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	345380	A. BUILDING ______ B. WING ______	C 08/03/2022

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VILLAGE GREEN HEALTH AND REHABILITATION	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/25/28 through 7/28/22 with additional information obtained offsite 8/1/22 through 8/3/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ISRZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 7/24/22 through 7/28/22 with additional information obtained offsite 8/1/22 through 8/3/22. Event ID#ISRZ11. The following intakes were investigated NC0000191094, NCNC00191184, NC00190991, NC00191065, NC00190287, NC00189587, NC00189426, NC00188174, NC00187889, NC00187423. 4 of the 24 complaint allegations were substantiated resulting in deficiencies. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		8/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/12/2022

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

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F 644	Continued From page 1 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with a newly evident diagnosis of a serious mental illness for Preadmission Screening and Resident Review Level II for 1 of 1 resident reviewed for Preadmission Screening and Resident Review (Resident #72). Findings Included: Resident #72 was admitted to the facility on 02/18/22 with diagnoses which included, in part, unspecified dementia without behavioral disturbance. A record review of Resident #72's Significant Change Minimum Data Set (MDS), dated 06/13/22, indicated Resident #72 was not currently considered by the State Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness. Diagnoses on the MDS included non-Alzheimer's dementia and psychotic disorder. The MDS also indicated Resident #72 had received antipsychotic medication on a routine	F 644	Facility failed to request a Preadmission Screening and Resident Review assessment secondary to a new diagnosis that would need to be assessed for a Level II PASRR. Resident #72 PASARR level II has been obtained on 7/29/2022. A PASRR audit will be conducted by the Social Worker for all current residents to ensure PASRR's are not expired and up to date. This audit will be completed by 8/1/2022. There were no other issues with PASRR's. Social Worker will be educated by the Executive Director on expectation that of PASRR's and when we need to reassess residents to include new diagnosis. The Social Worker will in-service the Clinical Administrative Team on diagnosis that would trigger a review of the PASRR. This education will be completed by 8/1/2022. Social Worker will audit all current residents PASRR to ensure they have the correct level of PASRR. The clinical team will discuss in Morning Clinical Meeting	

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F 644	Continued From page 2 basis only. A review of Resident #72's medical doctor's progress notes revealed she was diagnosed with psychotic disorder with hallucinations due to known physiological condition on 04/28/22. In the Plan of Care in the progress note, the medical doctor (MD) indicated Resident #72 was to continue taking her antipsychotic medication daily. On 06/10/22, Resident #72's MD note specified, "she has refused treatment and baseline has significant dementia with agitation ...will also continue quetiapine (an antipsychotic medication) for psychosis and sertraline (an antidepressant medication) for depression and behaviors." During an interview with the Social Worker (SW) on 07/26/22 at 3:39 p.m., the SW stated she was the person responsible for referring residents with a newly evident diagnosis of a serious mental illness for a PASRR Level II screen. The SW explained she had been unaware Resident #72 had been diagnosed with psychotic disorder with hallucinations due to known physiological condition. The SW was unsure whether psychotic disorder had been erroneously checked on the MDS assessment or not. An interview was held with the MDS Coordinator on 07/26/22 at 4:22 p.m. The MDS Coordinator explained she had indicated Resident #72 had a psychotic disorder on the significant change MDS after reading the new diagnosis on the two MD notes, dated 04/28/22 and 06/10/22. A second interview was held with the SW on 07/27/11 at 11:11 a.m. The SW explained the process she followed for making a PASRR Level	F 644	new diagnosis that would require a PASRR to be requested and notify the Social Worker with any new diagnosis. The Social Worker will audit weekly for 6 weeks to ensure the PASARR are being review appropriately. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Executive Director monthly x 2 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 644	Continued From page 3 II screen on new residents and on established residents. For established residents, she stated she would run a report on all residents which included their diagnoses monthly and provided her most recent report dated 06/30/22. She further explained that residents on the report with newly evident mental illness diagnoses would be referred for a PASRR Level II screen. During the survey, the SW discovered Resident #72's new mental illness diagnosis had not been added to the resident's diagnoses listing in her electronic health record and the opportunity to refer for a PASRR Level II screen was missed. During an interview with the Administrator on 07/28/22 at 12:08 p.m., the Administrator stated after discussion with her interdisciplinary team (IDT), Resident #72 was not referred for a PASRR Level II screen because her newly evident mental illness diagnosis had not been added to the diagnoses listing in her medical record. The Administrator explained going forward, new processes were being put in place to ensure the MD and the IDT communicated new mental health diagnoses to ensure those residents who require a referral for a PASRR Level II screen would be referred.	F 644		
F 689 SS=G	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.	F 689		

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F 689	Continued From page 4	F 689		

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with staff and Nurse Practitioner, the facility failed to provide care in a safe manner for 1 of 4 residents reviewed for supervision to prevent accidents (Resident #293). The resident rolled off the bed during care which resulted in a laceration above the left eye and fracture of the left 7th and 8th ribs.

Past noncompliance: no plan of correction required.

The findings included:
Resident #293 was admitted to the facility on 3/11/22. His diagnoses included cognitive communication deficit, dementia without behavioral disturbance and generalized muscle weakness.

The most recent comprehensive Minimum Data Set (MDS) assessment dated 3/18/22 indicated Resident #293 was severely impaired and required extensive assistance to accomplish activities of daily living (ADL) to include bed mobility, personal hygiene, dressing, and toileting. He was coded for one person assist. The Care Area Assessment (CAA) summary indicated Resident #293 was at risk for falls due to weakness, debility, and poor safety awareness secondary to severe cognitive decline.

Nursing note dated 4/3/2022 at 3:15 am indicated Nurse #3 was called to Resident #293's room by Nursing Assistant #1 (NA #1). He was informed by NA #1 that Resident #293 fell out of bed during patient care. Resident #293 was lying on his left side on the floor at the left side of bed. He complained of pain on left side of head, upon inspection found ½ -inch laceration above left eye

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F 689	Continued From page 5 just below eyebrow. Cleansed site and applied clean dry dressing. Resident #293 denied neck injury and stated he had pain on entire left side of body upon questioning but showed no change in baseline with range of motion to extremities or hip. He was repositioned back to bed with assistance from nursing assistants. Unit manager and physician were notified of the fall and Emergency Medical Services (EMS) were contacted to transfer Resident to the emergency room (ER). Nursing Assistant #1 (NA #1) statement dated 4/3/22 indicated NA #1 was performing patient care for Resident #293 when he rolled over too far. NA #1 attempted to catch Resident #293, but she was unsuccessful. During an interview on 7/27/22 11:48 am, Nursing Assistant #1 (NA #1) indicated she was changing resident #293's linen when he fell off the bed. She stated she had raised the bed to hip level, pulled resident #293 to the middle of the bed and turned him away from her so that she could tuck the dirty linen under him, he rolled too far and fell off the bed hitting his left side. She tried to hold onto Resident #293, but he slipped and hit the floor. She noticed Resident #293 had a skin tear above the left eye and she went to the doorway to call Nurse #3 who came in to assess Resident #293. Nurse #3 cleaned the skin tear, applied a bandage, and contacted Emergency Services to transport Resident #293 to the emergency room. An interview on 7/26/22 at 2:21 pm with Nurse #3 revealed he was the primary nurse for Resident #293 when he fell off the bed on 4/3/22. He indicated he became aware of the fall after Nursing Assistant #1 (NA #1) called for	F 689		

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F 689	Continued From page 6 assistance from Resident #293's doorway. When he walked into the room Resident #293 was on lying on his left side on the floor, he had a laceration above left eye and complained of pain on entire left side of body. Nurse #3 cleaned the site, applied a dressing then transferred Resident #293 back to bed. He notified physician of the fall and contacted EMS to come transfer Resident #293 to the ER for evaluation. Nursing note dated 4/3/2022 at 3:45 am indicated Nurse #3 assisted EMS staff with transferring Resident #293 onto stretcher for transfer to the ER. Emergency Room (ER) progress notes dated 4/3/22 indicated Resident #293 was seen at the ER for a fall and laceration in left eyebrow. The laceration measured 2 centimeters in length by 1 millimeter in depth and was repaired with 2 sutures. Computerized tomography (CT) of head and cervical spine revealed no acute intracranial hemorrhage or acute cervical spine fracture. Resident #293 was transferred back to the facility on 4/3/22 after the ER visit. During an interview on 7/26/22 at 12:15 pm with the Director of Nursing (DON), she indicated Resident #293 fell during patient care while being positioned in bed. NA #1 was changing Resident #293's bed linen when he rolled out of bed. The DON stated NA #1 should have turned Resident #293 toward her instead of away from her. She stated NA #1 had been trained to turn the resident toward the staff instead of away from the staff when utilizing one-person physical assist. The DON indicated Resident #293 was initially coded as requiring 1-person physical assist and his care plan was updated after the fall on 4/3/22	F 689		

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F 689	Continued From page 7 to include 2-person assist during ADLs. A nursing note dated 4/5/22 at 10:57 am indicated Resident #293 complained of pain/discomfort to left ribs. A nursing note dated 4/5/22 at 2:25 pm indicated new orders were received for lidocaine patch and diclofenac gel for pain for Resident #293. A nursing note dated 4/5/2022 11:12 pm indicated an order was received for Lidoderm patch 4% on for 12 hours and off 12 hours for Resident #293. Nurse Practitioner (NP) progress note dated 4/5/22 indicated Resident #293 reported recent onset of left rib pain, since fall and a 2-view x- ray was ordered to rule out any fractures or injuries. A physician's order dated 4/5/22 indicated an x-ray of left ribs status post fall with pain. Review of X-ray results dated 4/5/22 revealed Resident #293 had acute left 7th and 8th rib fractures. An interview was conducted with facility Nurse Practitioner (NP) on 7/27/22 at 10:31 am. The NP stated Resident #293 was send out to ER for fall on 4/3/22. The hospital sutured the laceration above left eye and completed a CT to head/neck. A chest x-ray or CT was not ordered at the hospital. When Resident #293 returned to the facility, he complained of rib pain and the NP ordered a chest x-ray on 4/5/22. The chest x-ray revealed acute left 7th and 8th rib fractures. The NP verbalized she gave an order for Lidoderm patch for Resident #293 for rib pain for 14 days.	F 689		

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F 689	Continued From page 8 An interview was conducted on 7/27/22 at 2:00 pm with the Administrator. She stated NA #1 should have turned Resident #293 toward her because she was providing care by herself. She stated all the nursing staff were retrained, after Resident #293's fall, on turning residents toward staff if utilizing one-person physical assist. The Administrator indicated the facility had completed a plan of correction related to the fall. The facility's corrective actions implemented after the accident to prevent a reoccurrence included the following: 1. Resident #293's care plan and Care card was reviewed, and appropriate changes were made as needed. 2. All residents were reviewed to ensure the following areas had been appropriately addressed by the Nursing Administration Team and was to be completed by 4/4/2022: a) Number of staff members needed to provide care; b) Bed surface to ensure sufficient room for turning and repositioning; c) Whether or not the resident had a physical impairment or behaviors that needed to be considered; and d) Any resident that could not assist with turning or repositioning. 3. Effective 4/3/2022, all Certified Nursing Assistants were re-educated on the locations of the resident Care Card, where on the Care Card to find the information needed to ensure appropriate care was provided to the resident. 4. Effective 4/3/2022, Certified Nursing Assistants were educated related to proper technique for turning and repositioning residents (+1/+2 staff assist). 5. No Certified Nursing Assistant would be allowed to work without the education. Education was completed by 4/4/2022. 6. All Current residents Care Card were reviewed,	F 689		

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F 689	Continued From page 9	F 689		

and changes were made as needed. This was completed 4/4/2022. The care plans were updated with any changes as needed by 4/4/2022
7. Effective 4/4/2022, the ADON added to orientation specific education regarding the Care Card to include the purpose of the Care Card and a detailed review of the information on the Care Card.
8. Effective 4/4/2022, the DON/designee conducted audits to ensure that care was being provided according to the resident care plan and Care Card. The audits were to be conducted daily for 14 days various shifts then weekly for 2 weeks. These audits would be conducted on all shifts.
9. Effective 4/4/2022, DON was to report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of the plan monthly x 2 months, or until the pattern of compliance was maintained. The QAPI committee could modify the plan to ensure the facility remained in substantial compliance. Alleged Compliance Date: 4/4/2022

On 7/27/22 the facility's Plan of correction was validated by the following: Audits conducted by the facility were reviewed and were found to be completed according to the plan of correction. All nurses and nursing assistants were educated on turning and repositioning. The training topic was "proper positioning when providing ADLs in bed to prevent Resident from falling" content included:
1. Roll resident toward person giving care
2. If resident requires extensive care or is not able to assist with care, utilize 2-person assist for ADLs.
Director of Nursing (DON) completed initial training for all staff and DON/Designee was

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F 689	Continued From page 10 responsible for ensuring all staff were trained on proper positioning to prevent falls. The validation confirmed the facility was still implementing steps of their corrective action plan on 4/4/22. The corrective action plan was validated to be completed as of 4/5/22.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record reviews, the facility failed to provide a resident's tube feeding in accordance with the physician's order for 1 of 2 residents (Resident	F 693	Facility failed to administer tube feeding at prescribed rate for resident #55. Resident #55 current order is 55 ml/hr, tube feeding setting was adjusted to	8/12/22

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Continued From page 11
#55) reviewed for tube feeding.

Findings included:

Resident #55 was admitted to the facility on 6/25/22 with diagnoses that included stroke with difficulty swallowing and feeding tube placement.

Review of physician's orders revealed an order dated 6/25/22 for standard tube feeding (TF) formula at 55 milliliters (ml) per hour through her feeding tube over 22 hours per day.

A Care Plan dated 6/29/22 focused on tube feeding included a goal for Resident #55 to receive the appropriate number of calories from her tube feeding to maintain weight and hydration. Interventions included provide tube feeding as ordered and notify dietitian, doctor, and family of any weight changes.

Resident #55's admission Minimum Data Set (MDS) dated 7/7/22 indicated a moderate cognitive impairment. She received greater than 51% of her calories and fluid from her TF.

An observation was made on 7/25/22 at 12:45 PM of Resident #55 in bed with TF formula running at 60 ml per hour through her feeding tube.

During an interview on 7/25/22 at 12:50 PM, Nurse #1 confirmed the TF was ordered for 55 ml per hour. She indicated that it was running at 60 ml per hour when she took over Resident #55's care from night shift and it had been changed by the night shift nurse. She revealed she had checked the TF that morning but was not aware it was not the correct rate.

F 693

prescribed rate by the Director of Nursing on 7/25/2022.

On 7/25/2022, 100% of all residents with tube feeding, were audited for correct settings by the Director of Nursing/Admin Nursing Staff. Any resident with inaccurate settings were corrected immediately.

100% of licensed staff were educated by Staff Development Coordinator on correct tube feeding settings. Any licensed or certified staff on leave will receive the required education prior to starting their shift. This education will be added to new hire orientation. This education will be completed by 7/29/2022. Unit Managers will audit all residents' orders being fed by a tube 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 1 month to ensure compliance.

Data obtained during the auditing process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months to determine if continued auditing is necessary to ensure compliance.

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F 693	Continued From page 12 During an interview on 7/26/22 at 1:15 PM, the Director of Nursing (DON) indicated that the nurses should check the order when they start a new bottle of tube feeding formula. The nurses on each shift should confirm the TF was running as ordered. During an interview on 7/26/22 at 3:00 PM, the Administrator revealed TF should run as ordered by a physician. The nurse should have reviewed the order when she changed out the TF bottle.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews, the facility failed to obtain a physician order to administer oxygen for 1 of 1 resident (Resident #214) reviewed for respiratory care. The findings included: Resident #214 was admitted to the facility on 7/7/22. His diagnoses included acute respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, congestive heart failure,	F 695	Facility failed to obtain an order to administer oxygen resident # 214. Resident #214 now has an order for O2 at 3 L/minute, O2 setting was adjusted to prescribed rate of 3L by the Director of Nursing on 7/27/2022. On 7/27/2022, 100% of all residents with oxygen, were audited for a current order and that they are on the correct oxygen settings by the Director of Nursing/ Nursing Administrative Staff. Any resident with inaccurate settings were	8/12/22

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F 695	Continued From page 13 and chronic obstructive pulmonary disease. The most recent comprehensive Minimum Data Set (MDS) assessment dated 7/11/22 indicated Resident #214 was cognitively impaired and received oxygen therapy. Review of Resident #214's physician orders on 7/25/22 at 09:32 AM revealed no order for oxygen administration. During observation on 07/25/22 09:33 AM Resident #214 was observed with the oxygen nasal canula. Resident #214's oxygen regulator on the concentrator was set at 3 liters/minute when viewed horizontally at eye level. During observation on 07/26/22 09:16 AM Resident #214 was observed with the oxygen nasal canula. Resident #214's oxygen regulator on the concentrator was set at 3 liters/minute when viewed horizontally at eye level. During observation on 07/26/22 11:15 AM Resident #214 was observed with the oxygen nasal canula. Resident #214's oxygen regulator on the concentrator was set at 3 liters/minute when viewed horizontally at eye level. Resident #214's oxygen regulator was verified with Medication Aide #2 to be set at 3 liters/minute. During an interview on 07/26/22 at 11:15 AM with Medication Aide #2, she stated she thought Resident #214 was supposed to be on oxygen at 2 liters/minute via nasal cannula, but she could not locate the order. Medication Aide #2 stated the order would be documented under physician orders and in the Resident 214's medication administration record (MAR).	F 695	corrected immediately. 100% of licensed staff were educated by Assistant Director of Nursing on ensuring they obtain an order before starting oxygen. Any licensed or certified staff on leave will receive the required education prior to starting their shift. This education will be added to new hire orientation. Completed 8/5/2022. Director of Nursing or Unit Managers will audit all residents on oxygen and their orders 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 1 month to ensure compliance. Data obtained during the auditing process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months to determine if continued auditing is necessary to ensure compliance.	

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F 695	Continued From page 14 During an interview on 07/26/22 at 11:22 AM with Nurse #2, she stated there was no order for Resident #214's oxygen administration under physician orders and medication administration records. Nurse #2 stated there should have been a physician order to administer the oxygen. An interview was conducted on 07/26/22 12:15 PM with the Director of Nursing (DON). She stated there should have been a physician order to administer oxygen to Resident #214. The DON further stated when the facility utilized standing orders, the standing order would be activated and documented under physician orders. During an interview on 07/26/22 at 12:32 PM with the facility Administrator, she stated she expected nursing staff to obtain a physician order to administer oxygen if there was need for oxygen administration. An interview was conducted on 07/27/22 08:38 AM with the facility Physician. He stated he could not recall if the facility had contacted him for an order to administer oxygen to Resident #214. He further stated if the facility had contacted him for an order, it would be documented under physician orders. The Physician stated he expected nursing staff to administer oxygen with an order and to contact him if there was need for oxygen administration or oxygen titration for any resident in the facility.	F 695		
F 888 SS=C	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	F 888		8/12/22

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F 888	Continued From page 15	F 888		

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 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:

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F 888	Continued From page 16 (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 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	F 888		

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F 888	Continued From page 17 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 (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	F 888		

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F 888	Continued From page 18 CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement the facility policy for unvaccinated employees when 2 of 12 unvaccinated (with exemptions) staff members were observed wearing KN95 masks instead of N95 masks as an additional precaution for unvaccinated staff members (Patient Care Attendant #1 and Laundry Aide #1). Additionally, the facility failed to track and document the COVID-19 vaccination status for 1 of 2 staff members documented as partially vaccinated (Nursing Assistant #2). The failures occurred when the facility was in COVID-19 outbreak status. Findings included: 1.The facility's COVID-19 Vaccination Policy dated January 2022 indicated additional precautions for staff with COVID-19 vaccination exemption which included, source control by use of the N95 respirator and physical distancing. As requested, on 07/27/22 the Administrator provided a list of unvaccinated employees that included Patient Care Attendant (PCA) #1 and Laundry Aide #1. 1a. An observation of PCA #1, an unvaccinated staff member (with an exemption), was made on 07/25/22 at 08:55 AM. She was observed wearing a KN95 mask while talking to Resident #33 in her room and was within 6 feet of Resident #33. An interview with PCA #1 on 07/25/22 at 09:00	F 888	All employees not fully vaccinated are now wearing the appropriate Personal Protective Equipment (PPE) per our policy. All employees now either are fully vaccinated or have an approved exemption. On 8/1/2022 an audit was completed of all staff to ensure that staff not fully vaccinated are now wearing PPE according to the policy and that all employees are fully vaccinated or have an approved exemption. The Director of Nursing will be educated by the Executive Director on expectation of tracking all employee's vaccination records and ensuring that all employees are fully vaccinated or have an approve exemption by July 29th, 2022. The Director of Nursing or designee will in-service all staff by August 12th on wearing the correct PPE and will one on one in-service those employees not fully vaccinated on wearing a N-95 mask at all times. This education will be completed by Director of Nursing and will a part of orientation. The Director of Nursing / or designee will audit weekly for 8 weeks to ensure all new hired staff have been fully vaccinated or have an approved exemption and will track and securely document the covid-19 staff vaccination matrix for any staff that have obtained any booster doses. The Director of Nursing / or designee will audit 3 times a week for four weeks then	

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F 888	Continued From page 19 AM revealed she had a COVID-19 vaccination exemption and was aware she was supposed to wear an N95 mask at all times while in the facility but the KN95 mask felt more comfortable for her. She stated she was assigned to pass ice and answer call lights in the 200 hallways. 1b. An observation of Laundry Aide #1, an unvaccinated staff member (with an exemption), was made on 07/26/22 at 11:50 AM. She was observed wearing a KN95 mask while folding laundry in the laundry room within 6 feet of other laundry department employees. During an interview with Laundry Aide #1 on 07/26/22 at 11:50 AM, she indicated she had a COVID-19 vaccination exemption. She stated she was not aware she was required to wear an N95 as an additional precaution while working in the building. She also stated she worked in the laundry room and transported linen to different halls. During an interview with the facility Infection Preventionist (IP) on 07/26/22 at 01:50 PM, she stated all unvaccinated staff members were aware of the requirement to wear an N95 mask at all times while in the facility. She stated all the staff that had been granted a COVID-19 vaccination exemption had signed an acknowledgement of the policy with additional mandated precautions to include donning an N95 mask at all times while working in the facility. During an interview with the facility Administrator on 07/26/22 at 01:55 PM, the Administrator stated unvaccinated staff members were made aware of the requirement to use an N95 mask and signatures were obtained from staff indicating	F 888	weekly for four weeks to ensure all unvaccinated staff is wearing the appropriate PPE. Data obtained during the auditing process will be analyzed for patterns and trends and reported to QAPI by Director of Nursing monthly x 3 months to determine if continued auditing is necessary to ensure compliance.	

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they had been made aware of the policy.

2. The facility's COVID-19 Vaccination Policy dated January 2022 indicated the facility would use a tracker to document employees' date of first vaccine, second vaccine as well as date of additional booster vaccine and securely document the information in employee medical file.

As requested, the Administrator provided a list of partially unvaccinated employees that included Nursing Assistant (NA) #2 on 07/27/22. The facility records indicated NA #2 received her 1st vaccination dose of a multi-dose vaccine on 6/16/21. The COVID-19 staff vaccination matrix provided by the facility indicated NA #2 was partially vaccinated.

On 08/03/22, the Administrator provided NA #2's COVID-19 Vaccination card which indicated she had received her 1st vaccination dose on 6/16/21 and her 2nd vaccination dose on 7/21/21.

During a follow up interview with the Administrator on 08/03/2022 at 09:15 AM, she stated NA #2 had received both doses of a multi-dose COVID-19 vaccine, but the facility failed to track and document it correctly which resulted in NA #2 being documented as partially vaccinated. The Administrator stated the facility should have ensured all staff COVID-19 vaccinations were documented correctly.