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	345193	A. BUILDING _____ B. WING _____	C 07/15/2022

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MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 07/11/2022 through 07/15/2022. The facility was in compliance with the requirement of CFR 483.73, Emergency Preparedness. Event ID NH6X11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted 07/11/2022 through 07/15/2022. One (1) of the 22 complaint allegations were substantiated resulting in deficiencies. Intakes NC00185367, NC00185560, NC00185652 and NC00187113. Event ID #NH6X11.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		8/13/22

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

Electronically Signed | 08/05/2022

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F 761	Continued From page 1 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 record review, observations and interviews with staff and resident, the facility failed to store an opened medication that was available for use in a safe and secure manner for 1 of 4 Residents reviewed for medication storage. (Resident #61) Findings included: Resident #61 was admitted to the facility on 06/29/22. The 5-day Minimum Data Set (MDS) dated 07/06/22 assessed Resident #61 with moderately impaired cognition. Review of Resident #61's medical records revealed he had never been assessed for self-administration of medication since admitted to the facility on 06/29/22. On 07/11/22 at 11:26 AM, 1 tube of zinc oxide 20% paste was observed unattended on the top of Resident #61's bedside table. It was opened and available for use. Interview with Resident #61 on 07/11/22 at 11:28 AM revealed he used the zinc oxide when he was in the hospital for skin irritations. He brought it with him when he admitted to the facility about 2 weeks ago. He left the zinc oxide paste on top of his bedside table since he was admitted and	F 761	Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor Nursing Center of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law 1. The zinc oxide paste was removed on 7/11/22 by a licensed nurse from Resident # 61□s room. No other medications were noted in Resident # 61□s room when the zinc oxide was removed. No other medications will be stored in Resident # 61□s room due to his inability to self-administer medications. Resident #61 was discharged from the facility on 7/28/22. No further corrective action may be taken for Resident #61. 2. All occupied resident rooms will be audited by a licensed nurse to check for any medication(s) that is stored in a resident□s room without a physician□s order. The audits will be completed by	

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F 761	Continued From page 2 none of the staff had told him that he could not keep it in his room. In an interview conducted on 07/11/22 at 11:31 AM, Nurse #2 stated she had provided care for Resident #61 in the past 2 weeks. She did not notice that Resident #61 had a tube of zinc oxide paste in his room. She acknowledged that it should be kept in the treatment cart or in a secured compartment. During an interview with the Director of Nursing (DON) on 07/11/22 at 3:00 PM, she stated the zinc oxide past should not be left unattended in Resident #61's room. Nursing staff should be more attentive to resident's room when providing care to ensure the facility free of unattended medications. It was her expectation for all the medications to be stored in a secured and locked compartment all the times. In an interview conducted on 07/14/22 at 12:20 PM, the Administrator stated the zinc oxide should not be left unattended in Resident #61's room. It was her expectation for all the medications to be stored in a locked compartment to ensure safety for all the residents.	F 761	8/13/22. If a medication is found to be stored in a resident□s room without a physician□s order, the licensed nurse will verify that a self-administration of medication evaluation has been completed or will update the evaluation for self-administration of medication as indicated and will obtain a physician□s order for self-administration of the medication as necessary. If the resident is unable to self-administer the medication and has a physician□s order for the medication, the medication will be stored in the treatment cart or the medication cart and administered by a licensed nurse. On 8/13 a licensed nurse assessed all residents for ability and desire to self-administer medication safely. Only one resident expressed a desire to self-administer medication and was deemed safe by the licensed nurse to self-administer medication. A physician□s order was obtained by a licensed nurse on 8/13/22 for the resident to self-administer her medication for migraine and the medication is being stored at the resident□s bedside in a locked drawer. The resident□s care plan was updated by a licensed nurse on 8/13/22 to reflect self-administration of her medication for migraine and bedside storage of the medication in a locked drawer. A licensed nurse will reconcile the count of the medications stored at bedside and approved for self-administration and compare to the resident□s self-report of the number of doses of the medication that were self-administered monthly. The resident will be reassessed by the	

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F 761	Continued From page 3	F 761	interdisciplinary team for safe self-administration of medication and the appropriateness of bedside medication storage if the resident has a significant change in condition, commits errors in self-administration of medication, or has difficulty keeping the migraine medication stored in a locked drawer in her room. 3. When a resident is admitted to the facility or at any time when the resident expresses a desire to self-administer medications, a license nurse will assess the resident for their ability to safely self-administer medications. The Interdisciplinary Team (IDT) will review the results of the assessment for self-administration of medication and if the IDT, which includes the physician, determines that the resident is safe to self-administer medications, a physician□s order will be obtained which approves the resident to self-administer medications. Any medication(s) approved for resident self-administration that is stored in a resident□s room will be maintained in the container dispensed by pharmacy and secured in a locked drawer. The resident□s plan of care will be updated by a licensed nurse to reflect the resident will self-administer medications and include the storage location of the medication(s) approved for self-administration. A licensed nurse will reconcile the count of any medication(s) stored in the resident□s room and approved for self-administration and compare to the resident□s self-report of the number of doses of the medication	

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F 761	Continued From page 4	F 761		

that were self-administered weekly. In the case that the medication being stored in the resident□s room cannot have an exact count reconciliation, such as when the medication is a topical ointment or cream, the nurse will observe and estimate the quantity of the medication on hand and compare to the resident□s self-report of medication administration. The resident will be reassessed by the interdisciplinary team for safe self-administration of medication and the appropriateness of any approved resident room medication storage if the resident has a significant change in condition, commits errors in self-administration of medication, or has difficulty keeping the medication approved for self-administration stored in a locked drawer.

The Director of Nursing or Assistant Director of Nursing will educate the licensed nurses on the policies and procedures for resident self-administration of medications including secure storage of medications in a locked drawer in the resident□s room and how to properly address any medications found unsecured in a resident□s room and/or unapproved for self-administration. A post-test will be administered to evaluate learning effectiveness. A passing score will be 80%.

The HR Manager will add self-administration and medication storage to the orientation checklist for new licensed nurses. All new hired licensed

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F 761	Continued From page 5	F 761	nurses will receive education from a licensed nurse during the orientation period on the policies and procedures for Self-Administration of Medication and the requirement for secure storage under lock of any medication approved for resident self-administration at bedside. The HR Manager will add medication storage in resident rooms to the general orientation checklist for new employees Newly hired employees will be educated by a licensed nurse during the orientation period on the facility□s policy to securely store medications approved for self-administration in a locked drawer. Education will include the need to pay attention in resident rooms when providing care and services to identify and report any unsecured medications (prescription or over-the-counter) observed in a resident□s room to a licensed nurse for follow-up corrective action. Education was provided to the facility staff by the Director of Nursing or designee by 8/13/22 on the proper storage of medication. A posttest was given to assess learning with a score of at least 80% to be considered passing. Make-up education and post testing will be given by the Director of Nursing or designee for any employee who is unable to attend the first education session. During the admission process, the resident, when cognitively aware, the responsible party or significant other will be educated by the Admissions Coordinator or designee on medication	

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F 761	Continued From page 6	F 761	storage in the resident□s room. The Director of Nursing or Assistant Director of Nursing will conduct a weekly audit of the medical records of newly admitted residents to check that an assessment for safe self-administration of medication has been completed and check the room of any resident approved by the IDT to self-administer medication whether a newly admitted or existing resident to monitor that bedside medications are secured in a locked drawer. The Director of Nursing, Assistant Director of Nursing, or RN designee will conduct a weekly random audit of residents□ rooms for storage of medications in the resident□s room without a physician□s order or stored in the resident□s room with a physician□s order but not securely stored under lock. The audits of the medical records of newly admitted residents for completion of assessments for safe self-administration of medications and the audits of secure storage at bedside of any medications approved for resident self-administration will continue weekly for a minimum of four weeks or until substantial compliance has been achieved and maintained as determined by the QAPI Committee. Corrective action will be taken for any identified deficient practice. 4. The Director of Nursing and/or RN designee will review the results of the audits for any trends/patterns and report the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee for review and further	

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F 761	Continued From page 7	F 761	corrective action as deemed necessary. The committee may choose to discontinue the audits if substantial compliance has been achieved and maintained or may choose to revise or continue the audits based on trends identified.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/13/22

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F 880	Continued From page 8	F 880		

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to implement their

1.Resident # 9 and Resident # 51 remained in isolation for exposure until

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F 880	Continued From page 9 infection control policies and procedures for special droplet contact precautions when 3 of 4 staff members (Housekeeper #1, Nurse #1, and Nurse Aide (NA) #1) failed to wear the required Personal Protective Equipment (PPE) when entering Resident #9 and Resident #51's shared room for 2 of 2 residents reviewed for infection control practices. The findings included: A facility policy entitled "Infection Prevention and Control Manual Interim Guidelines for Suspected or Confirmed Coronavirus (COVID-19)" dated 5/17/2022 read in part under the sections "Residents with/ or suspected to have COVID" and "Special Droplet Contact Precautions": * Observation for COVID-19- A resident who is not up to date with vaccination and who has had prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over 24 hours period) to someone with COVID-19 infection: - Resident should be placed on Special Droplet Contact Precautions -Staff should wear appropriate PPE, including a respirator (or facemask if pre-approved by infection control) at all times when in room -Housekeeping may clean room as usual. Housekeeping should wear appropriate PPE * Special Droplet Contact Precautions- Any resident with suspected or confirmed COVID-19 should be placed on Special Droplet Contact Precautions, which includes: gloves, gown,	F 880	7/23/22 and neither Resident #9 nor Resident #51 developed any signs and symptoms of COVID-19 and had negative COVID-19 test results on 7/13/22, 7/18/22, and 7/21/22. 2.On 7/13/22, the facility began testing all residents and staff during a 24-hour window for COVID-19 infection; three residents were found to have positive COVID-19 test results. These three residents were placed on transmission-based precautions. The facility continued to test residents and staff for COVID-19 infection as required by CMS and the CDC during an outbreak status and with consideration of community□s transmission level. 3.Nurse #1, NA #1, and Housekeeper #1 received re-education on infection control, including transmission-based precautions and the need to wear personal protective equipment (PPE) in isolation rooms by a Registered Nurse with IP training on 7/13/22. After the reeducation, Nurse #1, NA #1, and Housekeeper #1, immediately began following transmission-based precautions when appropriate and will continue to follow transmission-based precautions in accordance with the CDC guidelines and facility policy. A root cause analysis was performed by the Administrator and the IP. It indicated a lack of PPE training for all employees. The Infection Preventionist (IP) provided education to staff in all departments that	

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F 880	Continued From page 10 NIOSH- certified N95 respirator, and either goggles or a face shield. An observation on D hall on 7/14/2022 at 8:44 AM revealed there were several rooms with signage posted for special droplet contact precautions. Resident #9 and Resident #51's room door had a sign posted on the outside of the door titled "Special Droplet Contact Precautions" which instructed the staff to clean hands before entering and when leaving room, wear a gown when entering room and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting, protective eyewear (face shield or goggles) and wear gloves when entering room and remove before leaving. 1.a. An observation from 3 to 4 doors away on 7/14/2022 at 8:46 AM revealed Housekeeper #1 entered Resident #9 and Resident #51's room with an N95 facemask, gloves, and eye protection in place, but did not don a gown prior to entering the room. Housekeeper #1 was interviewed as she exited Resident #9 and Resident #51's room on 7/14/2022 at 8:47 AM which revealed Housekeeper #1 had seen the posted signs but stated she was told the only residents that were on quarantine were the ones with yellow bags, stocked with PPE, hanging on the doors. There was no PPE bag hanging on the door, but PPE was available for use on the hall. Housekeeper #1 was observed to remove her gloves and perform hand hygiene but did not remove her mask as she exited the room. b. An observation on 7/14/2022 at 8:51 AM revealed Nurse #1 entered Resident #9 and	F 880	included an overview of COVID-19 and a review of transmission-based precautions and PPE use on 8/2/22. A post-test was administered with a passing score of 80% required. This education was repeated by an RN with IP training on 8/4/22 for the night staff who did not attend the 8/2/22 training offering with a post-test that required a score of 80% to pass. This education will be repeated again by the IP on 8/5/22 for any staff who did not attend the education offering on 8/2/22 or 8/4/22. A posttest will be given to assess learning with a passing score of at least 80%. A makeup in-service and posttest will be provided to any employee that is unable to attend the 8/2/22, the 8/4/22 or the 8/5/22 in-service by 8/13/22. Any staff who has not received the infection control education by 8/13/22 will not be allowed to work until after successful completion. New employees will be provided education by a licensed nurse that includes an overview of COVID-19, a discussion of transmission-based precautions and a demonstration of PPE use with a return demonstration during the orientation period prior to job assignment. The orientation check lists for positions in all departments will be updated by the HR Manager to include the training on COVID-19, transmission-based precautions and demonstration/return demonstration of PPE use by 8/13/22 The Infection Preventionist or designated RN will conduct random weekly audits on proper use of transmission-based	

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F 880	Continued From page 11 Resident #51's room and called to NA #1 to assist her in the room. Nurse #1 entered the room with an N95 facemask, and eye protection in place, but did not don gloves or a gown prior to entering the room. NA #1 entered the room with eye protection in place but had a surgical facemask in place and did not don gloves or a gown prior to entering the room. Nurse #1 and NA #1 performed hand hygiene upon exiting the room and did not remove their masks after exiting the room. An interview with Nurse #1 on 7/14/2022 at 10:28 AM revealed Nurse #1 received regular in-services on infection control which included PPE training. Nurse #1 stated she was not aware Resident #9 and Resident #51 were on any precautions and thought the special droplet contact precaution signage posted on their door had been from a previous resident on precautions. An interview with NA #1 on 7/14/2022 at 10:04 AM revealed when NA #1 entered Resident #9 and Resident #51's room, the door was open, and she did not see the signage for special droplet contact precautions posted on the door. NA #1 stated she would have donned the appropriate PPE if she had seen the sign. Interviews were conducted with the Human Resources Director on 7/14/2022 at 9:15 AM and 9:50 AM which revealed Resident #9 and Resident #51 were exposed to COVID-19 on 7/13/2022 and were not up to date on their COVID vaccinations. The HR director stated she had posted the special droplet contact precautions signage on Resident #9 and Resident #51's door on the evening of 7/13/2022 and staff should have worn the appropriate PPE	F 880	precautions and appropriate wearing of PPE. The HR Manager will conduct weekly audits of the orientation checklists for new employees to monitor that education has been provided on COVID-19 and transmission-based precautions along with demonstration and return demonstration of PPE use. The audits by the IP or designated RN and the HR Manager will continue weekly for a minimum of four weeks or until substantial compliance has been achieved and maintained as determined by the QAPI Committee. Corrective action will be taken for any deficient practice identified during the audits. 4.The Director of Nursing or designee will review the results of the audits for trends/patterns and report the results of the audits to the QAPI Committee for review and direction any further necessary corrective action The committee may choose to discontinue the audits if substantial compliance has been achieved and maintained or may choose to revise or continue the audits based on trends/patterns identified 5. Completion Date is 08/13/2022	

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for special droplet contact precautions prior to entering the room.

Interviews were conducted with the Infection Preventionist (IP) assistant on 7/14/2022 at 10:32 AM and 11:58 AM which revealed staff should have read any signs that were posted on resident room doors because it typically meant the resident was on quarantine for some reason.

An interview was conducted with the housekeeping manager on 7/14/2022 at 1:23 PM which revealed housekeeping staff should read signs posted on residents' doors and should have worn the appropriate PPE prior to entering a room with a resident who was on any precautions.

An interview was conducted with the IP on 7/15/2022 and revealed infection control in-services were conducted at least yearly and any time there was a change in guidelines. The IP further revealed staff should have read the precaution signs and followed the guidance in the signage that was posted on Resident #9 and Resident #51's door prior to entering the room. The IP stated the precaution signage posted notified the reader that the occupant of the room was on quarantine and notified the reader of the appropriate PPE to wear prior to entering the room.

An interview was conducted with the Director of Nursing (DON) on 7/15/2022 at 11:21 AM which revealed staff should have read the posted precaution signs and donned the appropriate PPE prior to entering Resident #9 and Resident #51's room.

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F 880	Continued From page 13 During an interview with the Administrator on 7/15/2022 at 2:03 PM, the Administrator stated staff should have read the posted precaution signs on Resident #9 and Resident #51's door and donned the appropriate PPE prior to entering their room.	F 880		
F 888 SS=G	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		8/13/22

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F 888	Continued From page 14	F 888		

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

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

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

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F 888	Continued From page 16 (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 record review and staff interviews the facility failed to meet the staff vaccination requirement when the Director of Housekeeping and Laundry, Laundry Aide #1, and Dietary Aide #1 worked without being fully vaccinated and without an exemption. The facility also failed to implement an effective process for tracking COVID-19 Vaccination Status for 3 of 3 facility staff. The facility went into outbreak status during survey on 07/13/22 when two facility staff and one contract staff and three residents (Residents #46, 45, and 36) tested positive for COVID-19 on 07/13/22. The findings included: The facility's *COVID-19 Vaccine* policy with no reviewed date, read in part: It is the policy that all persons be offered the COVID-19 vaccine. This facility will ensure that all eligible employees are fully vaccinated against COVID-19, unless received religious or medical exemptions. Staff includes all fulltime, part-time, as needed employees, and contract staff.	F 888	1. Residents #46, #45 and #36 with positive COVID-19 test results were placed on transmission-based precautions on 7/13/22. Resident #45 and Resident #46 successfully recovered from COVID-19 and transmissions-based precautions ended on 7/23/22. Resident #36 expired on 7/20/22. No further corrective action may be taken for Resident #36. Staff assigned to work with Resident #45 and Resident #46 will be in compliance with CMS requirements and facility policy for staff COVID-19 vaccination or have an approved exemption by 8/13/22. Staff with an exemption from COVID-19 vaccination will wear an N-95 respirator and be tested for COVID-19 according to CDC guidelines, CMS requirements and facility policy. 2. All residents have the potential to be affected by this alleged deficient practice. All residents were and continue to be monitored at a minimum of daily by a	

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F 888	Continued From page 17 The facility COVID- 19 staffs vaccination spreadsheet 92provided by the Administrator on 07/12/22 was reviewed and included in-house staff and contract staff. Director of Housekeeping and Laundry, Dietary Aide #1 and Laundry Aide #1 who were all listed as facility staff were listed as partially vaccinated and had only received one dose of a two-dose vaccine. A review of on 05/13/22 of the National Healthcare Safety Network (NHSN) data for the week ending 06/26/22 revealed the following staff and resident vaccination information: Recent Percentage of Staff who are Fully Vaccinated = 81.8% Recent Percentage of Resident's who are Fully Vaccinated = 92.2% Review of medical records and facility vaccination documents revealed Resident #46 and Resident #36 were not vaccinated and tested positive for COVID-19 on 07/13/22. Resident #45 was partially vaccinated and tested positive for COVID-19 on 07/13/22. An interview was conducted with Director of Housekeeping and Laundry on 07/13/22 at 2:15 PM revealed she had received the first shot of the COVID-19 vaccine in November 2021 and was planning to receive the second shot of the vaccine. She stated each time she planned to go and receive the second shot something would come up at home or at work and she was not able to go. She revealed she was planning to go within the next week and receive the second shot of the vaccine. The Director of Housekeeping and Laundry was observed wearing an N95 mask and stated because she is not fully vaccinated, she	F 888	Licensed Nurse for signs and symptoms of COVID-19 infection or are being tested and will continue to be tested for COVID-19 infection per CDC guidelines, CMS requirements and facility policy. 3. The Director of Housekeeping and Laundry, Laundry Aide #1, and Dietary Aide #1, who were not up to date with all recommended COVID-19 vaccinations were reeducated by the Administrator of the need to be fully vaccinated or have an approved exemption from COVID-19 vaccination to continue working at the facility. The Director of Housekeeping received the second dose of the COVID-19 vaccine on 7/18/22. The Laundry Aide #1 received the second dose of the COVID-19 vaccine on 8/3/22. The Dietary Aide #1 received the second dose of the COVID-19 vaccine on 8/3/22. The IP will audit the vaccination records of all facility staff by 8/13/22 and review with the HR Manager the personnel files as necessary to identify any other staff who are unvaccinated or partially vaccinated and are not approved for an exemption from COVID-19 vaccination. The IP or RN designee will reeducate any unvaccinated or partially vaccinated staff without an approved exemption about the requirement to be fully vaccinated for COVID-19 or have an approved exemption from COVID-19 vaccination. Staff will not be allowed to work until they are in compliance with the CMS requirements and facility policy for COVID-19 vaccination for facility staff by	

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F 888	Continued From page 18 always wears an N95 mask in the facility and is tested bi-weekly. An interview was conducted with Laundry Aide #1 on 07/13/22 at 2:17 PM revealed she had received the first shot of the COVID-19 vaccine in March 2022 and was then diagnosed with Rheumatoid Arthritis. She stated she was going to discuss receiving the second shot with her physician at her next appointment. Laundry Aide #1 was observed wearing an N95 mask and stated she wears an N95 mask while in the facility and is tested bi-weekly. Dietary Aide #1 was not available for interview. An interview was conducted with the Administrator on 07/13/22 at 11:02 AM revealed Dietary Aide #1 received her first does of the vaccine in December 2021 and had not received second dose of vaccine due to her cerebral palsy diagnosis. She stated Dietary Aide #1 was supposed to discuss a medical exemption with her physician. A telephone interview was conducted with Infection Preventionist (IP) on 07/13/22 at 1:13 PM revealed she was responsible for COVID-19 testing, tracking staff and resident vaccinations, weekly NHSN reporting, and updating tracking reports weekly. She also revealed she reports staff vaccination status to the Administrator and Human Resources. She stated she was aware of the three staff members not being fully vaccinated. The IP stated she realized the seriousness of the tracking of the vaccination status of the employees and indicated she had reminded the three staff not fully vaccinated weekly they needed to receive their second	F 888	8/13/22. The IP will provide education to the Administrator, Director of Nursing, Assistant Director of Nursing, Department Heads, and HR Manager by 8/13/22 on the facility□s policy and CMS requirements for all staff to be fully vaccinated for COVID-19 or to be approved for an exemption from COVID-19 vaccination to continue working at the facility. A posttest will be given to assess learning effectiveness. The passing score on the posttest will be 80%. The IP or HR Manager will track the vaccination status of all new employees at the time of hire using a log and enter the staff member□s COVID-19 vaccination status or a notation of the approval for an exemption from COVID-19 vaccination prior to job assignment. Employees who are not fully vaccinated or who do not have an approved exemption from COVID-19 vaccination will not be permitted to work until in compliance with COVID-19 vaccination requirements. If the first dose of an approved COVID-19 vaccine is not received or an vaccination exemption is not approved within 2 weeks, or the second dose of the vaccine is not received timely in accordance with the facility□s policy and CDC guidelines, each employee in such a situation will have their employment with the facility terminated for refusing to comply with the facility□s policy for COVID-19 vaccination.	

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F 888	Continued From page 19 vaccine. She also stated she reported to the Administrator and Human Resources multiple times of the three staff not being fully vaccinated and needing to receive their second vaccine. She further indicated the three staff members not fully vaccinated had not requested exemptions. She stated the facility has held initial vaccine and first booster clinics for staff and residents and will be scheduling a second booster clinic for staff and residents as soon as vaccine arrives. An interview was conducted with Director of Nursing (DON) on 07/15/22 at 1:30 PM revealed IP handled all of staff vaccination. The DON stated staff that were not fully vaccinated were required to wear an N95 mask. She revealed she was not aware staff were employed at facility and worked who were not fully vaccinated and had no exemption. She stated staff should follow vaccination policy and be vaccinated or wear an N95 mask if not vaccinated. An interview was conducted with Administrator on 07/15/22 at 2:04 PM revealed according to staff vaccination policy, staff should be fully vaccinated or have an approved exemption. She stated she was aware of staff not having received their 2nd doses of vaccine. She also stated she had reached out to staff who had not received their second doses of vaccine and discussed with IP about those staff receiving their second dose of vaccine and or an exemption. The Administrator revealed all staff should be vaccinated according to policy and the facility should have followed up more closely to make sure the policy was being followed.	F 888	4. The DON or ADON will perform a weekly audit by comparing the current roster of facility staff and the vaccination tracking log maintained by the IP containing the COVID-19 vaccination and exemption from COVID-19 vaccination statuses of staff to identify discrepancies for a minimum of four weeks or until substantial compliance has been achieved and maintained as determined by the QAPI Committee. Corrective action will be taken for any identified issues with the COVID-19 vaccination or exemption from vaccination. Any unvaccinated staff identified as non-compliant with the COVID-19 vaccination requirements will not be allowed to work until in compliance with the COVID-19 vaccination requirements or approved for an exemption from COVID-19 vaccination and will be terminated from employment for sustained non-compliance with COVID-19 vaccination in accordance with facility policy. The DON will review the results of the audits for trends/patterns and report the results of the audits to the QAPI Committee for review and follow-up action as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The QAPI Committee may choose to discontinue the audits, revise the frequency of the audits, or continue the audits or revise the plan based on any trends or problems identified.	

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F 888	Continued From page 20	F 888	5. Completion Date is 08/13/2022	