STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING ______ B. WING ______	C 07/15/2022

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WINDSOR POINT CONTINUING CARE	**1221 BROAD STREET FUQUAY VARINA, NC 27526**

(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 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		8/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/04/2022

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

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to do an annual review of the emergency preparedness plan. The findings included: A review of the facility's EP manual on 7/1/22 revealed there was no evidence of a review of the emergency preparedness plan since January 2020. An interview was conducted with the Administrator on 7/1/22 at 3:06 PM. The Administrator stated she believed the EP plan was updated in January but was unable to locate any evidence on her computer system. The Administrator indicated she would be responsible for updating the EP plan and conducting the annual exercises.	E 001	Windsor Point Continuing Care Retirement Community proposes this plan of correction in order to maintain compliance with all applicable rules set forth by the Federal and State regulations. We will continue to provide quality care to all of our residents. This plan of correction is submitted as our written allegation of compliance. Windsor Point's response to this statement of deficiencies does not constitute agreement with the deficiencies nor does it decree concurrence that any deficiency imposed an adverse effect upon the quality care that is delivered to our residents. The comprehensive Disaster Preparedness plan was located on the Admissions Coordinator computer and last was reviewed on February 1, 2022. Administrator reviewed the 2/1/2022 plan on 7/1/2022 and transferred the Emergency Plan to the Administrator Computer. No updates were needed at this time. The Administrator will review, evaluate, and update the Disaster Preparedness Plan as necessary and annually and include the date of such reviews and/or updates in the plan document.	

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E 001	Continued From page 2	E 001	A QA tool entitled disaster preparedness will be utilized weekly for 4 weeks then monthly for 3 months, and then as needed to ensure that the Disaster Preparedness plan is reviewed. Any variances needed for the complete Emergency Preparedness Plan will be presented to the Quality Assurance and Performance Committee for review to be included in the plan as an update.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 06/27/22 through 07/15/22. Event ID# GULJ11. The following intake was investigated: NC00190184. One of the one complaint allegations was not substantiated. Immediate Jeopardy was identified at: CFR 483.80 at tag F888 at a scope and severity (J) Immediate Jeopardy began on 06/16/22 and was removed on 07/15/22. The Statement of Deficiencies (2567) was amended to reflect changes as result of the IDR conducted on 07/29/22.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		8/4/22

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F 640	Continued From page 3	F 640		

requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

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F 640	Continued From page 4 initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and transmit discharge Minimum Data Set (MDS) assessments for a resident (Resident #6) and failed to transmit an assessment for a resident (Resident #12). This was for 2 of 3 residents reviewed for Resident Assessment. The findings included: 1. Resident #6 was discharged from the facility on 2/16/22. Record review revealed no discharge MDS was completed for Resident #6. An interview was conducted with the MDS Nurse on 7/1/22 at 10:52 AM. She stated a discharge MDS should have been completed and transmitted for Resident #6. The nurse stated she began working at the facility on 4/16/22. She stated she was unaware the assessment had not been completed. During an interview with the Administrator on 7/1/22 at 3:14 PM she stated the former MDS Nurse left the facility in January. She reported the former MDS Nurse assisted on a part-time basis until a new MDS Nurse was hired in April.	F 640	The preparation and execution of this plan of correction does not constitute an admission of agreement by Windsor Point. Windsor Point proposes this plan of correction in order to maintain compliance with the state and federal regulations. We will continue to deliver quality care to all of our residents without decreeing concurrence that any deficiency imposed an adverse effect upon the quality of care that we provide. The discharge MDS for Resident #6 was completed on 7/1/2022. The discharge MDS for Resident #6 was transmitted on 7/1/2022. The discharge MDS for Resident #12 was transmitted on 7/1/2022. All of the residents discharged in the year 2022 were audited by the MDS Nurse to ensure that all discharge assessments were completed and transmitted. The MDS Nurse will audit discharges twice per week to ensure completion of a	

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F 640	Continued From page 5 She stated completion of the Resident #6's discharge assessment must have been overlooked. 2. Resident #12 was discharged from the facility on 2/16/22. A discharge MDS dated 2/17/22 was completed but not transmitted for Resident #12. An interview was conducted with the MDS Nurse on 7/1/22 at 10:52 AM. She stated a discharge MDS was completed but not transmitted for Resident #12. The MDS Nurse stated the assessment should have been transmitted. She reported she transmitted assessments weekly. The nurse stated she began working at the facility on 4/16/22. She stated she was unaware the assessment had not been transmitted. During an interview with the Administrator on 7/1/22 at 3:14 PM she stated the former MDS Nurse left the facility in January. She reported the former MDS Nurse assisted on a part-time basis until a new MDS Nurse was hired in April. She stated transmission of the assessment must have been overlooked.	F 640	discharge MDS and transmission of the completed discharge MDS via a modified Resident Status Checklist form. The MDS Nurse will report any findings/corrections from the audits to the Quality Assurance and Performance Committee for any additional audits or modification of this plan to transmit and complete a timely discharge MDS. The QAPI Committee will update this correction plan accordingly to ensure facility compliance. The Director of Nursing will be responsible for follow-up with this plan.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		8/4/22

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F 812	Continued From page 6 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure that food items that had been opened were securely closed, labeled, and dated. The facility also failed to maintain equipment used to prepare, store, and serve food in a sanitary condition. This was evidenced by carts and equipment that had a heavy accumulation of grease and dark matter, items that were stained, and an item with areas that were rusted through the metal surface. This was evident in 2 of 2 kitchen observations. Findings included: An observation of the facility kitchen on 6/27/2022 at 10:03 AM revealed the following: 1. In the reach-in refrigerator, there were two small clear plastic bags of shredded yellow cheese that were opened and not labeled and dated. Both bags were also open and exposed to the air in the refrigerator. An observation of the facility kitchen on 6/29/2022 at 9:50 AM revealed the following:	F 812	1. The two small, clear, plastic bags of shredded cheese that were opened, dateless and unlabeled were discarded on 6/27/2022. 2. a. On the open storage rack in the kitchen, 14 metal sheet pans that were reported to have heavy accumulation of thick, black grease around all four sides of each of the sheet pans were discarded. b. Four plastic rolling bins in the kitchen that contain sugar, rice, flour and seafood breader have all been dated. c. Three drains in the floor under 3 sinks that are labeled meat, poultry, and vegetable have been cleaned. New drain covers have been installed. d. The unused drain in the floor under the work table that holds juice equipment has been cleaned and the coffee mug was removed. e. The can opener blade has been	

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F 812

Continued From page 7

2. a. On an open storage rack in the kitchen, 14 metal sheet pans were observed to have heavy accumulation of thick, black grease around all four sides of each of the sheet pans.

b. Four plastic rolling bins in the kitchen that contained sugar, rice, flour, and seafood breader were observed. Each of the bins was observed to have food product in them and none of them are dated. Each of the bins were labeled.

c. Three drains in the floor under 3 sinks that were labeled meat, poultry, vegetable were observed. Each of the three drains were open and were stained with dark brown matter.

d. One drain in the floor under a worktable that holds juice equipment was observed. This drain did not have a line draining into it and was not being used. The drain was stained with dark brown matter and there was an empty plastic coffee mug in the drain.

e. One can opener that was mounted on a metal worktable was observed to have a heavy accumulation of food on the blade of the can opener.

f. A white plastic scoop that was used in the ice machine was observed to be heavily soiled. There were marks of dark black matter on the inside of the scoop.

g. A large open metal cart that had the capacity to hold 10 sheet pans was observed positioned next to the stove area. The metal cart was observed to be soiled with a heavy accumulation of grease and dark matter. There were two areas on the lower ledge of the cart that

F 812

cleaned.

f. The white plastic ice scoop has been cleaned. A new ice scoop has been ordered and received.

g. The large metal cart that has the capacity to hold 10 sheet pans has been replaced.

h. The large grey/black, heavy, plastic, divided service cart has been deep cleaned.

i. The small grey/black, heavy plastic, divided service cart has been deep cleaned.

j. All of the square dollies that hold the racks for the dish machine have been cleaned and/or replaced.

An in-service was conducted titled Proper Cleaning and Professional Standards for Food Service Safety by the Executive Director for the dietary staff. Topics included procedures for cleaning and the introduction of Sanitation Assignment forms.

The Registered Dietician will audit the sanitation assignments monthly to ensure proper sanitation and adherence to the assignments. The Administrator will receive the monthly reports and present the tools to the QAPI committee to ensure follow up and compliance.

The Administrator or designee will make

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F 812	Continued From page 8 were completely rusted through the metal surface. The dietary manager reported the cart is used to hold desserts, drinks, and cookies that were prepared for the residents and was currently being used in the kitchen to hold food and beverages for the residents. h. A large grey/black service cart that was made of heavy plastic was observed to have a divided area near the handle on the cart. The inside portion of the divided areas was observed to have a heavy accumulation of dark grey matter. i. A smaller grey/black service cart that was made of heavy plastic was observed also. This cart was also observed to have a divided area near the handle of the cart. The divided areas were stained with dark grey matter. j. One square rolling platform that held the racks for the dish machine and currently in use in the dish machine operation was observed to have some dark brown matter accumulated on the inside base of the rack. An interview with the dietary manager was conducted on 6/29/2022 beginning at 9:50 AM. She stated that all food items that have been opened should be labeled and dated. She also reported the large sheet pans probably need to be replaced because of the heavy accumulation of grease and dirt. She reported the sheet pans are used several times daily in preparation for resident meals and should be washed completely between each use. The dietary manager reported the open metal cart that can hold 10 large sheet pans was used to hold desserts, drinks, and cookies that were prepared for the	F 812	rounds in the kitchen weekly to implement corrections and to provide oversight.	

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F 812	Continued From page 9 residents and was currently being used in the kitchen to hold food and beverages for the residents. The dietary manager stated she was unaware when the food product was placed in each of the 4 bins and stated she was unaware the bins should be dated. The dietary manager stated the drains that were observed in the floor need to be cleaned to remove the stains. She also stated the can opener and the scoop used in the ice machine need to be cleaned. The dietary manager stated the large, open metal cart that was used to hold the food and beverage for residents will probably need to be replaced because the rusted areas cannot be repaired. And she reported the divided areas on both grey/black carts need to be cleaned. The dietary manager also stated the rolling platform in the dish machine area needs to be thoroughly cleaned. The dietary manager confirmed that these items, except for 1 floor drain, were currently being used in the daily preparation of food and beverages for the residents. She reported that each of these items were on the dietary routine cleaning schedule but was unable to specify when these items were most recently cleaned. A staff interview with the administrator on 6/30/2022 at 10:25 AM revealed that all opened food items in the kitchen should be stored, labeled, and dated according to regulations and all equipment should be maintained in a sanitary condition.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814		8/4/22

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F 814	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the area surrounding the cardboard dumpster free from trash and debris. This was evident in 1 of 1 observation of the dumpster area. The findings included: An observation of the cardboard dumpster area on 6/29/2022 at 09:50 AM revealed there was one dumpster on a concrete pad and the doors and lid to the cardboard dumpster were closed. Behind the cardboard dumpster were four large plastic cooking oil containers that were each enclosed in cardboard boxes. Each of the oil containers had the capacity to hold 35 lbs. of cooking oil. And each of the cardboard boxes that contained the jug-like containers were observed to be a dark blackish, brown color and were shriveled, wrinkled, saturated with oil and appeared to be in the process of decomposition and showed signs of rotting and decay. Interview with the dietary manager on 6/29/2022 at 09:50 AM revealed that she was unaware how long the oil containers in cardboard boxes had been in the area near the dumpster. She reported the cooking oil containers had come from the dietary department and had been delivered to the facility in the cardboard boxes. She reported someone from the dietary department probably put the containers in the dumpster area because each of the four containers was surrounded by cardboard. The dietary manager reported she did not know when the area was last cleaned, and she thought all departments worked together to keep the area	F 814	Four large plastic cooking oil containers that were enclosed in cardboard boxes and located behind the kitchen dumpster were discarded on 6/29/2022. The concrete pad under and around the dumpster area was power washed on 6/29/2022. The concrete pad will be power washed biweekly after the area has been deemed free of debris and storage via a sanitation assignment form. The Floor Technician and the Maintenance Staff will observe the dumpster area daily for cleanliness. All findings discovered during the dumpster area rounds will be reported to the Administrator for immediate correction. The dumpster area will be added to the general sanitation rounds conducted by the Registered Dietician once per month. Dietary staff will be educated on maintaining the area surrounding the dumpster clean and free of trash and debris. The Administrator or designee will visit the dumpster area 3 times per week for 4 weeks until 100% compliance is achieved. The findings of the Administrator visits will be presented during the QAPI meeting and this plan may be adjusted accordingly to ensure ongoing compliance.	

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F 814	Continued From page 11 surrounding the dumpster clean. Interview with the facility administrator on 6/30/2022 at 2:25 PM revealed that all departments in the facility work together to keep the dumpster area clean.	F 814		
F 888 SS=J	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting	F 888		8/4/22

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F 888	Continued From page 12 and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an	F 888		

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

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F 888	Continued From page 14 (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement their policy for COVID-19 vaccinations and to meet the requirement for staff vaccinations when Nursing Assistant (NA) #1 and NA #2 worked without being fully vaccinated and without an exemption. This was for 2 of 7 staff members reviewed for COVID-19 vaccinations. The facility was in outbreak status from 6/11/22 to 7/9/22 and had 4 resident infections from 6/11/22 through 6/20/22 (Residents #14, #16, #22 and #4) with one of those residents experiencing a hospitalization (Resident #16). Immediate Jeopardy began 6/16/2022 when Resident #16 tested positive for COVID-19, was admitted to the hospital for pneumonia related to COVID-19, and was the third resident to test positive for COVID-19 since 6/11/2022. Immediate Jeopardy was removed on 7/15/2022 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of	F 888	All residents are at risk as a result of the deficient practice. The facility has met the 100% staff vaccination rate requirement as of 7/14/2022. An audit was conducted by the Minimum Data Set Nurse and the Medical Records Clerk on 7/13/2022. The current vaccination policy was revised by the Administrator on 7/14/2022 in accordance with the regulation and staff were educated accordingly by the Director of Nursing and the Administrator beginning 7/14/2022. The education was completed by 7/14/2022. All hiring managers were educated by the Administrator on ensuring potential new hires are fully vaccinated as of 7/13/2022 prior to being scheduled to work. The Business Office Staff will assist with monitoring the vaccination status of the nursing home employees.The Business	

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D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place are effective and to complete employee in-service training.

Findings included:

The facility's COVID-19 testing documentation revealed there were four resident infections from 6/11/22 through 6/20/22 (Residents #14, #16, #22 and #4) with 1 of those residents experiencing a hospitalization (Resident #16).

a. Resident #22 tested positive for COVID-19 on 6/11/2022 and remained in the facility.

b. Resident #16 tested positive for COVID-19 on 6/16/2022 and was admitted to the hospital on 6/16/2022 with a diagnosis of pneumonia related to COVID-19. Resident #16 was treated with Dexamethasone (an anti-inflammatory medication) and Remdesivir (an anti-viral medication often used for treatment of COVID-19.) Treatment included oxygen therapy and labs and an ECG (recorded tracing of the electrical component of the heartbeat.) Resident #16 improved and returned to the facility on 6/21/2022.

c. Resident #14 tested positive for COVID-19 on 6/16/2022 and remained in the facility.

d. Resident #4 tested positive for COVID-19 on 6/19/2022 and remained in the facility.

A review of records revealed the facility began an outbreak on 6/11/2022 and remained in outbreak until 7/9/2022.

Office staff will request a copy of the COVID-19 card or exemption upon hire and will utilize the COVID-19 MATRIX form for tracking as a permanent tracking tool.

The vaccination status of all nursing home staff will be tracked by the Administrator utilizing the COVID-19 STAFF VACCINATION MATRIX form as a permanent tracking tool.

All variance to the required 100% vaccination rate on the COVID-19 Matrix will be forwarded to the Quality Assurance and Performance Improvement committee to ensure proper exemptions, regulatory compliance and that the Centers for Disease Control and Prevention guidelines are followed. The Administrator is responsible for implementing this plan to ensure that all staff are fully vaccinated for COVID-19.

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1. The facility COVID-19 Vaccination Policy, undated, stated employees were required to be fully vaccinated (2 weeks or more since they completed a primary vaccination series for COVID-19 was defined as the administration of a single dose vaccine, or the administration of all required doses of a multi-dose vaccine) against COVID-19.

The National Healthcare Safety Network (NHSN) data for the week ending 6/5/22 revealed the facility's recent percentage of staff who were fully vaccinated was 93.1 %.

The COVID-19 staff vaccination matrix was provided by the facility Administrator on 6/27/22 and included all facility staff. Nursing Assistant (NA) #1 and NA #2 were each checked as a temporary delay per Center for Disease Control/new hire.

a. The timecard sheets for NA #1 revealed the hire date was 5/9/22 and she had worked a regular work week (five days out of seven) every week since then.

The daily staffing schedules for the week of 6/27/22 revealed NA #1 was scheduled as a Certified Nursing Assistant with specific assignments each day.

NA #1 was observed on 6/27/2022 at 10:30 AM assisting Resident #15 with a bath. On 6/29/22 NA #1 was observed entering residents' rooms and carrying out breakfast trays at 8:30 AM and lunch trays at 12:40 PM.

In an interview with NA #1 on 7/5/22, NA #1

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stated she received her second dose of a multi-dose COVID-19 vaccine on 7/1/22.

The Administrator stated in an interview on 6/29/22 at 2:30 PM, NA #1 received her first dose of a COVID-19 multi-dose vaccine on 5/24/22 and had not received her second dose of the vaccine yet. The Administrator stated NA #1 could have received her second dose as early as 6/23/2022.

In a follow up interview on 7/5/22 at 3:45 PM, the Administrator stated NA #1 had received her second dose of a multi-dose COVID-19 vaccine on 7/1/22. The Administrator stated she realized she had filled out the vaccine matrix wrong and understood NA #1 should not have come to work with residents without being fully vaccinated. The Administrator stated she was responsible for vaccination of staff and ensuring staff were fully vaccinated prior to working.

b. NA #2's timecard sheet revealed the date of hire was 6/15/22 and NA #2 had worked 6/15/22 through 6/22/22 and returned to work 7/1/22.

In an interview on 7/5/22 at 1:43 PM, NA #2 stated she had gotten sick the week of 6/26/22 and had gone to her physician on 7/1/22 and the physician told her to wait at least one week before getting her second dose of the multi-dose COVID-19 vaccine due to an upper respiratory infection. She tested negative for COVID-19. NA #2 stated she had worked giving care to residents and had an assignment since she was hired on 6/15/22.

The Administrator stated in an interview on 6/29/22 at 2:30 PM, NA #2 had received her first dose of a multi-dose COVID-19 vaccine on

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5/27/22 and had not received her second dose of the vaccine yet. In an interview on 7/5/22 at 3:45 PM, the facility Administrator stated she realized she had filled out the vaccine matrix wrong and understood NA #2 should not have been hired without being fully vaccinated.

The facility Administrator was notified of the Immediate Jeopardy on 7/13/22 at 2:24 PM.

The facility provided an acceptable credible allegation on 7/15/22.

The credible allegation:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance:

Resident #22 tested positive for COVID-19 on 6/11/2022.
Resident #14 tested positive for COVID-19 on 6/16/2022.
Resident #16 tested positive for COVID-19 on 6/16/2022 and was admitted to the hospital on 06/16/2022. Resident #16 returned to facility on 6/21/2022 and has continued to improve. Hospital treatment included oxygen and Dexamethasone for inflammation and Remdesivir on 6/18/2022 which is an antiviral often used in COVID-19 treatment.
Resident #4 tested positive for COVID-19 on 6/19/2022.

Nursing Assistant #1 was hired on 5/9/2022.
NA #1 worked on 5/9/2022-5/12/2022, 5/14/2022-5/16/2022, 5/18/2022-5/20, 2022,

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5/23/2022, 5/24/2022, 5/26/2022, 5/27/2022, 5/30/202-6/1/2022, 6/3/2022, 6/4/2022, 6/9/2022, 6/10/2022, 6/12/2022-6/14/2022, 6/16/2022, 6/18/2022, 6/19/2022, 6/21/2022,6/24/2022, 6/27-6/30/2022, 7/4/2022-7/7/2022, 7/9/2022, 7/13/2022.

NA #1 received the first dose of a multi-dose COVID 19 vaccinations on 5/24/2022 and the second dose on 7/1/2022. NA #1 presented a religious exemption on 5/22/2022 and did not disclose a reason for being vaccinated 2 days later.

NA #1 last worked on 7/13/2022. NA #1 has been removed from the facility's schedule until 7/15/2022.

The facility policy states that all staff are required to be fully vaccinated by their first day of work or submit a negative test result dated no more than seven days prior to their first day of work, with subsequent weekly testing until the next vaccination clinic is held at the facility.

Administrator ensured that NA #1 was tested upon hire and weekly. The policy created by the Administrator was not aligned with the regulation. The Administrator was responsible for ensuring the regulation was followed and that the facility policy aligned with the regulation.

NA #2 was hired on 6/15/2022.
NA #2 worked on 6/15/2022-6/17/2022, 6/20/2022, 6/21/2022, 7/1/2022, 7/11/2022 and 7/13/2022.

NA #2 received the first dose of a multi-dose COVID-19 vaccination on 5/27/2002 and the

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second dose on 7/9/2022. NA #2 had a medical exemption for 7/1/2022-7/8/2022. NA #2 was eligible to receive a 2nd dose on 06/17/2022. NA #2 was out of the state 06/22/2022-6/30/2022. The medical exemption was written on 07-01-2022 by her physician related to an illness and NA #2 was advised to wait a week before getting her second vaccination.

Administrator ensured that NA #2 was tested upon hire and weekly.

NA #2 has been removed from the facility schedule until 7/23/2022. NA #2 last worked 07/13/2022.

All residents are at risk as a result of the deficient practice.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The facility has met the 100% staff vaccination rate requirement as of 7/14/2022. An audit was conducted by the Minimum Data Set Nurse and the Medical Records Clerk on 7/13/2022.

The current vaccination policy will be revised by the Administrator on 7/14/2022 in accordance with the regulation and staff will be educated accordingly by the Director of Nursing and the Administrator beginning 7/14/2022. The education will be completed by 7/14/2022.

All hiring managers will be educated by the Administrator on ensuring potential new hires are

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F 888	Continued From page 21 fully vaccinated as of 7/13/2022 prior to being scheduled to work. Alleged date of IJ removal 7/15/2022. On 7/15/22 it was confirmed there were no positive COVID-19 residents in the facility. Dates of previous residents' COVID 19 positive tests were confirmed. Hospital records of Resident #16 were reviewed, and treatment was confirmed. A review of staffing confirmed NA #1 and NA #2 were not scheduled to work until after 7/15/2022 (NA #1) and 7/23/2022 (NA #2). A review of COVID-19 vaccine cards for NA #1 and NA #2 revealed both NAs were fully vaccinated. A review of the facility policy for COVID-19 vaccination stated all staff were required to be fully vaccinated by their first day of work (2 weeks or more since they completed a primary vaccination series for COVID-19 is defined as the administration of a single dose vaccine, or the administration of all required doses of a multi-dose vaccine) against COVID-19. The facility was at 100% vaccination rate. The audit conducted by the Minimum Data Set Nurse and the Medical Records Clerk was a verbal audit and after interviewing the Medical Records Clerk, it was noted to be complete. The facility's immediate jeopardy removal date was validated as 7/15/2022.	F 888		