STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. BUILDING _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER COUNTY NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

(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 The State Agency (SA) conducted an Annual Recertification Survey at the facility from 3/20/23 through 3/23/23. During the survey, the facility was found to not be in compliance with the requirements of participation in Medicare and Medicaid and cited F561, F640, F677, F812, and F888. The facility had a census of 95 and was licensed for 110 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		4/28/23

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

Electronically Signed | 04/07/2023

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to accommodate resident preferences by not allowing bedfast residents to receive showers as their preferred bathing method for two (2) of two (2) residents reviewed for preferences. (Resident #7 and Resident #41) This had the potential to affect (12) of (12) bedfast residents. Findings include: Record review of the facility's, "Bed Bath Policy", undated, revealed, "It is the policy of this facility that a bed bath will be given as follows: For any bed bound resident ..." Resident #7 During an interview on 3/22/23 at 4:25 PM, with Registered Nurse (RN) #1, she confirmed Resident #7 received bed baths. She explained the facility did not have the equipment for bed bound resident to receive showers, but they were given bed baths daily. During an interview on 3/22/23 at 4:30 PM, Resident #7's father complained that the resident only received a bed bath. He stated he was told by the facility that she could only get bed baths because she was bed bound and required a Hoyer (mechanical) lift. He explained that the facility did not have the equipment to provide a shower for his daughter.	F 561	f561 #1 The two bedfast residents identified during the inspection, #7 & #41 were re-evaluated by the unit RN supervisor on 3/24/23 to determine their ability to be safely transferred using the hoyer lift. Once the reclining shower chair has been delivered to the facility and put into use, the unit RN supervisor will assess the bed fast residents #7 & #41 to determine their ability to be safely showered in the reclining shower chair. After the assessments are completed, the sponsors of the two bedfast residents #7 & #41 will be contacted for consent or denial for the two bedfast residents #7 & #41 to receive a shower at least weekly using the reclining shower chair. #2 All bedfast residents have the potential to be affected by the deficient practice. All other bed fast residents on the facility census have the potential to be affected by the cited deficient practice. #3 On 4/04/23 the facility placed an order for a reclining shower chair which will be used to allow bedfast residents to receive a shower at least weekly. The unit RN nursing supervisors for each unit will begin contacting the sponsors of all of the bedfast residents on 4/10/23 and will be ongoing and completed by 4/28/23 to	

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F 561	Continued From page 2 Record review of the "Facesheet" revealed Resident #7 was admitted by the facility on 3/16/10 with the diagnoses that included Anoxic Brain Damage and Hemiplegia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/23, revealed Resident #7 had severely impaired cognitive skills for daily decision making and she required total dependence on staff for transfers and bathing. Review of the facility's, "Completed Care Tasks" from 2/2/23 through 3/22/23, revealed Resident #7 received bed baths as the bathing method. Resident #41 During an interview on 03/21/23 at 1:17 PM, with Resident #41's husband, he expressed concern that his wife had not received a shower in two (2) years, and he wanted her to be able to receive showers. He said the facility stopped giving her a shower during the COVID-19 outbreaks and she became bed bound. He stated the facility used a (mechanical) lift to transfer her and that is why the facility did not provide the resident with a shower. During an interview on 03/22/23 at 01:28 PM, with Certified Nurse Aide (CNA) #3, she confirmed that residents who are bedridden did not receive showers because it was hard to get them into the shower chair. During an interview on 03/22/23 at 01:36 PM, with RN #1, she confirmed Resident #41 received bed baths daily and explained that bed bound resident did not receive showers.	F 561	determine their bathing preferences. The facility bed bath policy was reviewed and revised on 3/24/23 by the director of nurses. The facility shower policy was reviewed on 3/24/23 by the director of nurses with no revisions necessary. On 3/24/23 the staff development nurse began inservicing all direct care employees on the new bed bath policy. The inservice on the new bed bath policy was completed on 4/10/23. (see attached policy) #4 The registered nurse supervisor for each unit will begin monitoring bedfast residents on their unit once the reclining shower chair has been received and put into use to ensure those identified can be safely showered. Current bedfast residents will be assessed quarterly by the RN nursing supervisor on each unit and as deemed necessary to ensure that it is safe for them to continue receiving a shower. Bedfast residents admitted after the date of the survey will be assessed on admission by the RN nursing supervisor for each unit to determine their ability to shower safely. The registered nurse supervisor for each unit will include the assessments in their quarterly supervisor progress note. The registered nurse supervisor for each unit will provide a written report of the monitored results to the quality assurance performance improvement nurse to be presented to the quality assurance committee for recommendations or improvement if deemed necessary beginning on 4/18/23 and then monthly for 3 months or until	

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F 561	Continued From page 3 Record review of the "Facesheet" revealed the facility admitted Resident #41 on 2/09/2020 and she had diagnoses that included Encephalopathy, Muscle Weakness, and Obesity. Record review of the Quarterly MDS with an ARD of 11/07/22 revealed Resident #41 had a Brief Interview of Mental Status (BIMS) score of 03, which indicated she had severe cognitive impairment. Review of Section G revealed she required total dependence on staff for bathing. Review of the facility's, "Completed Care Tasks" from 2/2/23 through 3/22/23, revealed Resident #41 received bed baths as the bathing method. During an interview on 03/23/23 at 1:07 PM, with the Director of Nurses (DON), she confirmed the residents who are bed bound did not receive showers because those residents could not sit up in the facility's shower chairs. The DON explained that the facility did not have a shower bed or a reclining shower chair to safely provide showers to bed bound residents. During an interview on 03/23/23 at 01:42 PM, with the Administrator, he confirmed that he was aware that the facility did not have shower beds or reclining shower chairs, but he did not realize there was a problem with bed bound residents receiving showers.	F 561	compliance is met.	
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	F 640		4/28/23

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F 640	Continued From page 4	F 640		

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, 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.

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F 640	Continued From page 5 §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 staff interviews, record reviews, and facility policy review, the facility failed to transmit Minimum Data Set (MDS) Assessments by the target date, for seven (7) of 20 residents reviewed for MDS assessments. Resident #4, #12, #37, #40, #46, #49, and #59. Findings Include: Review of the "Resident Assessment Instrument Policy" (undated) revealed, "It is the policy of this facility that the RAI (Resident Assessment Instrument) will be done as follows: According to the guideline specified by: State Department of Health, Division of Medicaid, Case Mix Trainers, Completed by Inter Disciplinary Team, Coordinated by the RN (Registered Nurse) ... MDS Assessments will be submitted in timely manner within the 14 day timeframe ..." Record review of MDS Assessments revealed the following: 1. The yearly assessment for Resident #4 had a target date of 2/10/23 and was not transmitted until 3/17/23. 2. The quarterly assessment for Resident #12 had a target date of 1/30/23 and was not transmitted until 3/17/23. 3. The quarterly assessment for Resident #37 had a target date of 2/12/23 and was not	F 640	f640 #1 Resident #4, #12, #37, #40, #46, #49, #59 assessment schedule was reviewed during the survey on 3/22/23 by the Minimum Data Set (MDS) coordinator to identify other possible late assessments. #2 All residents have the potential to be affected by the deficient practice. All other residents on the facility census have the potential to be affected by this cited deficient practice. All residents on the facility census, assessment schedule was reviewed on 3/22/23 by the MDS coordinator to identify possible late assessment submissions. #3 The assessment submission policy was reviewed by the MDS coordinator on 3/23/23 to ensure compliance. The MDS coordinator was inserviced by the nursing home administrator on 3/23/23 regarding timely submission of all completed MDS assessments. A new assessment list form has been devised and implemented on 3/24/23 to track all admission assessments, annual assessment updates, significant change in status assessments, quarterly review assessments, a subset of items upon a resident transfer, re-entry, discharge, and	

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F 640	Continued From page 6 transmitted until 3/17/23. 4. The quarterly assessment for Resident #40 had a target date of 1/14/23 and was not transmitted until 3/22/23. 5. The quarterly assessment for Resident #46 had a target date of 2/13/23 and was not transmitted until 3/17/23. 6. The quarterly assessment for Resident #49 had a target date of 2/13/23 and was not transmitted until 3/17/23. 7. The yearly assessment for Resident #59 had a target date of 2/11/23 and was not transmitted until 3/17/23. On 3/23/23 at 10:00 AM, during an interview with RN #3/MDS Coordinator, she confirmed that the assessments for Residents #4, #12, #37, #40, #46, #49, and #59 were completed but were submitted late. She explained they were late due to a COVID-19 outbreak and because of other responsibilities in the facility. She confirmed that she is responsible for transmitting MDS Assessments and she had notified the Director of Nursing (DON) that she was behind with her MDS responsibilities. On 3/23/23 12:00 PM, an interview with the DON, she stated that the MDS Coordinator had made her aware that MDS department was behind in their work. The DON revealed that she had not put anything in place to ensure the MDS staff were provided with the time that they needed to complete their responsibilities. She stated that MDS Assessments are used for things such as case mix and resident care. On 3/23/23 at 12:30 PM, in an interview with the Administrator, he stated the MDS staff had been behind in January and February. He stated the	F 640	death, background (face sheet) information, if there is no admission assessment, for timely submissions. (see attached inservice) All resident assessments will be electronically transmitted in a format specified by CMS with encoded accurate and complete MDS data to the CMS system within 14 days after completion. #4 The MDS coordinator will monitor the submission schedule weekly beginning on 3/24/23 and as deemed necessary to ensure assessments are submitted in a timely manner within the 14 day time period after assessment completion. A validation report will be obtained weekly beginning on 3/24/23 and submitted to the quality assurance performance improvement nurse to be presented to the quality assurance committee beginning on 4/18/23 and then monthly for 3 months or until compliance is met for recommendations or improvement as deemed necessary. Any negative findings will be reported to and handled by the director of nurses or the nursing home administrator for any corrective action as deemed necessary	

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F 640	Continued From page 7 purpose of the MDS assessments is to determine the care needed for the residents and ensure payment.	F 640		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure a resident who was dependent on staff for personal hygiene received services related to nail care for one (1) of three (3) residents reviewed for Activities of Daily Living (ADLs). Resident #7 Findings include: Record review of the facility's, "Nail Care Policy", undated, revealed, "It is the policy of this facility that nail care will be done as follows: On a daily basis as a part of the resident's personal grooming, Provided to all residents requiring assistance with nail care...Includes: Cleaning fingernails and toenails (done daily and PRN [as needed]), Regular trimming of the nails (trimmed Q [every] 2 weeks and PRN), Filing to maintain a smooth edge ..." Resident #7 During an observation on 03/21/23 at 11:49 AM, Resident # 7 was in a Geri chair. Her left hand was contracted and pressed tightly against her body in her chest area and her left thumb nail	F 677	f677 #1 The sponsor for resident # 7 was contacted on 3/22/23 for consent to consult a specialist for treatment of the affected nail. Resident #7□s sponsor declined for the resident to be transported outside of the facility for treatment. Sponsor requested that resident #7 receive treatment of the affected nail inside the facility. On 4/04/23 two specialty clinics were contacted by the nursing home administrator for an on site consult visit and both declined. Resident #7□s attending physician visited on 4/10/23 for evaluation and treatment of the affected nail. Resident #7□s sponsor was notified of treatment received. #2 All residents have the potential to be affected by the cited deficient practice. All other residents on the facility census have the potential to be affected by this cited deficient practice. #3 On 3/23/23 the nail care policy was reviewed by the director of nurses with no	4/28/23

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F 677	Continued From page 8 was one and one-half (1½) inches in thickness, jagged, and had a dark discoloration. During an interview on 3/22/23 at 4:15 PM, Certified Nurse Aide (CNA) #1 stated that she cleaned the resident's nails but did not cut her left thumb nail because it was thick and jagged. She explained that the nurse performs nail care for that type of nail. She confirmed that Resident #7's left hand was contracted and was pressed against her chest. During an interview on 3/22/23 at 4:25 PM, with Registered Nurse (RN) #1, the Nurse Practitioner (NP), and the Director of Nursing (DON), RN #1 stated Resident #7's thumb nail had been thick, discolored, and jagged for the five (5) years she has been at the facility. She explained that she had not provided any care for the nail herself. RN #1 confirmed that Resident #7 kept her left hand pressed against her body. The NP confirmed that she was aware that Resident #7 had a left thumb nail that was thick, long, and jagged. The DON explained that she was aware of the left thumb nail for Resident #7 and that it had been in that condition for a while. The DON confirmed the residents nail is long, thick, and jagged and that Resident #7 kept her left hand pressed against her body. During an interview with a family member on 3/22/23 at 4:30 PM, he confirmed that Resident #7 kept her left hand pressed against her body. He stated that the facility did not tell him about the condition of the nail and "they should have noticed it during her bath". Record review of the "Facesheet" revealed Resident #7 was admitted by the facility on	F 677	revisions necessary. On 4/06/23 the staff development nurse began inservicing all direct care staff on the nail care policy addressing the proper care of nails including resident preferences and high risk conditions such as those having a diagnosis of Diabetes and those receiving Coumadin or other anticoagulants. This inservice is currently ongoing and will be completed by 4/28/23. On 4/07/23 finger and toenail assessments were performed on all residents by the RN nursing supervisor of each unit. #4 On 4/07/23 the RN nursing supervisor for each unit began conducting a nail care audit of five residents weekly. The nail care audit result reports will be submitted to the quality assurance performance improvement nurse beginning on 4/18/23 and then monthly for 3 months or until compliance is met to be presented to the quality assurance committee for recommendations or improvement if deemed necessary. Any negative findings will be reported to and handled by the director of nurses or the nursing home administrator for disciplinary action.	

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F 677	Continued From page 9 3/16/10 with diagnoses that included Anoxic Brain Damage, Hemiplegia, and Contracture of Muscle, Multiple Sites. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/23 revealed Resident#7 had severely impaired cognitive skills for daily decision making and she is totally dependent upon staff to perform personal hygiene. Record review of the "Physician Orders" for the month of March 2023 revealed Resident #7 had a Physician's Order dated 5/24/22 to "Perform Finger/Toenail care" with an "Interval Code" of "Q14Day (Every 14 days)".	F 677		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		4/28/23

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F 812	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to discard expired food and failed to serve food in a sanitary manner related to staff touching a resident's food item for two (2) of five (5) kitchen and dining observations. Findings include: A review of the facility's policy "Food Safety and Sanitation", undated, revealed " ... All local, state, and federal standards and regulations are followed in order to assure a safe and sanitary food service department. Procedure ... 4. Food Storage ... b ... All leftovers are labeled, covered, and dated when stored. They are used within 72 hours (or discarded) ..." On 03/20/23 at 12:20 PM, during a kitchen observation, there were 24 hot dog buns and nine (9) hamburger buns wrapped in plastic wrap in a clear container. The buns had an "open date" of 3/07/23 and a "use by" date of 3/13/23. The buns were firm and hard when touched. On 03/20/23 at 12:45 PM, in an interview with the Dietary Manager, she stated food items are dated to ensure foods served are fresh and not expired because serving expired foods could cause the residents to become sick. She explained that all staff are responsible for discarding expired items. On 03/23/23 at 01:20 PM, in an interview with the Administrator, he stated that he was not aware that the kitchen staff had not discarded expired foods, and he expected the kitchen staff to meet the needs of the residents and follow regulations.	F 812	f812 #1 The hotdog and hamburger buns found in the dietary department during the survey that were past the use by date were immediately removed on 3/20/23 from the dietary department and discarded by the dietary manager. #2 All residents have the potential to be affected by this deficient practice. All residents in the facility who receive meals from the dietary department have the potential to be affected by this cited deficient practice. #3 On 3/23/23 the food safety and sanitation policy was reviewed by the registered dietician with no revisions necessary. On 4/05/23 the certified dietary manager conducted an inservice with all dietary staff on food safety and sanitation. Beginning on 4/03/23 monthly dietary inspections regarding use by date food items will be conducted by the registered dietitian or dietary manager and recorded on the Sanitation Self Inspection Report form to ensure that no food items remain in the dietary department past the use by date. #4 On 4/03/23 the registered dietitian or dietary manager began conducting dietary department inspections weekly. The dietary department inspection result reports will be submitted to the quality assurance performance improvement nurse beginning on 4/18/23 and then	

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F 812	Continued From page 11 A record review of the "Foodservice Inservice Attendance Record:", dated 12/20/2022, revealed the DM provided education for dietary staff related to labeling, dating, and cross-contact. Dining Observation On 3/20/23 at 5:24 PM, during an observation of the resident dining, Certified Nurse Aide (CNA) #2 served a meal tray to an unsampled resident. She picked up a peanut butter and jelly sandwich that was wrapped in plastic wrap from the resident's meal tray. She removed the plastic wrap, touching the sandwich with her bare hands, and placed it on the resident's meal tray. She did not apply gloves before touching the sandwich and did not discard it once her bare hands contacted the food item. On 03/22/23 at 11:10 AM, during an interview with CNA #2, she explained she was not thinking when she pulled the sandwich out of the plastic wrap with her bare hands and she knew better. On 03/23/23 at 1:03 PM, during an interview with the Director of Nursing (DON), she stated CNA #2 should have put on gloves on before touching the resident's food. On 03/23/23 at 1:13 PM, during an interview with RN #2/Infection Preventionist (IP), she explained CNA #2 knew better than to touch a resident's food with her bare hands and that the facility had provided training to the staff. She stated that CNA #2 should have put on gloves before touching the food item or discarded it once she touched it with her bare hands.	F 812	monthly for 3 months or until compliance is met to be presented to the quality assurance committee for recommendations or improvement if deemed necessary. Any negative findings will be reported to and handled by the registered dietician or the nursing home administrator for disciplinary action. ********** #1 Upon notification of the deficient practice during the survey process the certified nursing assistant #2 who was responsible for the deficient practice was counseled on the proper way to serve meals and snacks without violating infection control practices and the facility policy and procedure on infection control was reviewed by the director of nurses on 3/21/23. #2 All residents have the potential to be affected by this deficient practice. All residents on the facility census who receive meals and snacks have the potential to be affected by this cited deficient practice. #3 The facility□s serving a meal policy and nursing service hand hygiene policy were both reviewed and revised on 4/04/23 by the director of nurses. On 4/06/23 the staff development nurse began inservicing all direct care staff on the serving a meal policy and nursing service hand hygiene policy. This	

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F 812	Continued From page 12	F 812	inservice is currently ongoing and will be completed by 4/28/23. On 4/10/23 certified nursing assistant supervisors began performing 5 meal tray checks during meal times to ensure that the tray serving policy and the nursing service hand hygiene policy is being followed with no violation of infection control practices. These meal tray checks will be conducted weekly for 3 months or until compliance is met. (see attached policies) #4 Certified nursing assistant supervisors will report the results of the weekly meal tray checks to the quality assurance performance improvement nurse weekly. The QAPI nurse will report the results of the weekly meal tray checks to the quality assurance committee monthly beginning on 4/18/23 for 3 months or until compliance is met for recommendations or improvement if deemed necessary. Any negative findings will be reported to and handled by the director of nurses or the nursing home administrator for disciplinary action.	
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	F 888		4/28/23

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completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting 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

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F 888	Continued From page 14	F 888		

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

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F 888	Continued From page 15 ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (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, interview, record review, and facility policy review, the facility failed to ensure policies and procedures addressed a	F 888	f888 #1 Upon notification of the deficient practice all Jasper County Nursing Home	

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F 888	Continued From page 16 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. This had the potential to affect 95 of 95 residents in the facility. Findings include: A review of the facility's policy, "COVID-19 Vaccination Policy", revised 10/11/22, revealed there were no additional precautions implemented to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated. On 3/22/23 at 11:57 AM, in an interview with the Infection Preventionist, she stated that the staff who are not vaccinated and have been granted an exemption are not required to do anything different than vaccinated staff and that all staff are required to wear a surgical mask. On 3/22/23 at 1:01 PM, in an interview with the Office Billing Clerk, she confirmed that she was not vaccinated and that she had a medical exemption. She stated that previously she was required to test more often than the vaccinated staff, but now the staff are not required to be tested unless they are symptomatic. She was wearing a surgical mask and confirmed that there are no additional precautions required because of her unvaccinated status and that she does not do anything any different than staff who are vaccinated. On 3/22/23 at 1:25 PM, in an interview with the Administrator, he stated the facility's policy previously had been that unvaccinated staff had	F 888	employees that had an approved exemption form taking the Covid 19 vaccination that were present were tested for Covid 19 by the Infection Control/ QAPI Nurse. This testing began on 3/22/23 and was completed on 3/24/23. #2 All residents have the potential to be affected by the deficient practice. All residents on the facility census who receive care from unvaccinated employees have the potential to be affected by this cited deficient practice. #3 The facility Covid 19 vaccination policy was revised on 3/22/23 and again on 4/04/23 by the nursing home administrator to read that all unvaccinated employees must test weekly if they work any hours in that week. Any unvaccinated employees that do not work any part of the week will be required to test the next day that they report to work. All current Jasper County Nursing Home unvaccinated employees were inserviced on the revised policy and the testing requirements by the Infection Control Nurse. This inservice began on 3/22/23 and was completed on 4/07/23. Any new hire employee will receive information on the newly revised Covid 19 vaccination policy during the orientation process by the Infection Control/ QAPI Nurse. #4 The administrator provided the Infection Control/ QAPI nurse an updated list of the unvaccinated employees on 3/23/23. On 3/23/23 the Infection Control/QAPI nurse cross checked the list	

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F 888	Continued From page 17 to be tested more often than vaccinated staff, but once the Centers for Disease Control (CDC) recommendations changed related to routine testing, it was removed from the policy. He confirmed that the facility's current policy does not address additional precautions for staff who are not fully vaccinated. He stated that effective today (3/22/23), all unvaccinated staff would be required to test weekly as an additional precaution.	F 888	with inservice records to ensure all unvaccinated employees are aware of the revised policy and the requirement to be tested weekly. On 3/22/23 the Infection Control/ QAPI nurse developed a tracking spreadsheet for weekly Covid 19 testing of unvaccinated employees to ensure unvaccinated employees are testing weekly per policy. Any employee that violates the revised policy by not testing weekly will not be allowed to work until cleared by the administrator. The spreadsheet will be included in the monthly Quality Assurance committee meeting beginning on 4/18/23 and then monthly for 3 months or until compliance is met for recommendations or improvement if deemed necessary. Any negative findings will be reported to and handled by the nursing home administrator for corrective action.	