Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 19, 2022

Mr. Carl Pratt, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Mr. Pratt:

Enclosed is a copy of your acceptable plans of correction for the investigation conducted on **April 27, 2022**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation and staff vaccination requirement review was conducted by the Division of Licensing and Protection at St. Johnsbury Health and Rehabilitation Center on 4/20/22 and 4/27/22. There were regulatory violations identified.	F 000	The filing of this Plan of Correction does not constitute an admission of the allegations set forth in the statement of deficiencies. St Johnsbury Health and Rehab has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	5/24/22
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that the services of a registered nurse [RN] were used for at least 8 consecutive hours a day, 7 days a week. Findings include: Registered Nurse staffing schedules and timecard punches covering the period of 1/1/2022- 4/19/22 were requested of and provided by the facility's Director of Nursing [DON] on 4/20/22 along with the facility's employee list. On 4/27/22, the Traveling Nurses	F 727	The facility has implemented a change in the schedule format to include the name of the RN covering to eliminate confusion. The daily schedule will be reviewed by the Administrator to ensure RN coverage is maintained on a daily basis. The scheduler, weekend supervisor and UM's have been educated to the requirement CFR: 483.35 (b)(1)-(3). Weekly random audits X4 and monthly X 2 will be conducted by the Regional Director of Clinical Services to ensure RN coverage is maintained. The audit results will be brought to QAPI for review and interventions if needed. **TAG F 727 POC Accepted on 5/19/22 by T. Dougherty/P. Cota**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carl V. Pisa

TITLE: Administrator

(X6) DATE: 5/18/22

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 727	Continued From page 1	F 727		

timecard punches were requested of and provided by the DON.
An interview was conducted with the facility's Infection Preventionist [IP] on 4/20/21 at 12:33 PM. The IP stated that the facility repeatedly lacked the minimum required amount of 8 hours of RN coverage on weekends.
Staff schedules provided by the DON were reviewed to verify RN coverage on the weekends and compared with the timecard punches from both facility nursing employees and traveler nursing employees.
Per record review of staff schedules provided by the DON and with time punch cards:
On 2/19/22, Staff 'B' was the only RN scheduled. There are no punch card times for the RN on that date.
On 3/27/22, Staff 'B' was scheduled for 8 hours of RN coverage. Review of punch card times reveal the RN was only present for 6 hours.
On 3/5/22, Staff 'D' was scheduled to work 8 hours of RN coverage. There are no punch card times for the RN on that date.
Further review reveals schedules for Staff 'E', 'F', 'G', and 'H', listing only the staff's first names. Review of the facility employee list and the traveler employee list supplied by the DON reveals no staff listed with first names corresponding to the schedules provided. Additionally, there are no time punches from either the travelers or employees time records, and no billing for any of these individuals from the traveling nurse agency.
Per record review:
Staff 'E' is scheduled for 8 hours of RN coverage on 3/12/22 and 3/13/22. There are no time punches for Staff 'E' on either of the dates.
Staff 'F' is scheduled for 8 hours of RN coverage on 3/12/22. There are no time punches for Staff

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F 727	Continued From page 2 'F' on that date. Staff 'G' is scheduled for 8 hours of RN coverage on 3/19/22 and 3/20/22. There are no time punches for Staff 'G' on either of the dates. Staff 'H' is scheduled for 8 hours of RN coverage on 3/12/22 and 3/13/22. There are no time punches for Staff 'H' on either of the dates. An interview was conducted with the facility's Director of Nursing [DON] on 4/27/22 at 10:30 AM. The DON reported that h/she also worked on weekends to contribute to the required RN coverage. Per record review, on 4/2/22, the DON was scheduled to work 8 hours. Review of the DON's time punches for 4/2/22 reveal the DON punched in at 6:30 AM and did not punch out. The time punches record the DON punched in again at 11: 54 AM and punched out at 3:00 PM. The time punches then record the DON did not punch back in again but punched out at 8:30 PM. Review of the time punches reveals no period of 8 consecutive hours with corresponding in and out time punches. Additional time punch reviews for Staff 'C' for 1/1/2022- 4/19/22 reveal single day total hours of 17.5, 25, 18.5, 24.5, 25, and 15 hours; none of which Staff 'C's punch times add up to. Per separate interviews with both the facility's DON and Administrator [ADM] on 4/27/22, both the DON and ADM confirmed RN coverage was below the required minimum. The ADM stated, "RN coverage is tight; we do not really have an RN to replace one when one calls out". Additionally, the DON volunteered that on 4/16/22, h/she was aware that the scheduled RN staff member had called out and was not replaced on the schedule, and therefore there was no RN coverage on that date.	F 727		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		

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F 760	Continued From page 3 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure 1 resident [Res. #1] of 5 sampled residents was free of a significant medication error related to the resident being administered a controlled narcotic despite documentation that the resident had an allergy to the medication. Findings include: Review of Res. # 1's medical chart reveals the resident was discharged from the hospital on 11/19/21 and admitted to the nursing home on the same day. Review of the hospital discharge summary lists 'Updated Allergies' which includes the drug 'Morphine Sulfate'. Further review of Res. # 1's medical chart reveals an allergy to the drug Morphine listed in the resident's "Allergy History" upon admission to the facility, with the severity listed as 'unknown'. Review of Res. #1's Admission Nursing Evaluation dated 11/19/21 lists allergy information as obtained from the resident, who was assessed as fully oriented to person, place, and time. Additional sources documenting that Res. #1 had an allergy to Morphine include a medication review report conducted for Res. #1 on 12/2/21, Physician Progress notes dated 1/31/22 and 3/17/22, and facility transfer forms on 3/20/22. Review of Res. #1's medical record reveals an order for 'Morphine Sulfate (Concentrate) Solution 20 milligrams per milliliter, *Controlled	F 760	Resident #1 no longer resides at the facility. All residents who receive controlled narcotics could potentially be affected by this alleged deficiency. A house wide audit was conducted of all residents allergies to determine if any have controlled narcotic allergies. All licensed nurses were re-educated on the Medication Administration Policy and the process when an allergy alert is prompted when an order is entered in PCC. The DNS or designee will conduct weekly random audits X 4 and monthly X 2 of all new controlled narcotic orders to ensure continued compliance. The audit results will be brought to QAPI for review and further interventions if needed. **TAG F 760 POC Accepted on 5/19/22 by T. Dougherty/P. Cota**	

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F 760	Continued From page 4 Drug*, Give 0.25 milliliters by mouth every 1 hours as needed for Shortness of Breath, Dyspnea, Pain.' dated 3/21/22 at 10:46 AM. Review of Progress Notes for Res. #1, also dated 3/21/22 at 10:46 AM reveals a system generated note: "The system has identified a possible drug allergy for the following order: Morphine Sulfate (Concentrate) Solution 20 MG/ML *Controlled Drug*". There is no documentation that the Nurse Practioner was notified of the allergy to the medication that was ordered. Review of Res. #1's Medication Administration Record reveals the resident received h/her first dose of Morphine on 3/21/22 at 11:55 AM. Approximately 2 hours later, Nurses Notes for Res. #1 reveal "Allergy is listed for Morphine, no adverse reactions noted. Will Update NP [Nurse Practioner] to see if orders should be changed." Nurses Notes then record that a family member, not the NP, was contacted regarding the resident receiving a medication they were allergic to. The Nurses Notes reads "Writer spoke with [Resident's son], he is okay with Morphine and end of life care." There is no reference to any family member reporting the resident did not have an allergy to the medication. Further review of Res. #1's Medication Administration Record reveals the resident received 6 more doses of Morphine over the next 16 hours before the resident expired on 3/22/22, at 3:45 AM. An interview was conducted with the facility's Director of Nursing [DON] on 4/27/22 at 10:30 AM. The DON stated that h/she was in the facility and the Nurse Practitioner [NP] was available and notified by the DON that Res. #1 was documented as having an allergy to Morphine and was administered Morphine shortly after the resident received the first dose. Per record review and confirmed by the DON, there is no	F 760		

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F 760	Continued From page 5 documentation by the DON or by the NP that the NP was notified of the resident's allergy to Morphine and that the resident was administered Morphine until the next day, 3/22/22, after the resident had received 7 total doses. The documentation, authored by the DON, is dated 3/22/22 at 9:25 AM- approx. 22 hours after Res. #1 received their first dose of Morphine, and approx. 6 hours after the resident had expired. Review of Physician Orders, ordered by the NP and confirmed by the DON, includes a verbal order to "Remove Morphine allergy from allergy list". The order is dated 3/22/22 at 11:21 AM- almost 8 hours after the resident had expired. Res. #1's Allergy History lists the allergy to Morphine as "struck out" on 3/22/22 by the DON, with the reason 'incorrect documentation'. Further review of Physician Orders revealed an order to discontinue the Morphine for Res. # 1 dated 3/25/22- 3 days after the resident had expired. Per interview with the DON on 4/27/22, the DON confirmed Res.#1 had an allergy to Morphine documented in multiple areas of the resident's medical record, including NP notes 4 days before the resident was given the Morphine, on facility transfer forms when the resident was transferred to the hospital on 3/20/22, and on the hospital notes from 3/20/22, one day prior to the administration of the Morphine, where both the Nurse Practitioner and a family member were contacted. The DON further confirmed that despite the documented allergy to the medication, Resident #1 was administered Morphine, a controlled narcotic, multiple times. The DON also confirmed the note that h/she authored documents that an order to change the Morphine allergy and to discontinue the Morphine order, along with the actual orders to do so, were not written until after	F 760		

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F 760	Continued From page 6 the resident had expired.	F 760		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility was not administered in a manner that enables it to maintain the physical well-being of each resident, whereby actions and decisions by the facility's Administrator [ADM] and Director of Nursing [DON] directly contributed to deficient practices at F884 and F888. Findings include: An interview was conducted with the facility's Infection Preventionist [IP] on 4/20/21 at 12:33 PM. The IP reported that the facility's staff provide proof of their COVID vaccination status to h/her, and h/she then provides an updated list of all staff's COVID vaccine status to the facility's Administrator [ADM] on a weekly basis. The IP was asked to produce proof of the COVID vaccination status for the facility's Director of Nursing [DON] and provided a photocopy of the DON's COVID-19 Vaccination Record Card, along with the updated list of all staff's COVID vaccine status provided to the ADM the day of the interview, 4/20/21. Per review of the photocopy of the DON's COVID-19 Vaccination Record Card, the card lists one dose of the two dose Pfizer vaccine administered on 12/1/21. The list of all	F 835	The Administrator and DNS have been relieved of their duties. A house wide audit was immediately conducted to ensure the facility had copies of all active employees Covid Vaccine record or an approved exemption. The new IP nurse has taken over the management of this process. The HR manager and IP nurse have received education on the process of obtaining copies prior to working in the facility. The Administrator will conduct random weekly audits X 4 and monthly X 2 of all new hires to ensure the facility maintains accurate Covid vaccination records for employees. The results of these audits will be brought to QAPI for review and any further interventions needed. **TAG F 835 POC Accepted on 5/19/22 by T. Dougherty/ P. Cota**	

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F 835	Continued From page 7 staff's COVID vaccine status provided to the ADM that day also lists the DON as having only received one dose of the two dose Pfizer vaccine on 12/1/21. Per interview with the facility's Administrator [ADM] on 4/20/21 and per record review on the same date, the ADM was asked to produce proof of the COVID vaccination status for the facility's Director of Nursing [DON] along with the current list of all staff's COVID vaccine status. The ADM submitted a photocopy of the DON's COVID-19 Vaccination Record Card, along with a list of all staff's COVID vaccine status. Review of the photocopy of the DON's COVID-19 Vaccination Record Card provided by the ADM revealed documentation that the DON had received two doses of the two dose Pfizer vaccine: the first dose on 12/1/21, and a second dose on 12/22/21. The documentation contained the lot number of the vaccine administered and the name of the clinic site where the dose was administered. The list of all staff's COVID vaccine status provided by the ADM documented that the DON was "completely vaccinated". An interview and record review were conducted with the facility's Director of Nursing [DON] on 4/27/22 at 10:30 AM. The DON was asked about h/her COVID vaccine status. The DON stated h/she had lost h/her first vaccine card but had a photocopy of it on h/her phone. The DON stated h/she gave a copy of h/her vaccine card to the ADM on the day h/she received h/her second dose, on 12/22/21. The DON stated h/she received both vaccine doses at the same location. The DON was supplied with the photocopy of h/her Vaccination Record Card provided by the facility's Infection Preventionist documenting one	F 835		

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F 835	Continued From page 8 dose of the vaccine received, along with the photocopy of the DON's Vaccination Record Card provided by the ADM documenting that the DON had received two doses of the vaccine. Additionally, the DON was supplied with documentation from the Vermont Department of Health's Immunization Registry which listed the DON as having received a single dose of the two dose Pfizer vaccine on 12/1/21. The DON was then asked if h/she wished to revise any part of h/her earlier statements. The DON then stated, "I know I hadn't gotten my second one [second dose] and I told you I did." Regarding the Vaccination Record Card provided by the ADM documenting that the DON had received two doses of the vaccine, the DON stated "I wrote the [second] date in. I spoke to [ADM] about it. [ADM] knows I wrote it in. I know [h/she] knows I had to reschedule the vaccination". Regarding the required facility report submitted weekly related to the facility's staff vaccination status, the DON confirmed h/she knew they were false reports submitted weekly related to the facility having completely vaccinated staff. An interview and record review were conducted with the facility's Administrator [ADM] on 4/27/22 at 11:43 AM. The ADM reported that h/she was responsible for submitting reports on the COVID vaccine status of the facility's staff. The ADM stated h/she "fill out the information based on information the Infection Preventionist [IP] gives me". The ADM confirmed that the COVID vaccine status of the facility's staff h/she submitted documents that the facility staff is 100% vaccinated and confirmed that the vaccine status h/she submitted for the DON documents that the DON had received both doses of a two dose	F 835		

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F 835	Continued From page 9 vaccine. The ADM stated that the DON had given h/her vaccine card to the ADM, and that the vaccine card had shown two doses. The ADM was then presented with a copy of the Infection Preventionist list of all staff's COVID vaccine status provided to the ADM on 4/20/22, that lists the DON as having only received one dose of the two dose Pfizer vaccine on 12/1/21. The ADM was supplied with the photocopy of the DON's Vaccination Record Card provided by the facility's Infection Preventionist documenting one dose of the vaccine received, along with the photocopy of the DON's Vaccination Record Card provided by the ADM documenting that the DON had received two doses of the vaccine. Additionally, the ADM was supplied with documentation from the Vermont Department of Health's Immunization Registry which listed the DON as having received a single dose of the two dose Pfizer vaccine on 12/1/21. The ADM was then asked if h/she wished to revise any of h/her earlier statements. Regarding the DON's vaccine card and vaccine status, the ADM stated "[h/she-DON] said I only have one dose. I said they are requesting a copy of it [vaccine card]. When I presented it, I saw it had two doses. I know [h/she] was scheduled to get [h/her] second dose several times and [h/she] didn't get it." When asked if h/she knew the DON's vaccine card showing two doses received was inaccurate when the ADM provided it to the Surveyor and Attorney General Civil Investigator, the ADM stated "Yes." The ADM further confirmed that the required reports submitted by the ADM to the CDC's National Healthcare Safety Network and to the Center for Medicare and Medicaid Services [CMS] were not accurate. The ADM stated that reports are submitted weekly. The ADM	F 835		

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F 835	Continued From page 10 confirmed that h/she was aware since 12/2/21 that the DON was not fully vaccinated and was aware that the information h/she submitted every week reporting that facility staff were fully vaccinated was inaccurate. The ADM stated that the reports h/she submitted "should never have been at 100%." The ADM reported that h/she was aware that the information submitted in the reports was linked to Medicare/Medicaid funding. After the ADM had revised h/her statements, h/she was asked "How would you have made things right?". The ADM stated, "I'm not sure there was a plan to present that false information was given." Review of the facility's Universal COVID-19 Vaccination policy reveals that "Executive Directors, supervisors, and business location managers are responsible for communicating the requirements of the Universal COVID-19 Vaccination Program to all individuals mentioned above, and for ensuring appropriate compliance." Based upon interview and record review, the facility failed to implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. Per interview and record review, actions and decisions by the facility's Administrator [ADM] and Director of Nursing [DON] directly contributed to deficient practices.	F 835		
F 884 SS=C	Reporting - National Health Safety Network CFR(s): 483.80(g)(1)(i)-(viii)(2) §483.80(g) COVID-19 reporting. The facility must-- §483.80(g)(1) Electronically report information about COVID-19 in a standardized format	F 884	The NHSN report has been updated to reflect accurate numbers. The Administrator was termed. The new Administrator has been educated on the NHSN reporting and the process for accurate reporting CFR: 483.80(g)(1)(i)-(viii)(2).	

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F 884	Continued From page 11 specified by the Secretary. This report must include but is not limited to— (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; and (viii) Other information specified by the Secretary. §483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general public. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility knowingly submitted inaccurate reports regarding staff vaccinations on a weekly basis to the Centers for Disease Control and Prevention's National Healthcare Safety Network; information which is posted publicly to support protecting the health and safety of residents, personnel, and the general public. Findings include: An interview and record review were conducted with the facility's Administrator [ADM] on 4/27/22	F 884	**TAG F 884 POC Accepted on 5/19/22 by T. Dougherty/ P. Cota**	

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F 884	Continued From page 12 at 11:43 AM. The ADM confirmed that the required reports submitted by the ADM to the CDC's National Healthcare Safety Network and to the Center for Medicare and Medicaid Services [CMS] were not accurate. The ADM stated that reports are submitted weekly. The ADM confirmed that h/she was aware since 12/2/21 that the facility's Director of Nursing [DON] was not fully vaccinated and was aware that the information h/she submitted every week reporting that facility staff were fully vaccinated was inaccurate. The ADM stated that the reports h/she submitted "should never have been at 100%." The ADM reported that h/she was aware that the information submitted in the reports was linked to Medicare/Medicaid funding. Refer to F835.	F 884	The Administrator, DNS and IP nurse no longer work at the facility. A house wide audit was conducted on all current employees to verify vaccination status or exemption status.	
F 888 SS=F	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	F 888	The new Administrator, IP nurse and HR manager have been educated on the Covid Vaccination Policy and requirements to work in the facility. The IP nurse, HR manager and new Administrator have been educated on reporting process for non-adherent employees. The Administrator will conduct random weekly audits X 4 and monthly X 2 of all new hires to ensure the facility remains in compliance with the regulations. The results of these audits will be brought to QAPI for review and any further interventions needed.	

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F 888	Continued From page 13 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 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	F 888	**TAG F 888 POC Accepted on 5/19/22 by T. Dougherty/P. Cota**	

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F 888	Continued From page 14 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 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	F 888		

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F 888	Continued From page 15 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 upon interview and record review, the facility failed to implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19, and failed to implement additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19. Findings include: 1.) An interview was conducted with the facility's Infection Preventionist [IP] on 4/20/21 at 12:33 PM. The IP reported that the facility's staff provide	F 888		

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F 888	Continued From page 16 proof of their COVID vaccination status to h/her, and h/she then provides an updated list of all staff's COVID vaccine status to the facility's Administrator [ADM] on a weekly basis. The IP was asked to produce proof of the COVID vaccination status for the facility's Director of Nursing [DON] and provided a photocopy of the DON's COVID-19 Vaccination Record Card, along with the updated list of all staff's COVID vaccine status provided to the ADM the day of the interview, 4/20/21. Per review of the photocopy of the DON's COVID-19 Vaccination Record Card, the card lists one dose of the two dose Pfizer vaccine administered on 12/1/21. The list of all staff's COVID vaccine status provided to the ADM that day also lists the DON as having only received one dose of the two dose Pfizer vaccine on 12/1/21. Per interview with the facility's Administrator [ADM] on 4/20/21 and per record review on the same date, the ADM was asked to produce proof of the COVID vaccination status for the facility's Director of Nursing [DON] along with the current list of all staff's COVID vaccine status. The ADM submitted a photocopy of the DON's COVID-19 Vaccination Record Card, along with a list of all staff's COVID vaccine status. Review of the photocopy of the DON's COVID-19 Vaccination Record Card provided by the ADM revealed documentation that the DON had received two doses of the two dose Pfizer vaccine: the first dose on 12/1/21, and a second dose on 12/22/21. The documentation contained the lot number of the vaccine administered and the name of the clinic site where the dose was administered. The list of all staff's COVID vaccine status provided by the ADM documented that the DON was "completely vaccinated".	F 888		

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F 888	Continued From page 17 An interview and record review were conducted with the facility's Director of Nursing [DON] on 4/27/22 at 10:30 AM. The DON was asked about h/her COVID vaccine status. The DON stated h/she had lost h/her first vaccine card but had a photocopy of it on h/her phone. The DON stated h/she gave a copy of h/her vaccine card to the ADM on the day h/she received h/her second dose, on 12/22/21. The DON stated h/she received both vaccine doses at the same location. The DON was supplied with the photocopy of h/her Vaccination Record Card provided by the facility's Infection Preventionist documenting one dose of the vaccine received, along with the photocopy of the DON's Vaccination Record Card provided by the ADM documenting that the DON had received two doses of the vaccine. Additionally, the DON was supplied with documentation from the Vermont Department of Health's Immunization Registry which listed the DON as having received a single dose of the two dose Pfizer vaccine on 12/1/21. The DON was then asked if h/she wished to revise any part of h/her earlier statements. The DON then stated, "I know I hadn't gotten my second one [second dose] and I told you I did." Regarding the Vaccination Record Card provided by the ADM documenting that the DON had received two doses of the vaccine, the DON stated "I wrote the [second] date in. I spoke to [ADM] about it. [ADM] knows I wrote it in. I know [h/she] knows I had to reschedule the vaccination". Regarding the required facility report submitted weekly related to the facility's staff vaccination status, the DON confirmed h/she knew they were false reports submitted weekly related to the facility having completely vaccinated staff.	F 888		

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F 888	Continued From page 18 An interview and record review were conducted with the facility's Administrator [ADM] on 4/27/22 at 11:43 AM. The ADM reported that h/she was responsible for submitting reports on the COVID vaccine status of the facility's staff. The ADM stated h/she "fill out the information based on information the Infection Preventionist [IP] gives me". The ADM confirmed that the COVID vaccine status of the facility's staff h/she submitted documents that the facility staff is 100% vaccinated and confirmed that the vaccine status h/she submitted for the DON documents that the DON had received both doses of a two dose vaccine. The ADM stated that the DON had given h/her vaccine card to the ADM, and that the vaccine card had shown two doses. The ADM was then presented with a copy of the Infection Preventionist list of all staff's COVID vaccine status provided to the ADM on 4/20/22, that lists the DON as having only received one dose of the two dose Pfizer vaccine on 12/1/21. The ADM was supplied with the photocopy of the DON's Vaccination Record Card provided by the facility's Infection Preventionist documenting one dose of the vaccine received, along with the photocopy of the DON's Vaccination Record Card provided by the ADM documenting that the DON had received two doses of the vaccine. Additionally, the ADM was supplied with documentation from the Vermont Department of Health's Immunization Registry which listed the DON as having received a single dose of the two dose Pfizer vaccine on 12/1/21. The ADM was then asked if h/she wished to revise any of h/her earlier statements. Regarding the DON's vaccine card and vaccine status, the ADM stated "[h/she-DON] said I only have one dose. I said they are requesting a copy	F 888		

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F 888	Continued From page 19 of it [vaccine card]. When I presented it, I saw it had two doses. I know [h/she] was scheduled to get [h/her] second dose several times and [h/she] didn't get it." When asked if h/she knew the DON's vaccine card showing two doses received was inaccurate when the ADM provided it to the Surveyor and Attorney General Civil Investigator, the ADM stated "Yes." The ADM further confirmed that the required reports submitted by the ADM to the CDC's National Healthcare Safety Network and to the Center for Medicare and Medicaid Services [CMS] were not accurate. The ADM stated that reports are submitted weekly. The ADM confirmed that h/she was aware since 12/2/21 that the DON was not fully vaccinated and was aware that the information h/she submitted every week reporting that facility staff were fully vaccinated was inaccurate. The ADM stated that the reports h/she submitted "should never have been at 100%." The ADM reported that h/she was aware that the information submitted in the reports was linked to Medicare/Medicaid funding. After the ADM had revised h/her statements, h/she was asked "How would you have made things right?". The ADM stated, "I'm not sure there was a plan to present that false information was given." 2.) Per review of the facility's COVID-19 Staff Vaccination Matrix, dated 4/20/22, the facility lists Staff 'I' as having been granted a religious exemption related to receiving the COVID-19 vaccination. Per interview with the facility's Administrator [ADM] on 4/20/22 at 12:57 PM., the facility's process for implementing additional precautions for all staff who are not fully vaccinated for COVID-19 includes twice weekly testing of all	F 888		

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F 888	Continued From page 20 employees. Review of the facility's 'Contingency Plans/Additional Measures' policy reveals "The facility will ensure contingency plans/additional measures that are intended to mitigate the spread of COVID-19 are utilized for those staff who: ...who have a pending or been granted an exemption". The policy reads "Contingency Plans/Additional Measures include but are not limited to the following protective measures: Testing: Staff must obtain a negative COVID-19 PCR or POC test every 7 days and present a copy of the weekly test report to the facility. This shall be in addition to any testing performed by the Facility as per CDC, Federal, State, or local guidance." An interview was conducted with the facility's Infection Preventionist [IP] on 4/20/21 at 12:33 PM. The IP confirmed that the facility tests its' staff twice weekly with a COVID-19 PCR test, and if that test does not have a negative result, the staff member is required to take a POC test. The IP confirmed that Staff 'I' was granted a religious exemption and was unvaccinated. Per interview with the IP and per record review confirmed by the IP, PCR tests for Staff 'I' dated 1/4/22, 1/8/22, 1/12/22, 1/21/22, 1/25/22, & 3/29/22 contained results that were "Invalid", with the performing laboratory noting that an invalid result can mean no nucleic acids [the physical components necessary to complete a valid result] were included in the staff's specimen. The IP stated that both h/she and the facility's ADM were aware that Staff 'I' "refused" to undergo POC testing, which is required when the PCR test does not have a negative result. Per interview with the IP and per record review of the facility's POC testing log, Staff 'I' received only one [1] POC test	F 888		

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F 888	Continued From page 21 from the facility from January through mid-April 2022. Further review of the facility's Universal COVID-19 Vaccination policy reveals that "Executive Directors, supervisors, and business location managers are responsible for communicating the requirements of the Universal COVID-19 Vaccination Program to all individuals mentioned above, and for ensuring appropriate compliance."	F 888		