STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. Building B. Wing	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ivy at Gastonia LLC	4414 Wilkinson Blvd Gastonia, NC 28056

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record review, observation and interviews with staff and the wound doctor, the facility failed to provide wound care to a venous ulcer per physician orders for 1 of 3 residents (Resident #4) reviewed for wound care. The findings included: Resident #4 was readmitted to the facility on [DATE] with diagnoses that included chronic venous hypertension with ulcer of left lower extremity. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 was severely cognitively impaired and was totally dependent on staff assistance with bed mobility. The MDS further indicated Resident #4 had a total of three venous ulcers and received application of nonsurgical dressings and ointments/medications other than to feet. Resident #4's care plan revised on 3/10/22 indicated Resident #4 had a venous ulcer to the left lower medial leg, a venous ulcer to the left lower lateral leg and a venous ulcer to the left lateral foot which was resolved on 3/10/22. Interventions included treatments as ordered. A physician order dated 3/12/22 for Resident #4 indicated the following treatment to the left lower leg: cleanse left lower leg (medial and lateral) with 1/4 (antiseptic) solution, apply (antifungal) cream, cover with oil emulsion dressings and abdominal pads, wrap site with a gauze bandage roll and change daily every day shift. A review of Resident #4's Treatment Administration Record (TAR) for March 2022 indicated the treatment order for Resident #4's left lower leg was marked as completed by Nurse #3 on 3/17/22 and 3/18/22, Nurse #5 on 3/19/22 and Nurse #4 on 3/20/22. During an observation of wound care on Resident #4 on 3/21/22 at 11:30 AM with Nurse #2, a dressing to Resident #4's left lower leg was noted with a date of 3/16/22. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Nurse #2 on 3/21/22 at 2:13 PM revealed that when she did Resident #4's wound care she did not look at the date on the old dressing and did not notice that it had been dated 3/16/22 before she removed it. Nurse #2 stated that she was focused on the procedure and was thinking about what she needed to do while changing Resident #4's dressing. Nurse #2 stated that Resident #4's treatment to her left leg should have been done daily and she was not sure why it had not been changed since 3/16/22. Nurse #2 stated that she did notice that Resident #4's left leg wound looked drier than usual. A phone interview with Nurse #3 on 3/21/22 at 2:10 PM revealed she worked with Resident #4 on 3/17/22 and 3/18/22 on the day shift from 7:00 AM to 7:00 PM. Nurse #3 stated she knew she was supposed to do Resident #4's treatment to her left lower leg but she didn't do it because the wound doctor was scheduled to come to the facility on either 3/17/22 or 3/18/22 but she couldn't remember which day he was supposed to come. Nurse #3 also stated that she worked with Resident #4 on 3/19/22 from 7:00 AM to 11:30 AM but she didn't do Resident #4's wound care because she thought she was only supposed to pass medications during the four hours that she worked on 3/19/22. A phone interview with Nurse #5 on 3/21/22 at 12:35 PM revealed she came in at 1:00 PM on 3/19/22 and worked with Resident #4 until the night shift. Nurse #5 stated the Director of Nursing (DON) had the keys to her cart when she reported for work because Nurse #3 had already left at 11:30 AM. Nurse #5 stated she didn't do Resident #4's treatment to her left leg because she thought Nurse #3 had already done it on her shift and just forgot to mark it off on her TAR. Nurse #5 also stated she didn't think to check Resident #4's left leg dressing before she marked it off as completed on Resident #4's TAR on 3/19/22 because she usually worked on the night shift and treatments were usually scheduled to be done on the day shift. A phone interview with Nurse #4 on 3/21/22 at 12:41 PM revealed she worked with Resident #4 on 3/20/22 from 7:00 AM to 3:00 PM but she never got around to doing Resident #4's treatment to her left leg. Nurse #4 stated when she got ready to do it, Resident #4 had requested for her to come back later in the shift. But when she had gathered the supplies she needed to do Resident #4's wound care, Resident #4 had already gotten up in her wheelchair and it was difficult for her to do it while she was in her wheelchair. Nurse #4 stated she reported this to the oncoming shift, but she could not remember the name of the nurse. A phone interview with the wound doctor on 3/21/22 at 3:53 PM revealed he usually came to the facility on Thursday, but he did not do rounds on 3/17/22 so the last time he saw Resident #4 was on 3/10/22. The wound doctor stated he had requested for the nursing staff to do daily dressing changes to Resident #4 who had a venous ulcer to her left leg which had been a difficult wound to heal. The wound doctor stated he prescribed an antifungal cream to be applied to the wound to decrease inflammation and decrease the fungal load. He stated the medicated cream loses its effectiveness when Resident #4's dressing was not changed for several days and would not be as effective in eliminating the problem. He also stated that a new batch of antifungal cream and a new dressing should be applied daily to Resident #4's venous ulcer to her left leg. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the Director of Nursing (DON) on 3/21/22 at 4:00 PM revealed she remembered telling the nursing staff that the wound doctor was not coming to the facility on [DATE] so she was not sure why Nurse #3 did not know about it. The DON also came in to work on 3/19/22 to relieve Nurse #3 when she left at 11:30 AM but she did not tell her that Resident #4's treatment to her leg had not been completed. The DON stated Nurse #3 told her that she had everything done and all the DON had to do was wait for Nurse #5 to come in at 1:00 PM. The DON stated there had been poor communication between the nurses which led to Resident #4 not receiving her wound treatment for several days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record review and staff interviews, the facility failed to maintain an accurate Treatment Administration Record (TAR) for wound care to a venous ulcer for 1 of 3 residents (Resident #4) reviewed for wound care. The findings included: Resident #4 was readmitted to the facility on [DATE] with diagnoses that included chronic venous hypertension with ulcer of left lower extremity. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 was severely cognitively impaired and was totally dependent on staff assistance with bed mobility. The MDS further indicated Resident #4 had a total of three venous ulcers and received application of nonsurgical dressings and ointments/medications other than to feet. A physician order dated 3/12/22 for Resident #4 indicated the following treatment to the left lower leg: cleanse left lower leg (medial and lateral) with 1/4 (antiseptic) solution, apply (antifungal) cream, cover with oil emulsion dressings and abdominal pads, wrap site with a gauze bandage roll and change daily every day shift. A review of Resident #4's Treatment Administration Record (TAR) for March 2022 indicated the treatment order for Resident #4's left lower leg was marked as completed by Nurse #3 on 3/17/22 and 3/18/22, Nurse #5 on 3/19/22 and Nurse #4 on 3/20/22. A phone interview with Nurse #3 on 3/21/22 at 2:10 PM revealed she worked with Resident #4 on 3/17/22 and 3/18/22 on the day shift from 7:00 AM to 7:00 PM. Nurse #3 stated she knew she was supposed to do Resident #4's treatment to her left lower leg but she didn't do it because the wound doctor was scheduled to come to the facility on either 3/17/22 or 3/18/22 but she couldn't remember which day he was supposed to come. Nurse #3 stated she couldn't remember signing off Resident #4's TAR on 3/17/22 and 3/18/22 as completed even though she didn't do her treatment to her left leg. A phone interview with Nurse #5 on 3/23/22 at 5:11 PM revealed she came in at 1:00 PM on 3/19/22 and worked with Resident #4 until the night shift. Nurse #5 stated the Director of Nursing (DON) had the keys to her cart when she reported for work because Nurse #3 had already left at 11:30 AM. Nurse #5 stated she didn't do Resident #4's treatment to her left leg because she thought Nurse #3 had already done it on her shift and just forgot to mark it off on her TAR. Nurse #5 also stated she went ahead and marked it off as completed so that it won't be flagged as incomplete and extremely late. Nurse #5 stated it was difficult to follow up on tasks that needed to be done that day because there had been three nurses who had worked on the cart for one shift but normally, she would check the dressing first and make sure it was completed before she would mark it off as complete on the TAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with Nurse #4 on 3/21/22 at 12:41 PM revealed she worked with Resident #4 on 3/20/22 from 7:00 AM to 3:00 PM but she never got around to doing Resident #4's treatment to her left leg. Nurse #4 stated she went ahead and marked Resident #4's wound care to her left leg as completed on the TAR when she got ready to do it but Resident #4 had requested for her to come back later and when she did, Resident #4 had already gotten up out of the bed. Nurse #4 stated she reported this to the oncoming shift, but she could not remember the name of the nurse. An interview with the Director of Nursing (DON) on 3/24/22 at 9:05 AM revealed the nurses should have documented Resident #4's treatment on her left leg on the TAR after they had completed it and if they weren't able to do it on their shift, they should have documented that it had not been completed and verbally communicated that it still needed to be done to the oncoming shift nurse.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on record review and interviews with the facility staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after each of the following surveys with citations that were recited on the current revisit/complaint survey of 6/23/22: 1) The complaint investigation of 7/9/19. This was for 2 recited deficiencies in the areas of Administration (F835) and QAPI/QAA Improvement Activities (F867); 2) The annual recertification/complaint investigation survey of 2/7/20. This was for 2 recited deficiencies in the areas of Resident Rights (F580) and QAPI/QAA Improvement Activities (F867); 3) The Focused Infection Control survey of 6/8/20. This was for 1 recited deficiency in the area of Infection Control (F880); 4) The Focused Infection Control and complaint investigation survey of 10/13/20. This was for 2 recited deficiencies in the areas of Resident Rights (F580) and Infection Control (F880); 5) The complaint investigation of 4/22/21. This was for 1 recited deficiency in the area of Infection Control (F880); 6) The annual recertification/complaint investigation survey of 7/14/21. This was for 2 recited deficiencies in the areas of Resident Assessments (F641) and Infection Control (F880); and 7) The complaint investigation survey of 3/24/22. This was for 3 recited deficiencies in the areas of Quality of Care (F684), Administration (F842), and Infection Control (F888). The continued failure of the facility during seven (7) federal surveys of record within the last 3 years show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F580: Notification of Changes. Based on record reviews, and interviews with staff, and Medical Director, the facility failed to notify the Primary Care Provider of significant changes in a resident's condition (Resident #9) when he developed a new opened sacral pressure ulcer, when the pressure ulcer deteriorated and when he continued to have hypotension (low blood pressure) despite receiving intravenous fluids. The facility also failed to report results of a urinalysis and urine culture resulting in a delay in treating the resident (Resident #9) for UTI (urinary tract infection). Resident #9 was hospitalized on [DATE] for severe sepsis/septic shock due to an infected stage 4 pressure ulcer to the sacrum. In addition, the facility failed to notify the Primary Care Provider when a resident had a severe unintended weight loss (Resident #10). Resident #10 had a cumulative weight loss of 24.4% from 1/19/22 through 4/6/22, was admitted to the hospital on 4/7/22 and had a feeding tube inserted in the stomach. These failures were for 2 of 3 residents reviewed for notification of changes (Resident #9 and Resident #10). During the recertification/complaint investigation survey of 2/7/20, the facility was cited for failing to notify a resident's legal representative that the resident missed two scheduled radiation treatments for 1 of 2 residents reviewed for notification of changes (Resident #45). During the Focused Infection Control and complaint investigation survey of 10/13/20, the facility was cited for failing to notify the legal guardian of a resident's transfer to the hospital for evaluation of vomiting for 1 of 3 residents (Resident #1) reviewed for notification. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F641: Accuracy of Assessments. Based on record review and staff interviews, the facility failed to obtain a resident's weight within 30 days of the Minimum Data Set (MDS) Assessment Reference Date (ARD, the last day of the look back period) for 1 of 4 MDS assessments reviewed (Resident #10). During the annual recertification and complaint investigation survey of 7/14/21, the facility was cited for failing to code the MDS assessment accurately in the areas of Pre-admission Screening and Resident Review (PASRR) Level II for 1 of 1 resident reviewed for PASRR (Resident #15). The facility also failed to code a resident accurately in the areas of active diagnoses and range of motion for 1 of 5 residents (Resident #25) reviewed for accidents. F684: Quality of Care. Based on record reviews, and interviews with staff, family member, Physician Assistant and Medical Director, the facility failed to identify the seriousness of significant changes in a resident's condition (Resident #9), complete and document on-going thorough assessments and identify the need for medical attention when the resident's medical condition continued to deteriorate. This resulted in a delayed treatment for UTI (urinary tract infection) and hospitalization for sepsis due to an infected stage 4 pressure ulcer. This failure was for 1 of 3 residents reviewed for quality of care (Resident #9). During the recertification/complaint investigation survey of 3/24/22, the facility was cited for failing to provide wound care to a venous ulcer per physician orders for 1 of 3 residents (Resident #4) reviewed for wound care. F835: Administration. Based on record reviews, and interviews with staff, family member, Physician Assistant and Medical Director, the facility failed to provide effective leadership and implement effective systems to manage unintended weight loss, change in condition, physician notification and pressure ulcers. This failure affected 5 of 5 residents reviewed for administration (Resident #2, Resident #6, Resident #9, Resident #10, and Resident #11). During the Focused Infection Control and complaint investigation survey of 7/9/19, the facility was cited for failing to provide effective leadership and oversight of processes to ensure facility staff completed and transmitted resident Minimum Data Set (MDS) assessments within the regulatory timeframe for 6 of 12 sampled residents reviewed (Residents #2, #3, #5, #6, #10, and #12). The facility's administration also failed to designate a Registered Nurse to serve as the Director of Nursing (DON) when the previous DON resigned her position on 06/27/19. F842: Complete and Accurate Resident Records. Based on record review and staff interviews, the facility failed to maintain accurate documentation on the Treatment Administration Record (TAR) for wound care to pressure ulcers and a peg tube insertion site for 1 of 2 residents (Resident #6) reviewed for wound care. During the complaint investigation survey of 3/24/22, the facility was cited for failing to maintain an accurate Treatment Administration Record (TAR) for wound care to a venous ulcer for 1 of 3 residents (Resident #4) reviewed for wound care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F867: Based on record review and interviews with the facility staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after each of the following surveys with citations that were recited on the current revisit/complaint survey of 6/23/22: 1) The complaint investigation of 7/9/19. This was for 2 recited deficiencies in the areas of Administration (F835) and QAPI/QAA Improvement Activities (F867); 2) The annual recertification/complaint investigation survey of 2/7/20. This was for 2 recited deficiencies in the areas of Resident Rights (F580) and QAPI/QAA Improvement Activities (F867); 3) The Focused Infection Control survey of 6/8/20. This was for 1 recited deficiency in the area of Infection Control (F880); 4) The Focused Infection Control and complaint investigation survey of 10/13/20. This was for 2 recited deficiencies in the areas of Resident Rights (F580) and Infection Control (F880); 5) The complaint investigation of 4/22/21. This was for 1 recited deficiency in the area of Infection Control (F880); 6) The annual recertification/complaint investigation survey of 7/14/21. This was for 2 recited deficiencies in the areas of Resident Assessments (F641) and Infection Control (F880); and 7) The complaint investigation survey of 3/24/22. This was for 3 recited deficiencies in the areas of Quality of Care (F684), Administration (F842), and Infection Control (F888). The continued failure of the facility during seven (7) federal surveys of record within the last 3 years show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During the complaint investigation survey of 7/9/19, the facility was cited for failing to maintain implemented procedures and monitor interventions that the committee put into place following the complaint investigation survey of 05/24/19. This was for two deficiencies that were originally cited in May of 2019 and subsequently recited on the current revisit and complaint investigation of 07/09/19. The recited deficiencies were in the areas of Activities of Daily Living (ADL) Care Provided for Dependent Residents and Labeling/Storage of Drugs and Biologicals. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During the recertification/complaint investigation survey of 2/7/20, the facility was cited for failing to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 03/07/19, the complaint investigation survey of 05/24/19 and the onsite follow up/complaint survey of 07/09/19. This was for two recited deficiencies. One recited deficiency was in the area of Quality of Life for activities of daily living (ADL) provided for dependent residents (F 677). A second recited deficiency was in the area of Pharmacy Services for free from unnecessary psychotropic meds/prn (as needed) use (F 758). The continued failure of the facility during 4 Federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Process Improvement Program. F880: Infection Control and Prevention. Based on record reviews, observations, staff interviews and the high level of transmission for COVID-19 in the county, the facility failed to implement their infection control policy and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 3 of 3 staff members (Nurse #2, Nurse #6 and the Interim Director of Nursing (IDON) failed to wear eye protection while providing care to 3 of 3 residents (Resident #2, Resident #15 and Resident #16) on 3 of 3 general halls. These failures occurred during a COVID-19 pandemic. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the Focused Infection Control survey of 6/8/20, the facility was cited for failing to implement their policy for COVID-19 screening when 17 of 30 staff failed to complete the screening process. Staff failed to complete the COVID-19 Employee Sign In/Out Log which included answering screening questions and self-monitoring their body temperature prior to reporting for work to provide direct resident care. In addition, 1 of 1 housekeeper who cleaned a resident's room that was on contact precautions, failed to remove his gloves and perform hand hygiene before he exited the room. These failures occurred during a COVID-19 pandemic. During the Focused Infection Control and complaint investigation survey of 10/13/20, the facility was cited for failing to quarantine readmitted residents, require staff to wear all recommended Personal Protective Equipment (PPE) when caring for residents on enhanced droplet contact precautions, and post required transmission-based precaution signage for 2 of 5 readmitted residents reviewed for infection control (Resident #8 and Resident #9). These failures occurred during a COVID-19 pandemic. On 10/5/20 there were 14 residents in the facility who had tested positive for the COVID virus. During the complaint investigation survey of 4/22/21, the facility was cited for failing to follow guidance provided by the Centers for Disease Control and Prevention (CDC) by not socially distancing 5 residents observed smoking in the courtyard adjacent to the facility for 5 of 5 residents (Residents #1, #2, #3, #4 and #5), all reviewed for infection control. During the annual recertification and complaint investigation survey of 7/14/21, the facility was cited for failing implement their infection control policies and procedures when 2 of 2 staff members (Nurse #2 and Nurse #3) failed to disinfect a glucometer according to manufacturer's recommendations after use on 2 of 2 residents (Resident #8 and Resident #14) reviewed for infection control. These failures occurred during a COVID-19 pandemic. F888: COVID-19 Vaccination of Facility Staff. Based on staff interviews and record reviews, the facility failed to implement an effective process for tracking the COVID-19 vaccination status for 5 of 6 facility and contract staff reviewed for vaccinations (Maintenance Staff Member #1, Dietary Staff Member #1, Nurse #8, Consultant Registered Dietitian, and Certified Occupational Therapy Assistant #1). The facility was not in outbreak status and had no positive cases for COVID-19 among the residents. During the complaint investigation survey of 3/24/22, the facility failed to implement an effective process for tracking COVID-19 vaccinations status of 1 of 3 staff reviewed for COVID-19 Vaccination Status (Nurse #1). The facility was not in outbreak status and had no positive cases for COVID-19 among the residents. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted on 6/22/22 at 2:40 PM with the facility's Administrator with a follow-up telephone interview conducted on 6/22/22 at 3:20 PM. During the interviews, the Administrator reported she was new to the facility (start date of 6/13/22). Upon inquiry, the Administrator reported she was aware of at least one repeat citation (F684) for the facility but had not yet reviewed all of the repeated citations as discussed during the interview. When asked, she stated it was the Administrator ' s responsibility to lead the facility's Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Pharmacy consultant, all department heads, and a Nurse Aide. The Administrator reported an ad hoc meeting was held with the QAPI committee on 6/13/22 to discuss the issues identified during the current revisit/complaint investigation survey. She also stated two separate meetings have been held with the Director of Nursing (DON) and the facility's Medical Director to discuss these same concerns in depth. When asked, the Administrator reported it was her expectation that the QAPI team meet monthly to review any tags cited, to make sure they were addressed in accordance with the facility's Plan of Correction (POC), and to, monitor the process you said you were going to do in the POC. In addition, the Administrator reported the QAPI committee would also be expected to identify and address any areas of trends and to initiate an internal POC at the facility, as needed.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 43643 Based on record review and staff interviews the facility failed to implement an effective process for tracking COVID-19 vaccinations status of 1 of 3 staff reviewed for COVID-19 Vaccination Status (Nurse #1). The facility was not in outbreak status and had no positive cases for COVID-19 among the residents. The findings included: A review of the facility's policy titled COVID-19 Vaccination, undated read in part: 2. COVID-19 vaccinations will be offered as per Centers for Disease Control (CDC) and/or Food and Drug Administration (FDA) guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. The facility staff vaccination spreadsheet was reviewed. The spreadsheet included in-house staff, staff exemptions, and contract/agency staff. A review of the facility spreadsheet revealed Nurse #1 was documented for receiving only one dose of the Moderna vaccination dated 1/26/22. A review on 3/21/22 of the National Healthcare Safety Network (NHSN) data for the week ending on 3/6/22 revealed the following staff vaccination information: Recent Percentage of Staff who are Fully Vaccinated = 83.5% A phone interview conducted with Nurse #1 on 3/21/22 at 3:52 PM revealed she had received her first dose of the COVID-19 vaccine on 1/26/22 but had not received a second dose. Nurse #1 further revealed she did not need to take her second dose until 3/27/22 because that was the expiration date on her card. Nurse #1 stated no one had told her the second dose of the vaccine needed to be completed. An interview conducted with the Director of Nursing (DON) on 3/21/22 at 4:12 PM revealed she had been in the facility since 3/4/22 and her duties included handling staff's vaccination status. The DON further revealed she was not aware Nurse #1 had not received a second dose of the COVID-19 vaccine and she did not have an exemption or waiver. The DON indicated she was unable to find copies of staff's vaccination records and had to go by a spreadsheet that was left by the prior DON. The DON stated Nurse #1 should had already been fully vaccinated and received both doses of the COVID-19 vaccine. An interview conducted with the Administrator on 3/21/22 at 3/21/22 at 4:30 PM revealed she was not aware Nurse #1 had not received a second dose of the COVID-19 vaccine. The Administrator further revealed copies of COVID-19 vaccine status were lost due to multiple management positions changing. The Administrator indicated Nurse #1 had thought the expiration date on the vaccine card was when the second dose was due but was in fact an expiration date. The Administrator revealed Nurse #1 did not have a waiver or exemption and should have been fully vaccinated.