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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/11/2022 through 07/15/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Prepardeness. Event ID #UGZX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 07/11/22 through 07/15/22. Event ID# UGZX11. The following intakes were investigated: NC00189296 and NC00189926. 2 of the 4 complaint allegations were substantiated resulting in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. An extended survey was conducted. The 2567 was amended to reflect changes as result of the IDR 8/3/22.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		8/4/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2022

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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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain a resident ' s dignity while administering injections in a resident ' s abdomen without pulling the privacy	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in	

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curtain in a semi-private room or closing the door for 1 of 1 resident reviewed for dignity, Resident #48.

Findings included:

Resident #48 was admitted to the facility on with diagnoses which included insulin dependent diabetes.

A review of the medical record for Resident #48 revealed a physician order dated 03/21/22 for Humalog insulin pen, 100/milliliters, give 50 units three times a day subcutaneously and Toujeo Max SoloStar 300/units/milliliters-give 70 units each day.

A review of Resident #48 ' s quarterly Minimum Data Set (MDS) dated 6/10/22 revealed Resident #48 was cognitively intact and was administered insulin injections.

An observation during medication administration on 07/13/22 at 8:55 am in Resident #48 ' s room revealed Resident #48 was sitting in her wheelchair next to her B-bed which was closest to the window and her roommate (Resident #62) was in A-bed closest to the entry door. Observation also revealed Nurse #2 asked Resident #48 to lift her dress because Nurse #2 needed to administer two insulin injections. Resident #48 lifted her dress which exposed her brief, bare legs and abdomen. Observation also revealed Resident #48 was visible from the hallway. Nurse #2 began to administer the insulin injections; one on the left side and one on the right side of her abdomen. Nurse #2 did not pull the privacy curtain and Resident #48 ' s room door remained open.

F 550

compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F550
The facility failed to treat residents in a dignified manner.

1. Corrective action for resident(s) affected by the alleged deficient practice:

On 7/13/22 Nurse #2 was educated Staff Development Coordinator.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected. On 7/28/22 the Unit Support Nurse rounded the entire facility to ensure there were no resident exposures observed nor were there any dignity concerns. No exposures or dignity concerns were observed.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 7/14/22, the Staff Development Coordinator began education with all full time, part time, and as needed staff. The education that was completed was related to during a when administering injections

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Interview with Nurse #2 on 07/13/22 at 9:05 am revealed she should have asked Resident #48 if she wanted the privacy curtain pulled before administering the insulin injections. Nurse #2 added Resident #48 and her roommate knew each other very well and Nurse #2 felt like it was acceptable to provide care to Resident #48 with her roommate present because they knew each other so well. Nurse #2 also stated she had provided care before to Resident #48 while her roommate was in the room without pulling the privacy curtain. Nurse #2 added she should have shut the door, asked Resident #48 about the privacy curtain and pulled the privacy curtain to maintain Resident #48 ' s dignity. Nurse #2 stated she forgot to close the door upon entering Resident #48 ' s room.

Interview with Resident #48 on 07/13/22 at 9:30 am revealed Nurse #2 should have asked her if it was okay to leave open the privacy curtain as well as her room door. Resident #48 also stated this kind of thing happened all the time. She explained that staff regularly came in and provided care with her roommate present without pulling the privacy curtain. Resident #48 stated she wished the nurse had asked her about the privacy curtain before administering the insulin injections. Resident #48 added she would have liked the privacy curtain to be pulled and the door shut before pulling up her dress.

Interview with the Director of Nursing (DON) and Nurse Consultant #1 on 07/13/2022 at 9:46 am revealed the nurses should always ask the resident, close the door and pull the privacy curtain to maintain dignity and respect.

F 550

and/ or exposing any part of the body the door must be shut and the privacy curtain must be pulled. Do not administer injections in the hallway. Education was completed by 8/4/22.

The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 8/4/22 will not be allowed to work until the training is completed.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nurses or Designee will monitor compliance utilizing the F550 Resident Rights Quality Assurance Tool related to dignity and exposures weekly x 4 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents are being treated with dignity and respect. This Quality Assurance tool will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

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F 550	Continued From page 4 In an additional interview with the DON and Nurse Consultant #1 on 07/13/2022 at 10:24 am revealed Resident #48 and her roommate were very familiar with each other, and the nursing staff were aware of the close relationship, and therefore Nurse #2 did not ask Resident #48 about pulling the privacy curtain prior to administering the two insulin injections. The DON and Nurse Consultant #1 added Nurse #2 should have closed the door and pulled the privacy curtain while administering injections to Resident #48 due to her abdominal area, her bare legs and brief being exposed. The DON and Nurse Consultant #1 added the facility ' s protocol was for staff to pull the curtain and shut the door prior to providing resident care and all staff should pull the privacy curtain and close the door prior to administering patient care.	F 550	Date of Compliance: 8/4/22	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		

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F 600	Continued From page 5 by: Based on record review, police report and interviews with the resident, staff and nurse practitioner interview the facility failed to ensure a resident was free of staff to resident physical abuse for 1 of 3 residents reviewed for allegations of abuse (Resident #69). Resident #69 had bruises on her right arm and right forehead as well as a laceration to the bridge of her nose. The findings included: Resident #69 was admitted to the facility on 5/25/21. Resident #69 ' s significant change Minimum Data Set assessment dated 3/22/22 revealed she was assessed as having a moderate cognitive impairment. She was assessed to have adequate hearing, clear speech and was able to make herself understood by others. She had no behaviors during the lookback period. She required extensive assistance with bed mobility and toilet use. Resident #69 was assessed as requiring physical assistance with bathing. Resident #69 ' s care plan dated 3/22/22 revealed no care plan for behaviors. Review of Resident #69 ' s physician orders revealed she was not prescribed an anticoagulant. An interview was conducted with Nurse Aide (NA) #2 on 7/13/22 at 10:22 AM who stated she worked with Resident #69 on 6/8/22 and 6/9/22. She stated she is very familiar with Resident #69 and Resident #69 frequently sleeps in her	F 600	Past noncompliance: no plan of correction required.	

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glasses and utilizes a bed rail for transfers and turning. NA #2 reported when she worked with Resident #69 on 6/8/22 she observed no bruising or lacerations on Resident #69. She reported she did not observe Resident #69 on 6/9/22 until lunchtime when she observed the bruising and laceration. Na #2 stated she saw the bruising to Resident #69 ' s forehead and the laceration to the right side of her face. She reported she observed blood on Resident #69 ' s pillow. NA #2 stated the employee with the outside agency was in Resident #69 ' s room when she entered the room. She stated Resident #69 stated that a nurse aide punched her and stated she would teach her a lesson. NA #2 stated she went to get the Unit Manager. She reported the Program of All-Inclusive Care for the Elderly (PACE) employee was in the room and asked Resident #69 if the person who struck her was NA #2. NA #2 stated she heard Resident #69 state she was not the employee who struck her.

During an interview with Resident #69 on 7/13/22 at 11:04 AM she stated a nurse aide who worked at the facility hit her in the eyes. She reported the aide was wearing pink pants. Resident #69 stated she has not seen the nurse aide since it occurred. She reported she felt safe since the nurse aide no longer worked in the facility.

An interview was conducted with Resident #11 on 7/13/22 at 11:05 who shared a room with Resident #69. She stated she did not see or hear the incident occur. Resident #11 stated she knew it happened because she saw the bruising and laceration on Resident #69 ' s face but did not know any details.

During an interview with Nurse Aide (NA) #1

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conducted on 7/13/22 at 11:45 AM. She reported she worked with Resident #69 from 3:00 PM until 8:00 PM on 6/8/22. NA #1 stated she did not provide any care to Resident #69. She reported she came in at approximately 3:00 PM and did a quick check on all her assigned residents. NA #1 stated she left the facility and returned at 4:15 PM. She reported when she returned an unnamed resident needed changing. NA #1 stated trays came out at approximately 5:00 PM and she assisted with passing trays. She stated she picked up finished dinner trays and then she changed Resident #11 who shared a room with Resident #69. She reported at approximately 7:30 PM she no longer was assigned Resident #69 ' s room. NA #1 stated she was contacted the next day and informed that Resident #69 specifically pointed her out as the person who struck her. She stated she resigned from the facility when she was questioned about striking Resident #69. She reported she did not strike the resident. NA #1 reported she was asked by the Director of Nursing to write a statement and she agreed. She stated she was arrested prior to writing a statement so it was never done. NA #1 indicated she was charged with felony abuse of an elderly person and has a court date scheduled for 11/17/22.

A PACE social work progress note dated 6/9/22 revealed Resident #69 reported NA #1 was assisting her and pulled her right arm and she pulled back. She stated the aide pulled back and struck her with a fist twice in the face. The PACE social worker reported the incident to Adult Protective Services.

The PACE social worker was unavailable for interview.

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F 600	Continued From page 8 Review of a skin review sheet completed by Nurse #3 on 6/9/22 at 12:35 PM revealed bruising on her forehead and right forearm. It also indicated another wound at her right eye and nose area. An interview was conducted with Nurse #3 on 7/14/22 at 2:00 PM who was the assigned nurse on 6/9/22. She stated Resident #69 told her that she was punched in the face. She reported the bridge of Resident #69 ' s face was burgundy and above her right elbow was light blue. Nurse #3 also stated Resident #69 ' s forearm has a light blue bruise which looked like two fingers had been pushed on her forearm. Nurse #3 stated Resident #69 did not give her any additional details. During an interview with the Unit Manager on 7/13/22 at 12:31 PM she stated she worked with Resident #69 on 6/8/22 and the resident did not have any injuries. She reported she did not work with Resident #69 on 6/9/22 and had no knowledge of the injuries. An interview was conducted with Nurse #4 on 7/13/22 at 2:06 PM who stated she worked the night shift on 6/8/22 and she had no knowledge of Resident #69 ' s injuries. She reported Resident #69 was asleep when she began her shift, and the room was dark. The police report dated 6/9/22 revealed a police officer was dispatched to the facility and was informed by Resident #69 that she was assaulted by a nurse aide when she was trying to get her up to get a bath. The police officer charged Nurse Aide #1 with abuse of an elderly person.	F 600		

F 600 Continued From page 9 F 600

Review of the facility incident report dated 6/9/22 revealed Resident #69 reported to PACE worker that a staff member punched in the face on the afternoon of 6/8/22. Resident #69 had a bruise on the bridge of her nose with a small laceration on the right bridge of her nose. A smaller bruise was noted on her forehead and a larger bruise on the right forearm.

The facility ' s investigation report dated 6/16/22 revealed the allegation of abuse was substantiated. The incident report read in part, "The resident stated the NA (nurse aide) grabbed her right arm. The resident pulled back and said to the NA ' don ' t do that, it hurts ' . The resident states the NA balled her fist and hit her twice in the face and told her, ' That would teach her how to treat people ' . The resident identified the alleged employee from a photo and identified the outfit she was searing the day/time frame the incident occurred. Reviewing the camera footage confirmed the alleged perpetrator was wearing what the resident described."

Review of a note written by the facility Nurse Practitioner (NP) on 6/9/22 read in part, "Patient seen today due to bruising to face and arm. Found to have bruising to mid forehead and hematoma with laceration to bridge of the nose. Drops of dried blood noted to nose as well as glasses to right nose pad and on right side of bridge of nose. Bruising and minor swelling noted to right forearm."

An interview was conducted with the facility Nurse NP on 7/13/22 at 11:06 AM who stated there were bruises on Resident #69 ' s face. She reported the bruising was very noticeable on Resident #69 ' s face. The NP stated after her examination she

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requested x-rays of her right humerus, elbow, wrist, forearm, and hand. She also requested x-rays of nasal bones and paranasal sinuses. All x-rays were negative.

An interview with the Director of Nursing (DON) on 7/15/22 at 2:30 PM revealed the facility substantiated abuse due to the consistency of Resident #69 ' s statements through time and the fact the police charged NA #1 with a felony. She further stated review of surveillance camera footage revealed Nurse #2 was wearing pink pants. The DON also stated Resident #69 identified NA #1 by a picture on her Facebook page. The DON stated the surveillance camera footage was not saved. The facility provided a statement written by the Administrator which stated the footage of the incident was not available.

The Administrator was notified of immediate jeopardy on 7/13/22 at 5:55 PM.

The facility provided the following corrective action plan:
F600

· For the resident affected by the deficient practice.

All residents are at risk to be affected by the deficient practice.

Resident #69 reported to an outside agency on 6/9/22 that she was struck by a Nurse Aide on the evening of 6/8/22. Records from the outside agency revealed Resident stated she was struck twice in the face by the nurse aide. Facility record review revealed Resident #69 had bruising to her

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face and right arm. She also had a laceration to the right bridge of her nose. Interviews with staff who worked on day shift on 6/8/22 revealed Resident #69 had no bruising or laceration at the end of the day shift. During an interview with the nurse aide who worked with Resident #69 on 6/9/22 she reported Resident #69 had bruising and a laceration on her face. Resident was examined on 6/9/22 by the facility Nurse Practitioner who ordered Resident #69 x-rays of her right arm (hand, wrist, forearm, elbow, upper arm, shoulder). She also requested x-rays of nasal bones and paranasal sinuses. All x-rays were negative. Resident #69 guardian was notified of the injuries and allegation on 6/9/2022.

An interview was conducted with the nurse aide who was accused of hitting Resident #69. She stated she resigned from the facility when she was questioned. The nurse aide stated she did not strike Resident #69. She reported she was asked by the Director of Nursing if she would write a statement and she agreed. She stated she was arrested prior to writing a statement so it was never done. The accused nurse aide was charged with felony abuse of an elderly person and has a court date scheduled for 11/17/22. The accused CNA was suspended on 6/9/22 when the facility was made aware of the allegation. The employee remained on suspension until terminated.

· Identification of potentially affected residents and corrective actions taken.

All residents have the potential to be affected by this deficient practice.

On 6/9/22, all current residents were audited by

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the Nurse Management team for abuse. Alert and oriented residents with a BIMS of 13 or higher were interviewed for abuse by asking the resident if they had been harmed, abused, or threatened in any way. Residents with a BIMS of 12 or less had full body skin assessments completed by the RN Supervisor for signs of abuse or injuries. No new allegations of abuse or injuries were identified.

· Systemic Changes
Training began on 6/9/22 by the Nurse Administration Team (Assistant Director of Nursing, Staff Development Coordinator and RN Supervisor). This training included all full time, part time, and as needed- all staff including agency staff. This training included:
Education topic included abuse and burnout. This included how to prevent abuse, how to identify residents at risk for abuse, how to report suspicion of abuse and how to recognize and avoid burnout. Strategies for how to care for residents who are at high risk due to refusing care was also discussed.
The Director of Nursing and Staff Development Coordinator will ensure that any staff who does not complete the in-service training by 6/13/22 will not be allowed to work until the training is completed.

·Quality Assurance (QA)
The Director of Nursing or designee will interview and audit a sample of residents for concerns of abuse, neglect, or injury of unknown origin and timely reporting of these areas. The audits will be completed by the Director of Nursing or designee interviewing residents for concerns of abuse and neglect. Non-interview able residents will be assessed for injuries of unknown origin,

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F 600	Continued From page 13 tearfulness, or withdrawal from activities. QA audits will be completed weekly x 2 weeks then monthly x 3 months. Reports will be presented weekly in QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed in the weekly QA Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Admissions Marketing, Dietary Manager, Maintenance Director, Social Services, Activities Director, Business Office Manager, Minimum Data Set Nurse, Medical Director, and Director of Rehab. Date of corrective action plan completion: 6/13/22 The plan of correction was validated through review of verification of education provided to both residents and staff, a review of the audits and monitoring documentation and quality assurance meeting minutes. Staff interviews verified the education provided. The facility reported the incident of alleged abuse and submitted their investigation. The facility ' s date of compliance of 6/13/22 was verified.	F 600		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 18	F 641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	8/12/22

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F 641

Continued From page 14

residents whose MDS assessments were reviewed (Resident #19, Resident #69).

Findings included:

1. Resident #19 was admitted to the facility on 1/20/20 with diagnoses including dementia and dysphagia.

The quarterly MDS dated 4/29/22 revealed Resident #19 had moderate cognitive impairment. The MDS indicated Resident #19 required extensive assistance with the help of 2 or more people with eating.

An interview was conducted with the MDS Nurse on 7/14/22 at 11:00 AM and she stated it doesn ' t take 2 people to assist a resident with a meal. She stated she was not the MDS Nurse at that time, but it was an error.

Resident #19 was observed eating her meal with the assistance of one person (Nursing Assistant #1) on 7/14/22 at 1:00 PM. NA#1 and Resident #19 were interviewed at the same time as the observation. NA#1 stated Resident #19 needed only 1 person to assist her with eating. Resident #19 stated she has never needed 2 people to assist her with eating. She stated it has always been 1 person.

2. Resident #69 was admitted to the facility on 5/25/21 with diagnoses that included dementia.

Resident #69 ' s quarterly Minimum Data Set assessment with a date of 3/22/22 revealed she was coded for supervision with eating with the assistance of two people.

F 641

alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F641 Accuracy of Assessments
For resident #19, a corrective action was obtained on 07/27/22.
• The specific deficiency was corrected on 07/28/22 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 04/29/22 in order to correct miscoding of question G0110H2 (Eating Support). This correction was completed by the facility Minimum Data Set Nurse. The corrected assessment was re-submitted and accepted by the state database on 07/28/22 in Batch #2139.

For resident #69, a corrective action was obtained on 08/11/22.
• The specific deficiency was corrected on 08/11/22by modifying the Minimum Data Set assessment with an Assessment Reference Date of 03/22/22 in order to correct miscoding of question G0110H2 (Eating Support). This correction was completed by the facility Minimum Data Set Nurse. The corrected assessment was re-submitted and accepted by the state database on 08/12/22 in Batch #2142.

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F 641	Continued From page 15 An interview was conducted with the MDS (Minimum Data Set) Nurse on 7/14/22 at 10:57 AM who stated it does not take two people to provide supervision with eating and this was an error. An interview was conducted with the Administrator on 7/15/22 at 11:10 AM who stated Resident #69's assessment should have been coded accurately.	F 641	Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents will be conducted in order to identify any other resident who may have been affected by this alleged deficient practice. All current residents' most recently completed Omnibus Budget Reconciliation Act Minimum Data Set assessment (Quarterly, Annual, Admission or Significant Change) will be reviewed in order to determine if the G0110H2 was accurately coded. These audits will be completed by the facility Minimum Data Set Nurse and will be completed no later than 07/28/22. Any coding errors that are identified during the audit will be immediately modified and corrected and 7re-submitted to the state database no later than 07/28/22. Systemic Changes On 07/29/22, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record including documentation completed by Nursing Aides during the assessment reference lookback timeframe prior to completion of Activities of Daily Living questions in Section G of the Minimum Data Set Assessment. This education also	

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F 641	Continued From page 16	F 641	emphasized the importance of the Minimum Data Set Assessment Nurse assessing the resident's functional abilities by assessing and interviewing the resident prior to completion of G0110H2 of the Minimum Data Set Assessment. In addition, the importance of interviewing direct care staff members prior to completion of the Minimum Data Set Assessment was also reviewed. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of MDS item G0110H2 using the quality assurance audit tool entitled "Accurate Minimum Data Set Coding Audit Tool." This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for	

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F 641	Continued From page 17	F 641	implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 08/12/22	
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		8/5/22

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resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete baseline care plans for 4 of 19 residents reviewed for baseline care plans, (Resident #68, Resident #65, Resident #33 and Resident #71).

1. Resident #68 was admitted to the facility on 06/13/22 with diagnosis including chronic respiratory failure, Type II diabetes mellitus and chronic kidney disease.

Record review revealed Resident #68 had no baseline care plan.

On 07/12/22 at 3:39 PM an interview was conducted with the Director of Nursing (DON) and Nurse Consultant #1 revealed they both stated a baseline care plan was not completed for Resident #68.

2. Resident #65 was admitted to the facility on 06/13/22 with diagnosis including fracture of the right hip, chronic kidney disease stage 5 and dependence on renal dialysis.

Record review revealed Resident #65 had no

F 655

F-655 Baseline Care Plan
Corrective action for affected residents:
Resident #33 Baseline care plan was completed on 7/28/22
Resident #71 no longer in facility
Resident #65 Baseline care plan was completed on 7/28/22
Resident #68 Baseline care plan was completed on 7/25/22
Corrective action for residents with the potential to be affected by the alleged deficient practice:

All residents have the potential to be impacted by the alleged deficient practice.
A 100% audit of all current residents who have been admitted to the facility within the last 30 days was completed in order to determine if the baseline care plan requirement was met for each of them.
Audit was completed by Assistant Director of Nursing on 07/25/22.

The results of this audit were:

" 1 of 13 residents were identified as

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baseline care plan.

On 07/12/22 at 3:39 PM an interview was conducted with the Director of Nursing (DON) and Nurse Consultant #1 revealed they both stated a baseline care plan was not completed for Resident #65.

3. Resident #33 was admitted to the facility on 03/01/22 with diagnosis including Alzheimer ' s disease and heart-valve replacement.

Record review revealed Resident #33 had no baseline care plan.

On 07/12/22 at 3:39 PM an interview was conducted with the Director of Nursing (DON) and Nurse Consultant #1 revealed they both stated a baseline care plan was not completed for Resident #33.

Interview with Nurse #1 on 07/12/22 at 03:27 pm revealed she completed most of the new admissions and stated she had not been completing a baseline care plan for any residents admitted since she began working at the facility. Nurse #1 added she was not aware she needed to complete a baseline care plan.

On 07/12/22 at 3:39 PM The DON stated nursing staff had not been educated on the baseline care plan process. Nurse Consultant #1 stated it was not a part of the new hire orientation process.

An additional interview with the DON on 07/15/22 at 5:47 pm revealed baseline care plans would be completed within 48 hours of the resident's admission date.

F 655

having not had the baseline care plan requirement met.
"   11 of 13 residents were identified as having had the baseline care plan requirement met.

All residents who were identified as not having had the Baseline Care Plan requirement met will have their care plan revised and updated in order to include all information necessary to provide quality and individualized care for them. This will be completed by 7/29/22.

Systemic Changes

On 07/27/22, all licensed nurses received education on requirements for completed of the Baseline Care Plan by the Staff Development Coordinator. This education reviewed CMS requirements for ensuring that the Baseline Care Plan requirement be met for all newly admitted residents including the following:

Baseline Care Plan Requirement:
The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:

1. Be developed within 48 hours of a resident□s admission.
2. Include the minimum healthcare information necessary to properly care for

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4. Resident #71 was admitted on 4/5/22 with diagnoses including dementia and adult failure to thrive.

Record review revealed Resident #71 did not have a baseline care plan developed.

On 07/12/22 at 3:39 PM an interview was conducted with the Director of Nursing and the Nurse Consultant, and they stated a baseline care plan was not completed for Resident #71. The Director of Nursing stated nursing staff had not been educated on the base line care plan process. The Nurse Consultant stated it was not part of the orientation process.

The Director of Nursing was interviewed on 07/15/22 at 5:47 PM and she stated she expected baseline care plans to be completed within 48 hours of the resident ' s admission date.

F 655

a resident including, but not limited to:
¿ Initial goals based on admission orders.
¿ Physician orders.
¿ Dietary orders.
¿ Therapy services.
¿ Social services
¿ PASARR recommendation, if applicable.

Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR ¿483.21(a)). In many cases, interventions to meet the resident□s needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident□s problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
The Director of Nursing or designee will review 5 random residents who have been

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F 655	Continued From page 21	F 655	admitted to the facility during the past 30 days in order to determine if the Baseline Care Plan was completed during the required timeframe. This audit will be completed using the Quality Assurance audit tool entitled Baseline Care Plan Completion Audit. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 08/5/22	
F 835 SS=G	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and	F 835	The statements made on this plan of	8/5/22

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F 835	Continued From page 22 interviews with resident representative and staff, the facility failed to provide effective leadership and oversight to ensure systems and policies were implemented related to COVID-19 staff vaccinations for 3 of 3 dietary staff (Dietary Aide #1, Dietary Aide #2, and Dietary Aide #3), resident vaccinations for 1 of 5 residents (Resident #39), and staff testing for 3 of 3 unvaccinated staff (Nurse #3, Nurse Aide #3 and Housekeeper #1). The facility was in COVID-19 outbreak status and had 18 residents test positive for COVID-19 since 6/15/22 (Resident #31, Resident #64, Resident #21, Resident#1, Resident #17, Resident #40, Resident #35, Resident #270, Resident #5, Resident #38, Resident #24, Resident #54, Resident #3, Resident #36, Resident #39, Resident #42, Resident #101, and Resident #102). Findings included: This tag is cross reference to: F888: Based on observation, record review and interviews, the facility failed to implement their policy on COVID-19 vaccinations and to meet the requirement for staff vaccination when Dietary Aide (DA) #1, DA #2, and DA #3 worked without being fully vaccinated and without an exemption. This was for 3 of 3 kitchen staff reviewed for vaccinations. The facility was in COVID-19 outbreak status and had 18 residents test positive for COVID-19 since 6/15/22 (Resident #31, Resident #64, Resident #21, Resident#1, Resident #17, Resident #40, Resident #35, Resident #270, Resident #5, Resident #38, Resident #24, Resident #54, Resident #3, Resident #36, Resident #39, Resident #42, Resident #101, Resident #102).	F 835	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 835 Corrective Action for Affected Residents Dietary Aide #1 up to date on COVID 19 Vaccinations as of 07/26/22. Dietary Aide #2 no longer employed at the facility Dietary Aide #3 up to date on COVID 19 Vaccinations as of 07/14/22 Resident #39 offered vaccination on 8/2/22 and received it on 8/3/22 Nurse #3 was tested on 7/15/22 Nurse aide #3 was tested on 7/15/22 Housekeeper #1 was tested on 7/23/22 Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 08/4/22, the Administrator audited the Staff Vaccination List, Resident Vaccination List, as well as the Facility testing log to ensure all current staff and have been vaccinated and tested according to policy. This was completed on 8/4/22. Systemic Changes On 07/29/22 the Administrator began in-servicing all Department Managers and	

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F887: Based on record review, resident representative interview and staff interviews, the facility failed to ensure residents not up to date with COVID-19 vaccinations were offered the COVID-19 vaccine prior to scheduled COVID-19 clinics and failed to maintain a record of refusal for the COVID-19 vaccine for 1 of 5 residents (Resident #39) reviewed for COVID-19 immunizations. This occurred during a COVID-19 pandemic, and the facility was in outbreak status for COVID-19.

F-886: Based on record review and staff interviews, the facility which was located in a county with a high community transmission level and was in an outbreak status for COVID-19 failed to conduct COVID-19 testing per Centers for Medicare and Medicaid guidelines every three days and track documentation of COVID-19 testing twice a week for 3 of 3 COVID-19 unvaccinated staff members (Nurse #3, NA #3 and Housekeeper #1) reviewed for COVID-19 testing. Eighteen residents and eleven staff members tested COVID-19 positive since the outbreak. This occurred during a COVID-19 pandemic.

In an interview with the Administrator on 7/15/2022 at 12:25 p.m., he stated the facility used broad based measures in response to the COVID-19 outbreak that began on 6/10/2022. He stated the last positive COVID case was on 6/30/2022 and the facility would remain in outbreak status until fourteen days without new positive cases. In an follow-up interview with

F 835

Staff. This in-service included the following topics:
" Ensuring that all staff follow the COVID testing plan, Importance of collecting the COVID vaccination card on hire, and the Importance of ensuring all residents are offered the COVID Vaccine. The Administrator will ensure that any Department Managers whom have not received this training by will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance
The Director of Nursing or Staff Development Coordinator will monitor this issue using the Survey Quality Assurance Tool for Monitoring Vaccination and testing Compliance. The monitoring will include reviewing Liberty Commons Direct Care and Contract Vaccine List. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

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F 835	Continued From page 24 Administrator on 7/15/202 at 5:16 p.m., he stated he had not explored into how residents were offered COVID-19 vaccination or the process when residents refused the COVID-19 vaccine and stated all staff were COVID-19 tested because of county's high community transmission level.	F 835	Date of compliance: 08/5/2022	
F 886 SS=E	COVID-19 Testing-Residents & Staff 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.	F 886		7/29/22

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F 886	Continued From page 25 §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 (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 record review and staff interviews, the facility which was located in a county with a high community transmission level and was in a n outbreak status for COVID-19 failed to conduct COVID-19 testing per Centers for Medicare and Medicaid guidelines every three days and track	F 886	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will	

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documentation of COVID-19 testing twice a week for 3 of 3 COVID-19 unvaccinated staff members (Nurse #3, NA #3 and Housekeeper #1) reviewed for COVID-19 testing. Eighteen residents and eleven staff members tested COVID-19 positive since the outbreak. This occurred during a COVID-19 pandemic.

Findings included:

The facility's policy "Staff Vaccination Policy" dated revised 2/2022 stated under "Unvaccinated Employees (include exempted)" employee that were not fully vaccinated or had been granted exemptions would be expected to follow all of the core principles of infection control. Additionally, they would be expected to do the following: (1) Test at least weekly or follow the facility testing plan based on county transmission rates. Staff that had been past positive in the last 90 days did not need to be tested.

Centers for Medicare and Medicaid Services guidance QSO-20-38-NH dated revised 4/27/2021 stated for outbreak testing, all staff should be tested regardless of vaccination status and all staff that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff for a period of at least 14 days since the most recent positive staff.

The facility's COVID-19 Policy dated 6/2022 stated under "Create a Plan for Testing Residents and Healthcare Personnel (HCP)" expanded screening testing of asymptomatic HCP should be as follows: in nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test

F 886

take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F 886
Corrective Action for Affected Residents
On 7/25/22 the Administrator revised the facility testing plan and schedule to Monday and Thursday.
Corrective Action for Potentially Affected Residents
All residents have the potential to be affected by this alleged deficient practice. On 8/1/22, the Administrator reviewed and audited the newly created COVID 19 Facility Testing Log to ensure all employees required for testing at that time received the COVID 19 Test per policy. This was completed on 08/3/22.
Systemic Changes
On 7/28/22 the Staff Development Coordinator began in-servicing all current staff. This in-service included the following topics:
" The Importance of COVID 19 Testing, the Mandatory Requirements, and the new facility testing plan and log.
The Staff Development and Director of Nursing will ensure that any staff member who has not received this training by 07/29/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the

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twice a week. If these HCP work infrequently at these facilities, they should ideally be tested within 3 days before their shift (including the day of the shift).

A review of the facility's COVID-19 surveillance log revealed the facility's outbreak status started on 6/10/2022. The last positive COVID-19 test was on 6/30/2022, and the facility was in outbreak status for COVID-19.

A review of the Centers of Disease Control and Preventions COVID-19 data dated 7/13/2022 revealed the facility was located in a county with high community transmission levels.

1. A review of the facility's COVID-19 Staff Vaccination Status for Providers revealed Nurse #3 was granted a non-medical exemption for the COVID-19 vaccinations.

A review of Nurse #3's Clock Audit Report from May 1, 2022 to July 15, 2022 revealed she worked in the facility the following dates:
Week 1: 5/5/2022, 5/3/2022, 5/6/2022 and 5/7/2022
Week 2: 5/7/2022, 5/8/2022 and 5/11/2022
Week 3: 5/16/2022, 5/17/2022, 5/20/2022 and 5/21/2022
Week 4: 5/22/2022, 5/25/2022 and 5/26/2022
Week 5: 5/30/2022, 5/31/2022, 6/3/2022 and 6/4/2022
Week 6: 6/5/2022 and 6/9/2022
Week 7: 6/13/2022, 6/14/2022, 6/17/2022 and 6/18/2022
Week 8: 6/19/2022, 6/22/2022 and 6/23/2022

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change has been sustained.
Quality Assurance
The Administrator of Designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring COVID Testing. The monitoring will include reviewing COVID 19 Facility Testing Log and COVID 19 Individual Testing form. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

Date of compliance: 07/29/2022

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Week 9: 6/27/2022, 6/28/2022 and 7/2/2022
Week 10: 7/3/2022, 7/6/2022 and 7/7/2022
Week 11: 7/11/2022, 7/12/2022 and 7/15/2022

A review of the facility's Point of Care COVID-19 Results Documentation forms from May 1, 2022 to July 15, 2022 for Nurse #3 revealed COVID-19 testing was not documented performed for 6 of 11 weeks (Week 1, Week 6, Week 7, Week 8, Week 9, Week 10) and was documented performed once a week for 5 of 11 weeks (Week 2, Week 3, Week 4, Week 5 and Week 11).

In an interview with Nurse #3 on 7/15/2022 at 2:31 p.m. she stated COVID-19 staff testing was scheduled for Monday and Wednesday each week, and as an approved COVID-19 vaccination exempted staff member, she was required to test twice a week. She stated every other week when she worked on Wednesday and Thursday, she was COVID-19 tested that Wednesday morning before reporting to work and on Thursday evening before leaving the facility and the opposite weeks she was tested on Monday and Friday when reporting to work.

2. A review of the facility's COVID-19 Staff Vaccination Status for Providers revealed NA #3 was granted a non-medical exemption for the COVID-19 vaccinations.

A review of NA #3's Clock Audit Report from May 1, 2022 to July 15, 2022 revealed she worked in the facility the following dates:
Week 1: 5/1/2022 and 5/5/2022
Week 2: 5/9/2022, 5/10/2022,

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5/11/2022, 5/13/2022 and 5/14/2022
Week 3: 5/15/2022
Week 4: 5/23/2022, 5/24/2022, 5/25/2022 and 5/28/2022
Week 5: 5/29/2022, 6/1/2022 and 6/4/2022
Week 6: 6/6/2022, 6/72022, 6/8/2022, 6/9/2022 and 6/11/2022
Week 7: 6/12/2022, 6/16/2022, 6/17/2022 and 6/18/2022
Week 8: 6/19/2022, 6/21/2022, 6/22/2022 and 6/25/2022
Week 9: 6/26/2022, 6/29/2022 and 6/30/2022
Week 10: 7/5/2022, 7/6/2022, 7/7/2022 and 7/9/2022
Week 11: 7/10/2022, 7/14/2022, 7/15/2022

A review of the facility's Point of Care COVID-19 Results Documentation forms from May 1, 2022 to July 15, 2022 for NA #3 revealed COVID-19 testing was not documented performed for 5 of 11 weeks (Week 1, Week 3, Week 7, Week 8, Week 11) and was documented conducted once a week for 3 of 11 weeks (Week 5, Week 9 and Week 10). COVID-19 testing documented performed twice a week for 3 of 11 weeks (Week 2, Week 4, and Week 6) revealed COVID-19 testing occurred with less than three days between testing on Mondays and Wednesdays.

In an interview with NA #3 on 7/15/2022 at 1:49 p.m., she stated due to receiving a COVID-19 vaccination exemption, she was required to test for COVID-19 twice a week at the facility on Monday and Wednesday. She stated when she was not working on Monday or Wednesday, she drove to the facility to receive the COVID-19 test.

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3. A review of the facility's COVID-19 Staff Vaccination Status for Providers revealed Housekeeper #1 was granted a medical exemption for the COVID-19 vaccinations.

A review of Housekeeper #1's Clock Audit Report from May 1, 2022 to July 15,2022 revealed she worked in the facility on the following dates:
Week 1: 5/1/2022
Week 2: 5/14/2022
Week 3: 5/15/2022
Week 4: 6/8/2022, 6/11/2022
Week 5: 6/12/2022

A review of the facility's Point of Care COVID-19 Results Documentation forms from May 1, 2022 to July 15, 2022 for Housekeeper #1 revealed COVID-19 testing was not documented performed for 3 of 4 weeks (Week 1, Week 2, Week 3 and Week 5) and was documented performed once a week for 1 of 4 weeks (Week 4) on 6/8/2022.

In a phone interview with Housekeeper #1 on 7/15/2022 at 3:54 p.m., she stated her COVID-19 vaccination exemption was approved by the facility and she was required to test twice a week for COVID-19 on Mondays and Wednesdays. She stated she worked every other Monday and Wednesday and drove into the facility to be COVID-19 tested on her days off.

In an interview with the Infection Preventionist (IP) on 7/13/2022 at 2:40 p.m., she stated the facility was in outbreak status and all staff members were tested twice a week on Monday and Wednesday. She stated COVID-19 testing was conducted at the front desk and Point of

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Care COVID-19 Results Documentation Forms were completed when staff reported to work before 8:00p.m. and by the night shift nursing supervisor after 8:00 p.m. She stated the Point of Care COVID-19 Results Documentation Forms were placed in the IP mailbox and placed in each staff members file. She stated the business office kept copies of the staff roster used to track which staff members tested for the week.

On 7/15/2022 at 2:01 p.m. in a follow up interview with the IP, she stated staff members completed Point of Care COVID-19 Results Documentation forms that included test dates and results of the COVID-19 test when COVID-19 test were performed. She stated the business office received the Point of Care COVID-19 Results Documentation forms, and the IP stated she was not tracking which staff members were COVID-19 tested each week.

On 7/15/2022 at 4:38 p.m. in an interview with Receptionist #1, she stated COVID-19 testing was conducted twice a week usually on Monday and Wednesday. She stated staff members that did not work weekly were tested prior to reporting to work. She stated she did not have a staff roster to track when staff members tested. She stated COVID-19 testing was track by completion of the Point of Care COVID-19 Results Documentation forms and were given to the Director of Nursing and Business Office Manager.

On 7/15/2022 at 4:40 p.m. in an interview with the Business Office Manager, she stated Point of Care COVID-19 Results Documentation forms documented COVID-19 testing and were used to report information on the National Healthcare Safety Network (NHSN) weekly. She stated she

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did not use a staff roster to identify which staff members tested for COVID-19. She stated she knew the staff members and when entering the information in NHSN would recognize if a staff member had not tested twice a week. She stated the Infection Preventionist received the original Point of Care COVID-19 Results Documentation forms and stated based on the COVID-19 testing process, staff members could have not been tested twice a week.

On 7/15/2022 at 4:45 p.m. in an interview with the Director of Nursing (DON), she stated all staff members were COVID-19 tested twice a week because of the facility's outbreak status and the county's high community transmission level for COVID-19. She stated COVID-19 vaccination exempted staff members were tested twice a week whether in outbreak status for COVID-19 or the county's COVID-19 community transmission level. She stated staff members completed Point of Care COVID-19 Results Documentation forms when tested, and there should be three days between COVID-19 testing. The DON stated she did not know who was tracking COVID-19 testing to ensure staff members were tested.

On 7/15/2022 at 5:16 p.m. in an interview with the Administrator, he stated the facility was conducting COVID-19 testing twice a week for the unvaccinated staff members and the vaccinated staff members. He stated the Infection Preventionist was responsible for tracking staff members were COVID-19 tested twice a week.

On 7/15/2022 at 5:35 p.m. in an interview with Nurse Consultant #1, she stated COIVD-19 testing should be conducted every three days.

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F 887	Continued From page 33	F 887		
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; (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	F 887		8/4/22

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F 887	Continued From page 34 (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, resident representative interview and staff interviews, the facility failed to ensure residents not up to date with COVID-19 vaccinations were offered the COVID-19 vaccine prior to scheduled COVID-19 clinics and failed to maintain a record of refusal for the COVID-19 vaccine for 1 of 5 residents (Resident #39) reviewed for COVID-19 immunizations. This occurred during a COVID-19 pandemic, and the facility was in outbreak status for COVID-19. Findings included:	F 887	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility�s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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The facility's policy "COVID-19 Vaccination" dated revised 2/2022 stated all persons be offered the COVID-19 vaccine and the facility would follow the recommendation of the Centers for Disease Control and Prevention related to boosters and additional doses. It further stated under "Procedure for Obtaining Consent" consent would be obtained before each visitation clinic and would not be offered at admission, and every eligible vaccine candidate would receive a Liberty Consent/Declination Form and would be educated on the vaccine. This will be accomplished by providing a copy of the Emergency Use Authorization (EUA) Fact Sheet and other documents that may be required by eternal partner and stated under "Documentation" resident consent and declination forms should be kept in the hard charts or scanned into the Point Click Care (PCC).
The Centers for Disease Control and Prevention (CDC) guidance dated 6/24/2022 recommended second COVID-19 booster for adults ages 50 years and older at least four months after the first booster.

Resident #39 was admitted to the facility on 4/25/2022, and diagnoses included dementia.

The admission Minimum Data Set (MDS) assessment dated 5/2/2022 and a quarterly MDS assessment dated 6/7/2022 indicated the resident was severely cognitively impaired and exhibited no behaviors for rejecting care.

Resident #39's care plan dated 5/9/2022 revealed a focus for impaired cognitive function and dementia or impaired thought processes related to anxiety, and interventions included communicating with the resident, family and

F 887

F 887
Corrective Action for Affected Residents
On 8/2/22 the Infection Preventionist offered resident #39 the COVID 19 Vaccine on the COVID 19 Vaccination Declination or Consent form. Resident #39 received the vaccination on 8/3/22.
Corrective Action for Potentially Affected Residents
All residents have the potential to be affected by this alleged deficient practice.
On 8/1/22, the Infection Preventionist and the Assisted Director of Nursing audited and reviewed the facilities Resident COVID 19 Vaccination List to ensure all residents not up to date on the COVID 19 vaccination, completed the consent/declination form. This was completed on 8/4/22.
Systemic Changes
On 07/29/22 the Quality Assurance Nurse Consultant inserviced the Infection Preventionist and now Interim Director of Nursing. This in-service included the following topics:
" Importance of ensure residents or RP are given a written choice for the COVID 19 Vaccine and the entire Vaccination Policy.
This information has been integrated into the standard orientation training for all Directors of Nursing and Infection Preventionist.
Quality Assurance
The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Resident Immunizations. The monitoring will include reviewing the COVID 19

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	345468	A. BUILDING ______ B. WING ______	C 07/15/2022

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F 887	Continued From page 36 caregivers regarding the resident ' s capabilities and needs. A review of Resident #39's immunization record revealed she received the first dose of COVID-19 vaccine on 1/20/2021, the second dose on 2/10/2021 and the first booster on 12/13/2021. A review of the facility's COVID-19 Clinic Schedule revealed a COVID-19 clinic was held for employees and residents on May 11, 2022, June 8, 2022 and July 6, 2022. There was no documentation in electronic medical record Resident #39 was offered and declined COVID-19 vaccine prior to the scheduled COVID-19 clinics on May 11, 2022 and June 8, 2022. The facility provided a COVID-19 vaccine consent form dated 6/24/2022 signed by Resident #39's Representative. A review of the facility's COVID-19 Surveillance log revealed the facility's outbreak status for COVID-19 started on 6/10/2022, and Resident #39 tested positive for COVID-19 on 6/27/2022. In an interview with Resident #39's representative on 7/11/2022 at 2:04 p.m., she stated Resident #39 was due the second COVID-19 booster vaccine in June 2022, and the facility did not contact her prior to the scheduled COVID-19 vaccination clinic in June 2022 for consent. She stated Resident #39 did not receive the second booster of COVID-19 vaccine and contracted COVID-19 in June 2022 while in the facility. In an interview with Infection Preventionist (IP) on 7/13/2022 at 2:40 p.m., she stated scheduled COVID-19 vaccine clinics were held monthly, and	F 887	Vaccination Consent/Decline Form. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 8/4/22	

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F 887	Continued From page 37 a local pharmacy came to the facility to administer staff and residents consenting to the COVID-19 vaccine. She stated she asked residents or resident representatives prior to scheduled COVID-19 vaccine clinics if they wanted the COVID-19 vaccine. If the vaccine was declined, it was documented on a declaration form and scanned in the electronic medical record (EMR). In a follow up interview on 7/15/2022 at 2:01p.m., the IP stated Resident #39 was offered the COVID-19 booster vaccination in May 2022 and June 2022, and Resident #39's Representative refused the vaccine. She stated declination forms were sent to medical records and would try to locate the forms since the information was not in Resident #39 s EMR. She stated Resident #39 was not given the COVID-19 booster vaccine in July 2022 on the scheduled COVID-19 clinic because Resident #39 had tested positive for COVID-19 in June 2022. On 7/15/2022 at 5:35 p.m., the IP stated she was unable to locate documentation of Resident #39's refusal for COVID-19 vaccination prior to May 2002 and June 2022 scheduled Covid-19 vaccination clinics. In an interview with Director of Nursing(DON) on 7/15/2022 at 4:45 p.m., she stated COVID-19 vaccination status was reviewed on admission, and the infection preventionist maintained a list of the residents not up to date with COVID-19 vaccinations. She stated the IP offered the COVID-19 to the residents prior to the scheduled COVID-19 vaccine clinics and the facility used a declination form to document refusal of the COVID-19 vaccine. In a follow up interview with the DON on 7/15/2022 at 5:39 p.m., she stated Resident #39's Representative did not think it was time for Resident #39 to have the COVID-19	F 887		

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F 887	Continued From page 38 booster vaccine in May 2022 and in June 2022 Resident #39 was positive for COVID-19. In an interview with the Nurse Consultant #1 on 7/15/2022 at 5:30 p.m., she stated when residents refused COVID-19 vaccines, a declination form needed to be completed.	F 887		
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	F 888		8/10/22

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

§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;

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F 888	Continued From page 40 (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all 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	F 888		

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for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to implement their policy on COVID-19 vaccinations and to meet the requirement for staff vaccination when Dietary Aide (DA) #1, DA #2, and DA #3 worked without being fully vaccinated and without an exemption. This was for 3 of 3 kitchen staff reviewed for vaccinations. The facility was in COVID-19 outbreak status and had 18 residents test positive for COVID-19 since 6/15/22 (Resident #31, Resident #64, Resident #21, Resident#1, Resident #17, Resident #40, Resident #35, Resident #270, Resident #5, Resident #38, Resident #24, Resident #54, Resident #3, Resident #36, Resident #39, Resident #42, Resident #101, Resident #102).

Findings included:

The facility ' s "Covid-19 Staff Vaccination Policy" revised 2/2/22 read in part "Staff must have the necessary vaccines to be fully vaccinated by February 26, 2022" and "newly hired employees

F 888 — Provider's Plan of Correction:

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F 888
Corrective Action for Affected Staff
Dietary Aide #1 up to date on COVID 19 Vaccinations as of 07/26/22 and tested twice weekly until considered fully vaccinated. 1st vaccine was 7/5/22. 2nd vaccine 7/26.
Dietary Aide #2 up to date on COVID 19 Vaccinations as of 07/28/22 tested twice weekly no longer with the company as of

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and other new staff will also be required to comply with this policy. In order for a person to be hired or eligible to provide services at the facility after 2/26/22, all such individuals must be fully vaccinated or request a medical/religious exception. Proof of vaccination will be required." Under the heading New Hires, the policy stated, "Employees will not be allowed to work with residents unless they have either one vaccine or an approved exception."

A review of the National Healthcare Safety Network (NHSH) data reported the week of 6/26/2022 indicated 84% of the staff had completed COVID-19 vaccinations and 84% of the staff had completed or was partially COVID-19 vaccinated.

A review of the facility ' s surveillance COVID-19 log revealed 18 residents (Resident #31, Resident #64, Resident #21, Resident#1, Resident #17, Resident #40, Resident #35, Resident #270, Resident #5, Resident #38, Resident #24, Resident #54, Resident #3, Resident #36, Resident #39, Resident #42, Resident #101, Resident #102) residing in the facility tested positive for COVID-19 since 6/15/2022.

a. A review of the facility ' s COVID-19 Staff Vaccination Status for Providers spreadsheet revealed DA #1 was partially vaccinated and DA #1 received the first dose of a two dose vaccination series on 7/5/2022.

The kitchen schedule for dietary employees revealed DA#1 was scheduled to work on 7/9/22, 7/10/22 and 7/12/22 through 7/14/22.

F 888

7/25/22.
Dietary Aide #3 up to date on COVID 19 Vaccinations as of 07/14/22 and tested twice weekly until considered fully vaccinated. 2nd vaccine was 7/26/22. Both Dietary Aides worked so our completion date is 8/10/22

Corrective Action for Potentially Affected Residents
All residents have the potential to be affected by this alleged deficient practice. On 08/04/22, the Administrator audited the Staff Vaccine List to ensure all current staff have been vaccinated according to policy. This was completed on 08/4/22.
Systemic Changes
On 07/29/22 the Administrator and SDC began in-servicing all Department Managers. This in-service included the following topics:
" Ensuring that all new hires provide a copy of an up to date COVID vaccination card prior to hire in the facility.
" COVID Vaccination Policy
The Director of Nursing will ensure that any Department Manager who has not received this training by 8/4/22 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff.
Quality Assurance
The Director of Nursing or Staff Development Coordinator will monitor this issue using the Survey Quality Assurance Tool for Monitoring Vaccination Compliance . The monitoring will include reviewing Liberty Commons Direct Care

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An observation and interview were conducted on 7/13/22 at 3:08 PM with DA #1. DA #1 was observed working in the facility ' s kitchen. He stated he started last week and started training after orientation. He stated he worked in the kitchen and had delivered meal carts to resident halls.

An interview was conducted with the Corporate Nurse Consultant on 7/13/22 at 3:30 PM and she stated the facility was following their policy for new hires. She stated she thought new employees could work in the facility if they had their first dose of a vaccine as long as they followed personal protective equipment and testing protocols for exempt employees.

b. A review of the facility ' s COVID-19 Staff Vaccination Status for Providers spreadsheet revealed DA #3 was partially vaccinated and received the first dose of a two dose vaccination series on 5/23/22. She was scheduled to work 7/7/22, 7/8/22, 7/10/22 and 7/12/22.

An interview was conducted with DA #3 on 7/14/22 at 4:00 PM, and she stated she had been working at the facility for approximately 2 weeks. She also stated she received her second shot on 7/14/2022.

An interview was conducted with the Corporate Nurse Consultant on 7/13/22 at 3:30 PM and she stated the facility was following their policy for new hires. She stated she thought new employees could work in the facility if they had their first dose of a vaccine as long as they followed personal protective equipment and testing protocols for exempt employees.

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and Contract Vaccine List. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

Date of compliance: 08/9/2022

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F 888	Continued From page 44 c. A review of the facility ' s COVID-19 Staff Vaccination Status for Providers spreadsheet revealed DA #2 was partially vaccinated and received the first dose of a two dose vaccination series on 6/28/22. Dietary work schedules revealed DA #2 was scheduled to work 7/7/22, 7/8/22, 7/11/22, and 7/15/22. An interview was conducted with the Corporate Nurse Consultant on 7/13/22 at 3:30 PM and she stated the facility was following their policy for new hires. She stated she thought new employees could work in the facility if they had their first dose of a vaccine as long as they followed personal protective equipment and testing protocols for exempt employees.	F 888		