STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

(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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/14/22 to 2/17/22. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing ADON- Assistant Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment,	F 640		3/25/22

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

Electronically Signed | 03/09/2022

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F 640	Continued From page 1 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and MDS Resident Assessment Instrument (RAI) 3.0 manual review, the facility failed to ensure MDS assessments were transmitted timely for 5 of 6 sample elders (#11, #12, #25, #26, #27) reviewed for MDS transmission. The findings were:	F 640	1. Corrective action for resident # 11 MDS transmission was completed on 02/21/2022. 2. Corrective action for resident # 12 MDS transmission was completed on 02/21/2022. 3. Corrective action for resident # 25	

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F 640	Continued From page 2 1. Review of the MDS assessment history for elder #11 on 2/16/22 showed a quarterly MDS assessment was dated 1/3/22 and had a status of "production batch." Further review showed the completion date was 1/12/22, however there was no evidence the assessment was transmitted or accepted. 2. Review of the MDS assessment history for elder #12 on 2/16/22 showed a quarterly MDS assessment was dated 12/27/22 and had a status of "production batch." Further review showed the completion date was 1/19/22, however there was no evidence the assessment was transmitted or accepted. 3. Review of the MDS assessment history for elder #25 on 2/16/22 showed a quarterly MDS assessment was dated 12/27/21 and had a status of "production batch." Further review showed the completion date was 1/19/22, however there was no evidence the assessment was transmitted or accepted. 4. Review of the MDS assessment history for elder #26 on 2/16/22 showed a quarterly MDS assessment was dated 1/3/22 and had a status of "production batch." Further review showed the completion date was 1/12/22, however there was no evidence the assessment was transmitted or accepted. 5. Review of the MDS assessment history for elder #27 on 2/16/22 showed a quarterly MDS assessment was dated 1/3/22 and had a status of "in process." Further review showed no evidence the assessment was completed, transmitted, or accepted.	F 640	MDS transmission was completed on 02/21/2022. 4. Corrective action for resident # 26 MDS transmission was completed on 02/21/2022. 5. Corrective action for resident # 27 MDS transmission was completed on 02/21/2022. Corrective action a. MDS coordinator reeducated on submission process 02/21/2022 -each MDS will be transmitted within 14 days of the MDS Completion Date. b. Corrective action taken to prevent other residents from being affected: MDS Coordinator will submit every Wednesday. Director of Nursing will audit MDS submission every Thursday. 6. Identification of others a. All new and current residents will be reviewed and monitored by the IDT team on the Quarterly/ Annual MDS Audit Tool. Corrective action taken to prevent other residents from being affected: MDS coordinator will be monitored on timely submission weekly by the Director of Nursing. 7. System measures DON educated MDS Coordinator of the systemic changes to MDS submission day to be scheduled every Wednesday. 8. Monitoring Maintain sustainability: The Director of Nursing will audit MDS submission for	

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F 640	Continued From page 3 6. Interview with RN #1 on 2/16/22 at 3:44 PM revealed she assisted with the completion of the MDS assessments and she was unsure what the different submission status messages meant. Further interview revealed the facility was aware some of the assessments were late and some had not been transmitted on time. 7. Interview with rehab coordinator #1 on 2/17/22 at 10:43 AM revealed the assessments were performed; however, none of the assessments were transmitted correctly and therefore were not in the system as completed. 8. Review of the MDS RAI manual 3.0, October 2019 showed "...Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days)..."	F 640	submission completion every Thursday for 12 weeks. After monitoring for 12 weeks, if MDS submission completion is compliant, monitoring will be reduced to monthly. Monthly monitoring will continue for the duration of three months. All monitoring will be reported to the QAPI Coordinator. QAPI team will review compliance based on audits completed. Monitoring will be discontinued after facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance approved by the Director of Nursing and QAPI Coordinator.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review,	F 689	1. Corrective action for resident #20 every clinical staff were issued a gait belt	3/25/22

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F 689	Continued From page 4 the facility failed to ensure elder safety during transfers for 2 of 7 sample elders (#20, #26) observed during stand and pivot transfers. The findings were: 1. Review of the annual MDS assessment dated 11/8/21 showed elder #20 had a BIMS score of 3 out of 15 which indicated severe cognitive impairment and diagnoses which included Alzheimer's dementia, cerebrovascular accident, and Parkinson's disease. Further review showed the elder required extensive physical assistance of 1 person for transfers. The following concerns were identified: a. Observation on 2/15/22 at 9:32 AM showed 2 unidentified staff members assisted the elder to stand and pivot transfer from the elder's wheelchair to his/her bed. The staff members stood on each side of the elder, placed one of their arms under the elder's arm, and physically lifted to assist the elder to stand. No gait belt or transfer-assisting device was utilized. b. Review of the care plan last reviewed on 2/10/22 showed no transfer status or required transfer assistance for the elder. 2. Review of the quarterly MDS assessment dated 10/4/21 showed elder #26 had a BIMS score of 13 out of 15, which indicated the elder was cognitively intact, and diagnoses which included Parkinson's disease. Further review showed the elder required limited physical assistance of 1 person for transfers. The following concerns were identified: a. Observation on 2/15/22 at 10:40 AM showed CNA #1 assisted the elder to stand and pivot transfer from the elder's wheelchair to his/her bed. The CNA stood on the right side of	F 689	02/17/2022. 2. Corrective action for resident #26 every clinical staff were issued a gait belt 02/17/2022. Corrective Action a. Gait Belt Policy reviewed on 02/17/2022 by QAPI coordinator and Administrator. b. Staff education provide on Gait Belt Policy between the dates of 02/17/2022-03/03/2022. Identification of Others: The Clinical Staff and DON, in conjunction with the interdisciplinary team (IDT) reviewed alternative methods to ensure best compliance for gait belt use. Each elder will be assessed for individual need of physical assistance of transfers on the MDS. Each individual resident that requires assistance with transfers was issued a gait belt in room and on adaptive equipment on 03/08/2022. Action plan to ensure compliance includes a continued education and monitoring of gait belt usage. System Changes Each elder will be assessed for individual need of physical assistance of transfers on the MDS. Each individual resident that require assistance with transfers were issued a gait belt in room and adaptive equipment on 03/08/2022. Action plan to ensure compliance includes a continued education and monitoring of gait belt usage.	

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F 689	Continued From page 5 the elder, placed one of her arms under the elder's right arm, and physically lifted to assist the elder to stand. No gait belt or transfer-assisting device was utilized. 3. Interview with CNA #1 on 2/15/22 at 10:42 AM revealed gait belts were used for "taking an elder to the restroom or if they need max assistance; each elder has one in their room if we need to use one." 4. Interview with the rehab coordinator on 2/17/22 at 10:51 AM revealed all stand and pivot transfers should be performed with the use of a gait belt and transferring elders by staff members placing their arms under an elder's and lifting was "not acceptable" as it could cause "tissue damage" to the elder. 5. Interview with CNA #2 on 2/17/22 at 11:19 AM revealed staff identified equipment elders required for transfers on the care plan, including gait belt use. 6. Interview with the rehab coordinator on 2/17/22 at 1:22 PM revealed the facility only identified gait belt refusals and mechanical lift transfers on elders' care plans. 7. Review of the policy titled "Gait Belt Safety" last reviewed on 7/27/17 showed "...All physical therapy personnel, CNA's [sic] and nurses will utilize gait belts with residents during pivot transfers, ambulation and gait training. The gait belt provides a firm grasping surface for the support staff and protects the resident from accidental trauma to the skin. The gait belt gives the resident a sense of security as it is tightened. The belt also allows the staff person to gradually	F 689	Monitoring Monitoring of approaches that proper gait belt use are effective will include: Weekly monitoring for 12 weeks. The Interdisciplinary team and DON will conduct on-going monitoring via observation to ensure staffs are complying with appropriate gait belt use. After monitoring for 12 weeks, if all staff demonstrates appropriate gait belt use, monitoring will be reduced to monthly. Monthly monitoring will continue for duration of three months. All monitoring will be reported to QAPI Coordinator. QAPI team will review compliance based on audits completed. Monitoring will be discontinued after the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance approved by the Director of Nursing and the QAPI Coordinator.	

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F 689	Continued From page 6 lower a person to the floor (if necessary) without injuring self or resident..."	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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;	F 880		3/25/22

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F 880	Continued From page 7 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, policy and procedure review, and Centers for Disease Control (CDC) guidelines review, the facility failed to ensure personal protective equipment (PPE) was doffed following care for 1 of 1 sample elders (#8) on transmission-based precautions. The findings	F 880	Corrective action for Resident #8 1. Staff implemented appropriate transmission □ based precautions while providing care to the resident. 2. Staff were educated from 02/16/2022 to 03/3/2022 per Centers for Disease Control (CDC) and Centers for Medicare	

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F 880	Continued From page 8 were: 1. Observation on 2/14/22 at 4:02 PM showed elder #8's room had a sign on the door which indicated the resident was on transmission-based precautions. An isolation cart with supplies was outside the room and a plastic barrier surrounded the door. Review of a list of COVID-19 positive elders provided by the facility on 2/15/22 showed the elder was on transmission-based precautions for COVID-19 and was expected to remain on precautions until 2/17/22. Review of a progress note dated 2/9/22 and timed 9:52 AM showed the elder had a positive COVID-19 result following a 2/7/22 COVID test and was moved to the "east side" on droplet precautions. The following concerns were identified: a. Observation on 2/16/22 at 11 AM showed RN #2 donned PPE, without changing her KN95 mask, and entered the room of elder #8, who was on transmission-based precautions for COVID-19 infection. Further observation showed upon exiting the room, the RN removed the PPE and returned to the nursing cart; however, the KN95 mask was not removed and was not changed to a clean KN95 mask. 2. Interview with RN #2 on 2/16/22 at 11:10 AM revealed staff normally wore a N95 mask into isolation rooms; however, since she only observed surgical masks on the isolation cart and she knew those were not appropriate to use, she did not apply a N95 mask. Observation at that time showed the RN checked the isolation cart and confirmed there were no N95 masks available. Continued observation showed the RN checked the medication supply room and confirmed there were no N95 masks available. Further interview revealed the housekeeping	F 880	and Medicaid Services (CMS) guidelines for Transmission based precautions. Corrective Action a. The Registered Nurse in charge of Infection Control, Quality Assurance, and Director of Nursing (DON) have completed the following: a. Staffs were educated from 02/16/2022 to 03/03/2022 per Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines on Transmission based precautions. b. Policy and Procedure of Proper PPE was updated and staffs were educated between the dates of 02/28/2022 to 03/03/2022. Identification of Others: The Registered Nurse in charge of Infection Control, Quality Assurance, and DON, in conjunction with the interdisciplinary team (IDT) reviewed the current COVID-19 nursing facility guidelines from the CDC and CMS. Detailed education provided to all staff on Transmission Based Precautions; specifically for COVID-19 positive residents. Policy and Procedure of Proper PPE updated in accordance with CDC and CMS guidelines. Action plan to ensure compliance includes an updated COVID Positive Communication form to be sent to all Department Managers. In the event a resident tests positive for COVID-19, the Positive Communication form outlines necessary PPE and precautionary measures that will be distributed throughout Morning Star Care	

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F 880	Continued From page 9 manager "usually" stocked the isolation carts; however, she was not available due to COVID-19. 3. Interview with the infection prevention (IP) nurse and facility administer on 2/17/22 at 11:43 AM confirmed the expectation was for all staff to wear N95 masks when entering a transmission-based precaution room. Further interview confirmed the facility had adequate supplies of N95 masks and the ability to request more from both "Tribal Health" and "the Public Health Department," if needed. 4. Review of the policy titled "Transmission-Based Precautions" dated 2017 showed " ...It is important to use the standard approaches, as defined by the CDC for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used. Communication (e.g., verbal reports, signage) regarding the particular type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available ..." 5. Review of the CDC Guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" last revised on 02/02/2022 showed "Source control options for HCP [healthcare personnel] include: A NIOSH-approved N95 or equivalent or higher-level respirator OR A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering face piece respirators (Note: These should not be used instead of a NIOSH-approved respirator	F 880	Center. System Changes The DON will ensure education is provided for Standard, Droplet, and Contact Transmission Based Precautions, and the proper use of PPE for each type of Transmission Based Precautions in accordance with the current CDC and CMS guidelines. Policy and Procedure of Proper PPE updated in accordance with CDC and CMS guidelines. Action plan to ensure compliance includes an updated COVID Positive Communication form, to be sent to all Department Managers. In the event a resident tests positive for COVID-19, the Positive Communication form outlines necessary PPE and precautionary measures that will be distributed throughout Morning Star Care Center. Monitoring Monitoring of approaches to ensure infection control and prevention are effective will include: Weekly monitoring for 12 weeks. The Infection Control Nurse, DON, and/or applicable IDT, will conduct on-going monitoring via observation to ensure staff are complying with appropriate PPE for all types of transmission based precautions. After monitoring for 12 weeks, if all staff demonstrates appropriate PPE use, monitoring will be reduced to monthly. Monthly monitoring will continue for duration of three months. All monitoring will be reported to QAPI Coordinator. QAPI team will review compliance based	

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F 880	Continued From page 10 when respiratory protection is indicated) OR A well-fitting facemask. When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved N95 or equivalent or higher-level respirator) during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions, they should be removed and discarded after the patient care encounter and a new one should be donned."	F 880	on audits completed. Monitoring will be discontinued after the facility completes three consecutive rounds of monthly monitoring that demonstrates sustained compliance approved by the Director of Nursing, Infection Control Nurse, and the QAPI Coordinator.	
F 888 SS=C	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;	F 888		3/25/22

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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
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(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§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

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	535050	A. BUILDING _____ B. WING _____	02/17/2022

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who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all 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;

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F 888	Continued From page 13 (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to 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 policy and procedure review and staff interview, the facility failed to ensure policies and procedures related to COVID-19 vaccination of staff were developed to include all requirements. The census was 29. The findings were: Review of the policy titled "COVID-19 Immunization Policy" provided by the facility on 2/15/22 showed the following identified concerns: a. There was no indication of a requirement for the initial dose or vaccine exemption prior to resident contact. b. There was no indication of additional CDC-recommended precautions required for staff	F 888	Corrective action COVID-19 Vaccination of facility staff Policy and Procedure was updated to reflect: 1. Indications of requirement for the initial dose or vaccine exemption prior to resident contact. 2. Indication of additional CDC-recommended precautions required for vaccination series, such as adhering to universal source control and physical distancing measures in areas that were restricted from resident access, even if the facility was located in a county with	

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F 888	Continued From page 14 who had not completed their primary vaccination series, such as adhering to universal source control and physical distancing measures in areas that were restricted from resident access, even if the facility was located in a county with low to moderate community transmission. c. There was no indication of required testing, at least weekly, for staff who had not completed the primary vaccination series, including those with exemptions. d. There was no indication staff who had not completed their primary vaccination series, including those with exemption or temporary delay, were required to use a NIOSH-approved N95 or equivalent or higher level respirator for source control, regardless of whether they were providing direct care to or otherwise interacting with residents. e. There was no indication of how the facility would track/secure documentation of delayed staff vaccination for clinical precautions/considerations. f. There was no indication of contingency plans the facility would take for staff that were not vaccinated for COVID-19, including but not limited to, actions the facility would take if staff indicated they would not get vaccinated and did not qualify for exemption, plan to address individuals who were not fully vaccinated due to an exemption or temporary delay in vaccination status, a deadline for staff to have obtained the COVID-19 vaccine, and action the facility planned to take if the deadline was not met. 2. Interview with the administrator on 2/17/22 at 12:46 PM confirmed the COVID-19 immunization policy needed to be updated as it did not include all the required components.	F 888	low to moderate community transmission. 3. Indication of required testing, at least weekly, for staff that had not completed the primary vaccination series, including those with exemptions. 4. Indication for who have not completed their primary vaccination series, including those with exemption or temporary delay, are required to use a NIOSH- approved N95, regardless of whether they are providing direct care to or otherwise interacting with residents. 5. Indication of how the facility will track/secure documentation of delayed staff vaccination for clinical precautions/ considerations. 6. Actions the facility will take if staff indicated they would not get vaccinated and did not qualify for an exemption, plan to address individuals who are not fully vaccinated due to an exemption or temporary delay in vaccination status, a deadline for staff to have obtained the COVID-19 vaccine, and action the facility planned to take if the deadline was not met. Corrective Action Policy and Procedure for COVID-19 Vaccination of Facility Staff was updated to meet requirements on 03/07/2022. All staff who have not received their primary vaccination series will be educated by 03/25/2022 of requirements and changes to Policy and Procedure for COVID-19 Vaccination of Facility Staff. Identification of Others: During the hiring process, the facility will obtain documented proof of vaccination	

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status and/or obtain an exemption prior to resident contact. Employees who have not received their primary vaccination series will follow policy and procedure of unvaccinated staff until two week post last vaccination in the series.
COVID-19 Vaccination Status Matrix has been created to monitor vaccination status of all employees.

System Changes
Policy and Procedure for COVID-19 Vaccination of Facility Staff was updated to meet requirements on 03/07/2022. All staff who have not received their primary vaccination series will be educated by 03/25/2022 of requirements and changes to Policy and Procedure for COVID-19 Vaccination of Facility Staff.
During the hiring process, the facility will obtain documented proof of vaccination status and/or obtain an exemption prior to resident contact. Employees who have not received their primary vaccination series will follow policy and procedure of unvaccinated staff until two week post last vaccination in the series.

Monitoring
Monitoring of approaches to ensure compliance with Policy and Procedure of COVID-19 Vaccination Facility Staff are effective will include:
Bi-Weekly audit by Infection Preventionist will review accuracy and updated information of COVID-19 Vaccination Matrix for 12 weeks.
After monitoring for 12 weeks, monitoring will be reduced to quarterly. Monitoring will

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