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F0000 SS=	INITIAL COMMENTS Christian Care Nursing Center was surveyed for a Recertification survey on 5/12/22. Intakes: MI00125944, MI00125997, MI00127960, and MI00127944. Census= 25.	F0000		
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired	F0656		

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

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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outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement care plan interventions to prevent falls for 1 Resident (R22) of 1 Resident reviewed for falls, resulting in R22 having 6 unwitnessed falls since admission and the potential for serious injury.

Findings:

Review of R22's face sheet dated 5/12/22 revealed she was a 96-year-old female admitted to the facility on 3/23/22 and had diagnoses that included: Atrial fibrillation, anxiety disorder, irritable bowel syndrome, overactive bladder, unsteady on feet, other abnormalities of gait and mobility, history of a traumatic brain injury, and weakness.

Review of R22's Minimum Data Set (MDS) nursing assessment tool, dated 3/30/22, revealed she required limited assistance of one person for transfers, walking and toilet use.

Review of R22's care plan revealed a focus concern dated 3/23/22 and revised on 4/12/22, "I admitted here from my home where I had been living independently for several years. Although my family helped me during the last several

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months, my impaired memory and cognition, confusion and difficulty with managing daily tasks including self-care made it necessary for me to admit here. This change is very difficulty for me as I don't need help or want others telling me what to do. I am very HOH (hard of hearing) which makes communication more difficult. All this makes me anxious. I have lost some strength and endurance over the last few months, so I am not safe to walk alone. I have back pain from a recent fall. I have a history of breast cancer and UTI's (urinary tract infections)."

Review of R22's care plan dated 3/23/22 and revised on 4/12/22 revealed, "I am at risk for falls related to injuries due to my impaired cognition and lack of safety awareness, potential for impaired perfusion due to RBBB (right bundle branch block), Afib w/pacemaker and hx (history) of TIA (transient ischemic attack) (brief stroke-like attack), impaired vision, overactive bladder w/ frequency, potential effects of Paget's disease, neuropathy and potential effects of cardiac medication w/ occasional postural hypotension. Review of interventions for this concern did not indicate how the facility was going to supervise when she was awake and how they planned to anticipate her care needs.

Review of the facility timeline for R22's falls revealed she fell on 4/3/22 at 8:15 pm, 4/12/22 at 5:00 AM, 4/12/22 at 6:15 AM, 5/1/22 at 9:00 PM, 5/2/22 at 7:50 PM, and 5/10/22 at 9:45 PM. The timeline showed R22 was placed on 1:1 (one-to-one) care after the falls on 4/12/22 at 6:15 am, 5/2/22 at 7:50 PM, and 5/10/22 at 9:45 PM. The timeline did not indicate what time the 1:1 was stopped or how the facility was going to supervise R22 once the 1:1 care was discontinued.

During shift report on 5/11/22 at 6:15 AM the

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	night shift nurse reported to the day shift nurse that R22 had fallen at 4:00 AM and had been put on 1:1 the rest of her shift. On 5/11/22 at 9:37 AM R 22 was observed sleeping in a recliner style chair in her room. No staff were within eyesight of R22. During an interview with the Unit Manager, Registered Nurse (RN) "T", and RN "S" on 05/12/22 at 01:47 PM the facility timeline of falls for R22 was reviewed. R22 had 6 falls since admission and all falls were unsupervised. RN "S" and RN "T" confirmed the facility currently had no fall interventions in place to ensure when R22 was awake and needed care staff were supervising R22 to provide the needed care. RN "S" and RN "T" confirmed the current equipment in place did not give staff enough notice to get to R22 before she could self-transfer. R22 was not able to notify staff when she needed assistance.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate assistance and supervision to prevent falls for 1 Resident (R22) of 1 Resident reviewed for falls, resulting in R22 having 6 unwitnessed since admission and the potential for serious injury.	F0689		

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	Findings: Review of R22's face sheet dated 5/12/22 revealed she was a 96-year-old female admitted to the facility on 3/23/22 and had diagnoses that included: Atrial fibrillation, anxiety disorder, irritable bowel syndrome, overactive bladder, unsteady on feet, other abnormalities of gait and mobility, history of a traumatic brain injury, and weakness. Review of R22's Minimum Data Set (MDS) nursing assessment tool, dated 3/30/22, revealed she required limited assistance of one person for transfers, walking and toilet use. Review of R22's care plan revealed a focus concern dated 3/23/22 and revised on 4/12/22, "I admitted here from my home where I had been living independently for several years. Although my family helped me during the last several months, my impaired memory and cognition, confusion and difficulty with managing daily tasks including self-care made it necessary for me to admit here. This change is very difficulty for me as I don't need help or want others telling me what to do. I am very HOH (hard of hearing) which makes communication more difficult. All this makes me anxious. I have lost some strength and endurance over the last few months, so I am not safe to walk alone. I have back pain from a recent fall. I have a history of breast cancer and UTI's (urinary tract infections)." Review of R22's care plan dated 3/23/22 and revised on 4/12/22 revealed, "I am at risk for falls related to injuries due to my impaired cognition and lack of safety awareness, potential for impaired perfusion due to RBBB			

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(right bundle block), Afib w/ pacemaker and hx (history) of TIA (transient ischemic attack) (brief stroke-like attack), impaired vision, overactive bladder w/ frequency, potential effects of Paget's disease, neuropathy and potential effects of cardiac medication w/ occasional postural hypotension. Review of interventions for this concern did not indicate how the facility was going to supervise when she was awake and how they planned to anticipate her care needs.

Review of the facility timeline for R22's falls revealed she fell on 4/3/22 at 8:15 pm, 4/12/22 at 5:00 AM, 4/12/22 at 6:15 AM, 5/1/22 at 9:00 PM, 5/2/22 at 7:50 PM, and 5/10/22 at 9:45 PM. The timeline showed R22 was placed on 1:1 care after the falls on 4/12/22 at 6:15 am, 5/2/22 at 7:50 PM, and 5/10/22 at 9:45 PM. The timeline did not indicate what time the 1:1 was stopped or how the facility was going to supervise R22 once the 1:1 care was discontinued.

During shift report on 5/11/22 at 6:15 AM the night shift nurse reported to the day shift nurse that R22 had fallen at 4:00 AM and had been put on 1:1 the rest of her shift.

On 5/11/22 at 9:37 AM R 22 was observed sleeping in a recliner style chair in her room. No staff were within eyesight of R22.

During an interview with the Unit Manager, Registered Nurse (RN) "T" and RN "S" on 05/12/22 at 01:47 PM the facility timeline of falls for R22 was reviewed. R22 had 6 falls since admission and all falls were unsupervised. RN "S" and RN "T" confirmed the facility currently had no fall interventions in place to ensure when R22 was awake and needed care staff were supervising R22 to

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	provide the needed care. RN "S" and RN "T" confirmed the current equipment in place did not give staff enough notice to get to R22 before she could self-transfer. R22 was not able to notify staff when she needed assistance.			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F0756		

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	when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct monthly pharmacy reviews and document pharmacy recommendations for 4 Residents (R3, R4 , R23, and R24) of 5 residents reviewed for medication usage, resulting in the potential for pharmacy irregularities to be missed. Findings include: R3 Review of R3's face sheet dated 5/12/22 revealed he was an 84-year-old male admitted to the facility on 11/2/17 and had diagnoses that included: Psychotic disorder with delusions due to know physiological condition, major depressive disorder, Dementia and Diabetes Mellitus. R3 was not his own responsibility party. During the antipsychotropic medication review for R3 on 5/12/22 at 11:50 AM, Social Worker (SW) "R" was not able to locate information on a gradual dose reduction (GDR) of the antipsychotic medication Geodon for R3. SW "R" said R3 did not have a GDR of Geodon in the last year. SW "R" was not able to locate any pharmacy recommendation for R3. During a telephone interview with the facility pharmacist supervisor (PHS) "V" said Pharmacist "U" does monthly reviews on all residents but he was not sure where he			

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documents the review as the facility has paper charts and electronic medical records for all residents. PHS "V" was not able to locate a pharmacist recommended for a GDR of the medication Geodon. PHS "V" said Pharmacist "U" attends the behavioral care meetings over the phone and could not locate any documentation of pharmacy recommendations during the behavior meeting. PHS "V" confirmed pharmacy should track yearly GDR of psychotropic medications.

On 5/12/22 at 2:46 PM, the Nursing Home Administrator (NHA) said she just received the pharmacy reviews for the facility residents.

R4

Review of R4's face sheet dated 5/12/22 revealed she was an 80-year-old female that was admitted to the facility on 1/3/22 and had diagnoses that included: Alzheimer's disease, Dementia in other diseases classified elsewhere with behavioral disturbance, psychotic disorder, and anxiety disorder. R4 was not her own responsibility party.

During the antipsychotropic medication review with Social Worker (SW) "R" on 5/12/22 at 11:33 AM, R4's use of Zoloft and Seroquel were reviewed. SW "R" was not able to locate any pharmacy recommendations in R4's medical records. SW "R" said pharmacy does participate in the behavior care conferences however SW "R" was not able to locate any information pharmacy provided during the behavior care conference.

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	On 5/12/22 at 2:46 PM, the Nursing Home Administrator (NHA) said she just received the pharmacy reviews for the facility residents. During a telephone interview with the facility pharmacist supervisor (PHS) "V" said Pharmacist "U" does monthly reviews on all residents but he was not sure where he documents the review as the facility has paper charts and electronic medical records for all residents. PHS "V" was not able to locate a pharmacist recommended for R4. R4 was on Seroquel (antipsychotic medication) on admission. R4's Seroquel was increased in April 2022. PHS "V" was not able to find any pharmacy reviews for R4 and confirmed that the Pharmacist should be tracking and monitoring the use of Seroquel. R23 A review of R23's Admission Record, dated 5/12/22, revealed R23 was an 83-year-old resident admitted to the facility on 7/9/21. In addition, R23's Admission Record revealed multiple diagnoses that included dementia, diabetes, and depression. A review of R23's medical record (electronic and paper), dated 7/9/21 to 5/11/22, failed to reveal any evidence that the pharmacist had reviewed R23's medications during the months of October 2021, December 2021, February 2022, March 2022, and April 2022. During an interview on 5/11/22 at 2:50 PM, the NHA was notified that the surveyor could not locate any evidence in the medical record that the pharmacist had reviewed R23's medications during the months of October 2021, December 2021, February 2022, March 2022, and April			

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	2022. The surveyor requested any documentation that would prove R23's medication regimen had been reviewed during these months. During a second interview on 5/12/22 at 10:00 AM, the NHA was notified the surveyor still did not have any documentation that R23's medications had been reviewed by a pharmacist during the months of October 2021, December 2021, February 2022, March 2022, and April 2022. The surveyor again requested any documentation that would prove R23's medication regimen had been reviewed during these months. During an interview on 5/12/22 at 11:45 AM, the DON stated she understood that the surveyor had requested documentation that R23's medications had been reviewed by a pharmacist during the months of October 2021, December 2021, February 2022, March 2022, and April 2022. The DON stated, "they are still working on getting that for you." A second review of R23's electronic medical record, dated 7/9/21 to 5/12/22, revealed Pharmacist (Pharm) "U" made the following Consultant Pharmacist Monthly Review late entries: - 10/30/21- No Recommendation on 5/12/22 at 1:57 PM. - 12/22/21- No Recommendation on 5/12/22 at 1:57 PM. - 2/27/22- No Recommendation on 5/12/22 at 1:59 PM. - 3/27/22- No Recommendation on 5/12/22 at 1:59 PM.			

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	- 4/21/22- No Recommendation on 5/12/22 at 1:58 PM. During an interview on 5/12/22 at 04:00 PM, the NHA stated she had provided all of the documentation that the surveyor requested and the facility did not have any other additional documentation. Therefore, prior to the pharmacist entering the above mentioned late entries into R23's electronic medical record, the facility did not have any documentation the pharmacist had conducted monthly medication regimen reviews for the months of October 2021, December 2021, February 2022, March 2022, and April 2022. R24 A review of R24's Admission Record, dated 5/12/22, revealed R24 was a 97-year-old resident admitted to the facility on 11/6/19. In addition, R24's Admission Record revealed multiple diagnoses that included dementia, anxiety, and depression. A review of R24's medical record (electronic and paper), dated 5/1/21 to 5/11/22, failed to reveal any evidence that the pharmacist had reviewed R24's medications from May 2021 to April 2022. During an interview on 5/11/22 at 2:50 PM, the NHA was notified that the surveyor could not locate any evidence in the medical record that the pharmacist had reviewed R24's medications from May 2021 to April 2022. The surveyor requested any documentation that would prove R24's medication regimen had been reviewed monthly by the pharmacist over the last 12 months. During a second interview on 5/12/22 at 10:00 AM, the NHA was notified the surveyor still did not have any documentation that R24's medications had been reviewed by a pharmacist			

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	from May 2021 to April 2022. The surveyor again requested any documentation that would prove R24's medication regimen had been reviewed monthly by the pharmacist over the last 12 months. During an interview on 5/12/22 at 11:45 AM, the DON stated she understood that the surveyor had requested documentation that R24's medications had been reviewed by a pharmacist from May 2021 to April 2022. The DON stated, "they are still working on getting that for you." A second review of R24's electronic medical record, dated 5/1/21 to 5/12/22, revealed Pharm "U" made the following Consultant Pharmacist Monthly Review late entries: - 5/11/21- No Recommendation on 5/12/22 at 9:29 AM. - 6/9/21- No Recommendation on 5/12/22 at 9:29 AM. - 7/26/21- No Recommendation on 5/12/22 at 9:29 AM. - 8/30/21- No Recommendation on 5/12/22 at 9:29 AM. - 9/14/21- No Recommendation on 5/12/22 at 9:30 AM. - 10/30/21- No Recommendation on 5/12/22 at 9:30 AM. - 11/26/21- No Recommendation on 5/12/22 at 9:30 AM. - 12/22/21- No Recommendation on 5/12/22 at 9:30 AM.			

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	- 1/31/22- No Recommendation on 5/12/22 at 9:31 AM. - 2/27/22- No Recommendation on 5/12/22 at 9:30 AM. - 3/27/22- No Recommendation on 5/12/22 at 9:31 AM. - 4/21/22- No Recommendation on 5/12/22 at 9:30 AM. During an interview on 5/12/22 at 04:00 PM, the NHA stated she had provided all of the documentation that the surveyor requested and the facility did not have any other additional documentation. Therefore, prior to the pharmacist entering the above mentioned late entries into R24's electronic medical record, the facility did not have any documentation the pharmacist had conducted monthly medication regimen reviews from May 2021 to April 2022.			
F0888 SS= F	COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the	F0888		

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	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 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			

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	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 facilitys 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			

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	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, and record review, the facility failed to maintain accurate records of staff COVID 19 vaccination status and failed to operationalize their COVID 19 Staff Testing and Vaccination policy, potentially affecting all facility residents, resulting in the facility not being aware of the vaccination status of ten staff members who provide care to residents and/or have contact with residents and the potential for the spread of illness to facility residents. Findings include: A review of the facility's Covid 19 Staff Testing and Vaccination policy, last revised 2/16/22, defined "Staff" as "Any individuals who work or volunteer at (the facility) regardless of clinical responsibility or resident contact. Thus, staff include employees, licensed practitioners,			

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	students, trainees, volunteers, and others who provide care, treatment, or other services for (the facility) and/or its residents ... 14. The Infection Preventionist will be responsible for tracking compliance". On 5/10/22 at approximately 8:50 AM the Nursing Home Administrator (NHA) reported that Maintenance Supervisor (MS) "K" had recently tested positive for COVID-19. A review of the COVID 19 Staff Vaccination Matrix provided by the Director of Nursing (DON) and the Staff Covid 19 Exemption Roster provided by the Director of Human Resources (DHR) "L" soon after the survey team entered the facility did not reveal the vaccination/exemption status of MS "K" (who had recently tested positive for COVID 19). Further review of the facility COVID 19 Staff Vaccination Matrix provided by the facility did not reveal the vaccination status of Medical Director (MD) "A". Additionally, review of the facility staff roster and staff schedule provided by the facility revealed an additional eight staff members (who were not listed on the Matrix, or the Exemption list the facility provided), and included: Activity Aide (AA) "M", Certified Nurse Aide (CNA) "N", Dietary Aide (DA) "O", CNA "P", Licensed Practical Nurse (LPN) "W", Med Tech "X", Nurse Aide "Y", and Physical Therapist and Therapy Program Manager (PTPM) "H". On 5/12/22 at 10:43 AM, Physical Therapist and Therapy Program Manager (PTPM) "H" reported she is a contract staff member and is in the facility usually three days a week. PTPM "H" reported that she has an exemption that was submitted and accepted by the facility. PTPM "H" was observed to be wearing the Personal Protection Equipment (PPE) required to be worn by staff with an exemption. Review of the facility			

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	COVID 19 Staff Vaccination Matrix and Staff Covid 19 Exemption Roster did not reveal the vaccination/exemption status of PTPM "H". On 5/10/22 at 2:50 PM the DON, who was verified as a Certified Infection Preventionist, provided an updated facility COVID 19 Staff Vaccination Matrix that included the data that MD "A" received the initial vaccination on 12/8/20 and the COVID 19 booster on 10/18/21. However, the updated Matrix did not reflect data about the status of MS "K" or the other eight staff members listed on the staff roster and schedule but not on the Matrix or Exemption Roster. On 5/11/22 at 2:43 PM, an email was sent to the NHA requesting the employee status of the nine staff members from the staff roster and schedule but not on the Matrix or Exemption list. On 5/11/22 at 4:11 PM, an email was received from DHR "L" that clarified the employee status of the nine staff identified from the staff roster but not on the facility COVID 19 Staff Vaccination Matrix or Exemption Roster. The email revealed that seven of the nine staff members were current employees (Med Tech "X" and Nurse Aide "Y" no longer worked at the facility). On 5/11/22 at 4:44 PM, the DON was asked about the Exemption list provided by the facility that reflected six religious exemptions and one "voluntary" exemption. The DON reported she does not know what a "voluntary" exemption is. This was later clarified by DHR "L" as a voluntary termination but without an explanation of why the former staff member remained on the Exemption Roster. A review of the COVID 19 Staff Vaccination Matrix and the Staff COVID 19 Exemption			

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	Roster revealed the facility staff vaccination rate was 91.3 % versus the 84.2% that the facility reported to the National Healthcare Safety Network (NHSN) the week of 4/24/22 (the latest data the survey team had prior to the survey). This was a discrepancy of 7.1%. However, because there were ten staff members (MD "A", PTPM "H", MS "K", and seven other listed staff members) whose vaccination/exemption status were not listed on the COVID 19 Staff Vaccination Matrix and the Staff Covid 19 Exemption Roster the survey team received soon after the entrance conference, the discrepancy between what was reported to the NHSN database and what the facility has in their records could be higher. In an interview conducted 5/12/22 at 9:45 AM, the NHA was informed the tracking and reporting of staff COVID 19 vaccination status was a concern. The NHA made no comment or asked any clarifying questions. On 5/12/22 at 9:49 AM, the DON provided hard-copy documentation of the COVID 19 vaccination status of the seven staff members not listed on the facility COVID 19 Vaccination Matrix or the Exemption list. The DON was informed that the tracking and reporting of staff COVID 19 vaccination was a concern. The DON did not indicate that additional information will be provided. On 5/12/22 at 1:56 PM, an interview was conducted with the NHA in her office during the Quality Assurance Quality Improved (QAPI) task. The NHA was asked if the facility COVID 19 Staff Vaccination tracking, and reporting was discussed during QAPI meetings. It was reiterated that this was an identified concern that is being carried forward. The NHA reported that there was a recent change in Human Resource staff and the			

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	previous staff were not sharing data with the DON. The NHA reported she feels that there are no issues with the tracking and reporting of employee COVID 19 status and that the DON is "very meticulous". No additional information was provided by survey exit.			