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E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain	E 036		

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

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E 036	Continued From page 1 an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Review on 2/21/22 of the facility's EP plan (last reviewed 2021) did not reveal staff had received recent training on the plan. Additional review of the facility documents did not include training for all staff working at the home. Interviews on 2/22/21 with Staff A and Staff B revealed they had not received any training on the facility's EP plan.	E 036		

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E 036	Continued From page 2 During an interview on 2/22/22, the ICF/IID Director indicated the last training on the facility's EP plan was in 2019; however, no documentation was provided.	E 036		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #3 received consistent opportunities for choice and self-management in her home environment. The finding is: During afternoon observations in the home on 2/21/22 from 12:10pm - 12:55pm, Staff A and Staff B repeatedly prompted client #3 to "Sit down" as she attempted to go to the kitchen or the dining room table. Staff consistently told the client, "It's not time yet" or "It's not ready yet" while physically blocking her movements and prompting her back to a couch in the living room. During morning observations in the home on 2/22/22 at 6:46am, Staff D prompted client #3 to "Sit down" and told the client "Not yet" as she stood from the couch and walked towards the dining room table. Interview on 2/22/22 with Staff D revealed, "Since COVID", the clients are made to wait in the living room until the food is ready. Review on 2/22/22 of client #3's Direct Support	W 247		

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W 247	Continued From page 3 Evaluation dated 7/2/19 revealed the client can make choices about when she wants to go to her room and what activities she wants to participate in. The evaluation noted staff "should honor her choice" and "praise [Client #3] for making a choice". Interview on 2/22/22 with the ICF/IID Director indicated client #3 should have free movement in "her home" and staff should be offering alternative activities to the client.	W 247		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 4 of 5 audit clients (#1, #3, #4 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, implementation of meal guidelines, use of eye glasses and domestic tasks. The findings are: A. During observations in the home throughout the survey on 2/21 - 2/22/22, various staff	W 249		

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prepared meals in the home without the participation of clients. Meals were prepared, served onto plates, drinks prepoured and provided to clients at the dining room table. Clients were not prompted or encouraged to actively participate with meal preparation tasks or serving themselves.

Interviews on 2/21 - 2/22/22 with Staff B, C, and D revealed clients in the home have not participated in cooking tasks for 2 years because of COVID-19.

Review on 2/22/22 of client #5's Direct Support Evaluation dated 1/24/21 indicated, "[Client #5] and her housemates participate in weekly rotation for cooking dinner. [Client #5] knows the function of kitchen utensils, pots and pans and can follow a simple recipe if it is written so that she can read it. [Client #5] knows how to safely use kitchen knives and will cut items for a salad with staff supervision." Additional review of client #5's IPP dated 4/7/21 noted objectives to prepare a meal with 2 verbal or less intrusive prompts 75% of opportunities (implemented 2/4/20) and to completed the steps needed to prepare for cooking her own meal with 2 verbal prompts or less intrusive prompts 80% of opportunities (implemented 2/4/20). The IPP noted the client joins her housemates in family style dining at meals.

Review on 2/22/22 of client #4's IPP revealed she "routinely helps with various household responsibilities alternating with her housemates including cooking dinner..." Additional review of the client's Direct Support Evaluation dated 3/16/20 indicated she also "helps cook dinner at least twice a week. [Client #4] gathers needed

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items for dinner from the pantry, refrigerator, and freezer. [Client #4] can also measure with assistance and stir items. [Client #4] can also assist with items in the oven and on the stove with supervision...[Client #4] is capable of serving herself but requires some help with appropriate serving sizes."

Review on 2/22/22 of client #3's Direct Support Evaluation dated 7/2/19 indicated, "[Client #3] has limited skills with preparing her meals and food and will usually require hand over hand assistance with most meal preparation. [Client #4] can help pour, mix, or measure items with hand over hand assistance. She can help make her lunch with hand over hand assistance." The evaluation also noted she can "assist with preparing a side item for dinner at least once weekly. If [Client #3] is helping cook dinner, she should help with preparing an item or prepping food such as measuring, pouring or mixing ingredients."

Review on 2/22/22 of client #1's Direct Support Evaluation dated 6/18/19 revealed, "She requires assistance from support professionals in preparing her food...She can help cut her food using the chopper/blender." Additional review of the evaluation noted she consumes a "soft mechanical diet - Food must be cut into 1/4 (inches) pieces". Further review indicated, "[Client #1] can assist with cooking dinner by stirring and mixing items...[Client #1] can help serve her food onto her plate..."

Interview on 2/22/22 with the ICF/IID Director confirmed clients in the home have not been assisting with meal preparation tasks due to fears of COVID-19 but they are in the process of

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transitioning back to allowing the clients to begin assisting again.

B. During lunch observations in the home on 2/21/22 at 12:55pm, client #3 began consuming her lunch meal. Staff A assisted the client by providing hand-over-hand assistance to scoop food and bringing it to her mouth. As the client attempted to grab food from her plate using her left hand, the staff covered the plate with a large plate cover. The staff prompted client #3 to chew her food, drink and swallow at the meal. After initially providing physical assistance, the staff began feeding client #3 her food until she finished eating. Client #3 was not the opportunity to feed herself.

During dinner observations in the home on 2/22/22 at 6:30pm, Staff C provided hand-over-hand assistance to client #3 as she consumed her meal. The staff covered the plate with a large plate cover between bites, checked the client's mouth for food in between bites and prompted her to drink. Client #3 did not independently feed her self.

Interview on 2/22/22 with Staff A revealed client #3 will grab food and put it in her mouth at meals and a plate cover is used to prevent this. Additional interview indicated the client can feed herself but they also feed her or provide assistance to prevent her from putting too much food in her mouth.

Review on 2/22/22 of client #3's meal guidelines (updated 6/2014) revealed, "While [Client #3] is eating, support professionals should remind quietly to look down at her plate or food when eating...Support professionals should verbally

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remind [Client #3] to take small bites and put her fork or spoon down in between bites to assist her with eating slower. During the meal if [Client #3] is eating quickly by taking multiple bites at a time before chewing what is in her mouth or taking really large bites, support professionals should follow the following guidelines: Immediately cover her plate with a clean plate cover and quietly tell [Client #3] what is expected; Tell her, 'small bites.' or 'one bite.' "

Additional review of the guidelines noted, "After [Client #3] finishes chewing the food that is in her mouth, support professionals should remove the plate cover and quietly remind [Client #3] to take small bites and one bite at a time...If [Client #3] reaches out for support professional's hand while eating, support professionals should hold her hand for a couple of minutes and then encourage her to put her hand in her lap..." Further review of the guidelines did not indicate client #3 should be provided full hand-over-hand assistance or that she should be fed during meals.

Interview on 2/22/22 with the ICF/IID Director indicated client #3 can feed herself and staff may need more training on her mealtime guidelines.

C. During observations throughout the survey in the home on 2/21 - 2/22/22, client #1 did not wear eye glasses. The client was not prompted or assisted to wear eye glasses.

Interview on 2/22/22 with Staff B revealed client #1 has eye glasses and she wears them mainly at meals. The staff then retrieved the client's eye glasses from a nearby room and showed them to the surveyor.

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W 249	Continued From page 8 Review on 2/21/22 of client #1's Direct Support Evaluation dated 6/28/19 revealed a strength to wear her glasses for increasing duration of time. Additonal review of the client's IPP dated 7/19/21 identified an objective to wear her glasses for at least 120 minutes throughout the day at least 25 days a month for two consecutive months. Interview on 2/22/22 with the ICF/IID Director confirmed client #1 does wear eye glasses and usually wears them at meals and when flipping through pages of her phone book. D. During 3 of 3 mealtime observations and one snack observation in the home on 2/21 - 2/22/22, various staff cleared client #1's dishes from the table without prompting or assisting her to complete this task. Interview on 2/21/22 with Staff B revealed client #1 cannot clear her dishes from the table after meals. Review on 2/22/22 of client #1's Direct Support Evaluation dated 6/28/19 noted, "After dinner, she will help with cleaning up from the meal..." Interview on 2/22/22 with the ICF/IID Director indicated client #1 should have the opportunity to clear her place after meals. E. During snack observations in the home on 2/21/22 and breakfast observations in the home on 2/22/22, staff cleared client #3's dishes from the table without prompting or assisting her to complete this task. Interview on 2/21/22 with Staff B indicated client #3 is not capable of clearing her dishes from the	W 249		

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W 249	Continued From page 9 table after meals. Review on 2/22/22 of client #3's Direct Support Evaluation dated 7/2/19 revealed, "After dinner, [Client #3] will assist with cleaning up her place at the table..." Interview on 2/22/22 with the ICF/IID Director confirmed client #3 can clear her dishes with assistance. D. During observations in the home throughout the survey on 2/21 - 2/22/22, three different staff brushed and styled client #4's hair without prompting or encouraging her to participate with this task. Interview on 2/22/22 with Staff D revealed client #4 could brush her hair; however, she usually just hits her self in the head with the brush if she does it herself. Review on 2/22/22 of client #4's Direct Support Evaluation dated 3/16/20 noted, "Staff should give [Client #4] the opportunity to brush and style her own hair...[Client #4] is able to brush her hair independently but requires some assistance to style her hair." Interview on 2/22/22 with the ICF/IID Director confirmed client #4 should be given the opportunity to brush and style her own hair and this would be an appropriate training opportunity.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the	W 260		

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W 260	Continued From page 10 process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 5 audit clients (#2 and #3) was updated as appropriate at least annually. The findings are: Review on 2/21/22 of facility documents revealed no IPP for client #2. Additional review revealed client #3's most current IPP was dated 7/19/20. No current IPP was provided for client #2 and client #3. Interview on 2/22/22 with the ICF/IID Director indicated she was sure the Qualified Intellectual Disabilities Professional (QIDP) held the planning meetings for client #2 and client #3 and she may have copies of the current program plans; however, QIDP was not available.	W 260		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the Medication Technician (MT) was sufficiently trained to document appropriately on the Medication Administration Record (MAR) and to effectively monitor clients during self-administration of their medications. This affected 1 of 5 audit clients (#5). The findings	W 340		

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are:

A. During observations of medication administration in the home on 2/21/22 at 4:33pm and 4:27pm and on 2/22/22 at 7:31am, the MT initialed the MAR before each client ingested their medication.

Interview on 2/21/22 with the MT revealed it was acceptable to sign the MAR before or after a client ingests their medication.

Interview on 2/22/22 with the ICF/IID Director indicated the MT should not initial the MAR until medications are ingested.

B. During observations of medication administration in the home on 2/22/22 at 7:40am, client #5 self-administered one drop of Artificial Tears solution 1.4% in to each eye. While standing at a table in the medication room, Client #5 retrieved each medication, including pills and a powder, identified them, dispensed them, applied a topical lotion and consumed her medications. During this time, the MT sat at a table and sporadically flipped through the MAR or cleaned client #5's eye glasses. The MT did not interact with client #5 verbally or physically as she dispensed, applied and consumed her medications.

Interview on 2/22/22 with the MT revealed she generally does not assist client #5 with taking her medications because she can dispense them independently. Additional interview indicated she does not assist unless client #5 asks for assistance.

Review on 2/22/22 of client #5's physician's

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W 340	Continued From page 12 orders dated 1/1 - 1/31/22 revealed an order for Artificial Tears solution 1.4%, "instill 2 drops in each eye" at 8am. Additional review of client #5's medication administration guidelines (no date) indicated the client should "hand the medication to the support professional to check it with the MAR...Staff should ensure that [Client #5] is sitting in a chair...She can dispense and apply all topical medications independently however she occasionally needs reminders to dispense the appropriate amount." Interview on 2/22/22 with the ICF/IID Director indicated the MT should be monitoring client #5 as the client dispenses her medications to ensure accuracy. The Director acknowledged the MT is ultimately responsible for ensuring the correct dosage of medications during the med pass.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all drugs were administered without error. This affected 1 of 4 clients (#5) observed receiving medications. The finding is: During observations of medication administration in the home on 2/22/22 at 7:40am, client #5 self-administered one drop of Artificial Tears solution 1.4% in to each eye. Review on 2/22/22 of client #5's physician's orders dated 1/1 - 1/31/22 revealed an order for	W 369		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 13 Artificial Tears solution 1.4%, "instill 2 drops in each eye" at 8am. Interview on 2/22/22 with the ICF/IID Director confirmed client #5 should have administered two drops of Artificial Tears solution in each eye as indicated.	W 369		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a sanitary environment was maintained in the home. The finding is: During observations in the home throughout the survey on 2/21 - 2/22/22, client #3 held a cloth in her hand and periodically chewed on it. The cloth was often noted to be moist and saturated with the client's saliva. Throughout the observations, the cloth was periodically located on the floor near client #3's feet. The client would pick up the cloth from the floor and continue chewing on it. On 2/21/22, the saturated cloth was noted on the kitchen counter and was later picked up by another client and placed on the dining room table just before lunch time. During these times, the cloth was not immediately replaced and surfaces touched by the cloth were not cleaned or sanitized. Interview on 2/22/22 with Staff D revealed client #3 likes to chew on old washcloths and these are	W 454		

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	34G142	A. BUILDING _____ B. WING _____	02/22/2022

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W 454	Continued From page 14 her "chew rags". Additional interview indicated if the cloth gets "soaked" they will prompt her to throw it in the laundry room and obtain a clean one. The staff noted client #3 will often throw the cloth on the floor and in that case, they would have her change it. Review on 2/22/22 of client #3's Direct Support Evaluation dated 7/2/19 revealed, "She will sometimes chew on her shirt or take her sock off to chew on but support professionals should assist her with getting a towel or rag to chew on instead." Interview on 2/22/22 with the ICF/IID Director confirmed client #3's cloth is used to deter her from grinding her teeth. Additional interview indicated the cloth should not be placed on common surfaces in the home and if this happens, those surfaces should be cleaned.	W 454		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a record of foods actually served was kept. The finding is: During lunch observations in the home on 2/21/22, clients consumed beef and noodles or peanut butter and jelly sandwiches, chips and kiwi. The dinner meal on 2/21/22 consisted of pork loin, cauliflower, noodles and pears. During breakfast observations in the home on 2/22/22, clients consumed cold cereal, wheat	W 481		

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W 481	Continued From page 15 toast, blueberries/raspberries and yogurt. Review of the menus for 2/21/22 and 2/22/22 indicated the following: 2/21/22 Lunch - Cold cut sandwich on wheat, vegetable choice, seasonal fruit Dinner - Ground beef (meatloaf), tossed seasoned Ramen, spinach, pears 2/22/22 Breakfast - Hot cereal, whole wheat toast, seasonal fruit, yogurt Additional review of the menu book did not reveal a menu substitution list. Interview on 2/22/22 with Staff B revealed they had to make food substitutions for lunch and dinner. Additional interview indicated they do not document substitutions made to menu items. Interview on 2/22/22 with the ICF/IID Director indicated each client's food intake is tracked; however, there is no formal process to document food substitutions when changes to the menu are made.	W 481		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement	W 508		

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W 508	Continued From page 16 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. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (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 clients, under contract or by other arrangement. (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 clients and other staff specified in paragraph (f)(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 clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have	W 508		

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W 508	Continued From page 17	W 508		

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 clients;

(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;

(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(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

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W 508	Continued From page 18 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 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: (ii) A process for ensuring that all staff specified in paragraph (f)(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 STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 508		

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W 508	Continued From page 19 failed to develop policies and procedures which include a process for tracking staff with temporary delays with obtaining their COVID-19 vaccination and contingency plans for staff who are not fully vaccinated for COVID-19. The findings are: A. Review on 2/21/22 of the facility's COVID-19 vaccination policy for employees (effective 2/14/22) did not include a contingency plan for staff that are not fully vaccinated, will not get vaccinated and do not qualify for an exemption. Interview on 2/22/22 via phone with the Executive Director confirmed the facility's current COVID-19 vaccination policy for employees did not include a contingency plan for unvaccinated staff who do not qualify for an exemption. B. Review on 2/21/22 of the facility's COVID-19 vaccination policy for employees (effective 2/14/22) did not include a process for ensuring the tracking and secure documentation of the vaccination status for staff if their vaccination must be delayed. Interview on 2/22/22 via phone with the Executive Director confirmed the facility's current COVID-19 vaccination policy for employees did not include a process for tracking the vaccination status of staff with a temporary delay in obtaining their vaccination.	W 508		