STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345292	A. BUILDING ______ B. WING ______	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTSBROOK NURSING AND REHABILITATION CENTER	**290 KEEL ROAD GRANTSBORO, NC 28529**

(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 recertification and complaint investigation survey was conducted on 3-19-23 through 3-22-23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4UUG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3-19-23 through 3-22-23. Event ID# 4UUG11. The following intakes were investigated: NC00187087, NC00191607, NC00193573, NC00194569, NC00196565, NC00197343, and NC00197408. 1 of the 12 complaint allegations resulted in deficiency.	F 000		
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.	F 582		4/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/05/2023

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 582	Continued From page 1 §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 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 record review and staff interviews the facility failed to provide a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN) to 2 of 3 residents	F 582	F582 Residents #34 and #2 continue to reside in the facility and remain in stable condition.	

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F 582

Continued From page 2

(Resident #34 and Resident #2) reviewed for Beneficiary Notification.

Findings included:

1. Resident #34 was admitted to the facility on 2/13/2018.

A review of her annual Minimum Data Set (MDS) assessment dated 8/17/22 revealed she was moderately cognitively impaired.

Resident #34's Medicare Part A Skilled services ended on 9/23/22. She remained in the facility.

A review of Resident #34's medical record did not reveal a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN) for this stay.

On 3/21/23 at 9:08 AM a telephone interview with Social Worker (SW) #2 indicated she no longer worked at the facility. She stated she did not recall Resident #34. She went on to say it would have been her responsibility to provide the completed form to Resident #34 at that time. She further indicated she thought perhaps she completed the form, but it did not get uploaded into Resident #34's medical record.

On 3/22/23 at 11:29 AM an interview with the Director of Nursing (DON) indicated she was not able to find a completed SNF-ABN for Resident #34's Medicare Part A Skilled services stay ending on 9/23/22.

2. Resident #2 was admitted to the facility on 10/20/20.

F 582

On 3/23/2023 QI Nurse initiated an audit of all Medicare A discharges for the past 30 days to ensure all Notifications of Medical Non-Coverage (NOMNC) were completed appropriately and signed. All of areas of concern were addressed by Social Work to include appropriate notification of noncoverage is provided to the resident/resident representative. Audit was completed on 3/27/2023.
QI Nurse inserviced the Social Worker and Accounts Receivable regarding Notifications of Medical Non-Coverage (NOMNC) with emphasis on providing appropriate notification related to non-coverage of Medicare A and Medicate B residents with the appropriate box checked and signature. Inservice was completed on 3/31/2023. After 3/31/2023 any newly hired Social Worker and/or Accounts Receivable will be inserviced during orientation regarding appropriate completion of Notifications of Medical Non-Coverage (NOMNC).
QI Nurse will complete an audit of 10% of all Medicare A discharges weekly x4 weeks then monthly x1 month utilizing NOMNC Audit Tool to ensure appropriate notification of medical non-coverage was provided to the resident/resident representative with the appropriate box checked and signature. The Social Worker and/or Accounts Receivable will address all areas of concern identified. The Administrator will review and initial NOMNC Audit Tool weekly x4 weeks then monthly x1 month to ensure all areas of concern are addressed.
Administrator will forward NOMNC Audit

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F 582	Continued From page 3 A review of her quarterly Minimum Data Set (MDS) assessment dated 2/13/23 revealed she was severely cognitively impaired. Resident #2's Medicare Part A Skilled Services ended on 2/13/23. She remained in the facility. A review of Resident #2's medical record did not reveal a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN) for Resident #2's Medicare Part A Skilled services stay ending on 2/13/23. On 3/21/23 at 9:16 AM a telephone interview with Social Worker (SW) #3 revealed she no longer worked at the facility. She stated she would have been responsible for completing the SNF-ABN for Resident #2 at that time. She went on to say she had not received any training on completing these forms by the facility and she had just been doing the best she could. On 3/21/23 at 9:35 AM an interview with the Administrator indicated it would have been SW #3's responsibility to complete the SNF-ABN for Resident #2. He stated he observed the Director of Nursing and the other members of the nursing administrative team providing training to SW #3. On 3/21/23 at 9:40 AM an interview with the DON indicated she trained SW #3 on completing the SNF-ABN forms for residents. She stated she had even walked her through the completion of several.	F 582	Tool to the Quality Assurance Committee monthly x2 months. The QA Committee will meet monthly x2 months to review NOMNC Audit Tool to determine trends and/or issues that may require further interventions put in place and to determine the need for further monitoring.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		4/5/23

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F 609	Continued From page 4 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to report to the state regulatory agency an incident related to an injury of unknown source (Resident #57) within the required timeframe for 1 of 3 residents reviewed for facility reported incidents. Findings included: Resident #57 was admitted to the facility on	F 609	F609 Resident #57 continues to reside in the facility and remains in stable condition. On 3/31/2023, Nurse Consultant reviewed all Nursing Home Self Reports beginning January 1, 2023 to present to ensure initial report and five (5) day follow-up report were completed timely. No concerns were identified. Nurse Consultant inserviced Administrator	

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F 609

Continued From page 5

12/6/22 with a diagnosis of dementia.

Review of fall incident report for Resident #57 dated 12/12/22 at 4:35 PM revealed he was found laying on the floor in front of the door to his room. He had socks and shoes on. His call light was not on. Resident #57 had a full body assessment done. He denied pain. He stated he had been trying to go outside. There were no injuries noted. He was assisted back into his wheelchair. His family member and physician were notified.

A review his admission Minimum Data Set (MDS) assessment dated 12/13/22 revealed he was severely cognitively impaired. He required the extensive assistance of 1 person for locomotion. He used a wheelchair for mobility. Resident #57 had 1 fall with no injury since his admission to the facility.

A nursing progress note for Resident #57 dated 12/27/22 at 10:23 PM written by Nurse #1 revealed he was complaining of new left hip and knee pain with movement. His physician was notified and an x-ray of his pelvis, left hip and knee was ordered.

A nursing progress note for Resident #57 dated 12/28/22 at 5:30 PM written by Nurse #1 revealed the result of his x-ray was received. His physician and family member were notified.

A nursing progress note for Resident #57 dated 12/28/22 at 5:40 PM revealed Resident #57 was sent to the emergency room via rescue squad transportation.

A review of the facility's initial allegation report revealed a report for an injury of unknown source

F 609

and Director of Nursing on 3/31/2023 regarding reporting within guidelines of 24 hours upon notification of injury and completing a follow-up report within 5 business days from initial report. Inservice completed on 3/31/2023. After 3/31/2023, all newly hired Administrator and/or Director of Nursing will be inserviced during orientation regarding timely reporting to state/local regulatory.
Nurse Consultant will audit resident reportables weekly x4 weeks then monthly x2 months utilizing Incident Reporting Audit Tool to ensure reporting to state regulatory agency is completed timely. Administrator will address concerns identified during audit.
Administrator will forward Incident Reporting Audit Tool to the Quality Assurance Committee monthly x2 months. The QA Committee will meet monthly x2 months to review Incident Report Audit Tool to determine trends and/or issues that may require further interventions put in place and to determine the need for further monitoring.

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F 609	Continued From page 6 was faxed to the state regulatory agency on 12/30/22 at 3:12 PM related to Resident #57 having a left hip fracture. The report was prepared by the facility's previous Administrator. The report further revealed the facility became aware of the incident on 12/28/22 at 5:30 PM. On 3/20/23 at 1:29 PM a telephone interview with the facility's previous Administrator indicated she recalled the incident with Resident #57. She stated he had a fall earlier in December 2022 when he tried to walk to an exit door that initially seemed to have not resulted in any injury. She went on to say while she did not recall who notified her, the time she became aware of Resident #57 having a fracture would have been the time she indicated on the initial report of the incident. She stated she began an investigation by talking with staff who were familiar with him and cared for him at the time of the incident and the Director of Nursing (DON). She went on to say their conclusion had been that the fracture likely resulted from the fall Resident #57 had earlier in the month because no other incidents had been identified. She stated when she reported this to the corporate team, she was advised on 12/30/22 that the time from the fall to when the fracture was identified was too long and she needed to report the fracture to the state regulatory agency as an injury of unknown source. She stated while she was aware that the timeframe for reporting this fracture as an injury of unknown source would have been 2 hours from the time the facility became aware of the incident, she wasn't advised by the corporate team to report it as such until 12/30/22. She stated the 5-day investigation report was sent 5 days after that.	F 609		

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F 609	Continued From page 7	F 609		

On 3/21/22 at 8:03 AM an interview with Resident #57's Physician indicated the facility was very quick to get x-rays after a fall if the resident was complaining of any pain. He stated this had not been the case for Resident #57 after his fall on 12/12/22. He indicated he saw Resident #57 at the facility after his fall and he had not been complaining of pain at that time. He further indicated when Resident #57 began complaining of new pain the facility immediately got an x-ray. He went on to say when this x-ray showed a fracture Resident #57 was sent to the hospital. The Physician stated what he thought likely happened was Resident #57 had the fracture after his fall on 12/12/22 but it had been non-displaced and thus had not been causing Resident #57 any pain. He stated as Resident #57 walked more and participated in therapy the fracture likely became displaced and began to cause him pain. He went on to say while he felt this was most likely, because Resident #57 had not had an x-ray after the fall on 12/12/22, he could not be certain.

On 3/21/23 at 9:57 AM an interview with the facility's Corporate Nurse Consultant indicated she had been involved in the discussion with the previous Administrator regarding Resident #57's fracture. She stated when the facility found out about a fracture, they were required to report this to the Corporate Risk Management Team. She went on to say while the Risk Management Team may have been notified of Resident #57's fracture on 12/28/22, they had not held a meeting until 12/29/22. The Corporate Nurse consultant stated this gave the facility time to start their investigation. She went on to say if there was a reasonable suspicion of a crime, the facility had 2 hours to report the incident to the state regulatory

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F 609	Continued From page 8 agency. She further indicated otherwise, the facility had 24 hours to report. She stated initially the facility was not considering the fracture an injury of unknown source. She went on to say they were attributing it to the fall he had on 12/12/22. She stated when the Risk Management Team held their review meeting, it was decided that because the fracture was identified so long after the fall, the facility should go ahead and report as an injury of unknown source. On 3/22/23 at 8:35 AM a telephone interview with Nurse #1 indicated she was familiar with Resident #57. She stated when he began complaining of new left hip and knee pain with movement she notified his physician. She stated an x-ray was ordered. She went on to say when the results came back showing that he had a hip fracture she notified Resident #57's physician, the DON, the Administrator and Resident #57's family member. She further indicated the physician advised her to send Resident #57 to the hospital which she did.	F 609		
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: §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	F 644		4/5/23

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F 644	Continued From page 9 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 request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 2 residents reviewed with a Level II PASRR (Resident #62). Findings included: Resident #62 was admitted to the facility on 10/31/22 with diagnoses that included intellectual disabilities. Review of the Resident #62's electronic medical record revealed an NC MUST (online system used for PASRR screenings) inquiry document dated 10/31/22 that indicated Resident #62 had a time-limited Level II PASRR ending in an "F" with an expiration date of 11/30/22. Review of the North Carolina Skilled Nursing Facility Preadmission Screening and Resident Review (PASRR) authorization codes document revealed a PASRR ending in "F" indicated a "Level II: 30, 60, or 90 day authorization for time limited skilled nursing facility stays". The admission Minimum Data Set assessment dated 11/07/22 revealed Resident #62 was coded as Level II PASRR with mental retardation.	F 644	F644 Resident #62 continue to reside in the facility and remain in stable condition. PASRR was completed for both resident on 3/27/2023. QAPI Director initiated 100% audit of all current residents to ensure each resident had up to date PASRRs. Admissions Director will address any concerns identified during the audit to include submitting information for PASARR evaluations for any resident who does not have a current PASRR, has an expired PASRR, or who has a need for a Level II PASRR review following changes in mental health status or new Level II qualifying diagnosis. Audit was completed on 3/27/2023. QAPI Director initiated an inservice regarding PASRRs with the Admissions Director, Social Worker, Minimum Data Nurse (MDS), and Director of Nursing with emphasis on referral for evaluation/re-evaluation of PASRR on admission, when PASRR expires, following changes in mental health status, or new Level II qualifying diagnosis. Inservice completed on 3/31/2023. After 3/31/2023, all newly hired Admission Director, Social Worker, Minimum Data	

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F 644	Continued From page 10 An interview on 3/21/23 at 9:19 AM with the Admissions' Coordinator revealed since the Social Worker (SW) was no longer employed at the facility, she was responsible for initiating and coordinating Level II PASRR reviews. She stated she was aware that some resident's PASRR had expired and had submitted renewals for some residents but was unaware that Resident #62's PASRR had expired. An interview on 3/21/23 at 10:31 AM with the Administrator revealed the PASRR process was for the SW to review the PASRRs to ensure they were renewed in a timely manner, but he did not think that the prior SW had been doing this.	F 644	Nurse (MDS), and/or Director of Nursing will be inservices during orientation regarding PASRR. Medical Director will review 10 residents charts weekly x4 weeks then monthly x1 month utilizing PASRR Audit Tool to ensure the resident has a current and accurate PASRR. Social Work, MDS Nurse and/or Admission Director will address all concerns identified during the audit. The Director of Nursing (DON) will review and initial the PASRR Audit Tool weekly x4 weeks than monthly x1 month to ensure all areas of concern have been addressed. Director of Nursing will forward PASRR Audit Tool to the Quality Assurance Committee monthly x2 months. The QA Committee will meet monthly x2 months to review PASRR Audit Tool to determine trends and/or issues that may require further interventions put in place and to determine the need for further monitoring.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		4/5/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 11 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post accurate nurse staffing information for 11 of 48 days reviewed for daily posted staffing. Findings included: Review of the daily posted staffing from February 2023 through March 2023 revealed the daily posted staffing sheets, with each individual staffing sheet reflecting all three shifts, were missing at least one shift of staffing information for the following days and shifts:	F 732	F732 No residents were affected by not posting Nurse Staffing Information On 3/27/2023 the Director of Nursing and IQ Nurse completed an audit of the Daily Staffing Sheets from 2/27/2023 to 3/27/2023 to ensure all sheets were completed accurately to include resident census and nursing staff hours per facility protocol. There were no additional concerns identified during the audit. On 3/27/2023 the QI Nurse in-serviced the Administrator, Director of Nursing, and	

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F 732	Continued From page 12 -February 2023: 2/6/23, 2/10/23, 2/12/23, 2/13/23, 2/16/23, 2/24/23, 2/25/23 and 2/26/23 were missing staffing information on the 7:00am to 3:00pm. 2/16/23 was missing staffing information on the 3:00pm to 11:00pm shift. 2/28/23 was missing staffing information on the 11:00pm to 7:00am shift. -March 2023: 3/7/23 and 3/14/23 were missing staffing information on the 3:00pm to 11:00pm shift. During an interview with the Administrator and Director of Nursing (DON) on 3-22-23 at 12:11pm, the DON discussed each shift nurse on hall 400 was responsible for completing the daily posted staffing sheet and provided an example of the 7:00am to 3:00pm nurse on hall 400 would complete the 7:00am to 3:00pm section of the daily posted staffing sheet and the 3:00pm to 11:00pm 400 hall nurse would complete the 3:00pm to 11:00pm section of the daily posted staffing then the 11:00pm to 7:00am 400 hall nurse would complete the 11:00pm to 7:00am section. She discussed believing the daily posted staffing was not completed in part due to a new nurse, who worked 7:00am to 3:00pm on the 400 hall was focused on learning nursing duties and not on completing the daily posted staffing sheet. The DON also stated she could not state why the other shifts also had not completed their section of the daily posted staffing sheet.	F 732	all clinical staff regarding Posting of Daily Staffing Sheet with complete information to include census at the beginning of each shift. Posting will be completed by the 400 Hall nurse. Inservice completed by 3/31/2023. After 3/31/2023, staff who have not worked will be inserviced prior to next scheduled shift. All new hired clinical staff will be inserviced in orientation regarding the posting of Daily Staffing Sheet. The DON, QI Nurse, and/or Nursing Supervisor will audit the Daily Staffing Sheets, to include weekends, daily x4 weeks and monthly x1 month to ensure daily posting includes complete information with emphasis on census and nursing staff hours prior to the beginning of the shift utilizing the Daily Staffing Audit Tool. Retraining will be completed immediately by the DON and/or QI Nurse for any identified areas of concern. The Administrator will review and initial Daily Staffing Audit Tool weekly x4 weeks then monthly x1 month for completion and to ensure all areas of concern have been addressed. The Administrator will forward the results of the Daily Staffing Audit Tool to the Quality Assurance Committee monthly x2 months. The QA Committee will meet monthly x2 months to review Daily Staffing Audit Tool to determine trends and/or issues that may require further interventions put in place and to determine the need for further monitoring.	
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5)	F 847		4/6/23

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§483.70(n) Binding Arbitration Agreements
If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

§483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

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§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:
Based on record review, resident representative and staff interviews the facility failed to explain the arbitration agreement to the resident representatives prior to having them sign the agreement. This occurred for 2 of 4 residents (Resident #18 and Resident #4) reviewed for arbitration.

Findings included:

The facility's "Resident and Facility Arbitration Agreement" dated 8-1-22 did not document the facility had offered the resident and/or the resident representative the opportunity to read the document in full or have the document read to them for understanding of what they were signing.

a. Resident #18 was admitted to the facility on 7-1-14.

The quarterly Minimum Data Set (MDS) dated 3-14-23 revealed Resident #18 was severely cognitively impaired.

A review of Resident #18's arbitration agreement form dated 2-27-23 revealed the resident's

F 847

F847
Residents #18 and #4 continue to reside in the facility and remain in stable condition and were not affected by prior Arbitration Agreement.
Residents/Resident Representatives who have executed the previous version of Arbitration Agreements, were notified of the revised Arbitration Agreement by the Admissions Coordinator or designee by 4-6-23. New admissions will be presented with and educated on revised Arbitration Agreement. Revised Arbitration Agreement reviewed and accepted prior to survey conclusion. Prior Arbitration Agreement has been archived and no longer in use.
On 3/27/2023, the Director of Nursing and QI Nurse completed an audit to identify residents and/or resident representatives that have previously executed Arbitration Agreements and presented resident/resident representative revised Arbitration Agreement for consideration. Audit completed on 3/27/2023.
The Admissions Director will present and educate the revised Arbitration Agreement

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representative signed the arbitration agreement.

Resident #18's representative was interviewed by telephone on 3-19-23 at 4:45pm. The representative stated the admissions coordinator had explained the form to her as a form needed in case something should happen to Resident #18's health, the Physician would be aware of the resident's wishes. The representative said the arbitration agreement was not explained to her as a legal document or that she was giving up her right to have any claims decided by a judge and jury. She further stated she may not have signed the agreement if she understood what she was signing.

b. Resident #4 was admitted to the facility on 3-2-20.

The annual Minimum Data Set (MDS) dated 2-18-23 revealed Resident #4 was severely cognitively impaired.

The review of Resident #4's arbitration agreement dated 2-16-23 revealed the resident's representative had signed the agreement.

A telephone interview with the resident's representative occurred on 3-19-23 at 3:08pm. The representative stated she had received the arbitration agreement in the mail with a letter instructing her to sign the form and return it to the facility. She said no one had explained the agreement to her and she was unaware of what she was signing. The representative explained if the form had been explained to her and she understood what the arbitration agreement was, she would not have signed the agreement.

F 847

to the identified residents/resident representatives as appropriate for consideration. All new admissions have been and will be presented with the revised Arbitration Agreement upon admission beginning on 3/27/2023.
The Director of Nursing and/or QI Nurse will audit at least 10% of new admissions weekly x4 weeks to ensure the revised Arbitration Agreement was utilized and presented to resident/resident representative for consideration. The Administrator will report findings of the audit to the QA Committee monthly x1 month. The QA Committee will review the audit to determine trends and/or issues that may need further interventions and the need for additional monitoring.

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F 847	Continued From page 16 The Admissions Coordinator was interviewed on 3-20-23 at 8:48am. The Admissions Coordinator discussed the facility receiving a new arbitration agreement from their legal department in August 2022. She stated once the new agreement was received, she proceeded in having the resident or their representatives sign the new agreement. The Admissions Coordinator explained some of the representatives were able to come to the facility to sign the agreement and other representatives had to have the new agreement sent to them by mail. She stated the representatives that came to the facility, she explained and/or read the agreement to them prior to them signing the agreement and the representatives that had their agreement mailed to them, she stated she told them she would explain the agreement if they had any questions. The Admissions Coordinator stated she was unaware of any of the representatives signing the agreement without understanding what they were signing. The Administrator was interviewed on 3-20-23 at 9:07am. The Administrator stated he would expect the residents and/or their representatives to have the arbitration agreement explained and to understand the arbitration agreement prior to signing.	F 847		
F 848 SS=D	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties.	F 848		4/6/23

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§483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident representative and staff interviews the facility failed to include the selection of a venue that was convenient to both parties in the arbitration agreement. This occurred for 3 of 4 residents (Resident #18, Resident #50 and Resident #4) who entered into an arbitration agreement with the facility.

Findings included:

a. Resident #18 was admitted to the facility on 7-1-14.

The quarterly Minimum Data Set (MDS) dated 3-14-23 revealed Resident #18 was severely cognitively impaired.

Review of the arbitration agreement signed on 2-27-23 by the resident's representative revealed there was no information to address the selection of a venue convenient to both parties.

During a telephone interview with Resident #18's representative on 3-19-23 at 4:45pm, the representative stated the admissions coordinator had not explained to her the right to select a venue that was convenient to both parties.

b. Resident #50 was admitted to the facility on

F848
Residents #18, #50 and #4 continue to reside in the facility and remain in stable condition and were not affected by prior Arbitration Agreement.
The Arbitration Agreement was revised to specify the selection of a venue convenient to both parties on 3-23-27.
Revised Arbitration Agreement reviewed and accepted prior to survey conclusion.
Prior Arbitration Agreement has been archived and no longer in use.
Residents/Resident Representatives who have executed the previous version of Arbitration Agreements, were notified and educated of the revised Arbitration Agreement by the Admissions Coordinator or designee by 4-6-23; and, notified of the option to sign the new agreement.
Admissions Director or designee will present and educate new admissions on revised Arbitration Agreement.
The Director of Nursing and/or QI Nurse will audit at least 10% of new admissions weekly x4 weeks to ensure the revised Arbitration Agreement was utilized and presented to resident/resident representative for consideration. The Administrator will report findings of the

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4-14-21.

The quarterly Minimum Data Set (MDS) dated 3-1-23 revealed Resident #50 was severely cognitively impaired.

Review of the arbitration agreement signed on 2-15-23 by the resident's representative revealed there was no information to address the selection of a venue convenient to both parties.

Resident #50's representative was interviewed by telephone on 3-19-23 at 3:00pm. The representative stated the arbitration agreement had been explained to her but she did not remember being informed of her right to select a venue that was convenient to both parties.

c. Resident #4 was admitted to the facility on 3-2-20.

The annual Minimum Data Set (MDS) dated 2-18-23 revealed Resident #4 was severely cognitively impaired.

Review of the arbitration agreement signed on 2-16-23 by the resident's representative revealed there was no information to address the selection of a venue convenient to both parties.

A telephone interview occurred with Resident #4's representative on 3-19-23 at 3:08pm. The representative stated the arbitration agreement was not explained to her and she did not remember reading anything in the agreement regarding her right to select a venue that was convenient to both parties.

The Admissions Coordinator was interviewed on

Provider's plan of correction (F 848):

audit to the QA Committee monthly x1 month. The QA Committee will review the audit to determine trends and/or issues that may need further interventions and the need for additional monitoring.

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F 848	Continued From page 19 3-20-23 at 8:48am. The Admissions Coordinator stated she was unaware of the parties involved in the arbitration agreement had the right to select a venue that was convenient to both parties. She stated when she explained the arbitration agreement to the resident or their representative she had not mentioned their right to select a venue. The Administrator was interviewed on 3-20-23 at 9:07am. The Administrator discussed not being employed by the facility when the new arbitration agreement had been released in August of 2022, so he had not reviewed the agreement. The Administrator explained he typically would review any new documentation requirements to ensure the document met regulation and he expected the arbitration agreement form to follow regulation.	F 848		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		4/5/23

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F 867	Continued From page 20 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	F 867		

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safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 22 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitoring interventions that the committee had previously put in place following the recertification and complaint investigation survey of 10-28-21. The deficiency was in the area of pre-admission screening and resident review (PASARR) (644). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag was cross referenced to: F644: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASARR) before the expiration date for 1 of 2 residents reviewed with a Level II PASARR (Resident #62).	F 867	F867 No residents were affected by deficient practice. On 3/27/2023, the Administrator initiated an audit of previous citations and actions plans for F644 Coordination of PASRR and Assessments to ensure the QA Committee has maintained and monitored interventions that were put in place. Action plans were revised and updated and presented to the QA Committee by QI Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include, but no limited to, education of staff. Audit was completed by 3/27/2023. On 3/31/2023 Facility Consultant completed an inservice with the Administrator, Director of Nursing, and Quality Assurance Nurse regarding the QA process and modification and correction if needed to prevent the recurrence of deficient practice to include	

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F 867	Continued From page 23 During the recertification and complaint survey on 10-28-21, the facility was cited for not referring a resident who had a diagnosis of a mental illness for a pre-admission screening and resident review (PASARR). The Director of Nursing (DON) and the Administrator were interviewed on 3-22-23 at 12:13pm. The DON explained the Social Worker who initially completed the PASARR assessments in 2021 was replaced, however the replacement had left the facility and the facility currently did not have a Social Worker to complete the PASARR assessments. The DON stated the PASARR assessment for Resident #62 "had fell through the cracks."	F 867	F644 citation of 10/28/2021. Inservice also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. Inservice was completed 3/31/2023. All newly hired Administrators, Directors of Nursing, and/or QA Nurses will be educated during orientation regarding an effective QA process. The QA Nurse will present data collected for identifying areas of concern, to include PASRR, to the QA Committee for review monthly x2 months. The QA Committee will review the data and determine if plan of correction is sustained. If changes are required to improve outcomes, if further education is required, and if increased monitoring is warranted. Minutes of the QA Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining and effective QA program by reviewing and initiating QA committee Quarterly meeting minutes and ensure implemented procedures and monitoring practices to address interventions, to include F644 and all current citations and that plans and corrections are maintained Quarterly x2 quarters. The Facility Nurse Consultant will immediately retrain the QA Committee members for any identified areas of concern Results of the monthly QA meeting will be presented by the QA Nurse to the Executive Committee Quarterly x2	

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F 867	Continued From page 24	F 867	quarters for review and the identification of trends, development of actions plans to determine the needed and/or frequency of continued monitoring.	
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 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)	F 888		4/5/23

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F 888	Continued From page 25 (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 exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;	F 888		

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F 888	Continued From page 26 (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 (x) Contingency plans for staff who are not fully vaccinated for COVID-19.	F 888		

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F 888	Continued From page 27 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 observations, record review and staff interviews the facility failed to: meet the requirement of 100 percent (%) staff COVID-19 vaccination rate which resulted in 2.2% of staff being partially vaccinated (Dietary Aide #1 and Housekeeper #1), implement an effective process for tracking COVID-19 vaccinations (Dietary Aide #2), and to follow their policy for source control at all times for staff who were not fully vaccinated (Dietary Aide #1). This was for 3 of 7 staff reviewed for COVID-19 vaccination status (Dietary Aide #1, Dietary Aide #2, and Housekeeper #1). The facility was not in outbreak status and had no positive cases of COVID-19 among residents. The facility's community transmission rate was moderate. Findings included: A review of the facility's Infection Control Manual last revised 12/12/22 Appendix A: COVID-19 Infection Prevention and Control Program Guidelines revealed in part, "9. Immunization Overview: [The facility] strives to provide and maintain a safe workplace for all employees, residents and visitors. Vaccinations have	F 888	F888 No residents were affected by 2.2% of staff being partially vaccinated nor affected by staff without source control. Three employees identified during the survey met requirement for vaccination with 1 receiving second dose, 1 receiving a medical exemption, and 1 not returning to work. On 3/27/2023, Director of Nursing review all vaccinated employees to ensure employees who require a 2-step COVID-19 vaccine received both doses of initial series. No areas of concern identified. 3/27/2023, QA Nurse completed education with Infection Control Nurse regarding appropriately tracking vaccine status of employees with emphasis on follow up of any required additional vaccination doses being provided to the employee timely. being given. On 3/27/2023, QA Nurse, Director of Nursing, and Nursing Supervisor initiated education with all staff regarding required source control if not completely vaccinated or	

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F 888	Continued From page 28 significantly reduced the mortality rate and provided for a reduction in serious illness of COVID-19 making nursing homes, both as a place to live and work, safer. In light of this, and in accordance with CMS (Centers for Medicare and Medicaid Services) mandates, [the facility] will require that all employees be fully vaccinated with some limited exceptions. Vaccination under this policy is a mandatory condition of employment unless a request for reasonable accommodation is approved. Vaccination Recommendations: a. Mandatory HCP (Health Care Personnel) Vaccination under this policy is a mandatory condition of employment unless a request for reasonable accommodation is approved. Applicants are required to be fully vaccinated and proof of full vaccination should be required at the time of hire. 3. Partial Vaccination: If the facility hires staff that are in the process of completing their vaccination series, these staff must follow the same guidelines as staff hired with approved exemptions which include wearing source control at all times." It further revealed, "The facility should maintain a log of [health care personnel] which includes employees, contracted staff, volunteers, and/or students' vaccination status." Review of the COVID-19 Staff Vaccination Status Matrix provided by the facility on 3/20/23 revealed 3 staff members of 92 total facility staff were partially vaccinated without an exemption. a. Review of the vaccination documentation provided by the facility revealed Dietary Aide #1's first day of work at the facility was 10/18/22. Dietary Aide #1 received the first dose on 10/17/22 and had not received a second dose. Dietary Aide #1 did not have an approved	F 888	during outbreak. Education also included when and what proper source control would be required in various occurrences of outbreak or non-outbreak scenarios. Educated will be completed 3/31/2023. After 3/31/2023, any employee who was not inserviced will complete inservice prior to beginning next scheduled shift. Newly hired employees will be inserviced during orientation to ensure knowledge of source control. QA Nurse will conduct weekly audits of vaccine tracking system and receipt of required second doses. Audits will be conducted weekly x4 weeks then monthly x1 month to ensure all employees receive all appropriate doses and/or have an approved medical or religious waiver. Infection Control Nurse, QA Nurse, and/or Nursing Supervisor will complete source control audits weekly x4 weeks then monthly x1 month to ensure employees are donning appropriate source control if not fully vaccinated and/or during outbreak. Employees will be re-educated immediately when a concern is identified. Further infraction of source control policy will result in disciplinary action. The QA Nurse will forward the results of the Vaccine Compliance to the Quality Assurance Committee monthly x2 months. The Infection Control Nurse will forward the results of Source Control Audits to the Quality Assurance Committee monthly x2 months. The QA Committee will meet monthly x2 months to review Daily Staffing Audit Tool to determine trends and/or issues that may require further interventions put in place	

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F 888	Continued From page 29 exemption. Review of Dietary Aide #1's timecard documentation for 3/7/23 through 3/21/23 provided by the facility revealed she was present working in the facility on 3/9/23 through 3/12/23, 3/16/23, and 3/18/23 through 3/20/23. On 3/20/23 at 11:47 AM an observation of Dietary Aide #1 revealed she was working in the facility kitchen. She was not wearing a source control mask. An interview with Dietary Aide #1 at that time indicated she did not wear a source control mask when working in the facility unless the facility's community transmission level was high. She went on to say in addition to working in the kitchen, she would deliver resident meal carts to resident halls and if a resident came to the kitchen door with a request for something, she would provide this to the resident. b. Review of the vaccination documentation provided by the facility revealed Housekeeper #1's first day of work at the facility was 2/7/23. Housekeeper #1 received the first dose on 9/3/21 and had not received a second dose. Housekeeper #2 did not have an approved exemption. Review of Housekeeper #1's timecard documentation for 3/7/23 through 3/21/23 provided by the facility revealed she was present working in the facility on 3/8/23, 3/11/23 through 3/13/23, 3/15/23 through 3/17/23, and 3/20/23. On 3/20/23 at 1:03 PM an observation of Housekeeper #1 revealed she was working in the facility wearing a source control mask.	F 888	and to determine the need for further monitoring.	

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On 3/20/23 at 3:05 PM an interview with the Housekeeping Supervisor indicated she was aware Housekeeper #1 was not fully vaccinated. She stated Housekeeper #1 was required to wear a source control mask when working because of this. On 3/21/23 at 1:33 PM a follow-up interview with the Housekeeping Supervisor indicated she had no role in ensuring employees received their vaccines. She stated the Staff Development Coordinator (SDC) did this and would let her know when employees received their vaccine.

c. Review of the vaccination documentation provided by the facility revealed Dietary Aide #2's first day of work at the facility was 12/1/22. Dietary Aide #2 received the first dose on 11/30/22 and had not received a second dose. Dietary Aide #2 did not have an approved exemption.

Review of Dietary Aide #2's timecard documentation for 3/7/23 through 3/21/23 provided by the facility revealed he was present working in the facility on 3/10/23 through 3/13/23 and on 3/21/23.

On 3/21/23 at 1:23 PM an observation of Dietary Aide #2 revealed he was working in the facility kitchen. He was not wearing a source control mask. In an interview at that time Dietary Aide #2 stated he did not wear a source control mask when working. He stated he had gotten the second dose of vaccine but had not provided the information to the facility. He stated he did not have his vaccine card with him and did not recall when he had gotten his second dose.

On 3/21/23 at 3:31 PM an interview with the facility Infection Preventionist (IP) indicated the

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F 888	Continued From page 31 Staff Development Coordinator (SDC) was responsible for ensuring staff were fully vaccinated. He stated it was his understanding that employees were required to be fully vaccinated or have an approved exemption. He went on to say employees who were not fully vaccinated or had exemptions were required to wear source control masks when working even if the facility's community transmission level was not high. On 3/21/23 at 1:49 PM an interview with the SDC she indicated she had no information regarding Dietary Aide #2 receiving his second dose of vaccine. She stated it used to be that employees had to be fully vaccinated when they were hired but it had gotten looser lately. She went on to say now employees could be hired if they had received their first dose of vaccine if they received their second dose in a timely manner. She further indicated she would notify department heads if employees were not fully vaccinated or had exemptions because these employees were required to wear source control masks when working. The SDC stated she let the Dietary Manager know that Dietary Aide #1 and Dietary Aide #2 were not fully vaccinated. She went on to say she had not seen Dietary Aide #2 in a while. She went on to say she had spoken to Dietary Aide #1 last week and let her know that the facility was going to get some vaccine ordered and she would give her second dose. She further indicated Housekeeper #1 had a bad reaction to her first dose of the vaccine and was hesitant to get a second dose. The SDC stated she let Housekeeper #1 know she would have to get a doctor's note and an approved exemption if she did not want to get it. She went on to say this had not happened yet. She further indicated she really	F 888		

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did not think it was a big rush for employees to get the second dose. She stated Dietary Aide #1, Dietary Aide #2, and Housekeeper #1 should be wearing source control masks while working until they provided proof of being fully vaccinated.

On 3/21/23 at 1:51 PM an interview with the Dietary Manager indicated when she first took over as the Dietary Manager the previous Dietary Manager let her know that she had 2 employees in the kitchen who had been granted vaccine exemptions. She stated she was aware that these 2 employees with exemptions were required to wear source control masks when they worked. She further indicated she did not keep up with staff vaccination status and had been unaware that Dietary Aide #1 and Dietary Aide #2 were not fully vaccinated. The Dietary Manager went on to say while she did monitor the exempted employees for mask wearing and she had not been monitoring Dietary Aide #1 and Dietary Aide #2.

On 3/22/23 at 11:36 AM an interview with the Administrator indicated he thought what was happening was the facility was not following up with tracking employee vaccination status. He stated his role in this process was minimal. He went on to say the SDC gathered employee vaccination status on hire and reported that to him. He further indicated he entered the information into the tracking tool. The Administrator stated the SDC needed to track to be sure employees who were not fully vaccinated either had an approved exemption or got their second dose of vaccine when they were eligible. He further indicated he was not sure whether it was the facility's policy that employees needed to be fully vaccinated on hire as he had not read it.

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