STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. BUILDING _____ B. WING _____	07/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARNETT WOODS NURSING AND REHABILITATION CENTER	604 LUCAS ROAD DUNN, NC 28334

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 7/22/22 and 7/23/22. 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# 2QW311	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 7/22/22 and 7/23/22. The facility was found to be out of compliance with 42 CFR §483.80 infection control regulations. Event 2QW311	F 000		
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	F 880		8/26/22

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

Electronically Signed | 08/08/2022

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F 880	Continued From page 1	F 880		

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 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

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F 880	Continued From page 2 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 observation, record review, staff interview, and physician interview the facility failed to update their policy regarding transmission-based precautions for COVID-19 prevention and thereby failed to place three (Resident # 1, #7, and #9) out of eight sampled residents reviewed for COVID-19 prevention on transmission-based precautions. This occurred during a coronavirus pandemic. The findings included. The facility's policy entitled, "Guidelines for Quarantine Considerations for Community Visits and Close Contact, dated as last revised on 10/8/21, read in part, "Residents, who are fully vaccinated that leave the facility for more than 24 hours or who have close contact with a COVID-19 positive individual in the facility, do not require quarantine. However, these residents must: wear a mask, socially distance, be tested two days after exposure and again at 5-7 days after exposure to confirm they are negative." Review of CDC (Center for Disease Control) guidance revealed CDC's guidelines had been updated again on 2/2/22; which was after the facility's last policy update. The 2/2/22 CDC guidelines read in part as follows: "Roommates of residents with SARS-CoV-2 infection should be managed as described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2	F 880	Harnett Woods Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Harnett Woods Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Harnett Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F880 Infection Prevention & Control On 8/1/2022 resident #1 completed required transmission-based precautions for COVID 19 infections, on 7/15/2022 resident #7 completed required	

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F 880	Continued From page 3 Infection." "Empiric use of Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses." "In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section; Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which of these residents require quarantine upon admission." Review of CDC's COVID transmission rates for the facility's county revealed for all the dates on which data was recorded between 6/15/22 and 7/23/22, the county's transmission rate was marked as high. On 7/22/22 a review of the facility's COVID case tracking information revealed the facility was currently in outbreak status. As of 7/22/22 one resident currently had COVID and was on TBP (transmission- based precautions). As of 7/22/22 one staff member currently was out of work due to testing positive for COVID. The facility's documentation showed they had been using contact tracing during the outbreak to identify high risk exposures. 1a. Resident # 9 was admitted to the facility on 2/5/21. Review of documentation provided by the	F 880	transmission-based precautions for COVID 19 infections, and on 7/14/2022 resident # 9 completed required transmission-based precautions for COVID 19 infections. On 7/22/2022 the facility nurse consultant initiated 100% audit of all current residents COVID vaccination status. This audit was to identify any resident not up to date on COVID vaccine/boosters. The Director of nursing, unit managers and infection preventionist addressed all concerns identified during the audit to include assessing the resident, providing vaccine/booster per resident preference and initiating transmission-based precautions for all residents who were not up to date on COVID vaccine/boosters and who had closed contact with someone with SAR-CoV-2 infection. On 7/26/22, the corporate executive team reviewed the CDC recommendations for transmission-based precautions for residents who have had close contact with someone with SAR-CoV-2 infection and updated the facility guidelines per CDC recommendations. The new Guidelines for Quarantine Considerations for Community Visits and Close Contact was initiated and reviewed with facility Administrator via teleconference to include the requirement to initiate transmission based precautions for any resident who were not up to date on COVID vaccine/boosters and who had closed contact with someone with SAR-CoV-2 infection.	

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F 880	Continued From page 4 facility regarding COVID vaccine and case tracking information revealed Resident # 9 was fully vaccinated but not up to date with her COVID vaccinations. Resident # 9 was documented to reside with Resident # 8 prior to the date of 7/1/22. According to the facility logs, Resident #8 tested positive for COVID on 7/1/22. Resident # 9 tested positive for COVID on 7/4/22. Resident #9's nursing notes on 7/5/22 at 10:37 AM, 7/8/22 at 12:55 PM, and 7/10/22 at 11:05 AM revealed the resident had non labored breathing, was afebrile, and had an occasional non-productive cough after being diagnosed with COVID. 1b. Resident # 7 was originally admitted on 12/16/21. Review of documentation provided by the facility regarding COVID vaccine and case tracking information revealed Resident # 7 was fully vaccinated but not up to date. Resident # 7 was documented as residing with Resident # 6 prior to the date of 7/1/22. Resident # 6 tested positive for COVID on 7/1/22. Resident # 7 tested positive for COVID on 7/5/22. Resident # 7's nursing notes on 7/7/22 at 2:24 AM, 7/8/22 at 1:47 PM, 7/9/22 at 10:54 AM and 7/13/22 at 1:22 PM revealed Resident #7 had no shortness of breath after being diagnosed with COVID. The note of 7/13/22 at 1:22 PM noted the resident "continues to only have runny stuffiness to nose." 1 c. Resident # 1 was originally admitted to the facility on 6/3/22 and readmitted to the facility on 7/21/22. According to Resident # 1's record, he was fully vaccinated for COVID but not up to date.	F 880	On 7/26/22, the Administrator and Infection Preventionist initiated an in-service with all nurses, nursing assistants, admission staff, accounts payable, accounts receivable, social worker, maintenance staff, dietary staff, therapy staff, receptionist/screeners, medical records, and activities staff regarding the updated Guidelines for Quarantine Considerations for Community Visits and Close Contact with emphasis on providing transmission based precautions for any resident who were not up to date on COVID vaccine/boosters and who had closed contact with someone with SAR-CoV-2 infection. The in-service will be completed by 8/26/2022. After 8/26/2022, any nurses, nursing assistants, admission staff, accounts payable, accounts receivable, social worker, maintenance staff, dietary staff, therapy staff, receptionist/screeners, medical records, and activities staff who has not received the in-service will complete the in-service prior to the next scheduled work shift. All newly hired staff will be in-serviced during orientation regarding Guidelines for Quarantine Considerations for Community Visits and Close Contact. The Unit Managers, Minimum Data Set Nurse (MDS) and Infection Preventionist will audit all current residents COVID vaccine status weekly x 4 weeks then monthly x 1 month utilizing the Immunization/TBP Audit Tool. This audit is to identify any resident who refuses	

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F 880	Continued From page 5 Resident # 1 tested negative for COVID upon readmission to the facility on 7/21/22. Resident # 1 was observed on 7/22/22 at 10:00 AM in a room residing with another resident. There was no signage on the door indicating Resident # 1 was on transmission- based precautions. Nurse # 1 was observed in Resident # 1's room at this time without full PPE (personal protective equipment). Nurse # 1 had eye protection and a N95 mask but no gown. Upon exiting Nurse # 1 was interviewed regarding whether the resident was on TBP and stated she had just returned to work and did not know. The Administrator was interviewed on 7/23/22 at 1 PM and reported the following. They had not updated their facility policy since the CDC updates on 2/2/22. They had not been placing new admissions or readmissions on TBP if they were not up to date with COVID vaccines because they were going by the former guidance which referenced vaccinated admission/ readmissions did not have to be placed on TBP. They had not been taking many admissions in the past month and therefore this would not have affected many residents. They also had not been placing roommates of residents who tested positive for COVID on TBP. They did restrict the roommate to their room while the facility tested the roommate on days 1,2, 3, 5 and 7 to determine if they would contract COVID. All staff, even if the facility was not in outbreak status, were required to wear N95 masks while providing care to residents. All the staff also were required to wear eye protection while caring for residents. The facility was also using plasma filters within their heating and air system in addition to using an electrostatic sprayer for disinfectant	F 880	COVID vaccines/booster or any resident not up to date on vaccine status to ensure the facility initiated the appropriate transmission-based precautions for any resident not up to date on COVID vaccine and that has had close contact with someone with SAR-CoV-2 infection. The Unit Managers, MDS nurse and/or Infection Preventionist will address all concerns identified during the audit to include assessment of the resident, providing vaccination per resident preference and initiating appropriate transmission-based precautions when indicated. The Director of Nursing (DON) will review the Immunization/TBP Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Immunization/TBP Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Immunization/TBP Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 880	Continued From page 6 application in targeted areas to control cases. At the current time of 7/23/22, the facility only had one resident who was COVID positive. The Administrator reported none of the residents who had been COVID positive in the facility's current outbreak had been very sick. None had been hospitalized or expired from COVID illness. The facility's Medical Director was interviewed on 7/23/22 at 1:45 PM and reported the following. During the facility's current outbreak status, none of the residents had any severe illness. Some residents, who had contracted the illness during the current outbreak, had both been vaccinated and historically had COVID before. This had boosted their immunity and therefore even if some of the residents had not been placed on TBP, it was his opinion that this had not significantly impacted the outcome of who had gotten sick. The Medical Director also stated that when the outbreak occurred, he had placed all residents on a prophylactic COVID cocktail of Vitamin D, Vitamin C, Zinc, and Pepcid.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		8/26/22

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F 883	Continued From page 7 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883	Continued From page 8 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure two (Residents # 4 and # 5) of five residents reviewed for immunizations had either received their pneumococcal immunization (Resident # 5) or that staff followed up to determine if a resident was eligible to receive one (Resident # 4). The findings included: 1. Resident # 5 was admitted to the facility on 7/4/22 and was over 65 years of age. The resident's quarterly Minimum Data Set Assessment, dated 7/4/22, coded the resident as cognitively impaired. A review of Resident # 5's record revealed Resident # 5's RP (Responsible Party) had signed consent that Resident # 5 could have the pneumonia vaccine. A review of Resident # 5's record on 7/22/22 revealed Resident # 5 had been immunized with the Pre-var 13 (one of the recommended pneumonia vaccines) on 11/14/20 but had never received the PPSV23 vaccine (a second Pneumonia Vaccine recommended for those over the age of 65.). It was validated with the Administrator on 7/23/22 at 1 PM that Resident # 5 had never had the PPSV23 and the staff should have followed up about the lack of immunization. According to the interview with the Administrator on 7/23/22 at 1 PM, the unit managers were responsible for assuring vaccines were given. 2. Resident # 4 was admitted to the facility on 6/28/22.	F 883	F883 Influenza and Pneumococcal Immunizations The Unit Managers and/or Infection preventionist will clarify immunization history for pneumonia vaccines for #4 and resident #5. The resident or resident representative will be education on the risk and benefits, consent obtained, and MD notified to obtain order per resident preference. Immunizations will be provided per physician's order by 8/4/2022. On 7/27/2022, the LPN Admissions Coordinator initiated an audit of all Pneumonia immunizations for all current residents. This audit was to identify any resident who had not received Pneumonia vaccines as recommended by the CDC or have a documented refusal of immunization per facility protocol. The RN Infection Preventionist/Staff Development Coordinator will address all concerns identified during the audit. Audit will be completed by 8/9/2022. On 8/5/2022 the Infection Preventionist and unit managers and staff LPN initiated an in-service with all nurses regarding Immunizations with emphasis on educating resident on risks and benefits of vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order	

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F 883	Continued From page 9 The resident's Admission Minimum Data Set assessment, dated 7/4/22, coded Resident # 4 as cognitively impaired. On 7/22/22 a review of Resident # 4's record revealed no history of pneumococcal vaccine administration. The Administrator was interviewed on 7/23/22 at 1:00 PM and again at 3:45 PM. The Administrator reported that the staff were supposed to be following up on whether Resident # 4 had had her pneumococcal vaccines prior to coming to the facility by the resident's outside medical practice, and there still had not been any verification by her staff. According to the Administrator, this should have been verified by the date of 7/23/22 in order that the staff know whether they should offer the vaccination to the resident by way of her responsible party.	F 883	with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. The in-service will be completed by 8/26/2022. All newly hired nurses will be in-serviced during orientation regarding Immunizations. Administrator will audit 10% of resident immunization record weekly x 4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks and benefits of Influenza and Pneumonia vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. The RN unit managers and Infection Preventionist will address all concerns identified during the audit. The DON will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Immunization Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Immunization Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 886 SS=D	COVID-19 Testing-Residents & Staff	F 886		8/26/22

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F 886	Continued From page 10 CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and	F 886		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 11 (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assure testing was done per CDC (Center for Disease Control) guidelines to assure the accuracy of the results for two of six staff members reviewed for COVID testing. The facility failed to assure a staff member, who was testing for COVID, was knowledgeable about the practice of testing. The facility also failed to wait at least 24 hours prior to testing a staff member who had been exposed to another COVID positive staff member per current CDC guidelines. The findings included: 1. On 7/22/22 at 11:25 AM dietary employee (DE)	F 886	F886 COVID-19 Testing-Residents & Staff On 7/22/22, dietary employee #1 (DE) was immediately re-tested for COVID 19 by the Director of Nursing (DON) and Infection Preventionist to ensure accuracy of testing. Dietary employee tested negative for SAR-CoV-2 infection. DE #1 was in-serviced by the DON and Infection Preventionist to notify the nurse immediately of any symptoms of SAR-CoV-2 infection and testing would be completed by the nurse.	

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F 886	Continued From page 12 # 1 was observed to enter the facility's conference room, where COVID testing materials were located. DE # 1 gathered COVID testing supplies and began testing herself for COVID. DE # 1 asked the surveyor if the surveyor knew how long she was supposed to wait to get a result and commented that "they" had told her to come and test and if the test was positive it would turn positive in just a few minutes. DE # 1 stated her nose was stuffy and she just wanted to make sure she did not have COVID. DE # 1 did not know if there was supposed to be someone who was to be helping her with the test. Immediately following the observation, Nurse Consultant # 1 was located in a different part of the facility by the surveyor. Nurse Consultant # 1 was informed that DE # 1 was testing herself for COVID and was unsure how long she was to wait for the results. Nurse Consultant # 1 responded that someone would help DE # 1. On 7/22/22 at 4:40 PM the facility's Infection Preventionist (IP) was interviewed and reported the following. DE # 1 had been retested by her and the Director of Nursing (DON) that day to make sure it was done correctly and DE # 1 tested negative. She and the DON had talked to DE # 1 after the surveyor had observed DE # 1 testing herself and learned that no one in a supervisory position had told DE # 1 to test herself. DE # 1 had been talking to the other dietary staff members earlier that day and let them know she did not "feel all that great." The other staff members had told her she could go test herself and that "it only takes a minute or two." The IP reported it was the facility's system that any employee who had COVID symptoms was to go directly to a nurse. The nurses were trained in the correct testing procedures and	F 886	On 7/4/2022 nurse #3 was retested and was negative for SAR-CoV-2 infection. On 8/8/2022, the Administrator initiated COVID testing of all employees to ensure testing was completed accurately, timely and by designated trained staff and that test results were documented in the testing log per facility guidelines. The Director of Nursing, RN unit mangers, Infection Preventionist and Staff LPN will address all concerns identified during the audit to include re-testing staff when indicated and/or retraining of staff. Testing will be completed by 8/26/2022. On 7/26/2022 the Infection Preventionist, Director of Nursing, Staff LPN and RN unit managers initiated an in-service with all nurses, nursing assistants, admission staff, accounts payable, accounts receivable, social worker, maintenance staff, dietary staff, therapy staff, receptionist/screeners, medical records, and activities staff regarding COVID Testing with emphasis on CDC guidelines for testing to include not completing testing less than 24 hours from exposure of SAR-CoV-2 infection and testing to be completed only by designated trained staff to ensure accuracy of testing with documentation of test results. In-service will be completed by 8/26/2022. After 8/26/2022, any nurses, nursing assistants, admission staff, accounts payable, accounts receivable, social worker, maintenance staff, dietary staff, therapy staff, receptionist/screeners, medical	

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F 886	Continued From page 13 would have made sure it was done correctly. The IP stated there was a nursing station right outside the dietary department and DE # 1 should have gone there to report to a nurse she was not feeling well. The Medical Director was interviewed on 7/23/22 at 1:45 PM and reported he felt that there should only be a few people, who were trained in correct testing, to be designated as the staff members to conduct COVID testing. 2. Review of the Center for Disease Control guidelines for testing, updated on 1/21/22, revealed the following information. "All HCP (health care personnel) who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested as described in the testing section. For those who have not recovered from SARS-CoV-2 infection in the prior 90 days, perform SARS-CoV-2 testing immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure."" Review of facility tracking information for COVID positive employees revealed Nurse # 2 tested COVID positive on 6/27/22. According to the contract tracing records, Nurse # 3 had ridden to work with Nurse # 2 on 6/27/22. Review of testing results revealed the facility tested Nurse # 3 on 6/27/22; the day she was exposed while riding to work with Nurse # 2. Interview with the Administrator on 7/23/22 at 3:45 PM revealed the facility did not wait to test Nurse # 3 for 24 hours after her initial exposure (which was her car ride on 6/27/22). Interview with the Administrator and review of facility records revealed Nurse # 3	F 886	records, and activities staff who has not received the in-service will complete training prior to next scheduled work shift. All newly hired nurses, nursing assistants, admission staff, accounts payable, accounts receivable, social worker, maintenance staff, dietary staff, therapy staff, receptionist/screeners, medical records, and activities staff will be in-serviced during orientation regarding COVID Testing. The Unit Managers and/or Infection Preventionist will monitor COVID testing of employees weekly x 4 weeks then monthly x 1 month utilizing COVID Testing Audit Tool, This audit is to ensure the facility follows CDC guidelines on COVID testing to include not completing testing less than 24 hours from exposure of SAR-CoV-2 infection and testing to be completed only by designated trained staff to ensure accuracy of testing with documentation of test results. The Unit Managers and/or Infection Preventionist will address all concerns identified during the audit to include but not limited to re-testing of staff when indicated by designated trained staff for accuracy of testing with documentation of test results and/or re-training of staff. The Director of Nursing will review the COVID Testing Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the COVID Testing Audit Tool to the Executive Quality Assurance	

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F 886	Continued From page 14 never contracted COVID from the exposure.	F 886	Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the COVID Testing Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;	F 887		8/26/22

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F 887	Continued From page 15 (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure one (Resident # 4) of two sampled residents who were not vaccinated for COVID received their COVID vaccine per their responsible party's choice to follow guidelines	F 887	F887 COVID-19 Immunization On 8/2/2022 resident #4 was educated on risks/benefits and potential side effects of COVID vaccine/boosters by the RN unit	

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F 887	Continued From page 16 and have the vaccine administered. The findings included: 1. Resident # 4 was admitted to the facility on 6/28/22. The resident's Admission Minimum Data Set assessment, dated 7/4/22, coded Resident # 4 as cognitively impaired. A review of the record revealed Resident # 4's RP (responsible party) had signed consent for Resident # 4 to have the COVID vaccine on 6/28/22 when the resident was admitted. On 7/22/22 a review of Resident # 4's record revealed no history of COVID vaccine administration. According to the record, the resident had not tested positive for COVID while residing at the facility. The Administrator was interviewed on 7/23/22 at 1:00 PM and again at 3:45 PM. The Administrator reported that their pharmacy comes to the facility and administers the COVID vaccine when residents or their responsible parties give permission. The Administrator reported the pharmacy could respond within a few days to administer the vaccine when contacted but verified that Resident # 4 had never received her COVID vaccine since her RP signed permission for it on 6/28/22. According to the Administrator she kept track of the residents who wanted to have the COVID vaccine and the reason Resident # 4 was not vaccinated was because she had not yet followed up with the pharmacy to alert them there was a need to come and administer the vaccine.	F 887	manager and was administered the vaccine per resident preference with documentation in the electronic record. On 7/28/2022 the administrator initiated an audit of all current residents Covid 19 vaccine status. This audit was to identify any resident who had not been provided a Covid 19 vaccine/booster per resident preference or a documented refusal of immunization per facility protocol. The Director of Nursing, RN unit managers, Infection preventionist, and Staff LPN will address all concerns identified during the audit to include educating resident on risks/benefits and potential side effects associated with the vaccine, obtaining consent and administering vaccine/booster per resident preference or documenting resident refusal in the electronic record. Audit will be completed by 8/9/2022. . On 8/5/2022, the Infection Preventionist and Staff LPN initiated an in-service with all nurses regarding Immunizations. Emphasis on educating resident on risks, benefits and potential side effects of vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 8/26/2022. All newly hired nurses will be in-serviced during orientation in regards regarding Immunizations.	

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F 887	Continued From page 17	F 887	Administrator will audit 10% of resident immunization record weekly x 4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks, benefits and potential side effects of Covid 19 vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. The RN unit managers, Infection Preventionist, Staff LPN will address all concerns identified during the audit to include educating the resident, obtaining consent, notification of physician for order when indicated and providing vaccine per resident preference with documentation vaccine provided in the electronic record or documentation of refusal if resident declined. The DON will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Immunization Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Immunization Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring	