STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495184	A. BUILDING _____ B. WING _____	C 08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN HALL AT WILLIAMSBURG LANDING	5500 WILLIAMSBURG LANDING DR WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/16/22 through 8/19/22. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems.	E 015		9/16/22

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

Electronically Signed | 09/06/2022

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E 015	Continued From page 1 (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to have policies and procedures for the provision of waste disposal. The Findings included: On 8/19/22, the facility's Emergency Preparedness Plan was reviewed with the Facility Administrator. The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures for how facility waste will be disposed.	E 015	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Our current waste contract was revised to include provisions and service during an emergency.	

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E 015	Continued From page 2 During the review, the Facility Administrator stated, "An Emergency Preparedness Plan allows us to prepare ahead of an emergency situation that could affect our facility". When asked about policies and procedures with regard to waste management, the Facility Administrator stated, "We do not have any formal arrangements specifically for waste management services in the event of an emergency, but we have plenty of dumpsters". No further information was provided by the facility staff.	E 015	2. Our Current Emergency Preparedness Plan was revised to include emergency waste services. 3. Our Director of Facilities, and Community Safety Committee was educated on current revisions to the Emergency Preparedness Plan. 4. All contracts associated with our Emergency Preparedness Plan will be reviewed annually with our Emergency Preparedness Plan. All Trends will be communicated and reviewed in our quarterly Quality Assurance Performance Improvement Committee and Community Safety Committee.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/16/22 through 8/19/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. VA00053375-Substantiated with Deficiency The census in this 73 certified bed facility was 43 at the time of the survey. The survey sample consisted of 47 resident reviews.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		9/16/22

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F 561	Continued From page 3 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to promote and facilitate resident self-determination through support of Resident choices, for 1 Resident (# 110) in a survey sample of 47 Residents. The findings included: For Resident # 110, the facility staff failed to assist the Resident out of bed at approximately 2:00 AM as he requested.	F 561	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1.) Residents #110 was interviewed by nursing staff and interviewed by social services. The resident's plan of care was updated to reflect the preferences of the	

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F 561	Continued From page 4 On 8/16/22 at approximately 1:30 PM an interview was conducted with Resident #110 and his family member. Resident #110 was admitted to the facility on 8/10/22 and stated that he had no problems with the facility until "Last night." When asked what happened, he stated that had recent hip surgery and often woke up uncomfortable and not able to sleep well. He stated that he wanted to get out of bed and get in his recliner and watch TV hoping the change of position would help his discomfort. Resident #110 stated that he rang his call bell and it was answered by the nurse who told him that he could not get out of bed. When he asked why he was told that he had been given pain medicine at 1:30 AM. The Resident stated that he then called his daughter to come to the facility at 2:00 AM. Resident #110's daughter stated that prior to the hip surgery her father was a restless sleeper and he did get up a few times a night and that was his normal routine. A review of the clinical record revealed the following note: "8/16/22 2:27 AM - Resident receiving skilled care for surgical repair of right hip d/t [due to] right hip FX [fracture]. Received awake and attempting to get oob [out of bed]. Resident at first stated he had no pain, then admitted that pain was 8/10. Nurse administered PRN [as needed] Oxycodone at 1:30 AM for pain, and he took it without issues. His daughter came in to visit because he called stating he wanted to get oob. (He is not and was told the same by the CNA [Certified Nurses Assistant] and myself. [Sic] He also stated that he needed to use the bathroom although urinal is next to bed. Daughter informed of pain med that	F 561	resident. 2.) Nursing staff performed interviews with residents and documented outcomes in medical records. Nursing staff has reviewed, amended and updated resident care plans to reflect resident preferences. 3.) The Director of Nursing/designee has in-serviced clinical nursing staff, including RNs, LPNs, and CNA's regarding resident preferences and allowing resident choice. The in-service includes, but is not limited to, the importance of allowing resident self-determination in their plan of care and specifically regarding bed schedule preference. 4.) The Director of Nursing/designee will conduct weekly audits of 8 residents for 6 weeks to ensure resident preferences are being identified and met. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate action will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.	

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F 561	Continued From page 5 was given." On 8/16/22 at approximately 3:45 PM an interview with the Director of Nursing (DON) was conducted and she stated that if a Resident prefers to get out of bed it does not matter what time it is, it is our staff's responsibility to assist them out of bed, should they require assistance, and as long as it is safe for the Resident to do so. On 8/17/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		9/16/22

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F 582	Continued From page 6 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to provide an ABN (Advanced Beneficiary Notice) for one Resident (Resident #54) in a sample size of 3 Residents. The findings included: On 08/17/2022 at approximately 11:45 A.M., the facility staff provided a list of Residents who were	F 582	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.	

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F 582	Continued From page 7 discharged from a Medicare covered Part A stay with benefit days remaining. Three Residents on the list were identified and placed in the sample. One Resident that remained at the facility following a discharge from Medicare Part A services with benefit days remaining was Resident #54. On 08/18/2022, Resident #54's closed clinical record was reviewed. A Social Services discharge note dated 03/30/2022 at 11:40 A.M. documented, "Writer met with resident and presented NOMNC [Notice of Medicare Non-Coverage] with last cover day by Medicare being April 1, 2022 with a discharge from Medicare A stay on April 2, 2022. Right to appeal was reviewed, and all questions addressed. Resident reported she is going to utilize respite days, and remain at [facility]." There was no evidence an ABN was provided. On 08/18/2022, the facility staff completed a Beneficiary Protection Notification Review form for Resident #54 as requested. According to the document, the facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted and an ABN form was not provided. On 08/19/2022 at 12:50 P.M., the Administrator was notified of findings. When asked why the ABN form was not provided, the Administrator confirmed that the facility staff were not providing them. The facility policy for ABN provision was requested. At approximately 1:30 P.M., the Administrator stated they don't have a policy pertaining to ABN.	F 582	1. Resident #54 is no longer a resident of the Health and Rehab Center. The individual who failed to issue the ABN is no longer working in the Center. The Health and Rehab Center has identified that all Medicare A residents are at risk from not receiving an ABN. 2. Administrator/designee audited all skilled discharges since 8/1/22 to ensure that the ABN was issued appropriately. No other concerns were identified. 3. The Administrator/designee has in-serviced The Rehab Director and Social Worker regarding ABNs and the newly developed policy and procedure. The in-service includes, but not limited to, the facility to provide ABN “information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.” 4. The Administrator/designee will meet with the therapy department and social services director weekly for 6 weeks to review all previous weeks SNF discharges from therapy services to ensure ABN was issued prior to discharge of services and documentation of such is completed appropriately. In addition resident discharges and ABN notifications will be discussed during our morning stand up. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be taken. The Administrator/designee will identify any	

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F 582	Continued From page 8	F 582	trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		9/16/22

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F 583	Continued From page 9 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review the facility staff failed to maintain privacy of personal medical record for 1 Resident (#110) in a survey sample of 47 Residents. The findings included: For Resident #110 the facility staff failed to ensure the computer screen was locked and closed so that the Resident's Medication Administration Record was not visible to anyone passing by the medication cart. On 08/18/22 08:35 AM, Surveyor C walked up to the medication cart across from room 178. On the medication cart, the computer screen was open, and Resident #110's picture and Medication list were displayed. Surveyor C waited approximately 2 minutes for Licensed Practical Nurse E (LPN E) to return to her cart. LPN E was asked if she was working with the cart and she indicated that she was. LPN E was asked why she had left the cart and she stated I had to hurry into a room. When asked if there was an emergency or a Resident in danger and she stated that there was not. LPN E stated that she was "an agency nurse" and that she should have closed the screen. She stated she was only going to be in the room a minute.	F 583	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. The agency nurse responsible for resident #110 was educated at the time of the deficient practice. There were no adverse outcomes to the deficient practice. 2. Assistant Director of Nursing/designee will educate all licensed nurses on the importance of resident privacy and not leaving computer screens open while unattended. Williamsburg Landing has identified that all residents are at risk for this deficient practice. 3. Assistant Director of Nursing/designee will educate all clinical staff on HIPAA and resident privacy. Williamsburg Landing nurses will educate and validate that agency nurses have been educated on the importance of HIPAA and maintaining privacy of electronic medical records while not in use at the beginning of each shift.	

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F 583	Continued From page 10 08/18/22 10:00 AM an interview was conducted with the Director of Nursing (DON), who stated that the computer screen should be logged off to protect privacy of the resident. On 8/18/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 583	4. Assistant Director of Nursing/Designee will conduct daily observations 5 days a week for 6 weeks to ensure compliance is being met. All patterns and trends will be reported to our Quality Assurance Performance Improvement Committee quarterly.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		9/16/22

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F 657	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for 2 Residents (Resident #43, Resident #113) in a sample size of 47 Residents. 1) For Resident #43, the facility staff failed to revise the care plan for 10 out of 10 falls that have occurred in March and April 2022. 2) For Resident #113, the facility staff failed to review and revise care plan upon discovery of arterial and pressure wounds. The findings included: 1) For Resident #43, the facility staff failed to revise the care plan for 10 out of 10 falls that have occurred in March and April 2022. On 08/17/2022, Resident #43's clinical record was reviewed. According to the progress notes, Resident #43 had 6 unwitnessed falls in March 2022 and 4 unwitnessed falls in April 2022. An excerpt of a nurse's note dated 03/12/2022 at 6:33 A.M. documented, "Bed in lowest position, fall mat in place, call bell within reach. Will continue to monitor resident for safety for duration of shift." The care plan was reviewed. A focus dated 12/17/2021 entitled "[Resident #43] has a potential for falls." The care plan was not revised to include actual falls in March and April and any associated interventions. On 08/19/2022 at 11:00 A.M., the Director of	F 657	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #43 was assessed by nursing staff and their medical records were reviewed. The residents care plan has been updated to reflect a current individualized plan of care, to include falls and fall interventions. Resident #113 is no longer residing in the Health and Rehab Center. 2. The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs are addressed appropriately and that results are being tracked. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified. 3. The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but not limited to, the importance of care plan reviews and updates with any	

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Nursing (DON) was interviewed. When asked about expectations for reviewing/revising the care plan pertaining to falls, the DON stated the care plan should be reviewed quarterly and with any changes in condition. The DON also indicated that the care plan should be revised as necessary with each fall incident.

On 08/19/2022 at 11:55 A.M., Certified Nursing Assistant B (CNA B) was interviewed. When asked about interventions in place for fall precautions for Resident #43, CNA B listed fall mats, scoop mattress, and bed in lowest position. This surveyor and CNA B entered Resident #43's room (which was situated near the nurse's station) for an observation. Resident #43 was not in the room at the time. There was a scoop mattress on the bed and fall mats up against the wall.

On 08/19/2022 at approximately 12:00 P.M., Licensed Practical Nurse B (LPN B) was interviewed. When asked about interventions in place for fall precautions for Resident #43, LPN B stated that Resident #43 has a sitter during the day and also, Resident #43 was moved to a room closer to the nurse's station.

On 08/19/2022, the facility staff provided a copy of their policy entitled, "Care Plan Process - Person Centered." In Section 10, it was documented, "The person-centered care plan is an on-going plan of care and will be revised as necessary as the needs, choices, or expectations of the resident change or are identified."

On 08/19/2022, the facility staff provided a copy of their policy entitled, "Fall Prevention and Management." In Section I Part 2 an excerpt

changes for each resident and care plans being reflective of individualized care needs.

4. The Director of Nursing/designee will conduct an audit of six resident's care plans weekly for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. The Director of Nursing/designee will also complete weekly audits of the care plans of all residents who experience a change in condition for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Updates to resident care plans will be communicated to clinical staff. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.

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F 657	Continued From page 13	F 657		

documented, "All Residents will have the potential falls addressed on their initial plan of care with revisions made as necessary."

2. For Resident #114 the facility staff failed to review and revise care plan upon discovery of arterial and pressure wounds.

Resident #113 was admitted to the facility on 06/14/21 with diagnoses that included, pressure ulcer of right heel stage I, pressure ulcer of left heel stage I.

On 8/17/22 a review of Resident #113's clinical record was conducted and Resent #113 was found also found to have developed arterial wounds.

A review of Resident #113 care plan revealed no care plan for his pressure ulcers and arterial wounds until 7/5/21.

On 8/18/22 an interview was conducted with the Director of Nursing (DON) who stated that care plans should be updated with each change in condition or treatment change. When asked who updates the care plans she stated that the nurses and the Interdisciplinary Team (IDT) make the updates and changes.

A review of the care plan policy read:
Page 3
"10. The person-centered care plan is an ongoing plan of care and will be revised as necessary as the needs, choices or expectations of the resident change or are identified."

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F 657	Continued From page 14 On 8/19/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, facility documentation and during the course of a complaint investigation the facility staff failed to provide care that meets professional standards of care for 2 Residents (# 113 and # 43) in a survey sample of 47 Residents. The Findings included 1. For Resident #113 the facility staff failed to accurately perform an admission assessment to include skin assessment. Resident #113 was admitted to the facility on 6/14/21. The admission assessment was performed on 6/15/21 the Admission Assessment has many areas that have been left blank excerpts are as follows: Pg. 2 - "Height - [area left blank]" "Weight - [area left blank]" Pg. 3-" Neurological"	F 658	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #113 is no longer residing in the Health and Rehab Center. Resident #43's care plan has been updated to reflect a current individualized plan of care to include fall interventions. 2. The Director of Nursing/designee has performed an audit of all admission skin assessments for the last 30 days to ensure RN oversight, completion, and accuracy. An audit of all residents with falls in the last 30 days has been conducted to ensure appropriate completion of post fall interventions to include neurological assessments, post	9/16/22

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F 658	Continued From page 15 "Hand grasp - [area left blank]" Pg. 3 "Sleep" "Sleep Pattern- [area left blank]" Pg. 6 - "Pulmonary" "Presence of Sleep Apnea" "No History of Sleep Apnea" [Please note Resident #114 uses a CPAP at night] Pg. 8 - "Skin Integrity" "Skin intact- [area left blank]" "Skin color - Normal appearance for race" "Skin temperature - cool" "Skin Moisture - Dry" "Skin turgor - good" "Other skin problems - [area left blank] "Wounds - [area left blank]" "Foot Problems - [area left blank] This Admission Assessment was signed by an LPN, with no RN co-signature and the last line on page 9 read: "**Please do not lock form unless signed by an RN**" On 8/16/22 an interview was conducted with the Director of Nursing (DON) who was asked if LPN's can do an Admission Assessment without an RN co-signature and she stated that they could not. When asked if this Resident's Admission Assessment had an RN co-signature she stated that it did not. On 8/16/22 during the end of day meeting the Administrator was made aware of the finding and no further information was provided. 2. For Resident #43, the facility staff failed to complete neurological assessments, a fall risk assessment, or a fall investigation in accordance	F 658	fall risk assessments, and fall investigations were completed. 3. The Director of Nursing/designee has educated licensed nursing staff on the importance of the admission assessment to include skin and wound assessments. Additionally, all licensed nursing staff were educated on the post fall process (to include neurological checks, post fall risk assessments, and fall investigations.) 4. The Director of Nursing/designee will conduct an audit of all new admissions weekly for six weeks to ensure admission assessments were completed in totality with RN oversight. The Director of Nursing/ designee will review all fall processes upon occurrence weekly for the next six weeks to ensure compliance. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.	

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with professional standards of practice following an unwitnessed fall on 01/17/2022.

On 08/18/2022, Resident #43's clinical record was reviewed. Resident #43's Minimum Data Set with an Assessment Reference Date of 03/16/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "6" out of possible "15" indicative of severe cognitive impairment.

An excerpt of a nurse's note dated 01/17/2022 at 11:44 A.M. documented, "Resident was observed on the floor near her bed. Resident was unable to state what happened or what she was trying to do. No new injury noted. Resident had no complaints of pain or discomfort. Nurse and CNA [certified nursing assistant] assist resident up and into her wheelchair."

On 08/19/2022 at approximately 9:40 A.M., the neurological assessments, fall risk assessment and investigation pertaining to the fall on 01/17/2022 were requested and the Director of Nursing (DON) confirmed there were no neurological assessments, fall risk assessment, or investigation pertaining to Resident #43's fall on 01/17/2022.

According to Perry & Potter "Clinical Nursing Skills & Techniques", 2018, 9th Edition, under the header "Fall Prevention in Health Care Agencies", the following excerpts were documented: "Identified interventions that have shown some success in reducing ...fall rates: Using validated fall risk assessments that are predictive of falls ..." "Conducting post-fall follow-up and quality improvement." "

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F 658	Continued From page 17 On 08/19/2022, the facility staff provided a copy of their policy entitled, "Fall Prevention and Management." In Section I Part 1, an excerpt documented, "All Residents will have a Fall Risk Assessment completed on admission ....or change in condition. An excerpt in Section II(4) documented, "Take note of the Resident's positioning, environment, and activities involved in prior to the fall to assist in the investigation of causative factors and subsequent implementation of appropriate interventions." Section II(5)(c) documented, "Neurological Assessment for all falls ...where involvement to the head cannot be determined due to the Resident's cognitive status." On 08/19/2022 at approximately 2:00 P.M., the administrator and Director of Nursing were notified of findings.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure freedom from accident hazards by providing adequate supervision to prevent accidents, for 1 Resident (# 14) in a survey sample of 47 Residents.	F 689	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas	9/16/22

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F 689	Continued From page 18 The findings included: For Resident # 14 the facility staff failed to ensure the Resident #14 was supervised to prevent falls. Resident #14 has diagnoses that include anxiety disorder, age related osteoporosis, cerebral infarction, dementia with behavioral disturbance, repeated falls, restlessness and agitation, and visual impairment from glaucoma with detached lens. On 8/17/22 a review of the clinical record revealed the following progress note: "8/13/22 11:02 PM - At 5:20 PM Assigned sitter reported to this writer "resident fell out of chair and was on the floor" Sitter stated she "went to get food try [sic] off the cart on the unit and went back to room and found that her wheelchair was flipped over and the resident was laying on right side of her body on the floor with both legs sitting on top of the leg rests on the wheelchair with the wheelchair flipped forward." When this writer approached room 156, resident was laying on right side with blood pooling on the floor from the right forehead cut above the right eyebrow. Resident alert and oriented to self, and able to flex and extend bilateral lower and upper extremities independently and on command. Hospice notified. Resident taken to [hospital name redacted] by ambulance and 2 EMT's. Son [name redacted] notified." A revealed that the Resident has been care planned for falls and fall interventions included the following:	F 689	cited have been made and the facility is in compliance with participation requirements. 1. Resident #14 has been reassessed by nursing staff and the recommendation is to continue current care plan approaches including supervision while awake. The private duty caregiver has been reeducated on the importance of supervision at all times, and current care plan recommendations. 2. The Director of Nursing/designee has performed an audit of all residents who have had more than one fall in the past 30 days, to ensure care plan interventions are appropriate and effective. All private duty caregivers have been educated on current plans of care. 3. The Director of Nursing/designee has in-serviced all clinical staff to include privately paid caregivers on resident specific fall interventions. The in-service will include but is not limited to fall precautions, supervision, common risk factors, and resident specific trends. 4. The Director of Nursing/designee will audit all resident falls five times a week for 6 weeks to ensure compliance and effectiveness of care planned interventions. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education	

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F 689	Continued From page 19 "Frequent room checks when not in common area. STATUS -Active (current) Created 12/14/16" "Do not leave unsupervised in bathroom. STATUS - Active (current) 12/14/16" "Assess on afternoon rounds if [Resident #14 name redacted] is positioned comfortably or is needing to get up. If already awake she needs to be placed in wheelchair and near to staff. Status: Active (current) Created 12/12/18" "Try to keep [Resident #14 name redacted] near staff for close supervision when out of bed. STATUS: Active (current) 12/14/16" "Reeducate family to not leave [Resident 14 name redacted] in the room in her wheelchair after visits. Request that they bring her back to be nearby staff or at least tell staff they are leaving so she can be easily viewed by staff. STATUS: Active (current) Created 3/22/20." On 8/18/22 at approximately 1:00 PM an interview was conducted with RN C who stated that the staff was aware of the history of repeated falls with this resident. She stated this resident had a sitter because she could not be left alone. She stated the fall was due to the sitter leaving the room to get the Resident's dinner tray. She was asked if the sitter should have left the resident unattended and she stated that she should have either asked staff to bring the tray to her or asked another staff to sit with the Resident while she went to get the tray. On 8/19/22 during the end of day conference the Administrator was made aware of the concerns	F 689	and training will be provided to employees and caregivers on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.	

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F 689	Continued From page 20 and no further information was provided.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to appropriately label and store insulin in one of the two medication carts. The findings included:	F 761	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in	9/16/22

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F 761	Continued From page 21 For one medication cart (located on Annex Hall), Surveyor C found 2 insulin pens opened and undated. On 8/19/22 at approximately 8:00 AM while completing the medication storage task it was noted that 2 insulin pens were not dated when opened. Pen #1 was a Lantus insulin pen opened but not dated, and pen #2 was a Humalog Lispro pen opened but not dated. When Licensed Practical Nurse F (LPN F) was asked about the pens, LPN F stated she thought the meds were brought from home. When asked how you would know when they were opened she stated she would not be able to tell. On 8/19/22 at approximately 10:00 AM an interview was conducted with the Director of Nursing (DON) who stated that insulin is to be dated when opened so that you will know when it expires. We keep insulin only for 28 or 30 days depending on which type of insulin that is why it's important to date the insulin when opened. She further stated that the LPN was wrong. The insulin in question came from the pharmacy when the Residents were admitted. One was 7/29/22 and the other was 8/4/22 therefore they were both still ok to use however should have been dated when opened. On 8/19/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 761	compliance with participation requirements. 1. Director of Nursing/designee has discarded the identified undated insulin pens and checked medication carts and has ensured all medications were labeled and dated correctly. It is the policy of the Health and Rehab Center to ensure medications are stored, labeled, dated and that expired medications are disposed of. All residents receiving medications have the potential to be affected by this alleged deficient practice. 2. The Director of Nursing/designee has performed a walk-through inspection of all medication carts and medication storage areas and discarded out-of-date items and has ensured all medications were labeled and dated correctly. A system has been implemented to audit and correct the storage, labeling, dating and destruction of medications. 3. The Director of Nursing/designee has re-educated licensed clinical staff (including RNs and LPNs) on proper labeling, dating, storage, and destruction of medications as per policy. The education included, but was not limited to, medication storage, labeling, dating, and wasting of out-of-date medications. 4. The Director of Nursing/designee will perform walk-through audits of all medication carts and medication storage areas five times weekly for 4 weeks until substantial compliance is achieved. Any variances identified will be immediately corrected and further education will be provided to staff regarding prevention of these variances. Certified Dietary	

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F 761	Continued From page 22	F 761	Manager will present audit findings and any trends/patterns to the Quality Assurance Performance Improvement committee on a quarterly basis.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		9/16/22

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F 842	Continued From page 23 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to provide and accurate clinical record for 1 Resident (# 114) in a survey sample of 47 Residents.	F 842	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is	

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F 842	Continued From page 24 The findings included: For Resident #114 the facility staff failed to ensure the accuracy of the physician progress notes with regards to wound care. On 8/17/22 at approximately 1:00 PM a review of the clinical record was conducted and the following are excerpts from the physician's progress notes. "6/21/21" "Exam Findings - Derm. [Dermatological] - NO Rash - Ulcer." "6/22/21" "Right leg edema to the knee - +/- from walking boot too tight but will treat." "6/25/21" "Exam Findings - Derm [Dermatological] - NO Rash - Ulcer." "6/28/21" "Exam Findings - Derm [Dermatological] - NO Rash - Ulcer." "6/30/21" "Boot on RLE [right lower extremity] 2+ pitting edema in LLE, multiple wounds in distal LLE with wound between 4th and 5th phalanges, slough build up noted, extremity is erythematous, but no warmth." "A&P" "Cellulitis vs Osteomyelitis" "-Start Bactrim DS BID X 7 days." "-Evaluate for Osteo. L foot XR; CBC, BMP, CRP, ESR" A review of the Admission Assessment done on	F 842	an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. An interdisciplinary care-plan meeting was held for resident #114. The resident's plan of care was reviewed and updated to reflect their resident-specific needs and accuracy of physician records and documentation. We have identified that all residents are at risk from this alleged deficient practice. The facility has secured the service of a new Medical Director as of 8/1/2022. 2. The Director of Nursing/designee has performed an audit of all current resident physician documentation to ensure accuracy of information. The new medical practice that was obtained and secured has begun completing a baseline of each resident. Any variances have been corrected and staff has notified residents and/or responsible parties and providers of updated orders and plans of care. 3. The Chief Clinical Officer/designee has educated the Director of Nursing, Assistant Director of Nursing, and Social Worker on ensuring the accuracy of physician documentation. 4. The Director of Nursing/designee will review physician documentation of 8 residents weekly for 6 weeks to ensure accuracy of clinical documentation. Any issues identified will be addressed immediately by the Director of	

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F 842	Continued From page 25 6/15/21 revealed that the nurse who did the assessment did not list any wounds for Resident #114, nor did she initiate any wound assessment forms. A review of the clinical record also revealed a Braden Scale with a score of 19 out of a possible 19, indicating No Risk Pressure Sore. The Braden scale was performed on 6/19/21 excerpts are as follows: "Sensory Perception: Ability to respond meaningfully to pressure-related discomfort." "No Impairment" "Activity: Degree of Physical Activity - Walks occasionally" Please note: this Resident uses a walker or wheelchair and has a boot to his right foot due to recent ankle fracture. "Ability to change and control body position. NO Limitation" "Problem" A review of the care plan revealed the following excerpts: "[Resident name redacted] has a potential for impaired skin integrity effective: 6/15/22" "GOAL" "[Resident name redacted] will not experience impaired skin Interventions: "Inspect skin and report any bruises, open areas, or discoloration" "Encourage [Resident name redacted] to re-position or provide assistance with turning and	F 842	Nursing/designee and appropriate action will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.	

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F 842	Continued From page 26	F 842		

repositioning as needed."

Please note: this Resident has a diagnosis of CIDP (Chronic Inflammatory Demyelinating Polyneuropathy), of which one of the symptoms is numbness and inability to feel sensations in extremities. This should have lowered the score of the assessment.

A review of the MDS from July 2021 revealed that the Resident was coded as requiring #3 -Extensive assistance with bed mobility and transfers this also should have lowered the score of the Braden Scale.

On 8/18/22 at approximately 2:45 PM an interview was conducted with the DON and the Administrator when asked about the Resident the Administrator stated that this Resident was in the facility prior to his starting there. The DON was aware of the Resident and the issues with this Resident, however she stated she was not the DON at the time Resident #114 was in the building.

The Administrator also stated that the Medical Group (Doctors and Nurse Practitioners) that was working at the facility at that time are no longer working in the building.

The DON was asked to read over the progress notes from the Physician and was asked if they appeared accurate. She indicated that they were not. She stated that the Resident had wounds the physician did not address in his notes. When asked if the Braden Scale appeared accurate she stated that it was not accurate it did not include factors that would have lowered the score.

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F 842	Continued From page 27 When asked if the Admission Assessment was accurate she stated that it was not because the Resident was admitted with a fractured right ankle wearing a cam boot and bilateral stage 1 pressure ulcers to heels. On 8/17/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, 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:	F 880		9/16/22

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F 880	Continued From page 28 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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:	F 880		

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F 880	Continued From page 29 Based on observation, interview, and facility documentation the facility staff failed to appropriately wear PPE in a facility currently in outbreak and failed to post the appropriate signage to indicate which PPE to wear in the quarantined Resident's room. The findings included 1. The Preventionist (IP) Nurse failed to wear a mask. The IP was observed behind the nurses' desk on the Annex Hall without a mask. On 08/18/22 at 11:26 AM, the IP Nurse was noted not to be wearing mask at the nurses station near annex unit. The Administrator was in hall and made aware, he told her to put on a mask. The Signage at the main entrance to facility as well as on entrance to the unit read "Everyone must wear a mask in all buildings on campus." 8/18/22 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON) who stated it is the expectation that everyone wear a mask while in the facility. She stated if you are in the Administration area (not in patient care areas) you may wear a surgical mask however if you are in a patient care area you must wear an N-95. On 8/18/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #158 (on Transmission-Based Precautions), the facility staff failed to post	F 880	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirement 1. The Infection Preventionist was educated at the time of the deficient practice. Signage to indicate what personal protective equipment should be worn for resident #158 was replaced at the time of the deficient practice. There were no adverse outcomes to the deficient practice. 2. The Infection Preventionist/designee completed a review of all residents on transmission-based precautions at the time of the deficiency to ensure that the proper signage was posted indicating what PPE should be worn prior to entering the room. Rounds were completed at the time of deficiency to ensure all staff were wearing masks appropriately. 3. The Director of Nursing/designee educated the Infection Preventionist and all HRC staff on the requirement that appropriate signage be placed outside the room of all residents on transmission-based precautions which indicates what PPE should be worn prior to entering the room. The Infection Preventionist and all HRC staff have been educated on mask-wearing guidelines to include “Face Masks Do’s and Don'ts”	

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F 880	Continued From page 30 signage to indicate what personal protective equipment (PPE) should be worn prior to entering the room. On 08/16/2022 at approximately 1:05 P.M., this surveyor observed Transmission-Based Precautions (TBP) supplies outside Resident #158's room but there was no signage to indicate what PPE should be worn prior to entering the room. At approximately 1:10 P.M., Certified Nursing Assistant E (CNA E) was observed at nurse's station. When asked about what PPE should be worn prior to entering Resident #158's room, CNA E indicated that all PPE, except eye protection, should be worn upon entering Resident #158's room. On 08/16/2022 at 2:30 P.M., CNA D was interviewed. When asked what PPE should be worn prior to entering Resident #158's room, CNA D explained that all the staff know what to wear because "it's all right here" and pointed to the TBP supplies on Resident #158's room door. CNA D then noticed one of the pouches on the supply caddy was empty and stated that the masks needed to be replenished. CNA D then stated that they have morning meetings with all department heads so all the staff will know what PPE to wear. On 08/17/2022 at approximately 9:15 A.M., this surveyor observed signage outside Resident #158's room indicating Resident #158 was on Contact Precautions and PPE to be worn prior to entering the room was gown, gloves, mask, and eye protection. The pouch on the supply caddy that was empty on 08/16/2022 was now fully stocked with faceshields.	F 880	and “Respirator On/ Respirator Off.” 4. The Infection Preventionist/designee will complete walking-rounds on each resident on transmission-based precautions five days a week for six weeks to ensure the proper signage is present on the residents door that indicates what PPE should be worn prior to entering the room. The Infection Preventionist will complete audits on staff members five days a week for six weeks to validate appropriate mask-wearing. Any issues identified will be addressed immediately by the Infection Preventionist/designee and appropriate actions will be taken. The Infection Preventionist/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the Quality Assurance Performance Improvement committee on at least a quarterly basis.	

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F 880	Continued From page 31 On 08/17/2022 at 3:00 P.M., the Infection Preventionist was interviewed. When asked about the expectation for TBP signage, the Infection Preventionist stated the type of isolation and the donning/doffing sign should be posted outside the room. On 08/17/2022 at approximately 5:30 P.M., the Administrator and Director of Nursing were notified of findings. On 08/18/2022, the facility staff provided a copy of their policy entitled, "Isolation Precautions.: In Section IV Part C, it was documented, "Obtain appropriate signage and post outside doorframe of resident's room ..."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		9/16/22

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F 883	Continued From page 32 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide pneumococcal immunizations for 3 residents in a survey sample of 5 residents	F 883	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or	

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F 883	Continued From page 33 reviewed for pneumococcal vaccination. The facility staff failed to provide pneumococcal immunizations for Residents #8, #14, and #53. The findings included: On 8/18/22, clinical record review was performed for Residents #8, #14, and #53 and revealed no documentation with regard to pneumococcal immunization including the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication. The admission dates for these residents include, Resident #8 admitted 8/20/2019, Resident #14 admitted 5/29/15, and Resident #53 admitted 10/1/19. These findings were verified with the Infection Preventionist and stated, "we are supposed to assess whether or not a resident has received a [pneumonia] vaccine or not when they are admitted here and offer them one if they have not had it, it does not appear that this was done for these residents [Residents #8, #14, and #53]". A facility policy on pneumococcal immunization was requested and received. On 8/18/22, review of the facility policy entitled, "Pneumococcal Vaccination", dated June 2021, read: "Policy...The facility supports vaccination activities to prevent the development of pneumonia in residents" and "Procedure", item 1, read, "Upon admission to the nursing facility, the resident and/or resident representative will be interviewed to determine [resident's eligibility to receive a pneumococcal vaccination]".	F 883	that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Residents number 8, 14, and 53 have been offered the pneumococcal vaccine. They each have documentation regarding their current pneumococcal vaccination status, the choice to receive the pneumococcal vaccine, and either the administration or declination of the vaccine recorded in their chart. Williamsburg Landing HRC has identified that all residents are at risk from this alleged deficient practice. 2. The Director of Nursing/Designee will review each resident’s chart for documentation of the pneumococcal vaccine. Any other residents missing current pneumococcal vaccination status documentation will be offered the vaccine, and have this, the offer to administer the vaccine, and either the administration or declination of the vaccine recorded in their chart. 3. The Director of Nursing/Designee will educate all licensed nurses on the following requirements: (1) That all residents must be offered the pneumococcal vaccine upon admission. (2) That each resident and/or resident representative must be provided with	

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F 883	Continued From page 34 On 8/18/22 at approximately 5:00 PM, the Facility Administrator and the Director of Nursing were updated on the findings. No further information was provided.	F 883	education regarding the benefits and potential side effects of receiving this vaccination. (3) The offering of the vaccine, the providing of education regarding the vaccine, and the administration/declination of the vaccination must be recorded in the resident's chart. 4. The Director of Nursing/Designee will review all newly admitted resident's charts for current pneumococcal vaccination status, proof of the provision of education on the vaccine, and the signed consent form either accepting or declining the vaccination for six weeks. The Director of Nursing /Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	
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;	F 886		9/16/22

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F 886	Continued From page 35	F 886		

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

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

§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

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F 886	Continued From page 36 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 for 4 out of 6 staff members, staff members #4, #5, #6, and #8, the facility staff failed to maintain documentation of COVID-19 testing occurrences and results for all facility staff, and the facility staff failed to conduct COVID-19 testing for 4 out of 4 newly admitted residents, residents #46, #57, #110, and #209. The findings included: 1. The facility staff failed to conduct expanded screening COVID-19 testing for staff members #4, #5, #6, and #8. On 8/16/22 at approximately 1:00 PM, a group interview was conducted with the Facility Administrator, Director of Nursing (DON), and the Infection Preventionist (IP). The IP stated the facility was currently conducting COVID-19 testing twice per week, on Tuesdays and Fridays, due to the high levels of transmissibility in the local community. The IP stated the community levels have been high for most of the year.	F 886	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Williamsburg Landing Health and Rehab employees who are not up-to-date with their COVD-19 vaccinations, or who have an approved exemption, are tested at a frequency determined by the transmission rate of the community. All agency staff members who are not-up-date are tested daily prior to their shift. All newly admitted and readmitted residents to Williamsburg Landing HRC will have COVID-19 testing performed on the day of admission, and seven days later. Williamsburg Landing HRC has identified that all residents are at risk from this alleged deficient practice. 2. The Infection Preventionist/designee will maintain a log of all staff, agency, and resident testing to include name, date of	

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F 886	Continued From page 37 The IP further stated that she is only responsible for resident testing and staff testing is handled by the Human Resources (HR) department. She stated, "Human resources generates a list of staff members that need to be tested and then sends it down to me, we perform the tests and send the results back to them, I don't know what happens after that". The Facility Administrator confirmed that the HR department handles all matters involving staff members with regard to COVID vaccination and testing. A staff COVID vaccination matrix, staff testing records, and COVID testing policies were requested and received. A review was conducted of these documents and revealed the following: 1a. For staff member #4, the facility staff failed to perform COVID-19 testing. Staff member #4, who was agency staff, had completed a primary COVID-19 vaccine series on 2/15/21 but did not receive a booster, was not up to date with COVID-19 immunization. An interview with the HR Director was conducted and she stated, "I do not handle anything with Agency staff, the Clinical Staff Coordinator is responsible for all of that, I do not know any of them [agency staff], I am not involved with following their [COVID-19] vaccination status nor do I prompt any COVID testing for them, that is the responsibility of the clinical team". An interview with the Clinical Staff Coordinator was conducted and she stated, "We use 3 different agencies for nurses and nurse aides on almost a daily basis, I try to get the agency	F 886	testing, results, and tester initials. For all employees of Williamsburg Landing HRC, all COVID-19 test results, including both positive and negative results, will be kept as a part of the employee's medical record. For all residents of Williamsburg Landing HRC, all COVID-19 results will be recorded in their medical chart. 3. The Infection Preventionist/designee will educate all Williamsburg Landing HRC staff who are not up-to-date with vaccinations or who have an approved exemption on the requirement of testing based on community transmission rates. Agency staff members who are not up-to-date will be educated on the requirement to be tested prior to every shift worked. The Infection Preventionist/designee will educate licensed nurses (RNs and LPNs) on the requirement that all newly admitted and readmitted residents be tested on the day of admission and seven days later. 4. The Infection Preventionist oversees the testing of HRC and agency staff members and ensures compliance. Staff who are noncompliant with the required testing receive disciplinary action and are removed from the schedule until testing occurs. The Infection Preventionist/designee will complete weekly audits of all newly and readmitted residents for six weeks to validate that COVID-19 testing is being performed on admission and seven days later. Any issues identified will be addressed immediately by the Infection	

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F 886	Continued From page 38 contact to send over some basic information on the employee that they may be sending over to us which would include their COVID vaccination status but I do not keep any records on agency staff and I am not involved with any COVID testing for them". A follow-up interview was conducted with the IP and the Facility Administrator who confirmed the facility is not performing COVID-19 testing for any agency staff members. 1b & 1c. For staff members #5 and #6, the facility staff failed to perform COVID-19 testing at the recommended frequency of twice per week. Staff members #5 and #6 were granted a non-medical exemption from COVID-19 immunization by the facility. Review of staff member #5's August 2022 work schedule and test results revealed that staff member #5 worked on August 2, 3, 4, 6, 7, 9, 10, 11, 12, 16, ten shifts in total, with one COVID-19 test performed on the 9th. Review of staff member #6's August 2022 work schedule and test results revealed that staff member #6 worked on August 1, 3, 5, 6, 7, 8, 9, 11, 12, 15, 16, eleven shifts in total, with one COVID-19 test performed on the 9th. An interview was conducted with the HR Director who confirmed the COVID-19 vaccination status for staff members #5 and #6 and stated, "[names redacted, staff members #5 and #6] signed an agreement when the exemption was granted which required compliance with [COVID] testing, I do not send their names down on the staff testing	F 886	Preventionist/designee and appropriate actions will be taken. The Infection Preventionist/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the Quality Assurance and Performance Improvement committee on at least a quarterly basis.	

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rosters for privacy reasons, they know that they should be testing, I'm assuming that the clinical leadership is providing oversight for compliance, I get notified if a test is positive".

1d. For staff member #8, the facility staff failed to perform COVID-19 testing at the recommended frequency of twice per week. Staff member #8 had completed a primary COVID-19 vaccine series on 9/17/21 but did not receive a booster and therefore, was not up to date with COVID-19 immunization.

Review of staff member #8's July 2022 work schedule revealed that staff member #8 worked on July 1, 2, 4, 6, 7, 8, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 25, 26, 28, 29, 30, and 31, twenty-two shifts in total, with no documented COVID-19 test being completed, including results.

Review of the facility policy titled, "COVID-19 Infection Prevention Testing Guidelines", issued March 2021, "Policy" read, "The Health and Rehab Center (HRC) will test residents and facility staff coming in and out of HRC, including individuals providing services under arrangement and volunteers, for COVID-19" and subheading, "Conducting Testing", page 4, read, "The facility will conduct testing according to nationally recognized guidelines, outlined by the Centers for Disease Control and Prevention (CDC)".

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

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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)".

2. The facility staff failed to maintain documentation of COVID-19 testing occurrences and results for all facility staff.

An interview conducted with the HR Director was conducted and she stated, "The clinical team will perform COVID testing on our staff members from the list that I give to them, they send the results to me, and I only record positive results, I do not keep any other results, the clinical leadership team--the Facility Administrator, Director of Nursing and Infection Preventionist are responsible for oversight for [COVID-19] testing compliance, I do not follow-up with staff members otherwise".

Review of the facility policy titled, "COVID-19 Infection Prevention Testing Guidelines", issued March 2021, "Policy" read, "The Health and Rehab Center (HRC) will test residents and facility staff coming in and out of HRC, including individuals providing services under arrangement and volunteers, for COVID-19" and subheading, "Documentation of Testing", page 5, item 3 read, "...Also, document the date(s) that testing was performed for all staff, and the results of each

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test" and "For staff, including individuals providing services under arrangement and volunteers, the facility will document testing results in a secure manner...".

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., 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...".

3. For Residents #46, #57, #110, and #209, facility staff failed to conduct COVID-19 testing upon admission to the facility.

3a. For Resident #46, the facility staff failed to conduct COVID-19 testing upon her arrival to the facility.

On 8/17/22, a clinical record review was conducted and revealed that Resident #46 was admitted to the facility on 8/5/22, however there was no evidence of any COVID-19 testing.

3b. For Resident #57, the facility staff failed to conduct COVID-19 testing upon her arrival to the facility.

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On 8/17/22, a clinical record review was conducted and revealed that Resident #57 was admitted to the facility on 7/6/22, however there was no evidence of COVID-19 testing until 8/6/22.

3c. For Resident #110, the facility staff failed to conduct COVID-19 testing upon his arrival to the facility.

On 8/17/22, a clinical record review was conducted and revealed that Resident #110 was admitted to the facility on 8/10/22, however there was no evidence of any COVID-19 testing.

3d. For Resident #209, the facility staff failed to conduct COVID-19 testing upon his arrival to the facility.

On 8/17/22, a clinical record review was conducted and revealed that Resident #209 was admitted to the facility on 8/9/22, however there was no evidence of any COVID-19 testing.

On 8/17/22 at approximately 2:30 PM, an interview was conducted with the IP who confirmed the facility conducts COVID-19 testing for all residents in accordance with CDC recommendations. The IP was asked about the facility's protocol for testing newly admitted residents for COVID-19 and she stated, "The Admissions Coordinator requires that a COVID-19 test be conducted within 48 hours prior to their admission, we do not require any further testing after admission unless there is a specific reason".

Review of the facility policy titled, "COVID-19 Infection Prevention Testing Guidelines", issued

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F 886	Continued From page 43 March 2021, "Policy" read, "The Health and Rehab Center (HRC) will test residents and facility staff coming in and out of HRC, including individuals providing services under arrangement and volunteers, for COVID-19" and subheading, "Conducting Testing", page 4, read, "The facility will conduct testing according to nationally recognized guidelines, outlined by the Centers for Disease Control and Prevention (CDC)". 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". The Facility Administrator, Director of Nursing, Infection Preventionist and the Chief Operating Officer were made aware of the findings at the end of day meeting held on 8/18/22 and again at the pre-Exit Conference meeting held on 8/19/22. No further information was provided.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been	F 887		9/16/22

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F 887	Continued From page 44 immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical	F 887		

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F 887	Continued From page 45 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 and facility documentation review, the facility staff failed to provide COVID-19 immunization for 2 staff members, staff #7 and #8, in a survey sample of 5 staff members reviewed for COVID-19 vaccination. The facility staff failed to provide COVID-19 booster vaccines for staff members #7 and #8. The findings included: On 8/16/22 at approximately 1:00 PM, a group interview was conducted with the Facility Administrator, Director of Nursing (DON), and Infection Preventionist (IP). The IP stated that the Human Resources (HR) department handles all matters involving staff members with regard to COVID vaccination and testing. A staff COVID vaccination matrix and COVID vaccination policies were requested and received. On 8/18/22, staff vaccination records for staff member #7 and #8 were reviewed and revealed	F 887	1. Employees #7 and #8 were educated on the newly revised HRC policy based on the CDC recommendation for being up-to-date on COVID-19 vaccinations. 2. Infection Preventionist/designee has reviewed all HRC employees to determine who is or is not up-to-date. 3. Infection Preventionist/designee has educated all HRC employees who are not up-to-date on the newly revised policy based on CDC guidelines that all employees be up-to-date with their COVID-19 vaccinations. All employees who are not up-to-date with their COVID-19 vaccinations are required to wear an N95 respirator at all times and to be tested at a frequency based on community transmission rates, and will be educated and made aware of CDC recommendations with weekly testing in order to mitigate the transmission and spread of COVID-19 for all staff who are	

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F 887	Continued From page 46 the following: Staff member #7, hire date 10/27/20, had completed a primary COVID-19 vaccine series on 3/2/21 but had not received a booster dose. Staff member #8, hire date 6/15/21, had completed a primary COVID-19 vaccine series on 9/17/21 but had not received a booster dose. On 8/19/22, an interview was conducted with the HR Director who confirmed the findings and stated, "I do not follow-up on whether or not a staff member gets a booster shot, I will send them an email when they become eligible to receive a booster vaccine but it's up to the staff member to go get one if they want one, I do not provide them with any education about the boosters and we don't have a declination form either--is this something that I should be doing?". Review of the facility policy titled, "COVID-19 Vaccination Mandate", reviewed January 2022, "Policy" read, "All persons with a....employment arrangement with [facility name redacted] will take necessary precautions and adhere to mandated guidelines through this policy, the intent of this policy is to safeguard...from COVID-19, this policy will comply with all applicable laws and is based on guidance from federal, state, and local health authorities, as applicable". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, page 3, subtitle, "Vaccinations", read, "Remaining up to date with	F 887	not fully-vaccinated. 4. The Infection Preventionist/designee will conduct a weekly audit for six weeks to validate compliance with the requirements for wearing an N95 respirator and mandatory testing based on community transmission levels. The Infection Preventionist/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the Quality Assurance and Performance Improvement committee on at least a quarterly basis.	

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F 887	Continued From page 47 all recommended COVID-19 vaccine doses is critical to protect both staff and residents against SARS-CoV-2 infection". The Facility Administrator, DON, and IP were updated. No further information was received.	F 887		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility 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	F 888		9/16/22

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F 888	Continued From page 48	F 888		

and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(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

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exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and 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

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F 888	Continued From page 50 (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their policy and procedure to ensure that all facility staff were fully vaccinated for COVID-19. The facility staff failed to document the COVID-19 vaccination status for 56 contracted nursing agency staff members who provided direct resident care during the months of June, July, and August 2022. The findings included: On 8/18/22, an interview was conducted with the Facility Administrator and the Infection Preventionist (IP). The IP stated that the Human Resources (HR) department was responsible for all staff COVID vaccinations. A copy of the facility policy was requested and received. An interview was conducted with the HR Director who stated, "I do not handle anything with Agency staff, the Clinical Staff Coordinator is responsible	F 888	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Additional Precautions, including antigen testing of all agency staff members working in the facility each day, and the mandatory use of N95 respirators for agency staff who are not up-to-date with vaccinations have been implemented to mitigate COVID-19 exposure risk to residents and staff. Williamsburg Landing HRC has identified that all residents are at risk from this alleged deficient practice. 2. The Infection Preventionist/designee will review the COVID-19 vaccination status for all agency employees prior to	

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F 888	Continued From page 51 for all of that, I do not know any of them [agency staff], I am not involved with following their [COVID-19] vaccination status...". An interview with the Clinical Staff Coordinator was conducted and she stated, "We use 3 different agencies for nurses and nurse aides on almost a daily basis, I try to get the agency contact to send over some basic information on the employee that they may be sending over to us which would include their COVID vaccination status but I do not keep any records on agency staff...". She verbally confirmed that there was no documentation of Agency staff COVID-19 vaccination status kept at the facility, stating, "The people I work with at the agencies know that we want vaccinated staff". A request was made for agency clinical staff work schedules for June, July and August 2022 and was received. Review of the agency work schedules revealed a total of 56 agency nurses and nurse aides, with unknown COVID-19 vaccination status, were permitted by the facility to provide direct care to residents from 6/6/22 through 8/19/22. Review of the facility policy titled, "COVID-19 Vaccination Mandate", reviewed January 2022, "Policy" read, "As a condition of employment, all employees are required to be fully vaccinated against COVID-19" and "Guidelines", item 2 read, "...Documentation related to employees' COVID-19 vaccination status will be maintained by [name redacted, HR department], this tracking system will include any applicable booster vaccinations received by facility staff". The Facility Administrator, Director of Nursing, Infection Preventionist, and the Chief Operating	F 888	working in the facility. All exempted employees and employees who are not up-to-date with vaccination have had additional precautions implemented to mitigate COVID-19 exposure risk to residents and staff. The additional precautions include antigen testing of all agency staff members working in the facility each day, and the mandatory use of N95 respirators. 3. All staffing agencies contracted with Williamsburg Landing HRC have been notified of the requirement that all agency staff members be fully vaccinated for COVID-19 in order to work at the facility. The notification includes, but is not limited to, the importance of being fully vaccinated, being up-to-date with vaccinations, acceptable exemptions to vaccination, and the additional precautions necessary to protect staff and residents from COVID-19 exposure by unvaccinated and non up-to-date staff. 4. The Infection Preventionist/designee will complete weekly audits for 6 weeks to ensure that the vaccination status of agency staff members are accurate and up-to-date. Any issues identified will be addressed immediately by the Infection Preventionist/designee and appropriate actions will be taken. The Infection Preventionist/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

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F 888	Continued From page 52 Officer were made aware of the findings at the end of day meeting held on 8/18/22 and again at the pre-Exit Conference meeting held on 8/19/22. No further information was provided.	F 888		