STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted 3/7/22 though 3/9/22. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b) (6), Subpart-B-Requirements for Long Term Care Facilities. Event ID # T9BV11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation was conducted on 3/7/22 through 3/9/22. The facility was found not in compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices related to staff vaccinations to prepare for COVID-19. 13 of the 82 complaint allegations were substantiated resulting in deficiencies. Intake Numbers: NC00177838, NC00177862, NC00178309, NC00179652, NC00180629, NC00181130, NC00182239, NC00182265, NC00182444, NC00183507, NC00183616, NC00183641, NC00183675, NC00184592, NC00184729, NC00184776, NC00184803, NC00184835, NC00184943, NC00185025, NC00185407, NC00185419, NC00185834, NC00186068, NC00186138, NC00186313, NC00186347 On 4/6/22 the 2567 was amended to reflect changes as a result of the IDR.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		3/10/22

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

Electronically Signed | 03/31/2022

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F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations, the facility failed to provide a dignified dining experience by standing while assisting a resident with eating for 1 of 14 residents reviewed for dignity (Resident #16). Findings Included: Resident #16 was admitted to the facility on 11/29/21 with diagnoses that included cerebral infarction. The Medicare 5-day Minimum Data Set (MDS) revealed Resident #16 had moderate cognitive impairment and required supervision for eating with 1 person physical assist. A continuous observation was completed on 3/7/22 from 1:19 PM to 1:22 PM during the lunch mealtime. Nursing Assistant (NA) #9 was observed standing next to Resident #16 ' s bed providing him assistance with eating his meal. An interview was conducted with NA #9 on 3/7/22 at 1:22 PM and she stated she knew she was to provide meal assistance while seated next to the resident. She stated she did try looking for a chair. An observation was completed on 3/7/22 at 1:23 PM of NA #9 getting a chair from inside Resident #33's room and placing it next to his bed. An interview was conducted with the Administrator on 3/9/22 at 11:50 AM and she stated meal assistance should be provided while	F 550	F 550 1. The facility failed to maintain Resident #16 dignity when the Nursing Aide (NA) #9 was observed standing next to Resident #16□s bed providing him assistance with eating his meal. NA #9 received education on Promoting Resident's Dignity During Mealtimes on 3/9/2022 by Director of Nursing on 3/9/2022. 2. All current dependent residents that are needing assistance with feeding have the potential to be affected by the alleged practice. An audit was completed by Unit Managers, Staff Development Coordinator Nurse and Director of Nursing, on all current residents who are assist with meals and staff to ensure that all staff Certified Nursing Assistant, Personal Care Assistants and/or License Nurses are seated while feeding a resident. This audit will be completed by 3/31/2022. 3. All nursing staff, which includes agency staff before their first assignment, will be educated by DON and/or nurse managers regarding expectations that the residents are to be fed with staff in seated position to promote dignity. Nursing staff were also educated on promoting/maintaining resident dignity. This education, provided in person or via telephone, will be completed 3/31/2022. Effective 3/31/2022 any current Licensed Nurse, Certified Nursing Assistant and/or	

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F 550	Continued From page 3 seated next to the resident to maintain dignity of the resident.	F 550	Personal Care Aide that has not been educated will not be allowed to work until received education in- person or via telephone by Director of Nursing and/or designee. Nurse managers will audit (5) nursing staff to ensure staff is sitting while feeding the resident. assist with meals resident list at each meal pass. Audit will be conducted 3x weekly x 4weeks, weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 month, along with auditing random shifts. Director of Nursing will review the results of the weekly audits to ensure any issues identified are corrected. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing.	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		3/31/22

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F 636	Continued From page 4	F 636		

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive

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F 636	Continued From page 5 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit comprehensive Minimum Data Set (MDS) assessments within the regulatory time frames as specified in the Resident Assessment Instrument (RAI) manual for 2 of 30 residents reviewed. (Resident #1, Resident #2) Findings included: 1. Resident #1 was admitted to the facility on 1/10/2022 with a diagnoses of a fractured right femur. Review of Resident #1's electronic medical record revealed the admission MDS had not been completed or transmitted in the timeframe outlined in the RAI manual. The assessment was forty-five days overdue. 2. Resident #2 was re-admitted to the facility on 1/24/2022 with a diagnoses of sepsis. Review of Resident #2 's electronic medical	F 636	Based on record review and staff interviews, the facility failed to complete and transmit comprehensive Minimum Data Set (MDS) assessments within the regulatory time frames as specified in the Resident Assessment Instrument (RAI) manual for 2 of 30 residents reviewed. (Resident #1, Resident #2). Effective 3/31/2022 residents admitted 3/8/2022 through 3/31/2022 was reviewed to ensure MDS Comprehensive Assessments were completed. Resident #1 Admission MDS assessment was completed on 3/24/2022. (The ARD was 1/17/2022.) Resident #2 does not require a full comprehensive assessment. He was re-admitted to the building. His annual MDS was 10/13/2021. He had a quarterly MDS completed 2/24/2022 (scheduled 1/11/2022).	

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F 636	Continued From page 6 record revealed the admission MDS had not been completed or transmitted in the timeframe outlined in the RAI manual. The assessment was forty days overdue. An interview with the Corporate Vice President of Clinical Reimbursement on 3/9/2022 at 9:07 a.m. revealed that the MDS position had been open for sixty days. She stated the Clinical Corporate Specialist was at the facility once a week and part-time staff assisted with MDS assessments as needed. She stated comprehensive admission assessments were to be completed within fourteen days of admission. An interview with the Administrator on 3/9/2022 at 9:28 a.m. revealed that comprehensive MDS assessments were to be completed accurately by the due date. An interview with the Clinical Corporate Specialist (MDS Nurse) on 3/9/2022 at 10:09 a.m. revealed the facility did not have a permanent MDS Nurse in the facility. She stated she was in the facility once a week and monitored the electronic records remotely to review MDS data workload. She stated comprehensive assessments were due within fourteen days of admission.	F 636	Effective 3/31/2022 current residents were reviewed by Regional MDS Nurse to ensure Comprehensive Assessments were completed within the required timeframe. Effective 3/31/2022 Regional MDS Consultant will educate new MDS nurses on completing the comprehensive MDS within the required timeframe. Administrator will audit 5 comprehensive assessments weekly to ensure comprehensive assessments are completed within the required timeframe for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 months for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	F 638		3/31/22

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F 638	Continued From page 7 Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 2 of 2 residents reviewed for timely quarterly MDS assessments. (Resident #3, Resident #7) Findings Included: 1. Resident #3 was admitted to the facility on 10/26/2021. Record review revealed Resident #3's admission MDS assessment was completed on 11/1/2021, and an incomplete quarterly MDS assessment with an assessment reference date (ARD, the last day of look back period) of 2/1/2022 was twenty-two days overdue. On 3/9/2022 at 9:07 a.m. in an interview with the Corporate Vice President Clinical Reimbursement, she stated the MDS position had been open for sixty days. She stated the Clinical Corporate Specialist was at the facility once a week and part-time staff assisted with MDS assessments as needed. She stated quarterly assessments needed to be completed every three months. On 3/9/2022 at 9:28 a.m. in an interview with the Administrator, she stated quarterly MDS assessments were to be completed accurately by the due date. On 3/9/2022 at 10:09 a.m., in an interview with the Clinical Corporate Specialist (MDS), she stated the facility did not have a permanent MDS Nurse in the facility. She stated she was in the facility once a week and monitored the electronic	F 638	Based on record review and staff interviews, the facility failed to complete a quarterly Minimal Data Set (MDS) assessment within the required time frame for 2 of 2 residents reviews for timely quarterly MDS assessments. (Resident #3, Resident #7). Resident #3 Quarterly MDS was completed on 3/14/2022. (Scheduled ARD was 2/1/2022) Resident # 7 Quarterly MDS was completed on 3/10/2022. (Scheduled ARD was 1/17/2022) Effective 3/31/2022 current residents were reviewed by Regional MDS Nurse to ensure Quarterly Assessments were completed within the required timeframe. Effective 3/31/2022 Regional MDS Consultant to educate new MDS nurses completing Quarterly MDS assessments in the required time frame. Administrator will audit 5 quarterly assessments weekly to ensure Quarterly MDS are completed in the required time frame for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 months for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 638	Continued From page 8 records remotely to review MDS data workload. She stated quarterly assessments were due ninety-two days after the admission assessment, and Resident #3's quarterly assessment was overdue. 2. Resident #7 was admitted to the facility on 12/18/20. A review of the resident's MDS assessment revealed the last assessment was the completed Annual MDS dated 10/16/21, and as of 03/09/22, no other MDS assessment was listed in Resident #7's medical record. In an interview on 03/09/22 at 10:10 AM Corporate MDS Nurse stated the quarterly review should have been completed by 02/01/22. The MDS Nurse indicated the reason the assessment was late was because the facility was short staffed with no MDS Nurse and she was scheduled to visit the facility one day a week to complete all resident MDS assessments, which was not enough time, resulting in the facility having late MDS assessments. She indicated the facility was currently in the process of hiring an MDS nurse. In an interview on 03/09/22 at 10:25 AM the Regional Director of Clinical Services and Administrator stated they expected all the MDS assessments to be completed in a timely manner per the regulation.	F 638		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		3/31/22

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F 655	Continued From page 9	F 655		

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details

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F 655	Continued From page 10 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan for 1 of 1 resident reviewed for care plans. (Resident #1) Findings included: Resident #1 was admitted to the facility on 1/10/2022. His diagnoses included fractured right femur. Resident #1's care plan dated 1/14/2022 contained one focus area, nutrition. A record review on 3/9/2022 revealed Resident #1's admission Minimum Data Set (MDS) assessment dated 1/17/2022 was incomplete and in progress. On 3/9/2022 at 9:15 a.m. in an interview with the Director of Nursing, she stated a baseline care plan and a comprehensive care plan had been completed for Resident #1. She stated the nursing staff should have started the baseline care plan on admission, and the MDS nurse should have completed a comprehensive care plan.	F 655	Resident #1 was admitted to the facility on 1/10/2022. A record review on 3/9/2022 revealed that Resident #1's admission Minimum Data Set (MDS) assessment dated 1/17/2022 was in complete and in progress. Education of Baseline Care Plan and Comprehensive Care Plans were completed by Director of Nursing and done with nursing staff on 3/28/2022. 2. Effective 3/14/2022 residents admitted 3/8/2022 through 3/28/2022 was reviewed to ensure Baseline Care Plans were completed and accurate. 3. Effective 3/28/2022 Director of Nursing and/or designee will education current license nurses and agency staff before their first assignment on ensuring a Baseline Care Plan is completed and accurate upon a new admission. In person or via telephone. Effective 3/30/2022 any current License Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee. 4. Director of Nursing and/or designee will audit new admissions to ensure a Baseline Care Plan was completed weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 months for further problem resolution if needed. Person Responsible: Director of Nursing Completion date: 3/31/2022	

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to date three opened insulin medications for 3 of 4 medication carts (2-A, 1-B and SCU) used for medication administration. Findings Included: 1. On 03/08/2022 at 8:00 AM, observation of the medication administration cart known as "2-A"	F 761	1. Facility failed to label medications with the minimum identifying information required dating insulin vials in medication carts and medication room. Failed to store medications in accordance with the manufacturer's storage instructions. On 3/8/2022, medication cart 2-A with Nurse #8 revealed the following medication was open and without an open date: one Lantus SoloStar Flex Pen, 100 units, 3ml	3/31/22

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	345081	A. BUILDING _____ B. WING _____	C 03/09/2022

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F 761	Continued From page 12 with Nurse #8 revealed the following medication was open and without an open date: one Lantus SoloStar Flex Pen (insulin for Diabetes), 100 units/mL (units per milliliter), 3mL for Resident #5. A review of the manufacturer 's recommendation for the use of Lantus SoloStar® Flex Pens revealed they can be used for up to 28 days after the initial opening. An interview with Nurse #8 on 03/08/2022 at 8:10 am revealed the insulin pen should have had a written date on the insulin pen when the seal was broken. She also stated without a written date on the pen, there would be no way of knowing when the pen would expire. Nurse #8 stated the insulin pen would expire 28 days after opening of the insulin pen. 2. On 03/08/2022 at 8:22 AM, observation of the medication administration cart known as "SCU" with Nurse #6 revealed the following medication was open and without an open date: one Novolog Flex Pen (insulin for Diabetes) for Resident #4. A review of the manufacturer 's recommendation for the use of Novolog Flex Pens revealed they can be used for up to 28 days after the initial opening. An interview with Nurse #6 on 03/08/2022 at 8:37 am revealed there should have been an open date written on the insulin pen when the seal was broken, and the pen was first used. Nurse #6 stated the undated insulin pen could not be used and would need to be discarded. 3. On 03/08/2022 at 9:00 AM, observation of the	F 761	for Resident #5. A review of the manufacturer□s recommendation for the use of Lantus SoloStar Flex Pens revealed they can be used for up to 28 days after the initial opening. On 3/08/2022, observation of the medication cart SCU with Nurse #6 revealed the following medication was open and without an open date: one Novolog Flex Pen for Resident #4. A review of the manufacturer□s recommendation for the use of Novolog Flex Pens revealed they can be4 used for up to 28 days after the initial opening. On 3/8/2022 expired medications were removed and discarded properly by pharmacy customer service consultant. Medications were properly labeled. Medications were stored according to manufacturer's instructions. 2. All medication carts and medication rooms were audited by the pharmacy consultant. Expired medications were removed and discarded properly. Medications were properly labeled. Medications were stored according to manufacturer's instructions. This audit was conducted on 3/08/2022. 3. Director of Nursing and/or Staff Development Coordinator Nurse will educate license nurses and medication aides on removing and discarding expired medications properly, labeling medications with minimum identifying information and storing medications according to manufacturer's storage	

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F 761	Continued From page 13 medication administration cart known as "1-B" with Nurse #7 revealed the following medication was open and without an open date: one Lantus SoloStar Flex Pen (insulin for Diabetes), 100 units/mL (units per milliliter), 3mL for Resident #2. A review of the manufacturer 's recommendation for the use of Lantus SoloStar® Flex Pens revealed they can be used for up to 28 days after the initial opening. An interview with Nurse #7 on 03/08/2022 at 9:11 am revealed all opened insulin pens should have a written date on them which would indicate when the pen was first opened. Nurse #7 stated insulin pens expire 28 days after opening and without the knowing the open date, there would be no way of knowing when the pen would expire. Nurse #7 continued by saying she would discard the undated insulin pen and obtain a new one. An interview with the Director of Nursing (DON) on 3/08/2022 at 9:53 am revealed all insulin pens should be dated with an opened date at the time when the seal is broken and should be discarded 28 days after opening.	F 761	instructions. This education will be completed by 3/31/22. Newly hired licensed nurses and medication aides will receive education during orientation. Director of Nursing and/or nurse managers will audit 5 medication carts and medication rooms weekly x 12 weeks to ensure that medications are labeled with minimum identifying information required and that medications are stored in accordance with the manufacturer□s storage instructions. The weekly audit will include all medication carts and medication rooms. Director of Nursing will review the results of the audit weekly to ensure that medications are labeled with minimum identifying information required and that medications are stored in accordance with the manufacturer□s storage instructions. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person responsible: Director of Nursing Completion Date: 3/31/22	
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		3/31/22

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F 888	Continued From page 14 §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)(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.	F 888		

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§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;
(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

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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.

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

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F 888	Continued From page 17 the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to fully vaccinate employees when two partially vaccinated staff members were observed working inside the facility (Nursing Assistant #9, Nursing Assistant #10), after the Centers for Medicare & Medicaid Services (CMS) Phase-2 Requirement requiring all staff to be fully vaccinated, by 02/28/22. This was for 2 of 8 staff reviewed for COVID-19 vaccination status. The facility had no positive cases of COVID-19 among residents. Findings included: The facility's "Employee COVID-19 Vaccination Mandate Policy", revised 12/28/21, included, "Compliance Guidelines: facility will ensure that all eligible employees are fully vaccinated against COVID-19, unless religious or medical exemptions are granted. Employees, who provide any care, treatment, or other services for the facility and/or its residents regardless of clinical responsibility or resident contact are required to be fully vaccinated against COVID-19. These include the following: a. Facility employees b. Licensed practitioners c. Students, trainees, and volunteers; and d. Individuals who provide care, treatment, or other services for the facility and/or its residents. under contract or by other arrangement." As requested, the Regional Director of Clinical	F 888	Corrective Action for Covid □ 19 Vaccination of Facility staff 1. Nursing Assistant #9 (NA #9) and Nursing Assistant #10 (NA#10) were not fully vaccinated by 2/28/2022 and were working in the facility. On 3/9/2022 NA#9 was educated on being fully vaccinated and allowed to work now that she is fully vaccinated. NA#9 was fully vaccinated on 3/8/2022. On 3/9/2022 NA#10 was sent home and not allowed to come back to work until the 3/10/2022 after showing her vaccination card proving that she was fully vaccinated. 2. On 3/10/2022 All staff brought in their vaccination cards to show that they were current with their vaccinations and a copy of their cards were made and are now kept in a binder and on a spreadsheet. No staff will be allowed to work until they are fully vaccinated. 3. On 3/10/2022 Staff Development Coordinator and Director of Nursing educated current nursing staff, agency staff, therapy staff, dietary staff, maintenance, and housekeeping staff on the Covid 19 Vaccination policy. No staff will be allowed to work until they have been educated on the Covid Policy effective date 3/10/2022. 4. All new staff must bring in their vaccination card to ensure vaccination	

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F 888	Continued From page 18 Services provided a list of partially vaccinated employees that included Nursing Assistant (NA) #9 and NA #10 (Agency Staff). a. An observation of NA #9, a partially vaccinated staff member, was made on 03/07/22 at 12:54 PM. She was observed working as an NA on the skilled care unit hall. NA #9 had 12 to 14 residents assigned to her and she said she was able to complete her assignments timely. A review of working staff time sheets on 03/09/22 revealed NA #9, a partially vaccinated staff member worked as an NA in the facility on 03/07/22. A review of NA #9's COVID-19 vaccination card revealed: NA #9 received her 1st vaccination dose on 12/03/21 and her 2nd vaccination dose on 03/08/22. b. During an interview with NA #10 (agency staff) on 03/09/22 at 10:32 AM stated she had worked for the agency for 3-months and her agency and facility mandated that she be vaccinated. She stated she had received the COVID-19 vaccine on her own. She stated the facility verified her vaccination and had gotten her first COVID-19 vaccine on 01/31/22 and was scheduled to receive the 2nd COVID-19 vaccine today (3/9/22). She stated the facility performed a screening (temperature checked and asked COVID-19 screening questions) prior to entering the workplace and was tested for COVID two times per week (Mondays and Thursdays). A review of working staff time sheets on 03/09/22 revealed NA #10, a partially vaccinated agency staff member worked as an NA in the facility on 03/07/22, 03/08/22, and 03/09/22.	F 888	according to The Center of Disease Control and Prevention before they can start working their shift. The receptionist will collect all vaccination cards new staff is coming in. This will be reviewed weekly 12 weeks. Results of these reports will be presented to the quarterly Quality Assurance committee x 3 months by the Administrator to ensure corrective action Person Responsible: Administrator Completion Date : 3/31/2022	

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A review of NA #10's COVID-19 vaccination card revealed: NA #10 received her 1st vaccination dose on 01/31/22 and as of 03/09/22 she had not obtained her 2nd vaccination dose.

During an interview with the Administrator on 03/08/22 at 10:50 AM., she stated she compared a listing of all staff who worked at the facility (Agency & Facility Staff) with the staffs' COVID-19 vaccination cards and stated that all staff were 100% vaccinated per facility's Vaccination Mandate Policy.

During an interview with the Regional Director of Clinical Services on 03/09/22 at 12:26 PM revealed it was her expectation that all staff to have been 100 % fully vaccinated by 02/28/22, per CMS requirement.

During an interview with the Regional Director of Clinical Services and Administrator on 03/09/22 at 1:35 PM revealed it was their expectation that all staff to have been 100 % fully vaccinated per facility policy, which NA #9 and NA #10 did not meet. They both explained going forward, all staff would be 100% fully COVID-19 vaccinated, with verified vaccinations, before they would be allowed to work inside the facility.