, was reviewed. This policy read, "... 2) Residents determined to have close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In this situation, testing is recommended immediately and, if negative again 5-7 days after exposure..."

The CMS (Centers for Medicare and Medicaid Services) issued QSO-20-38-NH with a revision date of 03/10/2022. It read, "...Testing of Staff and Residents in Response to an Outbreak: An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak.

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Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, regardless of vaccination status, should be tested immediately, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. See CDC guidance "Testing Guidelines for Nursing Homes" section Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2..."

The CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, was reviewed. It read, "...Manage Residents with Close Contact: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection. Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). Residents can be removed from Transmission-Based Precautions after day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, healthcare providers could consider testing for SARS-CoV-2 within 48 hours before the time of planned discontinuation of Transmission-Based Precautions. Residents can be removed from Transmission-Based

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Precautions after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of Transmission-Based Precautions.

Residents who are up to date with all recommended COVID-19 vaccine doses and residents who have recovered from SARS-CoV-2 infection in the prior 90 days who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described in the testing section..."

5. The facility staff failed to obtain a physician order prior to conducting COVID testing for 1 Resident, (Resident #1).

Review of the clinical chart of Resident #1 revealed the following note dated 8/18/22 at 9:50 AM, "Resident noted very lethargic and increased confusion. Resident tested + for COVID-19, MD [medical doctor], nursing supervisor & RP [responsible party] made aware".

On 8/25/22 at 3:54 PM, Surveyor B and the Infection Preventionist (IP) reviewed Resident testing. Resident #1 had COVID testing conducted and there was no evidence of a physician order for testing. The IP reviewed the clinical record and said, "Usually they do have an order, but clearly no one entered an order for her".

During the above interview the IP confirmed that a physician order is required prior to obtaining

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any type of diagnostic test.

The facility policy titled, "COVID-19 Testing-Routine, Symptomatic, and Outbreak" with a revision date of 3/14/22, was reviewed. This policy read, "...Residents: 1) A physician/practitioner order (standing order is acceptable) will be obtained prior to administration of test..."

Review of the Centers for Medicare and Medicaid Services (CMS) Memo titled, "QSO-20-38-NH DATE: August 26, 2020, REVISED 04/27/2021", was conducted. This memo stated, "...Conducting Testing: In accordance with 42 CFR § 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing (see F773). This may be accomplished through the use of physician approved policies (e.g., standing orders), or other means as specified by scope of practice laws and facility policy..."

6. The facility staff failed to conduct COVID-19 of new admissions, for 2 of 4 Residents (Resident #4 and #5) reviewed for testing.

On 8/25/22 at 3:54 PM, Surveyor B and the Infection Preventionist (IP) reviewed Resident testing.

The IP confirmed Resident #4 had been admitted to the facility on 6/24/22. There was a physician order for testing on admission and again 5 days

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later. Review of the testing revealed that Resident #4 had no testing occurrences from 6/24/22, to the date of review, 8/25/22.

Resident #5 was admitted to the facility on 8/17/22. She was tested on 8/17/22, and had no testing following that date.

During an interview with the IP, she stated Residents are to be tested upon admission and then again 5 days later.

The facility policy titled, "COVID-19 Testing-Routine, Symptomatic, and Outbreak" with a revision date of 3/14/22, was reviewed. This policy references regulatory references from QSO-20-38 and QSO-20-29. It also read, "Communities will follow the CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 Pandemic" for residents ...3) b) Communities will follow current CDC guidelines based on the outcome of the COVID-19 tests..."

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".

On 8/25/22 and again on 8/26/22, during the end of day meetings, the facility Administrator, Director of Nursing and Infection Preventionist

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F 886	Continued From page 35 were made aware of all of the above noted COVID testing 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 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	F 887		10/17/22

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F 887	Continued From page 36 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: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to document COVID immunization status and failed to offer immunizations to 3 Residents (Resident #2, 3, and 6), in a sample of 5 Residents reviewed for immunizations, and the facility staff failed to provide evidence that staff who are eligible for COVID vaccine doses were educated and offered the vaccine for 3 staff (Staff	F 887	1. Resident #2 will have her COVID vaccination status verified. The COVID-19 vaccine (primary series or updated booster) will be offered if resident has not received the vaccine. Resident #3 was discharged on 8/22/2022. Resident #6 was discharged on 8/26/2022.	

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F 887

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#2, 6, and 8) in a sample of 14 staff.

The findings included:

1. The facility staff failed to failed to document COVID immunization status and failed to offer immunizations to 3 Residents (Resident #2, 3, and 6), in a sample of 5 Residents reviewed for immunizations

On 8/25/22, clinical record reviews were conducted for the sampled Residents in the presence of the Infection Preventionist (IP). The review revealed the following with regard to immunizations for COVID:

1a. Resident #2 had been admitted to the facility on 6/7/22. On the immunization tab of the electronic health record (EHR) no information with regards to COVID immunization status. The Infection Preventionist looked throughout the clinical record and indicated there was no information available.

1b. Resident #3 had been admitted to the facility on 6/6/22. Surveyor B and the IP reviewed the clinical record of Resident #3 and noted no information was present to indicate Resident #3's immunization status with regards to COVID.

1c. Resident #6 had been admitted to the facility on 8/11/22. Review of the clinical record for Resident #6 revealed no information was available regarding Resident #6's vaccination status for COVID.

Additionally, there was no evidence that Residents #2, 3 and 6, were educated or offered vaccination for COVID-19.

F 887 (Plan of Correction)

Staff# 2, 6, and 8 were vaccinated but not included on the team member vaccination log. Staff #2 was vaccinated on 1/14/21 and 2/4/21, Staff #6 was vaccinated on 1/14/21 and 2/4/21, and Staff #8 was vaccinated on 2/4/21 and 2/25/21. Vaccinations for these team members have been confirmed and these team members are now included on the team member vaccination log maintained by Human Resources Director daily Monday through Friday.

2. An audit of 100% of resident records will be done by the IP or designee and any resident found to not be COVID-19 vaccinated will be educated and offered the primary series or declination will be documented. Administration will be documented in resident record.

All residents will be educated and offered the updated COVID-19 bivalent booster and appropriate documentation done in residents□ record. Administration of the updated booster will be documented appropriately.

Human Resources is maintaining a team member vaccination log and reconciles this log daily Monday through Friday with scheduler to ensure agency staff are included and with current team member roster.

3. The Vice President of Clinical services educated the Infection Preventionist and Director of Human Resources on

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The Infection Preventionist (IP) stated that it is the responsibility of the admitting nurse to document all of this information and offer immunizations upon admission. When asked how the Resident's vaccination status was known and able to be reported in NHSN (National Healthcare Safety Network), the IP stated she looks it up in VIIS (Virginia Immunization Information System). When asked if she puts this document into the clinical record of the Residents she stated, "No".

During the above interview with the IP accessed the EHR for Residents #2, 3 and 6. She observed and confirmed the immunization tab had no data recorded. She reviewed the remainder of the record and confirmed there was no information for the missing immunizations and that no information was available to indicate they had been educated on or offered the immunizations.

On 8/25/22 at 10:37 AM, an interview was conducted with the facility's Infection Preventionist (IP). The IP was asked, "Why is it important for the immunization status to be documented?" The IP stated, "We should know their immunization status, if they don't have the immunizations we should offer it". When asked if the doctor and other providers should know the immunization status of Residents, the IP said, "Yes". When asked where the doctor would look for that information, the IP said, "In the chart".

During the above interview, the IP was asked if the immunization status of a Resident affects the care that is provided to them, she said, "Yes, it is important for isolation purposes, you have to

F 887

8/28/2022 regarding the tracking of COVID-19 vaccination status, including boosters, of all team members, as well as documenting education and declination, or approved exemption of the COVID-19 immunization and placing in their personnel file as appropriate.

All new team members, including agency staff, will have vaccination status confirmed prior to starting. All new team members are required to be COVID vaccinated per facility policy and if not vaccinated must have an approved exemption on file prior to starting. Human Resources Director will maintain a current team member vaccination status log and will include all agency staff. This log will be updated daily Monday through Friday and available to clinical leadership.

The Infection Preventionist or designee will educate the nursing staff on offering the COVID-19 vaccine to all newly admitted residents, education on the benefits of the vaccination and documentation of declination or administration in the residents electronic medical record.

IP will follow up with any resident who needs a COVID-19 vaccination to ensure administration and/or documentation in record.

All residents will have the updated COVID-19 booster offered (educated, offering, administration will be documented appropriately).

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isolate for 10 days if they haven't had their second booster".

Review of the facility policy titled, "COVID-19 Vaccination- Federal CDC LTCF (Long Term Care Facility) Pharmacy Partnership and Independent Pharmacy Partnership, Revised 3/15/21", was conducted. This policy read, "[Company name redacted] is committed to protecting the health and safety of residents and team members and to taking necessary action to ensure the appropriate mitigation of the spread and impact of COVID-19 on residents, team members, and the general public. [Company name redacted] will offer, or arrange for the offering of, the COVID-19 vaccination to residents and team members to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19..."

On 8/25/22 and again 8/26/22, the facility interim Administrator, Director of Nursing and Infection Preventionist were made aware of the above findings.

No further information was provided.

2. The facility staff failed to document that employees who were eligible for COVID vaccine doses were educated on the benefits of vaccination and were offered vaccination(s) for Staff #2, 6, and 8, in a sample of 14 staff.

Review of the staff vaccination matrix submitted revealed that Staff #2, 6 and 8, were noted to not be up to date with COVID immunizations, as they had not received a booster dose.

On 8/25/22, the facility Infection Preventionist

F 887

4. The IP or designee will audit residents medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical record of declination or administration once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to responsible staff.

The Administrator or designee will audit the team member vaccination log for up to date COVID-19 immunization information or approved exemption for team members and agency staff once per week for 4 weeks, then twice a month for two months, and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to HR Director.

Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated and staff will be re-educated and/or counseled as indicated.

5. Date of compliance: 10/17/2022

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F 887	Continued From page 40 stated that human resources maintains the information with regards to employee vaccination. On 8/25/22, a meeting was conducted with Employee H, the HR Director. The HR Director was given the names of Staff #2, 6, and 8. Surveyor B explained that they were listed on the staff vaccination record as not receiving the booster dose. Employee H had no evidence that these employees had been offered and declined. On 8/26/22 at 9:31 AM, the Infection Preventionist stated she had no evidence to provide that would indicate the staff were offered the COVID immunizations. She said an all staff meeting was held were she discussed vaccinations and that if they wanted it to see her. On 8/26/22, during the end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 887		
F 888 SS=G	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	F 888		10/17/22

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§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

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

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

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F 888	Continued From page 42 vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive	F 888		

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F 888	Continued From page 43 and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation review, and clinical record review, the facility staff failed to implement their infection control policies and procedures regarding COVID-19, including maintaining an accurate record of staff's COVID-19 vaccination status and wearing proper personal protective equipment	F 888	1.Resident #3, who was hospitalized on 8/22/22 after testing positive for COVID-19, was discharged from the hospital to her daughter's home approximately 1 week after hospital admission per the resident #3's daughter. As of 9/20/22 this resident remains at her	

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Continued From page 44
(PPE). In addition, the facility had a COVID-19 outbreak, which resulted in 14 residents testing positive for COVID-19 and one resident (Resident #3) being hospitalized, which is harm. This noncompliance affected residents on all 5 halls/units within the facility.

The findings include the following:

The facility staff failed to implement their infection control policies and procedures regarding COVID-19, as evidenced by:

1. The facility staff has failed to maintain complete and accurate documentation with regards to employees' vaccination status. Staff # 9 was noted on the staff vaccination matrix as having completed the COVID-19 primary vaccination series and had received a booster dose; however, her immunization record on-file indicated she had only received one of a two-dose vaccination series;

2. Two observations were made of staff entering rooms of residents (Residents #1 and #20) on transmission based precautions (TBP) with confirmed COVID-19, without wearing proper PPE;

3. Staff were observed on all 5 nursing units/halls providing direct resident care without wearing any eye protection. Due to being in an area with a high level of community transmissibility, eye protection was to be worn during all patient care encounters;

4. Nine residents (Residents #5, 6, 7, 9, 10, 12, 13, 14, and 16) who were exposed to COVID-19 and were not up-to-date with COVID-19

F 888

daughter's home and is receiving home health services for therapy.

All residents (as noted in the 2567 as all 5 resident care hallways), including the 11 affected residents identified, began being cared for with proper PPE (N95 respirators and eye protection) on August 26, 2022 per CDCs recommendations for healthcare workers in counties with substantial or high transmission during resident care encounters.

Residents who were on transmission-based precautions (TBP) for confirmed COVID-19 infection (Residents #1 and #20) began being cared for on August 26, 2022 with PPE that is required for TBP (gloves, gown, N95 respirator, and eye protection).

Beginning on August 27, 2022 and ongoing all team members were educated on the proper use of PPE (N95 respirators and eye protection) by the Director of Nursing (DON), Staff Development Coordinator (SDC), and other designees for both counties in substantial/high transmission and for residents who are COVID positive.

The nine residents identified (Residents #5, 6, 7, 9, 10, 12, 13, 14, and 16) who were not up to date with their COVID immunizations and had experienced a COVID exposure during an outbreak were placed on TBP on August 26, 2022.

All residents were tested for COVID-19 on

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F 888	Continued From page 45 immunizations were not placed on quarantine per CDC guidance. Observations: 1. The facility staff has failed to maintain complete and accurate documentation with regards to employees' vaccination status. Staff # 9 was noted on the staff vaccination matrix as having completed the COVID-19 primary vaccination series and had received a booster dose; however, her immunization record on-file indicated she had only received one of a two-dose vaccination series. On 08/24/2022, during the entrance conference with the facility Administrator, Director of Nursing and Infection Preventionist, they identified that Human Resources (HR) tracks the staff vaccination status. On 08/25/2022 at 11:34 a.m., a meeting was held with the HR Director, Employee H. She was given staff members' names of Staff #1 and Staff #7. When verifying their vaccination status, Employee H stated the Scheduling Coordinator keeps copies of the agency staff's records. During the same interview on 08/25/022 at 11:34 a.m., Employee H confirmed the staff vaccination matrix submitted listed Staff #9 as having completed the primary vaccination series and had received a booster dose. When Employee H pulled the vaccination information for Staff #9, it was a print out of the Virginia Immunization Information System that noted Staff #9 only had 1 dose of the primary series of a Pfizer vaccine. Employee H confirmed the findings and stated the matrix was inaccurate.	F 888	8/25/22, 8/27/22, 8/31/22, and 9/7/22. The results of their COVID-19 test were documented in the resident□s electronic medical record. Any residents testing positive for COVID-19 had transmission-based precautions implemented based on the facilities policies and procedures and CMS guidelines. All staff members were tested for COVID-19 per CMS guidance. All staff members, including agency staff, began being tested for COVID-19 per CMS guidance. Twice a week testing began the week of 8/29/2022 and continues. Staff #1 was tested 8/29/22 and 8/30/22 and will continue to be tested per facility policy. Staff #7 was tested 8/29/22 and will continue to be tested per facility policy. Staff #3 who had been granted an exemption was COVID tested on 8/26/22, 8/30/22, 9/1/22, 9/8/22, 9/13/22, 9/15/22 and will continue to be tested per facility policy which is in accordance with CDC/CMS guidance. On August 26, 2022 a broad based facility wide testing approach was initiated (and will be used when a new case of COVID-19 is identified) so that proper contact tracing could be learned and implemented appropriately by the community Infection Preventionist (IP). Outbreak status concluded 9/12/22. Staff	

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On 08/25/2022 at 2:00 p.m., Employee H provided Surveyor B with a copy of Staff #9's vaccine card. Employee H said, "She works the 11:00 p.m. to 7:00 a.m. shift, so we called and woke her up and she took a picture and sent it to us." Employee H confirmed that prior to this, they were unaware that she had completed her primary series and the vaccination matrix was inaccurate.

On 08/25/2022 at 12:18 p.m., Surveyor B met with Employee G, the Scheduling Coordinator. Employee G was asked if she keeps any record of the agency staff's vaccination status. Employee G stated, "We require everyone be vaccinated and the agency knows they can't send us anyone who isn't vaccinated."

On 08/26/2022 at 9:10 a.m., Surveyor B met with Employee G again. When asked about agency staff's vaccination status, she said she just knows the facility requires everyone be vaccinated, so when the agency sends her information, she just puts it in the file. She confirmed she does not keep a log or record of their immunization status. Employee G opened her desk drawer and pulled out a file that had copies of various agency staff's COVID-19 vaccine cards. Review of this file revealed 7 employees who indicated they they received 1 dose of a 2-dose primary series. When asked about this, Employee G said she would have to call the agencies.

On 08/26/2022 at 2:00 p.m., Employee H, the Human Resources Director, was conducting an audit of the employee vaccination matrix. She had only gotten 1/3 of the review completed and informed Surveyor B that she had identified 14

F 888

continue to be tested twice weekly due to the high county transmission rate and will continue while the county transmission rate remains substantial or high.

All testing is being recorded on a team member testing log and a resident testing log by the IP.

Staff #9's COVID immunization document was obtained by Human Resources Director, placed in personnel file and reflects the information on the staff vaccination log. Staff member was vaccinated on 1/14/21, 2/4/21, and 10/27/21.

Staff # 2, 6, and 8 were vaccinated but not included on the team member vaccination log. Staff #2 was vaccinated on 1/14/21 and 2/4/21, Staff #6 was vaccinated on 1/14/21 and 2/4/21, and Staff #8 was vaccinated on 2/4/21 and 2/25/21. Vaccinations for these team members have been confirmed and these team members are now included on the team member vaccination log maintained by Human Resources Director daily Monday through Friday.

2. All residents have the potential to be affected by the deficient practices. All residents are at risk for transmission of COVID-19.

All residents are being cared for using the proper PPE both for substantial/high transmission rates and for TBP this

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	495403	A. BUILDING ______ B. WING ______	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	1900 LAUDERDALE DRIVE RICHMOND, VA 23238

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employees whose vaccination status was recorded incorrectly.

2. Two observations were made of staff entering rooms of residents (Resident #1 and Resident #20) on transmission based precautions (TBP) with confirmed COVID-19, without wearing proper PPE.

On 08/24/2022 at approximately 12:50 p.m., CNA B was observed exiting the room of Resident #1. CNA B was not wearing any eye protection. There was signage on the door to indicate Resident #1 was on TBP and a station was set-up with personal protective equipment (PPE) outside of the room. When asked, CNA B confirmed that she was feeding Resident #1. When asked about eye protection, she stated she usually does wear it in the rooms of COVID-19 residents, but "I had washed it off and was waiting for it to dry." CNA B confirmed that Resident #1 has an active COVID-19 infection.

On 8/25/22 at 9:55 a.m., CNA H was observed entering the room of Resident #20, who had signage on the exterior of the room indicating they were on TBP. CNA H was wearing a KN-95 mask and she was observed entering the resident's room without putting on an N-95, eye protection, isolation gown, or gloves. CNA H stepped back out into the hallway a moment later with gloves in her hand. When asked what PPE she is supposed to wear when entering the room she stated, gloves, gown, and eye protection. When asked why she had entered without wearing those items she stated she had gone in to get gloves. When asked what was wrong with the gloves on the cart outside of the room, she said she didn't see those. There were two boxes

F 888

began August 26, 2022.

An audit of all residents vaccination status was done and all residents who were not up to date with COVID-19 vaccination were placed on TBP this was completed by August 29, 2022. Residents TBP were discontinued after the required 10 days of isolation.

All residents were tested for COVID-19 on 8/25/22 and 8/27/22 and proper protocol followed based on test results. (NOTE: appropriate outbreak testing was carried out per facility policy and procedure for residents and team members and the outbreak concluded on September 12, 2022).

Since August 29, 2022, all new admissions have been COVID tested upon admission and 5 days after admission. Appropriate transmission-based precautions were implemented based on facility policy.

Resident testing and staff member testing (including agency staff) was started and carried out as described above in #1.

An audit of 100% of resident records will be done by the IP or designee and any resident found to not be COVID-19 vaccinated will be educated and offered the primary series or declination will be documented. Documentation of administration will be documented in resident record.

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of gloves observed and pointed out that were on top of the cart that contained isolation gowns. CNA H then put on an isolation gown, gloves, and eye protection and reentered the room.

On 08/25/2022, during an end of day meeting with the facility's Administrator and Director of Nursing, they confirmed they follow CDC guidance with regards to COVID-19.

3. Staff were observed, on all 5 nursing units/halls, providing direct resident care without wearing any eye protection. Due to being in an area with a high level of community transmissibility eye protection was to be worn during all patient care encounters.

On 08/24/2022 at approximately 12:00 p.m., a tour of the facility was conducted by Surveyor B. Nurses, certified nursing assistants (CNA), therapy staff, and housekeeping employees were all observed entering residents' rooms wearing no eye protection on all 5 of the resident care hallways and entering resident rooms to provide direct care or be within a few feet of the residents.

The following specific observations were noted on the third floor:

a. Employee F was in a room providing care to a resident without eye protection. According to the staff vaccination matrix, Employee F was not up-to-date with COVID-19 immunizations.
b. LPN C entered a room to provide medication wearing no eye protection. LPN C was not up-to-date with COVID-19 immunizations.
c. CNA C was pushing a resident in the hallway to their room, wearing no eye protection. CNA C was not up-to-date with COVID-19 immunization

F 888

All residents will be educated and offered the updated COVID-19 bivalent booster and appropriate documentation done in residents record. Administration of the updated booster will be documented appropriately.

The Vice President of Clinical services educated the Infection Preventionist and Director of Human Resources on August 28, 2022 regarding the tracking of COVID-19 vaccination status, including boosters, of all team members and residents, as well as documenting education and declination, or approved exemption of the COVID-19 immunization and placing in their personnel file or resident electronic medical record as appropriate.

An audit was done of 100% personnel files by Human Resources to confirm all team members have been fully vaccinated or received an exemption as required by CMS and to confirm the required documentation is present in personnel files. HR is maintaining a team member vaccination log and reconciles this log daily Monday through Friday with scheduler to ensure agency staff are included and with current team member roster.

3. Beginning on August 27, 2022 and through August 29, 2022 all team members were educated on the proper use of PPE (N95 respirators and eye protection) by the Director of Nursing

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F 888	Continued From page 49 per the staff vaccination matrix. d. Employee E was ambulating a resident in the hallway wearing no eye protection. Employee E was not up-to-date with COVID-19 immunizations. e. CNA D was distributing meal trays to various residents, setting up the resident and food for the meal and had no eye protection on. CNA D was up-to-date with COVID-19 immunizations. On 08/24/2022 at approximately 12:30 p.m., the following specific observations were made on the second floor: a. CNA E was distributing meal trays to residents and was wearing no eye protection. b. CNA F was sitting beside a resident feeding them with no eye protection on. c. LPN B was administering eye drops to a resident wearing no eye protection. LPN B was not up-to-date with COVID-19 immunizations. d. CNA B was feeding a resident and had no eye protection on. e. CNA K entered a room to put a towel around the resident in an effort to provide protection to the resident's clothing while they ate. CNA K did not have on eye protection. f. CNA K entered the room of a resident and sat beside them to start feeding them without wearing eye protection. On 08/24/2022 at 4:00 p.m., observations were made on all of the resident care halls and staff were entering rooms to provide care without any eye protection. They included, but were not limited to, CNA G and LPN D. On 08/25/2022 at 9:10 a.m., observations were made on each of the resident care units/hallways.	F 888	(DON), Staff Development Coordinator (SDC), and other designees for both counties in substantial/high transmission and for residents who are COVID positive. On August 26, 2022 the VP of Clinical Services re-educated the DON, IP, and SDC on the facility COVID-19 testing policy and procedure which is based on CDC and CMS guidance. The Infection Preventionist, Director of Nursing, Interim Administrator, and SDC were educated on August 28, 2022 on CDC and CMS guidelines for COVID using the two documents Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and Interim Infection Prevention and Control Recommendations for HC Personnel During the COVID-19 Pandemic. Also reviewed were facility policies and procedures which are based on the CDC and CMS guidance. This education included proper conduction of contact tracing when a new COVID-19 case is identified in a team member or resident. The Vice President of Clinical services educated the Infection Preventionist and Director of Human Resources on August 28, 2022 regarding the tracking of COVID-19 vaccination status, including boosters, of all team members, as well as documenting education and declination, or approved exemption of the COVID-19 immunization and placing in their	

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LPN E was observed in a resident room administering medications and did not have on eye protection. Eye protection was observed on top of her medication cart, which had been left in the hallway while she entered the resident room.

On 08/25/2022 at 9:14 a.m., Surveyor B knocked on the door of Resident #7. Upon opening the door, a therapy staff member was observed in the room providing treatment and not wearing eye protection.

On 08/25/2022, during an end of day meeting with the facility's Administrator and Director of Nursing, they confirmed they follow CDC guidance with regards to COVID-19.

4. Nine Residents (Residents #5, 6, 7, 9, 10, 12, 13, 14 and 16) who were exposed to COVID-19 and were not up-to-date with COVID-19 immunizations were not placed on quarantine per CDC guidance.

On 08/24/2022, a review of the listing of residents' COVID-19 immunization status was conducted. This review revealed that 12 current residents are not up-to-date with COVID-19 immunizations. Three (3) of the 12 residents were currently on transmission based precautions (TBP) for an active COVID-19 infection. The other 9 Residents (Residents #5, 6, 7, 9, 10, 12, 13, 14, and 16) rooms were observed and there was no identified signage or indication they were on TBP.

On 08/25/2022 at 9:00 a.m., a facility tour was conducted with special attention being made to Residents #5, 6, 7, 9, 10, 12, 13, 14, and 16's rooms. There was still no indication the residents

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personnel file as appropriate.

On August 26, 2022 LifeSpire VP of Clinical Services developed a policy specific to PPE use in counties with substantial or high transmission titled Use of PPE in Facilities Located in Counties with Substantial or High Transmission. This policy was adopted by facility and incorporated into the August 28, 2022 training described above.

On August 29, 2022 LifeSpire VP of Clinical Services revised policy titled Transmission Based Precautions including TBP specific for COVID-19 to include more specific instructions around PPE use for COVID-19. This revised policy was adopted by facility and clinical leadership educated. On August 29, 2022 team members were educated regarding this revised policy.

The Infection Preventionist or designee will educate the nursing staff on offering the COVID-19 vaccine to all newly admitted residents, education on the benefits of the vaccination and documentation of declination or administration in the residents electronic medical record. The Vice President of Clinical services educated the Infection Preventionist and Director of Human Resources on August 28, 2022 regarding the tracking of COVID-19 vaccination status, including boosters, of all team members, as well as documenting education and declination, or approved exemption of the COVID-19 immunization

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Continued From page 51
were on TBP.

In review of the COVID-19 line listing/infection report submitted by the facility, it was revealed that each of the nine residents who were not up-to-date with immunizations had a possible exposure to COVID-19. The facility had not identified this during their contact tracing.

Resident #14 was potentially exposed to CNA M on 08/14/2022 and 08/15/2022. CNA M tested positive for COVID-19 on 08/16/2022.

Residents #5, 6, and 16 were potentially exposed to COVID-19 by CNA L on 08/17/2022. CNA L tested positive for COVID-19 on 08/19/2022. On 08/19/2022, LPN G cared for Residents #5, 6, and 16. LPN G then tested positive for COVID-19 after her shift on 08/19/2022.

Residents #7 and #12 were potentially exposed to CNA L on 08/16/2022. CNA L tested positive for COVID-19 on 08/19/2022.

Resident #13 was cared for by CNA B on 08/16/2022 and 08/17/2022. CNA B tested positive for COVID-19 on 08/18/2022.

Residents #9 and #10 were cared for by LPN H on 08/17/2022. LPN H reported having COVID-19 symptoms on 08/17/2022 and then tested positive for COVID-19 on 08/18/2022.

Residents #7, 9, 10, 12, and 13 were cared for by LPN F on 08/17/2022. LPN F had COVID-19 symptoms on 08/17/2022, then tested positive for COVID-19 on 08/18/2022.

On 08/25/2022 at 10:21 a.m., an interview was

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and placing in their personnel file as appropriate.

Infection Preventionist has the following new processes in place:
" tracking all residents vaccination status and is maintaining a current log - this log includes resident testing, and resident isolation
" tracking all new resident admissions to ensure TBP are implemented if COVID-19 vaccination status is not up to date
" weekly documentation of county transmission rate
" educate all new team members on proper use of PPE and COVID-19 practices (vaccination, testing) during new employee orientation and during annual in-service sessions.
" make rounds daily to ensure team members are utilizing PPE properly and use an audit form
" contract tracing form to show proper contact tracing is being implemented for all positive cases (within a resident or team member, including agency staff)

The Infection Preventionist or designee will educate admissions and nursing on the criteria for testing newly admitted residents and on appropriate documentation in the resident□s medical record including physician□s order to test, testing results, and RR notification.

Human Resources Director will maintain a current team member vaccination status log and will include all agency staff. This

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F 888	Continued From page 52 conducted with the facility Infection Preventionist (IP). The IP stated nobody had trained her on how to conduct contact tracing, but she knew to look back two days for potential exposures due to COVID-19 having an incubation period. When asked to explain this, the IP said, "That is when they may be infectious prior to exhibiting symptoms." When asked if she looked at who the staff had provided care to in the two days prior to a confirmed test, she said, "No."	F 888	log will be updated daily Monday through Friday and available to clinical leadership. IP will document facility county transmission rate weekly on the weekly transmission rate log. IP will maintain resident testing log daily Monday through Friday when resident outbreak testing is being conducted. IP will maintain team member testing log daily Monday through Friday. All new team members, including agency staff, will have vaccination status confirmed prior to starting. All new team members are required to be COVID vaccinated per facility policy and if not vaccinated must have an approved exemption on file prior to starting. Human Resources Director will maintain a current team member vaccination status log and will include all agency staff. This log will be updated daily Monday through Friday and available to clinical leadership. The Infection Preventionist or designee will educate the nursing staff on offering the COVID-19 vaccine to all newly admitted residents, education on the benefits of the vaccination and documentation of declination or administration in the residents electronic medical record. IP will follow up with any resident who needs a COVID-19 vaccination to ensure administration and/or documentation in	

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F 888	Continued From page 53	F 888	record. All residents will have the updated COVID-19 booster offered (educated, offering, administration will be documented appropriately). 4.DON, or designee, will review resident vaccination log, weekly documentation of transmission rate, and daily PPE round audit form every week for 4 weeks, then twice a month for two months and then quarterly for two quarters. DON, or designee, will review the new resident admission log daily for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. Identified areas of concern will be corrected as appropriate and feedback provided to IP. All completed contact tracing forms will be reviewed by the Administrator and VP of Clinical Services for each positive COVID case within a team member or resident. This will be done for each new case for 2 months. Identified area of concern will be corrected and IP re-educated. The Infection Preventionist or designee will audit resident medical records for COVID-19 testing per facility policy once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be addressed and responsible staff re-educated. DON, or designee, will review resident testing log, weekly documentation of	

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F 888	Continued From page 54	F 888	transmission rate, and team member testing log week for 4 weeks, then twice a month for two months and then quarterly for two quarters. DON, or designee, will review the new resident admission log daily for 2 weeks, then weekly for 2 weeks, then monthly for 2 months. Identified areas of concern will be corrected as appropriate and feedback provided to IP. The Infection Preventionist or designee will audit residents medical records for offering the COVID-19 immunization to all newly admitted residents, education on the benefits and documentation in the electronic medical record of declination or administration once per week for 4 weeks, then twice a month for two months and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to responsible staff. The Administrator or designee will audit the team member vaccination log for up to date COVID-19 immunization information or approved exemption for team members and agency staff once per week for 4 weeks, then twice a month for two months, and quarterly for two quarters. Identified areas of concern will be corrected as appropriate and feedback provided to HR Director. Results of all audits will be reviewed and reported at the next scheduled QAPI meeting for recommendations. Variances will be investigated, and staff will be	

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F 888	Continued From page 55	F 888	re-educated and/or counseled as indicated. 5. Date of compliance: 10/17/2022	