DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLETED: February 25, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from February 16, 2022 through February 25, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 57. The survey sample totaled six (6) residents.		
3201.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed February 25, 2022: F608, F689, and F888.		
16 Del.			

Provider's Signature ____________ Title __Administrator_____ Date ___3/15/2022________

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Code, 1162 Nursing Staffing:	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** RN/LPN — CNA* Day: 1 nurse per 15 res. — 1 aide per 8 res. Evening: 1:23 — 1:10 Night: 1:40 — 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on March 2, 2022. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for two days out of 21 days reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include:	1.All residents were affected by the staffing ratio that failed to meet the requirements on 2/1/2022 and 2/18/2022. 2.All residents are affected by the staffing ratio. The staffing schedule will be reviewed in advance to de-termine if there are days that fail to meet the required staffing ratio of at least 3.28 each day. Unsched-uled will be asked to pick up the shift, a bonuses offered for picking up the shift, and a staffing agree-ment will be in place. 3.The root cause stems from the in-dustry-wide healthcare staffing shortage, lack of staffing agency agreement, combined with un-timely staff vacations. DON and ADON will proactively review the schedule in advance and daily. Of-fering bonuses for unscheduled staff to pick up the shift and a staffing agreement will be in place. Offering bonuses should serve to prevent recurrent lower than ac-ceptable staffing ratios. The admin-istrator will update agreement with a local staffing agency. 4.Administrator, DON, and/or ADON will review the success of the staffing schedule correction measures daily for one month. Af-ter 30 days of 100% success rate of adequate staffing, we will review at least monthly for 3 months until 100% success rate. Findings will be discussed in QAPI.	

Provider's Signature ____________ Title __Administrator_____ Date ___3/15/2022________

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	Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 2/1/2022 PPD = 3.18 2/18/2022 PPD = 3.12 March 2, 2022 at 3:15 PM - Findings were reviewed with E1 (NHA) via email regarding the facility's failure to meet staffing requirements. The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature ______________________ Title __Administrator____ Date ___3/15/2022_______

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING ______ B. WING ______	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	**254 WEST MAIN STREET NEWARK, DE 19711**

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F 000	INITIAL COMMENTS	F 000		

An unannounced Complaint Survey was conducted at this facility from February 16, 2022 through February 25, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 57. The survey sample totaled six (6) residents.

Abbreviations and Definitions used in Survey:

ADON - Assistant Director of Nursing;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 -15.
13-15: Cognitively Intact
8-12 Moderately Impaired
0-7 Severe Impairment;
COVID-19/Coronavirus - a respiratory illness that can be spread person to person;
DON - Director of Nursing;
EHSD - Environmental Health Services Director;
Elopement - to run away or leave an area without staff knowledge;
MDS (Minimum Data Set) assessment - standardized assessment form used in nursing homes;
NHA - Nursing Home Administrator;
PO - Police Officer;
RN - Registered Nurse;
SE - Staff Educator;
Wander Alert - bracelet worn by a resident on their wrist or ankle or attached to an assistive device, such as a wheelchair, that alerts staff with an audible alarm when the resident is near an alarmed door.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2022

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 608 SS=E	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedure (P & P), it was determined that the facility failed to develop and implement a P & P that included requirements for the reporting of reasonable suspicion of a crime. In addition, the facility failed to ensure that notice	F 608	F608: A. The policy for Freedom from Abuse,Negelect,Mistreatment,Serious Injury, Misappropriation of Property,	4/10/22

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F 608	Continued From page 2 of employee rights for the reporting of reasonable suspicion of crime was posted. Findings include: Review of the facility's P & P titled Freedom From Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of Property, Exploitation, Sexual Abuse, and Injury of Unknown Origin, dated 1/18/18, lacked evidence of requirements for the reporting of reasonable suspicion of a crime. 2/25/22 Beginning at approximately 1:15 PM - A joint observation with E2 (DON) of the 2nd floor and the 1st floor employee break room lacked evidence of a posting of employee rights for the reporting of reasonable suspicious crime which included the prohibition and prevention of retaliation. 2/25/22 1:40 PM - An interview with E1 (NHA) confirmed that the facility failed to develop and implement a policy and procedure for the reporting of suspicion of a crime and the required posting for employees to report reasonable suspicion of a crime. 2/25/22 at 2:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA and E2 (DON).	F 608	Exploitation, sexual abuse, and injury of unknown origin did not include a provision for reporting a crime. The policy was reviewed and revised. (attachment A). Signage was posted throughout the facility if you have a reasonable suspicion of a crime and report it with direction on how to do so. (attachment B). B. Immediately the policy for Freedom from Abuse,Negelect,Mistreatment,Serious Injury, Misappropriation of Property, Exploitation, sexual abuse, and injury of unknown origin was revised to include suspicon of crime without retalation from employer to employee for reporting such events. (attachment A) Signage was posted throughout the facility making staff and vendors aware that if they see any reasonable suspicion of crimes committed against a resident of this facility they should report it either to the administrator who will then report on their behalf or to State Survey Agencies(SAs)and Law enforcement. Reporting number and directions on how to report are listed on signage. (attachment B) C.Staff will be educated on the policy revision for Freedom form abuse, neglect, mistreatment, serious injuy, misappropriation of property, exploitation, sexual abuse suspicion of crime and injury of unknown orgin. Signage throughout the building informing them if	

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F 608	Continued From page 3	F 608	they see suspicion of crime they have an obligation to report without relation from the employer. D.A knowledge assessment related to the placement and purpose of the signage if you see something say something will be conducted by DON on 3 random staff members/vendors weekly x 3 until 100 % compliance is noted to ensure staff knowledge on the updated policy and signage for reporting suspicion of crimes. Results of the knowledge assessment will be shared and discussed at the quarterly quality assurance meeting. An audit of If you see something say something signage throughout the building in designated areas will be monitored by the maintenance director to ensure compliance of signage visibility weekly x4 until 100% then the monthly x 2 then quarterly ongoing results will be brought to the quarterly quality assurance meetings. Incident reports will be monitored by the ADON or designee on a daily basis to ensure appropriate incidents have been reported to the Office of long-term care in a timely fashion.	
F 689 SS=J	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	F 689		4/10/22

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F 689	Continued From page 4 §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, record review, interviews, review of the facility's policies and procedures, and review of the police report, it was determined that the facility failed to provide adequate supervision and an environment as free of accident hazards as possible for one (R1) out of four (4) sampled residents. R1, a resident known with a behavior of wandering and assessed as an elopement risk was identified as missing on 2/12/22 at approximately 11:55 AM. At 2:07 PM, R1 was found outside, unresponsive, stiff, skin cold to touch, without a pulse, and was pronounced deceased at 2:43 PM. The facility failed to provide adequate supervision to ensure that R1 did not leave the facility unattended; she was found approximately two hours and 12 minutes later outside on the facility grounds without a pulse. The lack of established preventative maintenance measures for the wander management system and the exit alarms, in addition to the lack of trained staff on the timely implementation of the facility's elopement response posed an immediate jeopardy (IJ) for R1 and other residents who were assessed as elopement risks. This deficient practice placed R1 in IJ as it resulted in a serious adverse outcome as evidenced by R1 being found unresponsive without a pulse deceased. The IJ was identified on 2/17/22 at 6:00 PM and was abated on 2/24/22 at 4:00 PM. Findings include: The facility's Code Alert and Wander Guard use policy, dated 4/10/12, stated, " ...Procedure: 1.	F 689	689.(supervision/preventive maintenance) A. Unable to correct for R1. The facility failed to provide adequate supervision and an environment as free of accident hazards for R1. Immediately all exit doors were checked to ensure they were functioning properly throughout the building. All potential exit routes were checked to ensure intact and without errors. Video surveillance was reviewed to see if the resident was seen exiting from the main entrance. All staff were interviewed to determine the last time the resident was seen and where she was located. B. Every resident's elopement risk assessment was updated by the DON and care plans reviewed to reflect accuracy of elopement risk. Additional wander guards placed on those residents identified as a high risk for elopement. Each shift nurse continues to check the function, placement and expiration of each resident's wander guard during the shift; this information is recorded on the MAR/TAR. Active resident wander guards checked	

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F 689	Continued From page 5 All residents will be assessed for elopement potential on admission and quarterly. 2. Any resident that is found to be an elopement risk will be placed on one of the lock units ...". The facility's policy and procedure titled Missing Person Policy (undated and followed by E3 [ADON] during the search of R1 on 2/12/22), stated, " ...B. Purpose: To find patient/resident as quickly as possible ...D. Equipment: 1. Nurse in charge of patient/resident directs search or consults with director of nurses (sic), registered nurse, or administrator. 2. Missing patient/resident to be treated with same sense of immediacy as if it were a fire alarm code ...E. Procedure: 1. Inform the nurse in charge of patient/resident when discovered missing. 2. Nurse's responsibility: a. Alert staff in building that a patient/resident is missing. b. Staff on all units immediately look for patient/resident making sure that all areas within building are searched. c. On telephone, call unit from which the patient is missing after area is thoroughly searched and report completed search ...e. Direct search to facility grounds if it is determined that the patient/resident is not in (sic) building; remain in building and coordinate search (spend only few minutes searching the grounds). f. If patient/resident is not found immediately, call fire department or police and report that a patient/resident is missing. g. Notify family that patient/resident is missing ...". Review of R1's clinical record revealed the following: 7/20/20 - R1 was originally admitted to the facility with a diagnosis of dementia and she resided on the 3rd floor of the facility, a secured unit with a	F 689	for function, placement and expiration, care plans reviewed, updated and staff educated on the policy and procedure updates. Immediately the medication cart on the third floor was relocated to a more visible area for better vision of the resident area. Immediately the third floor elevator keypad security system was checked for proper functioning as well as the 3rd floor stairwell exit door for proper functioning. A padlock was immediately placed on the gated generator area fence for added safety. . The lobby front door is under 24 hours supervision until the mag locking system is put into place for added wander guard enhancement and security. C. The elopement policy and procedure (attachment D) was revised and the staff were educated on the revisions. Hot wash questions (attachment E) were added to the conclusion of each elopement drill . The scenario presents a resident not found in the building or on the premises and who will be contacted when the resident is not found. A clarification was added that nothing else has to occur once the charge nurse concludes the resident cannot be located before the four mentioned people (police, resident representative,	

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F 689	Continued From page 6 key pad entry for elevators and emergency exits. 7/31/20 - The facility initiated a care plan for elopement risk/wanderer related to R1's impaired safety awareness and as R1 wanders aimlessly. The goal was that R1 would not leave the facility unattended. Interventions included to monitor location of R1 multiple times throughout the shift, to place a Wander Alert bracelet on R1's right wrist and to check placement and function every shift. 3/5/21 - The Elopement Risk Assessment documented that R1 was at risk for elopement. 2/2/22 - The quarterly Minimum Data Set assessment stated that R1's daily decision making skills were severely impaired with a BIMS score of 3 and that R1 required the supervision of one staff person for transfers and walking on and off the unit. 2/2/22 through 2/12/22 day shift (7 AM to 3 PM) - Review of the Treatment Administration Record revealed that R1's Wander Alert bracelet was checked for proper placement and function. 2/12/22 - The facility's Incident Follow-up documentation, in addition to written staff statements revealed that at 11:00 AM on 2/12/22, R1 was observed in her room by E9 (LPN). At 11:55 AM on 2/12/22, E6, the assigned RN to R1 was unable to locate R1. E6 subsequently notified the charge nurse for the shift, E3 (ADON). E3's statement documented that E3 was notified at approximately 12:20 PM of a Code W (missing resident) by E6 and all staff began searching the building and the grounds. E3 contacted E2 (DON) at 1:06 PM and E1 (NHA) at	F 689	Administrator and DON) are contacted. Staff were also re-educated on the wander guard system and which door this system works with. They were also re-educated on the proper wonder guard function, placement and expiration. (attachment G) Elopement drills were conducted each shift to obtain a 100% compliance of working staff. Those staff that are not working for various reasons will be educated upon return to work. A mag locking system will be installed on the front door on 3-11-22 for those residents wearing a wander guard to deter exiting the facility via the main exit door. All exit doors were checked to ensure they were functioning properly throughout the building. All potential exit routes were checked to ensure intact and functioning as designed. The lobby front door is under 24 hour supervision until the mag locking system is installed for added wander guard enhancement and security. Anaconda contracted to place a Mag locking system on the front lobby exit on 3-11-22. Third floor hall door exit had a loud audible alarm placed on it in addition to the keypad that was already in place that would sound when the door is unlocked alerting the staff resident movement. This may be modified to be delayed to contribute to a more peaceful environment. An evaluation of each door alarm function	

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F 689	Continued From page 7 1:09 PM. E3 conducted a second search of the building. 911 was called at 1:40 PM and R1's family member (FM1) was notified that R1 was missing. During a search of the facility grounds, E3 (ADON) was met by Police Officer (PO1). R1 was found outside in the generator area leaning on a fence without a pulse. 2/12/22 1:35 PM - The Police Report documented that the facility notified the Police Department that R1 was missing. Although R1 was at risk for elopement, the facility failed to provide adequate supervision to prevent R1 from eloping from the facility. It is unknown how R1 eloped from the facility. 2/17/22 9:38 AM - An email from E1 (NHA) revealed that the facility did not have a written expectation for preventative maintenance of the Wander Alert and the emergency exit alarm systems to include how often functional testing and monitoring would be performed. E1 stated " ... We do fix things when an exit alarm is found to not function properly, but no written policy driving that practice. In response to this incident [2/12/22] we will be adding monthly function checks of the alarm doors with documentation ...". 2/17/22 1:15 PM - An interview with E4 (Environmental Health Services Director/EHSD) revealed that he began employment as the EHSD on 11/11/21 and there was no formal orientation to his role. E4 stated that he was not responsible for periodically checking the Wander Alert system or any of the exit alarms in the facility. 2/17/22 2:30 PM - An interview with E5 (Staff Educator) was conducted and revealed that prior	F 689	and feature was conducted to have a good understanding of each device and how they are designed. A policy was created for Maintenance security door checks and the maintenance director was educated on this policy. (attachment C1) An assessment was conducted of all alarm exit devices to determine if they are functioning on the emergency power system. Two alarm exits identified as not being on the emergency power system. The 2nd floor half door and 2nd floor green room exit door are not on the emergency power system. Delcollo electric rectified the half door on 3-2-22 and the exit door in the green room pending completion by 3-18-22.system. The first floor day shift nurse continues to check the function of the wonder guard exit door each day during the shift by triggering the main door with a wander guard bracelet to ensure the system is functioning correctly. The findings are recorded. D. An audit tool was created in order to perform a weekly check of each exit device throughout the building to ensure each feature is functioning as designed. Audits are conducted by the maintenance director or designee weekly until 100% success for three consecutive weeks, THEN, bi-wekly until 100% success for two consecutive weeks, THEN monthly	

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F 689	Continued From page 8 to the 2/12/22 incident in which R1 eloped from the facility, routine missing resident drills were not performed and after the 2/12/22 incident, the facility had not conducted an inservice related to elopement and/or a mock missing resident drill. 2/17/22 6:00 PM - During an interview, E1 (NHA) was advised that the lack of a system to ensure the safety of residents with wandering behavior and/or were assessed to be at risk for elopement was an Immediate Jeopardy. Findings were confirmed by E1. 2/17/22 7:00 PM - The facility's abatement plan included: - Development and implementation of a policy and procedure for preventative measures of the facility's wander management and the emergency exit alarms to include how often functional testing and monitoring will be performed. - Education of all staff on the newly developed Elopement Response Guideline (Missing Resident) procedure. - Conduct Missing Resident drills with all staff. - Evaluate all exits and update systems to prevent elopement. 2/24/22 12:30 PM - An interview with E3 (ADON) revealed that she was the charge nurse during the day shift on 2/12/22 and worked from approximately 6 AM to 8 PM. E3 stated that E6 (RN) came to her at 12:20 PM to advise her that R1 was missing. E3 stated that Code W was not called over the facility's paging system. After the initial search of the facility and the outside grounds, R1 remained missing, thus, E3 proceeded to independently conduct a second search of the facility and outside grounds. E3 stated that R1 was not found and subsequently, a	F 689	ongoing. Audit assessments will be brought forth at the quarterly quality assurance meeting. (attachment C). The Maintenance Director or designee will conduct weekly audits of all door exit devices throughout the building weekly to ensure each feature is functioning as designed x4 until 100% compliance then bi-weekly x4 until 100% compliance. Finally, monthly audits of all door exit devices throughout the building will remain ongoing. Audit findings will be shared at the quarterly Quality Assurance meeting. Elopement drills will be conducted on each shift monthly x3 months then one per shift quarterly. Elopement education is included in any new hire packet. Elopement policy will be reviewed at least annually and as needed with all staff. At the conclusion of each elopement training the facilitator will evaluate the staff's response and performance. Insight will be offered on how to improve or expedite the search. Results will be shared with the team members at the quarterly quality assurance meetings.	

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F 689	Continued From page 9 call to 911 was placed. At the conclusion of the interview, E3 provided a copy of the facility's policy titled Safety & Emergency Protocol Missing Person Policy that E3 stated she followed during the 2/12/22 incident. E3 stated that she received education on Missing Person protocol during orientation approximately two years ago, however, E3 had not participated in a missing person drill until 2/17/22 during the survey, after R1's elopement. E3 stated that she was aware of the new Elopement written guideline and the mock drill will include paging Code W (missing resident) in their facility wide paging system. 2/23/22 9 AM - The facility provided evidence of the following: - Policy and procedure for preventative measures of the facility's wander management and the emergency exit alarms to include how often functional testing and monitoring would be performed and E4 (EHSD) was educated. - Education of the newly developed Elopement Response Guideline (Missing Resident) with 89% of current staff and a plan to educate the remaining staff prior to working the next time they were working at the facility. - Evaluation of all exits and systems to prevent elopement was completed, including the process to secure an active locking system on the front door when approached by a resident with a Wander Alert bracelet. - A written lesson plan for the missing resident drill utilizing the Elopement Guideline developed during the survey. 2/23/22 1:15 PM - The Surveyor observed a missing resident drill in which the resident was located inside of the building. The drill failed to incorporate when the resident was not found.	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 10 2/23/22 1:20 PM - During an interview with E1 (NHA), the Surveyor advised that the missing resident drill must incorporate when a resident was missing. 2/24/22 3:55 PM - The Surveyor verified the missing resident drill was completed with 61% of the current staff and there was a plan to complete the training with the remaining staff prior to the next time they were working at the facility. 2/24/22 4:00 PM - During an interview, E1 (NHA) revealed that the facility received a proposal for an active securing device for the front door and until the system was implemented, the facility would continue to ensure staff visual monitoring of the front door 24 hours a day, 7 days a week. E1 was advised that the IJ was removed. 2/25/22 at 2:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 689		
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.	F 888		3/10/22

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F 888	Continued From page 11 §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting 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	F 888		

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F 888	Continued From page 12 vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an 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	F 888		

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F 888	Continued From page 13 and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (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 interview and review of the facility's policy and procedure ("P & P"), it was determined that the facility failed to develop and implement a P & P which included requirements for staff COVID-19 vaccinations. Findings include: Review of the facility's P & P titled COVID-19	F 888	F888 (COVID-19) A. Unable to correct the deficient practice.	

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F 888	Continued From page 14 Immunization for Staff, dated 12/16/21, lacked evidence that the components of §483.80(i)(3) were incorporated into the facility's P & P. 2/25/22 1:30 PM - An interview with E1 (NHA) confirmed that the facility failed to develop a P & P for Staff COVID-19 vaccination which incorporated the requirements. 2/25/22 at 2:45 PM - Findings were reviewed during the Exit Conference with E1 and E2 (DON).	F 888	B. Policy for COVID vaccine Requirement for HCW was revised to reflect the current standards related to vaccination status for HCW, exemptions for medical/religious reasons and reasons for temporary delay, and tracking (attachment F). C .The requirement for an additional updated policy for COVID vaccination requirement for HCW was not met due to lack of staff and the need to use management to prioritize resident care needs. The infection preventionist was educated on the new staff vaccination rule issued by CMS. D. Staff will be educated on revised policy and all new hires will be required to meet the requirements of the healthcare workers COVID-19 policy. Any staff with a medical/religious/temporary delay in receiving the vaccination will be monitored by the DON or designee to ensure the steps implemented to mitigate the spread of COVID is followed by the staff member. Monitoring will consist of: reassignment of duties to non resident areas if practical or assignment to residents who are ot immunocompromised or not up to date on there COVID 19 vaccination requirements Weekly testing for COVID-19 regardless of community level of transmission Must wear a NIOSH approved N95 respirator for source control at all times	

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F 888	Continued From page 15	F 888	regardless of weather they are providing direct care to or otherwise interacting with patients. Requiring staff to adhere to universal source control and physical distancing measures in areas that are restricted from patient access (e.g., staff meeting room, kitchen) even if the facility or service site is located in a county with low to moderate community transmission). The administrator will report weekly to NHSN the COVID 19 vaccination status of each employee/ resident and vendor. The DON or designee will keep a log of those staff who are not up to date with all required COVID-19 vaccinations and who are required to test based on the county positivity rate. All findings will be brought forth to the quality assurance quarterly committee meeting.	