STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 00 B. WING	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00374965 and IN00374140. Complaint IN00374965 - Unsubstantiated due to lack of evidence. Complaint IN00374140 - Unsubstantiated due to lack of evidence. Survey dates: March 11, 14, 15, 16, 17, and 18, 2022. Facility number: 000212 Provider number: 155319 AIM number: 100285040 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 4 Medicaid: 38 Other: 13 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 29, 2022.	F 0000	The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the communities' desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction.	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding			

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	his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not			

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	confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure the grievance policy was followed for a resident with missing personal property for 1 of 1 resident reviewed for personal property (Resident 5). Findings include: During an interview on, 3/11/22 at 10:11 a.m., Resident 5 indicated she had bras and slacks missing. Her daughter had purchased some other clothing items a couple of weeks ago. The staff had taken them to the laundry to mark them with her name, and she had not seen them since. 03/15/22 11:22 AM Resident 5's record was reviewed on 3/15/22 at 11:22 a.m. The record indicated the resident had been admitted to the facility on 12/6/21. The resident's diagnoses included but were not limited to, unspecified dementia without behavioral disturbance (a mental disorder in which a person loses the	F 0585	1. The missing clothing items for resident 5 were replaced. -No other residents were affected by the deficient practice. 2.-All residents are at risk for unresolved concerns/grievances. All grievances were reviewed by ED/Designee to ensure the policy was followed and resolution was achieved for the filed grievances. 3.-All concern/grievance forms will be reviewed for completion/resolution by the SSD or designee and the IDT team. 3.-All staff will be re-inserviced regarding correct procedure of completing a concern/grievance form. 4. SSD or ED/Designee will complete 1 QAPI form weekly for 4 weeks and monthly for 6 months. If 95% compliance is not achieved an action plan will be	04/15/2022

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	ability to think, remember, learn, make decisions, and solve problems). Review of the events section of the resident's record lacked documentation of any reported missing personal items. A "Concern/Grievance Form," dated 3/3/22, indicated the Memory Care Coordinator (MCC) had received a concern from the resident that she only had 6 of 8 bras that were with her at admission. The form indicated the department responsible for the concern was the laundry. The form indicated the MCC had went to the laundry to look for the items but lacked documentation of the laundry department's notification of the missing items. A "Concern/Grievance Form," dated 3/16/22, indicated the MCC had received a concern from the resident's family that the resident was missing 2 tops, bras, and several pairs of socks. The form indicated the department responsible for the concern was the laundry. The form lacked documentation of the laundry department's notification of the missing items. During a telephone interview, on 3/17/22 at 9:25 a.m., the resident's family member indicated she had reported missing clothing items to the facility at least 3 weeks or so ago. She had requested to do the resident's personal laundry when she moved in but was told that the facility preferred to do the resident's laundry. The family member figured this was due to COVID-19. The missing items were again mentioned to the facility during a care plan meeting for the resident on 3/16/22. During an interview, on 3/17/22 at 9:29 a.m., the		developed. Any concerns/trends will be presented to the QAPI Committee for review.	

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	Social Services Director (SSD) indicated she was the person responsible for handling reported concerns of any resident's missing personal property. She had been notified of the resident's missing items, by the resident's family member on 3/3/22. She recommended the family member to report the missing items to the MCC. During an interview, on 3/17/22 at 11:15 a.m., the Laundry Supervisor indicated she had only been notified about the resident's missing items about 1 week prior to the date of this interview. She had been told of the missing items by the Registered Nurse (RN) on the Memory Care Unit. At that time, she went and spoke directly to the resident. When missing items are reported to the laundry, she would first look for the items and, if the items were not found, she would report the missing items so a grievance report could be established. When she was unable to located any of the missing items and had reported it to the MCC on 3/16/22. During an interview, with the Administrator (ADM) and the Director of Nursing (DON), on 3/17/22 at 10:02 a.m., both the ADM and DON indicated they were not aware of the resident's missing items. Any reported missing items should be documented as grievance on the grievance form. All reported grievances would be brought to the morning meeting of the Interdisciplinary Team (IDT) and discussed. The ADM indicated if the missing items had been reported and documented on a grievance form, they should have been brought to the morning meeting and discussed with all members of the IDT. On 3/17/22 at 11:45 a.m., the ADM provided a document, with a revision date of January 2019,			

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	titled, "Resident Concerns and Grievances," and indicated it was the policy currently being used by the facility. The policy indicated, "POLICY: Resident, representative or family concerns/grievances occurring during the resident's stay shall be responded to promptly...the Executive Director/Grievance Official shall review all complaints...PROCEDURE: ...The Concern/Grievance Form is then referred to the Department...for review...." 3.1-7(a) 3.1-7(2)(b)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview the facility failed to ensure treatments were completed as ordered by the physician for a resident with a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) for 1 of 1 residents reviewed for pressure ulcers (Resident 53).	F 0686	1. -Resident had no adverse effects from the treatment not completed as per MD order for a pressure ulcer. -MD was notified of treatment not completed as ordered for Resident 53. No new orders were	04/15/2022

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	Findings include: Resident 53's record was reviewed on 3/15/22 at 11:52 a.m. An annual Minimum Data Set (MDS) assessment, dated 6/15/21, indicated the resident had a moderate cognitive impairment and one stage four pressure ulcer (a deep wound that reaches the muscles, ligaments, or even bone), present upon admission to the facility. Diagnoses on the resident's profile included, but were not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis) following cerebral infarction (a disruption in blood supply to the brain) affecting right dominant side. An observation, dated 2/21/22, titled interdisciplinary team (IDT) wound review, indicated the resident had a stage four pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin). The area worsened since the previous week, and the treatment was changed to medihoney (a gel used to treat wounds and burns) with foam dressing change daily and as needed. A physician's order, dated 2/25/22, and discontinued on 3/15/22, indicated cleanse wound to coccyx with foaming cleanser, pat dry, apply medihoney gel 80 percent, and cover with foam dressing daily to stage four pressure ulcer of sacral (tailbone) region. A Treatment Administration Record (TAR), dated February 2022, lacked documentation the medihoney treatment was offered, refused, or completed to the stage four pressure ulcer to the sacral region on 2/26/22 and 2/27/22.		received. 2.-All residents with pressure ulcers have the potential to be affected by the deficient practice. -All nurses will be inserviced in proper procedure of MD notification when a prescribed treatment has not arrived at the facility. No other residents have pressure ulcers. 3.-DNS, wound nurse, or designee will run a daily missed medication report and daily missed medication report and review for treatments not yet in the facility ~~m-f~~ and address any discrepancies with the clinical team. -4.The DNS/Designee will be responsible for completing the QAPI tool 1 weekly for 4 weeks and monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 95% is not achieved, and action plan will be developed. Any trends/concerns will be presented to the QAPI Committee.	

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A TAR, dated March 2022, indicated the medihoney treatment was not applied to the stage four pressure ulcer to the sacral region related to it being unavailable on 3/2/22, 3/3/22, 3/4/22, 3/5/22, 3/6/22, 3/7/22, 3/8/22, 3/9/22, and 3/12/22, but lacked documentation the physician was notified. On 3/11/22, the medihoney was on back order, would arrive Monday, the physician was aware, but lacked documentation of a new treatment being ordered.

A physician's order, dated 3/15/22, indicated cleanse wound to coccyx (tailbone) with wound spray or normal saline, pat dry, apply Therahoney gel to wound bed and cover with a foam dressing, change daily.

A care plan, goal target dated 5/5/22, indicated the resident admitted to the facility with a stage four pressure ulcer that involved the sacrum, coccyx, and spine area. Interventions included but were not limited to treatments to be completed as ordered.

During an interview, on 3/16/22 at 9:28 a.m., the Assistant Director of Nursing Services (ADNS) indicated there was an issue with the pharmacy getting the medihoney delivered to the facility. She was not aware it was an issue until later. The facility now has it in the house stock supply and is Therahoney. The treatment was changed to Therahoney because that is the brand, they were able to obtain. The wound deteriorated on 2/24/22, so the treatment was changed at that time. The wound has not deteriorated since.

On 3/16/22 at 11:25 a.m., the Medical Records Nurse provided a document titled, "SKIN MANAGEMENT PROGRAM," and indicated it

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	was the policy currently being used by the facility. The policy indicated, "...POLICY: It is the policy of...to ensure that...a resident with a pressure ulcer receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing...." 3.1-40(a)(2)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for 2 of 5 residents reviewed for unnecessary medications (Residents 40 and 8). Findings include: 1. Resident 40's record was reviewed on 3/15/22 at 9:13 a.m. Diagnoses on the resident's profile included, but were not limited to, type two diabetes mellitus (impairment in the way the body regulates and uses sugar) without complications. A quarterly Minimum Data Set (MDS) assessment, dated 2/10/22, indicated the resident had a severe cognitive impairment. A physician's order, dated 1/26/22, indicated Lantus insulin pen, 100 units (u)/milliliter (ml), administer 40 u subcutaneous (SQ) (the fatty layer between the skin and muscle) daily at bedtime related to type two diabetes mellitus	F 0760	1. -Resident had no adverse effects from the missed medication administration. -MD was notified of the missed mediation administration for resident #40 and #8. No new orders were received. Resident #40 has orders for parameters when insulin is to be held. -2. All residents have the potential to be affected by the deficient practice -All nurses will be re-educated in proper medication administration by 4/15/22. -3. DNS or designee will run a daily missed medication administration and address any discrepancies with the clinical team. 4. -The DNS/Designee will be responsible for completing the QAPI tool 1 weekly for 4 weeks and monthly for 6 months and quarterly thereafter for at least 2	04/15/2022

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	without complications. The order lacked parameters for when the medication should be held. A Medication Administration Record (MAR), dated February 2022, indicated the Lantus was not administered on 2/5/22 related to no intake, 2/9/22 related to poor intake, 2/18/22 related to fasting blood sugar 116, and 2/20/22 related to poor intake and fasting blood sugar 111. The MAR lacked documentation the physician was notified the insulin was not administered. A MAR, dated March 2022, indicated the Lantus was not administered on 3/6/22 related to blood sugar 139 and no intake, 3/8/22 related to the resident's condition, 3/9/22 related to resident lethargic and no intake, and 3/12/22 related to fasting blood sugar 101. The MAR lacked documentation the physician was notified the insulin was not administered. During an interview, on 3/15/22 at 1:27 p.m., the Director of Nursing (DON) indicated the insulin should have had parameters to hold the insulin if there were specific instances the physician did not want the medication administered. 2. Resident 8's record was reviewed on 3/14/22 at 1:41 p.m. Diagnoses on the resident's profile included, but were not limited to, constipation unspecified, rheumatoid arthritis (a chronic inflammatory disorder affecting many joints) unspecified. An admission Minimum Data Set (MDS) assessment, dated 3/4/22, indicated the resident was cognitively intact. A physician's order, dated 2/25/22, indicated		quarters. If threshold of 95% is not achieved, and action plan will be developed Any trends or concerns will be presented to the QAPI Committee.	

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	Miralax (a laxative) 17 grams orally daily related to constipation unspecified, to be administered at 7:00 a.m. A physician's order, dated 2/25/22, indicated gabapentin (a medication for nerve pain) 300 milligrams (mg) by mouth three times a day at 7:00 a.m., 1:00 p.m., and 8:00 p.m. for rheumatoid arthritis unspecified. A physician's order, dated 2/25/22, indicated oxycodone-acetaminophen 10-325 mg every six hours as needed for moderate to severe pain. A Medication Administration Record (MAR), dated February 2022, lacked documentation the Miralax and gabapentin were administered, offered, or refused at 7:00 a.m., on 2/26/22 and 2/27/22. A MAR, dated March 2022, lacked documentation the Miralax and gabapentin were administered, offered, or refused at 7:00 a.m., on 3/2/22, 3/7/22, 3/8/22, 3/9/22, 3/12/22, and 3/13/22. During an interview, on 3/15/22 at 9:17 a.m., Licensed Practical Nurse (LPN) 20 indicated medications scheduled to be administered at 7:00 a.m., should have been administered by the day shift nurse. If the medication was not signed off, it was not documented as administered. On 3/15/22 at 1:27 p.m., the Director of Nursing (DON) provided a document titled, "...General Dose Preparation and Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...6. After medication administration, facility staff should take all			

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	measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information...." 3.1-48(c)(2)			
F 0888 SS=E Bldg. 00	483.80(i)(1)-(3)(i)-(x) 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 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			

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	155319	A. BUILDING 00 B. WING	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON GARDENS	375 S 11TH ST CLINTON, IN 47842

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	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 COVID-19 vaccination status of all staff specified in paragraph (i)(1)			

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	of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination			

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	status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on observation, interview, and record review, the facility failed to ensure the COVID-19 Infection Control vaccination policy and procedures were followed for 7 of 7 contracted staff working in the facility near residents for 6 of 6 days working in the facility. Findings include: On 3/11/22 at 9:50 a.m., during the initial tour of the facility, contractors, wearing medical face masks, were present in the C-wing unit, observed replacing the cove base and lower wall covering in the hall. On 3/11/22 at 10:37 a.m., during the initial tour	F 0888	-1. No residents were affected by the deficient practice. The contractors are no longer working in the facility -2. All residents had the potential to be affected by the deficient practice. -All staff will be inserviced on correct screening procedures of vendors, contractors, or outside service providers and following policy. -3. Screening tools will be reviewed by ED, DNS, or designee. Any discrepancies noted will be reviewed with the screener and re-education provided.	04/15/2022

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	of the memory care unit, contractors were present in the unit observed replacing the cove base and the lower wall covering. The contractors were present in the dining/activity room area during an activity with five residents present and one resident wandering around the area who was re-directed each time the resident began to walk towards the area where the contractors were working. All the contractors were observed wearing medical face masks. On 3/11/22 at 11:53 a.m., during the lunch meal observation of the memory care unit, the contractors were present prior to the meal trays being passed. Seven residents were present in the dining room and one resident was observed being redirected by staff, when the resident would walk to the area where the contractors were working. The contractors completed their work, left the unit, and exited the building through the front doors of the facility for a lunch break. On 3/14/22 at 1:39 p.m., contractors, wearing medical face masks, were observed in the central hall of the facility by the nurses' station, replacing the cove base and lower wall covering. On 3/14/22 at 1:47 p.m., contractors, wearing medical face masks, were observed in the memory care unit replacing the cove base and lower wall covering. On 3/15/22 at 1:18 p.m., the Administrator (ADM) indicated the lower wall covering had to be replaced due to the covering was not fire resistant and needed to be replaced with a fire-resistant covering. On 3/15/22 at 3:06 p.m., ADM indicated the seven contractors, sent by the facility's		Any contractor who is not up to date with the COVID 19 vaccine, will be requested to provide an exemption approved by the contractor company. If the contractor is not up to date, or does not have an approved exemption, contractors will not be allowed in the facility where residents are located. IP nurse/designee will ensure contractors who are not up to date and have an approved exemption follow the facility policy that additional COVID precautions are implemented. -4. The ED/Designee will be responsible for completing the QAPI tool 1 weekly for 4 weeks and monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 95% is not achieved, and action plan will be developed . Any trends/concerns will be presented to the QAPI Committee.	

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	corporation, were working in the building on March 7, 8, 9, 10, 11, and 14, 2022. The contractors were screened with the COVID-19 questionnaire prior to entering the building. The contractors were not vaccinated nor tested for COVID-19 and were not exempted by the facility corporation for the COVID-19 vaccinations. On 3/16/22 at 2:38 p.m., ADM indicated the facility staff screened everyone including the contracted staff with the COVID-19 questionnaire. If the contracted staff were not vaccinated, facility staff would ask if they had an exemption with their contracted company. The facility had asked the contracted companies, like hospice companies, to only send vaccinated staff. ADM indicated the contractors, replacing the cove base and lower walls in the facility, were not vaccinated, but did not provide direct care to any of the residents in the facility. On 3/16/22 at 2:52 p.m., the Director of Nursing (DON) indicated all staff were instructed to redirect all residents away from the contractors that were replacing the cove base and lower wall covering in the building. On 3/14/22 at 3:00 p.m., ADM provided and identified a document as a current facility policy, titled "COVID-19 Employee Vaccination Requirement," with a revision date of 2/11/22, which indicated, "...The Company is committed to the safety and health of our team members, the community and most importantly, the residents we serve. The Company must implement a mandatory vaccination policy requiring COVID-19 vaccination(s) for all employees in all locations for all ASC affiliated healthcare employers. This will include new employees hired as well as all contractors, vendors and			

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	students as well as volunteers and trainees who provide any care, treatment or other services for the facility and the Company. This will be in accordance with the US Government's COVID-19 Vaccination Mandate for healthcare workers and the Centers for Medicare & Medicaid Services (CMS)...." 3.1-18(b)			