ACCORDIUS HEALTH AT STATESVILLE 520 VALLEY STRI STATESVILLE, I (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	COMPLETED R-C 05/25/202 S, CITY, STATE, ZIP CODE
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING     345128     NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS     ACCORDIUER OR SUPPLIER     STREET ADDRESS     ACCORDIUS HEALTH AT STATESVILLE     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PREFIX (EACH CROSS     {F 000}   INITIAL COMMENTS   {F 000}   {F 000}   An onsite revisit was conducted on 05/25/22. Tags F561, F565, F568, F688, F689, F693, F695, F698, F761, F804, F812, F842, F880, and F887 were corrected as of 05/25/22. Repeat tags were cited. New tags were also cited as a result   I   I	COMPLETED R-C 05/25/202 S, CITY, STATE, ZIP CODE S, CITY, STATE, ZIP CO
NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS     ACCORDIUS HEALTH AT STATESVILLE   SUMMARY STATEMENT OF DEFICIENCIES   STREET ADDRESS     (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PR     PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID   PR     {F 000}   INITIAL COMMENTS   {F 000}   {F 000}   {F 000}     An onsite revisit was conducted on 05/25/22. Tags F561, F565, F568, F686, F688, F689, F693, F695, F698, F761, F804, F812, F842, F880, and F887 were corrected as of 05/25/22. Repeat tags were cited. New tags were also cited as a result   Image: Construction of the state is the	05/25/202   S, CITY, STATE, ZIP CODE   REET   NC 28677   ROVIDER'S PLAN OF CORRECTION   COMP   COMP   S-REFERENCED TO THE APPROPRIATE
NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS     ACCORDIUS HEALTH AT STATESVILLE   SUMMARY STATEMENT OF DEFICIENCIES   STREET ADDRESS     (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PR     PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID   PR     {F 000}   INITIAL COMMENTS   {F 000}   {F 000}   {F 000}     An onsite revisit was conducted on 05/25/22. Tags F561, F565, F568, F686, F688, F689, F693, F695, F698, F761, F804, F812, F842, F880, and F887 were corrected as of 05/25/22. Repeat tags were cited. New tags were also cited as a result   Image: Construction of the state is the	S, CITY, STATE, ZIP CODE EEET NC 28677 ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE
S20 VALLEY STRESS     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PREFIX PREFIX TAG   ID PREFIX TAG   PREFIX (EACH CROSS     {F 000}   INITIAL COMMENTS   {F 000}   {F 000}   {F 000}   F561, F565, F568, F686, F688, F689, F693, F695, F698, F761, F804, F812, F842, F880, and F887 were corrected as of 05/25/22. Repeat tags were cited. New tags were also cited as a result   Image: 1000 minipage   Image: 1000 minipage	REET NC 28677 ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE
ACCORDIUS HEALTH AT STATESVILLE     STATESVILLE, I     (X4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PREFIX (EACH CROSS     {F 000}   INITIAL COMMENTS   {F 000}	NC 28677 ROVIDER'S PLAN OF CORRECTION (( COMP COMP S-REFERENCED TO THE APPROPRIATE D
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPREFIX (EACI CROSS{F 000}INITIAL COMMENTS{F 000}An onsite revisit was conducted on 05/25/22. Tags F561, F565, F568, F686, F688, F689, F693, F695, F698, F761, F804, F812, F842, F880, and F887 were corrected as of 05/25/22. Repeat tags were cited. New tags were also cited as a resultID PREFIX ID PREFIX	ROVIDER'S PLAN OF CORRECTION (C H CORRECTIVE ACTION SHOULD BE COMP S-REFERENCED TO THE APPROPRIATE D
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conducted at the time as the revisit. The Directed Plan of Correction including the Root Cause Analysis were reviewed. The facility remains out of compliance. Event ID# ZN7X13. QAPI/QAA Improvement Activities{F 867} GAPI/QAA Improvement Activities{F 867} SS=DGARI/QAA Improvement Activities{F 867} CFR(s): 483.75(g)(2)(ii){F 867}§483.75(g)(2) The quality assessment and assurance.§483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the completion date of 5/3/22. This was for one repeated deficiency for COVID 19 Vaccination of Facility Staff which was originally cited on 04/01/22 during a revisit and complaint investigation survey and cited again on the revisit and complaint investigation completed on 5/25/22. The continued failure of the facility during the two federal surveys showed a pattern 	

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE		
345128		345128	B. WING			R-C 05/25/2022		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
					520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	/ILLE			STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
{F 867}	record review and sta process failed to idem contract who were no to implement an effect COVID-19 vaccination reviewed for COVID-1 (Dietary Aide #1 and I was not in outbreak s cases for COVID-19 a During the revisit and survey completed on implement an effective COVID-19 vaccination staff working in the fa- COVID-19 Vaccination staff working in the fa- COVID-19 Vaccination staff working in the fa- COVID-19 Vaccination the Administrator was 4:30 PM. The Administ of the April 2022 surve process in place for tr status for all staff, but currently had that pro- Administrator stated t 2 dietary staff under cov vaccinated, but the pl 2nd dose of a multi-do next COVID 19 clinic Administrator also stat the dietary staff could COVID 19 vaccine els was planning to offer The Administrator state	referred to: F888: Based on ff interviews the facility's tify 2 staff employed under t fully vaccinated and failed tive process for tracking ns status for 2 of 5 staff 19 Vaccination Status Dietary Aide #2). The facility tatus and had no positive among the residents. complaint investigation 04/01/22 the facility failed to e process for tracking the n status for 49 of 105 (47%) cility who were reviewed for n Status. s interviewed on 05/25/22 at strator stated that at the time ey, the facility did not have a acking the vaccination that now the facility cess in place. The hat the facility was aware of contract who were not fully ans were to offer them the base vaccine at the facility's on 06/7/22. The ted that she was aware that obtain their 2nd dose of the sewhere, but that the facility it to them at the next clinic. ted that per federal	{F ε	367				
		was only required to at least one dose of a vaccine, and that the 2nd						

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/09/20 FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     345128		(X1) PROVIDER/SUPPLIER/CLIA	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING _		R-C 05/25/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET	
				STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
{F 867}	Continued From page		{F 86	57}	
	dose was not current				
{F 888} SS=D			{F 88	38}	
	must develop and imp procedures to ensure vaccinated for COVIE section, staff are cons has been 2 weeks or a primary vaccination completion of a prima COVID-19 is defined a single-dose vaccine required doses of a m §483.80(i)(1) Regard or resident contact, th must apply to the folk provide any care, treat the facility and/or its m (i) Facility employees (ii) Licensed practitio (iii) Students, trainees (iv) Individuals who p other services for the under contract or by o	that all staff are fully 0-19. For purposes of this sidered fully vaccinated if it more since they completed series for COVID-19. The ary vaccination series for here as the administration of e, or the administration of all nulti-dose vaccine. Illess of clinical responsibility ne policies and procedures owing facility staff, who atment, or other services for residents: s; ners; s, and volunteers; and provide care, treatment, or facility and/or its residents, other arrangement.			
	section do not apply t (i) Staff who exclusive telemedicine services	licies and procedures of this to the following facility staff: ely provide telehealth or s outside of the facility setting any direct contact with			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345128	B. WING			R-C 05/25/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH AT STATESVILLE				5	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	/ILLE		8	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 888}	contact with residents paragraph (i)(1) of this §483.80(i)(3) The pol include, at a minimum (i) A process for ensu- paragraph (i)(1) of this staff who have pendir been granted, exemp requirements of this s whom COVID-19 vac delayed, as recomme clinical precautions ar received, at a minimu vaccine, or the first do vaccination series for vaccine prior to staff p treatment, or other ser its residents; (iii) A process for ensu additional precautions transmission and spre who are not fully vac (iv) A process for trac documenting the COV all staff specified in pa section; (vi) A process for track documenting the COV any staff who have ob as recommended by to (vi) A process for track documenting informat	a who do not have any direct a and other staff specified in s section. licies and procedures must a, the following components: uring all staff specified in s section (except for those ng requests for, or who have tions to the vaccination section, or those staff for cination must be temporarily ended by the CDC, due to nd considerations) have im, a single-dose COVID-19 ose of the primary a multi-dose COVID-19 providing any care, ervices for the facility and/or suring the implementation of s, intended to mitigate the ead of COVID-19, for all staff cinated for COVID-19; king and securely /ID-19 vaccination status of aragraph (i)(1) of this king and securely /ID-19 vaccination status of obtained any booster doses the CDC; ch staff may request an taff COVID-19 vaccination on an applicable Federal law;	{F 8	888}			

Facility ID: 922999

If continuation sheet Page 4 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES   (X1) PROVIDER/SUPPLIER/CLIA     AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345128	B. WING				25/2022
NAME OF P	ROVIDER OR SUPPLIER		ł	9	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 888}	has granted, an exem COVID-19 vaccination (viii) A process for en- documentation, which clinical contraindication and which supports si- exemptions from vacca and dated by a licens the individual request is acting within their re- as defined by, and in applicable State and I ensuring that such do (A) All information spe authorized COVID-19 contraindicated for the and the recognized cli contraindications; and (B) A statement by the recommending that the exempted from the fa- vaccination requirement recognized clinical co- (ix) A process for ensist secure documentation staff for whom COVID temporarily delayed, a CDC, due to clinical p considerations, includindividuals with acute COVID-19, and individuals vaccinated for COVID Effective 60 Days After	aption from the staff in requirements; suring that all in confirms recognized ons to COVID-19 vaccines taff requests for medical cination, has been signed ed practitioner, who is not ing the exemption, and who espective scope of practice accordance with, all local laws, and for further recumentation contains: ecifying which of the vaccines are clinically e staff member to receive inical reasons for the d e authenticating practitioner ne staff member be cility's COVID-19 ents for staff based on the intraindications; uring the tracking and n of the vaccination must be as recommended by the orecautions and ling, but not limited to, illness secondary to duals who received s or convalescent plasma ent; and a for staff who are not fully 0-19.	{F 8	388)			

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C 05/25/2022		
		345128	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		•	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
{F 888}	staff specified in para are fully vaccinated for those staff who have the vaccination requir those staff for whom 0 be temporarily delaye CDC, due to clinical p considerations; This REQUIREMENT by: Based on record revir facility's process faile under contract who w failed to implement ar tracking COVID-19 va staff reviewed for CO (Dietary Aide #1 and was not in outbreak s cases for COVID-19 a The findings included A review of the facilit "Employee COVID-19 Policy" revised 12/28/ facility will ensure tha fully vaccinated again religious or medical e employees, licensed students/trainees/and who provide care, tra- the facility and/or its r by other arrangement	graph (i)(1) of this section or COVID-19, except for been granted exemptions to rements of this section, or COVID-19 vaccination must ad, as recommended by the orecautions and is not met as evidenced ew and staff interviews the d to identify 2 staff employed ere not fully vaccinated and n effective process for accinations status for 2 of 5 VID-19 Vaccination Status Dietary Aide #2). The facility tatus and had no positive among the residents. : ty document titled 0 Vaccination Mandate /21 read in part: 1. The t all eligible employees are ust COVID-19, unless xemptions are granted. 2.All e following: Facility practitioners, I volunteers, and individuals atment, or other services for esidents, under contract or t. 14. The facility will track in the vaccination status of urrent and as new	{F 8	388)				

Facility ID: 922999

If continuation sheet Page 6 of 8

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
	345128		B. WING	-			-C 25/2022
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT STATES	/II I F		5	520 VALLEY STREET		
				5	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 888}	The facility staff vacci reviewed. The spread staff, staff exemptions A review of the facility Dietary Aide #1 was conly only one dose of the F 12/03/21. The review was documented for r the Moderna vaccinat A review on 05/25/22 Safety Network (NHS on 05/23/22 revealed information. On 05/25/22 at 11:48 Administrator stated t staff who are fully vac On 05/25/22 at 12:30 conducted with Dietar interview he stated he facility for one year. H dose of the Pfizer vac had not received a se stated he was waiting to administer his secc know when that would On 05/25/22 at 12:45 conducted with Dietar interview she stated se facility for a total of 5 received her first dose vaccination on 01/27/ second dose. She stat that she would need a	nation spreadsheet was Isheet included in-house s, and contract/agency staff. r spreadsheet revealed Iocumented for receiving Pfizer vaccination dated revealed Dietary Aide #2 receiving only one dose of ion dated 01/27/22. of the National Healthcare N) data for the week ending no staff vaccination AM The facility he recent percentage of scinated was 100%. PM an interview was ry Aide #1. During the had been working in the le stated he received his first scination on 12/03/21 but cond dose. He further on someone in the facility and dose but that he did not d be. PM an interview was ry Aide #2. During the had been working in the months. She stated she	{F 8	388}			

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED	
		345128	B. WING			R-C 05/25/2022		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT STATES	VILLE			520 VALLEY STREET			
					STATESVILLE, NC 28677		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 888}	facility had come to he dose. She stated she On 05/25/22 at 2:15 F conducted with the Bu (BMO). She stated she vaccination status and members hadn ' t rec stated she reviewed t spreadsheet and mus interview revealed the vaccination clinics on 04/26/22 and 05/03/2 mentioned to all staff signed up for the clini revealed the dietary st the facility did not acc contract staff. She stat if the dietary staff men vaccinated. On 05/25/22 at 2:30 F conducted with the Ac interview she stated s staff vaccination spre- staff members were in stated she believed it the regulation and tho initial vaccination, and them to receive the for	er and offered the second had been waiting to take it. PM an interview was usiness Office Manager he was handling the staff's d had not seen the two staff eived the second dose. She he staff vaccination st have just missed it. The e facility had already had 3 the dates of 04/20/22, 2 in which she had and only two staff members c on 04/26/22. The interview staff were contract staff and expt exemptions from ated she could not speak to mbers should be fully PM an interview was dministrator. During the she had been overseeing the adsheet and knew the two not fully vaccinated. She was okay because she read ought they just needed the d a plan was in place for blowing dose in June. She her vaccination clinics to e up to date with the	{F 8	388)				

Facility ID: 922999

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