| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. Building<br>B. Wing | 04/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oak Glen Post Acute | 9246 Avenida Miravilla<br>Cherry Valley, CA 92223 |

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038<br><br>Based on observation, interview, and record review, the facility failed to ensure for one of 16 sampled residents (Resident 54), the call light was within the resident's reach.<br><br>This failure had the potential to result in Resident 54 not being able to call for staff assistance when needed.<br><br>Findings:<br><br>On April 9, 2024, at 8:01 a.m., Resident 54 was lying in bed. The call light was observed not within reach by Resident 54, it was on his right side hanging in between the floor and the bed. Resident 54 stated he could not call for assistance. Resident 54 stated, the call light was not by his side.<br><br>On April 9, 2024, at 8:33 a.m., during a concurrent interview and observation in Resident 54's room with CNA 1, CNA 1 stated, Resident 54's call light was not within reach. CNA 1 further stated, the call light should be placed within easy reach of the resident.<br><br>A review of Resident 54's Admission Record, dated April 10, 2024, indicated the resident was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke- occurs as a result of disrupted blood flow to the brain) and left hemiplegia (left sided paralysis).<br><br>A review of Resident 54's Minimum Data Set (MDS- an assessment tool), dated March 6, 2024, indicated, Resident 54 had a Brief Interview of Mental Status (used to assess cognitive status in elderly) score 14 (cognitively intact).<br><br>A review of the facility policy and procedure titled, Answering the Call Light, dated October 2010, indicated, . When the resident is in bed or confined to a chair be sure the call is within easy reach to the resident . |

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.

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

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202<br><br>Based on observation, interview, and record review, the facility failed to ensure a copy of the Advance Directive (AD - written statement of a person's wishes regarding medical treatment) was available in the resident's record readily accessible to the staff, for one of three residents reviewed for AD (Resident 49).<br><br>This failure had the potential for Resident 49's AD to not be readily retrievable by the staff and the physician, making them unaware of, and unable to honor the residents' wishes regarding their medical treatment.<br><br>Findings:<br><br>On April 10, 2024, Resident 49's record was reviewed. Resident 49 was admitted to the facility on [DATE].<br><br>A review of Resident 49's Minimum Data Set (an assessment tool), dated March 14, 2024, indicated Resident 49 had severe cognitive impairment.<br><br>A review of Resident 49's Advance Directive Acknowledgement, dated January 22, 2024, indicated Resident 49 had executed an Advance Directive.<br><br>There was no documented evidence a copy of the AD was provided in Residents 49's medical record.<br><br>On April 10, 2024, at 09:40 a.m., during a concurrent interview and review of Resident 49's record with the Social Service Director (SSD), the SSD stated if a resident had an AD, a copy of the AD would be obtained and placed in the resident's record. The SSD stated, Resident 49's AD was not available in the resident's record. The SSD further stated, Resident 49 had an AD that should have been available and accessible to the staff and physician.<br><br>The facility Policy and Procedure titled, Advance Directive, dated December 2016, indicated .Prior to or upon admission of a resident, the Social Service Director .Will inquire of the resident .family members .legal representative .about existence of any written advance directive .Information about .an advance directive shall be displayed prominently in the medical record . |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202<br><br>Based on observation, interview, and record review, the facility failed to follow up Level II Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) evaluation from the appropriate State-Designated Authority (SDA) upon admission, for two of four residents (Residents 42 and 44).<br><br>This failure had the potential for Residents 42 and 44 not to receive the services required in an appropriate setting as determined by the SDA.<br><br>Findings:<br><br>1. On April 10, 2024, Resident 42's record was reviewed. Resident 42 was admitted to the facility on [DATE], with diagnoses which included major depressive disorder and mild neuro cognitive disorder (types of mental disorders).<br><br>A review of Resident 42's PASARR Level 1 Screening document dated March 21, 2024, indicated, .Level 1 - Positive .Result: Positive for suspected MI (sic) (Mental Illness) .Level II Mental Health Evaluation Referral: Required .<br><br>Further review of Resident 42's record indicated there was no documented evidence the PASARR Level II was followed up as required by PASARR Level 1 screening.<br><br>On April 10, 2024, at 9:28 a.m., during a concurrent interview and review of Resident 42's PASARR with the Director of Nursing (DON), the DON stated all residents admitted to the facility should be screened for PASARR. The DON stated, nursing should follow up if the screening indicated positive for PASARR Level I.<br><br>The DON stated Resident 42's initial PASARR Level 1 screening resulted positive and a PASARR Level II is required. The DON further stated, Resident 42's PASARR Level II was not followed up as indicated.<br><br>2. On April 10, 2024, Resident 44's record was reviewed. Resident 44 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (type of mental disorder).<br><br>A review of Resident 44's PASARR Level 1 Screening document dated December 6, 2022, indicated, .Level 1 - Positive .Result: Positive for suspected MI .Level II Mental Health Evaluation Referral: Required .<br><br>Further review of Resident 44's record indicated, there was no documented evidence the PASARR Level II was followed up as required by PASARR Level 1 screening.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On April 10, 2024, at 10:04 a.m., during a concurrent interview and review of Resident 44's PASARR with the DON, she stated Resident 44's initial PASARR Level 1 Screening resulted positive and a PASARR Level II is required. The DON further stated, Resident 44's PASARR Level II was not followed up as indicated.<br><br>The DON stated the facility and nursing should have followed up for Resident 42 and 44's PASARR Level II screening. The DON further stated it is important for PASARR Level II to be followed up to determine the appropriate care and setting for residents with mental disorders and for the safety of the other residents in the facility.<br><br>The facility's policy and procedure titled, Admission Criteria, dated March 2019, indicated, .All new admission and readmissions are screened for Mental Disorders (MD) .per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .If level 1 screen indicates that the individual may meet the criteria for MD .he or she is referred to the state PASARR representative for Level II (evaluation and determination) screening process . |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038<br><br>Based on observation, interview, and record review, the facility failed for one of 16 residents reviewed for quality of care (Resident 10) to ensure resident was monitored for signs and symptoms of bleeding or bruising (discoloration and tenderness of the skin resulting from pooling of blood beneath the skin) and the physician was notified.<br><br>This failure had the potential for delayed treatment and management.<br><br>Findings:<br><br>On April 9, 2024, at 8:51 a.m., a concurrent observation and interview with Resident 10, in his room, was conducted. Resident 10 was observed with skin discoloration (bruising) approximately three centimeters (cm) by 0.5 cm. on the right upper arm. Resident 10 stated she could not remember when she got it. Resident 10 stated she could have gotten it from wheeling her wheelchair.<br><br>A review of Resident 10's Admission Record, indicated , she was admitted to the facility on [DATE], with diagnoses which included cerebro-vascular accident (stroke- a result of disrupted blood flow to the brain).<br><br>A review of Resident 10's Physician Order, dated February 26, 2024, indicated:<br><br>- Clopidogrel Bisulfate (Plavix- anticoagulant) Oral Tablet 75 MG (milligram- unit of measurement) Give 1 tablet by mouth two times a day for CVA .<br><br>- Eliquis (Apixaban- anticoagulant) Oral Tablet 5 MG (unit of measurement) Give 1 tablet by mouth two times a day for CVA .<br><br>A review of Resident 10's Care Plan, dated March 14, 2024, indicated, .Focus: Medication-anticoagulant - Resident is at risk for potential bleeding and bruising due to anticoagulant therapy secondary to history of CVA .Interventions .Administer medication as ordered .Monitor for bruising or bleeding .Report abnormal findings to physician .<br><br>During a concurrent observation in Resident 10's room and interview with Certified Nurse Assistant (CNA) 1 on April 12, 2024, at 9:21 a.m., CNA 1 stated Resident 10 had a discoloration (bruise) on her right upper arm. CNA 1 stated she was not aware of the resident's bruise. CNA 1 stated, if she observed the bruise she should have reported it to the licensed nurse.<br><br>During an interview with Licensed Vocational Nurse (LVN) 1 on April 12, 2024, at 9:27 a.m., LVN 1 stated the CNA should report to the licensed nurse any skin changes. LVN 1 further stated the licensed nurse should assessed any skin issue.<br><br>During an interview with LVN 2, on April 12, 2024, at 9:42 a.m., LVN 2 stated, if a resident developed bruise, the resident should have been monitored and the physician should have been notified.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and review of Resident 10's record with LVN 2 on April 12, 2024, at 9:52 a.m., LVN 2 stated, the resident is at increased risk for bruises, bleeding, skin discoloration and should have been monitored every shift. LVN 2 stated, there were no documentation Resident 10 was monitored for signs and symptoms of bleeding or bruising for the past two weeks.<br><br>During a concurrent interview and observation of Resident 10's right upper arm with LVN 2 on April 12, 2024, at 9:56 a.m., LVN 2 stated Resident had a right upper arm discoloration measuring 0.5 x 3 cm (centimeter- unit of measurement). LVN 2 stated Resident 10 should have been monitored for bruising and bleeding and the licensed nurse should have notified the physician. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>36038<br><br>Based on observation, interview, and record review, the facility failed to ensure the dietary staff performed testing of the sanitizing solution according to manufacturer's instructions.<br><br>This failure had the potential to cause foodborne illness (illness that comes from eating contaminated food) among the 56 vulnerable residents in the facility.<br><br>Findings:<br><br>During a concurrent observation, interview, and review of the manufacturer's instruction for testing QUAT concentration, on April 10, 2024, at 8:26 a.m., the [NAME] was observed to had dipped the strip into sanitizing solution for five seconds, then compare the strip to a color scale found on the strip container. The [NAME] stated according to the manufacturer's instruction, dip the test strip for 1-2 seconds, and then compare within 10 seconds the strip with the color scale. The [NAME] stated he dipped the strip for five seconds and did not follow the manufacturer's instruction. The [NAME] further stated he should have followed the manufacturer's instruction. The [NAME] stated, otherwise it would not reveal an accurate result and would promote the growth of bacteria that could cause food borne illness.<br><br>A review of the manufacturer's instruction in testing the QUAT concentration of the sanitizer, indicated, . CONTROL TESTING .QAC QR Test Strip .Dip test strip into test solution for 1-2 seconds. Within 10 seconds, compare the test pad with color scale .<br><br>During a review of the facility policy titled, QUATERNARY AMMONIUM LOG POLICY, dated 2018, indicated, .Follow container and test strip instructions .A high concentration may be potentially hazardous and may be a chemical contaminate of food . |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>36038<br><br>Based on observation, interview, and record review, the facility failed to follow the menu for a Fortified (a food that has extra nutrients added to it or has nutrients added that are not normally there) NAS (no added salt) Mechanical Soft with chopped meat- diet, for one of 16 residents (Resident 33).<br><br>This failure had the potential to not meet the resident's nutritional needs.<br><br>Findings:<br><br>On April 10, 2024, at 11:54 a.m., the FNSD was interviewed. The FNSD stated for fortified diet, the [NAME] should add extra gravy to make it fortified.<br><br>A review of Resident 33's meal tray card, for lunch, indicated Mechanical Soft/chopped meats, Fortified NAS.<br><br>During a concurrent observation and interview, on April 10, 2024, at 12:14 p.m., during lunch tray line in the kitchen with the Cook, the [NAME] was observed not adding extra gravy to Resident 33's lunch meal tray. The [NAME] placed Resident 33's lunch meal tray onto the meal delivery cart, ready to serve. The [NAME] was asked about Resident 33's lunch meal tray, the [NAME] stated he did not add another scoop of gravy to Resident 33's meal tray. The [NAME] stated, Resident 33's meal tray card indicated, Mechanical Soft/chopped meats, Fortified NAS. The [NAME] stated adding another scoop of gravy would make it a fortified diet.<br><br>During a review of Resident 33's Weight Change Note, dated January 16, 2024, indicated .RD (Registered Dietician) NOTE .CBW 205 # (pounds- unit of measurement) Weight Change-8# /3.7% x 1 week .RD Recs. (sic) (recommendations) Fortify current diet order .<br><br>A review of Resident 33's Order Summary Report, dated March 5, 2024, indicated, .Fortified NAS diet Mechanical Soft with chopped meat texture .<br><br>During a review of the facility's policy and procedure (P&P) titled, FORTIFICATION OF FOOD, dated 2018, the P&P indicated, The goal is to increase the calorie and /or protein of the foods commonly consumed by the resident to promote improvement in their nutrition status .EXTRA GRAVY AND SAUCES .Adds 20-50 calories/item . |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>36038<br><br>Based on observation, interview, and record review, the facility failed for one of seven residents (Resident 159), to accommodate Resident 159's food preference for no fish, when Resident 159 was served fish.<br><br>This failure resulted in Resident 159's food preference not being honored, potentially leading to the resident not consuming the food served and having the potential for weight loss.<br><br>Findings:<br><br>A review of the facility document titled, Cooks Spreadsheet, for Week 3 Wednesday, indicated, .SPRING MENUS .Garden Fresh Meatloaf .<br><br>A review of the facility document titled, Good For Your Health Menus, for April 8-14, 2024, indicated, . Wednesday April 10 .Garden Fresh Meatloaf .<br><br>During tray line observation in the kitchen on April 10, 2024, at 12:45 p.m., the ktichen was observed to run out of meatloaf while serving meal trays. The [NAME] was observed preparing chicken and fish replacing meatloaf. Seven residents were not served meatloaf.<br><br>In a concurrent interview with the Cook, the [NAME] stated, the facility ran out of meat loaf. The [NAME] stated, seven residents were not served meatloaf and were served fish or chicken instead.<br><br>On April 11, 2024, at 9:33 a.m., Resident 159 was interviewed. Resident 159 stated she was served fish for lunch. Resident 159 stated, she had food preference of no fish.<br><br>During a concurrent interview and review of Resident 159's meal service card, on April 11, 2024, at 11:09 a. m., with the Food and Nutrition Service Director (FNSD), the FNSD stated, on the dietary meal service card, Resident 159 dislikes fish. The FNSD stated she should not have been served fish for lunch.<br><br>During a review of the facility policy and procedure titled FOOD PREFERENCES, dated 2018, indicated . Resident Food preferences will be adhered to within reason .Substitutes for all food disliked will be given from the appropriate food group . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>36038<br><br>Based on observation, interview, and record review, the facility failed to ensure food items were stored, prepared, and served under sanitary conditions when:<br><br>1. The fifteen pounds of bacon were thawed and were refrozen; and<br><br>2. There was no thawing log available for review in accordance to the facility's policy and procedure.<br><br>These failures had the potential to result in food borne illnesses (illness that comes from eating contaminated food) to 56 medically vulnerable residents.<br><br>Findings:<br><br>1. On April 8, 2024 at 9:08 a.m., during initial tour of the kitchen with the Food and Nutrition Service Director (FNSD), inside the freezer, four-one-gallon plastic bags containing bacon were observed not frozen solid. A concurrent interview was conducted with the FNSD, FNSD stated the bags of bacon were not in their original container. The FNSD further stated the bacon should be frozen solid, when stored in the freezer.<br><br>On April 10, 2024, at 8:06 a.m., during an interview with the FNSD, the FNSD stated, the fifteen pound bacon in original container was thawed and placed in the walk-in refrigerator. The FNSD stated, the cook took a portion of the thawed bacon and placed the remaining portion of the thawed bacon back in the freezer. The FNSD stated, the cook should have thawed only the necessary portion of bacon, and the remaining portion should have been placed back in the freezer. The FNSD stated, once the meat was thawed, the meat should not be refrozen, to prevent bacterial growth that could cause food borne illness.<br><br>A review of the U.S FDA (Food and Drug Administration) Food Code 2022, Annex 3 Section 3-501.11 Frozen Food, the Food Code indicated, Freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins. If the food is then refrozen, significant numbers of bacteria and/or all preformed toxins are preserved.<br><br>2. On April 10, 2024, at 8:16 a.m., the [NAME] was interviewed. The [NAME] was asked about the facility's thawing process. The [NAME] stated when thawing meat, the frozen meat would be placed inside the walk-in refrigerator for 3 days. The [NAME] stated, the thawed meat should have a pull out date and use-by date. The [NAME] further stated, they did not have a thawing log. The [NAME] stated there should be a thawing log, to keep track of food being thawed, to ensure the food stay within safe range (out of Danger Zone-41-135 degree F).<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of the facility policy and procedure titled, FOOD PREPARATION .FOOD DEFROSTING METHODS, dated 2018, indicated .The preferable method of defrosting frozen perishable food is to defrost in the refrigerator and kept refrigerated until completely thawed. Food must be labeled and dated with item name, pull date and use-by date no more than three days past use by date . |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>36038<br><br>Based on observation, interview, and record review, the facility failed to ensure that leftover food brought by visitors or family members was stored properly when the temperature of the refrigerator was at 44 degree F (Farenheit - unit of measurement). In addition, food found inside the refrigerator at the nurses' station was not labeled.<br><br>This failure had the potential for residents to be exposed to foodborne illness.<br><br>Findings:<br><br>On April 10, 2024, at 8:50 a.m., during a concurrent observation of the resident's refrigerator at nurses' station 2 and an interview with the Food and Nutrition Service Director (FNSD), it was observed that the residents' refrigerator was 44 F (degrees fahrenheit - a scale for measuring temperature). Inside the refrigerator, a cup of soup was observed, which was not labeled with a name or date. The FNSD stated, the food should be labeled with the resident's name and a use- by date. The FNSD stated, the refrigerator temperature should be below 41 F.<br><br>The facility document policy and procedure titled, Foods Brought by Family/Visitor, dated October 2017, indicated .Family /visitors are asked to prepare and transport food using safe food handling practices including .holding temperature (below 41 F) .Perishable foods must be stored .Containers will be labeled with the resident's name, the item and the use by date . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555492 | A. Building<br>B. Wing | 04/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Glen Post Acute | 9246 Avenida Miravilla<br>Cherry Valley, CA 92223 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>47202<br><br>Based on interview and record review the facility failed to ensure one of two staff reviewed was offered the COVID-19 (a respiratory infection caused by a virus) vaccination and provided education regarding the benefits and risks of the COVID-19 vaccine.<br><br>This failure had the potential for the staff not to have guidance and information regarding the COVID-19 vaccine.<br><br>Findings:<br><br>On April 11, 2024, at 2:45 p.m., during a concurrent interview and review of CNA 2's Employee Onboarding File, with the Director of Staff Development (DSD), the DSD stated, CNA 2 was hired on March 19, 2024. The DSD stated, CNA 2's COVID-19 vaccination was on February 10, 2022 (2 years ago). The DSD stated, she should have offered COVID-19 vaccine to CNA 2 upon hire.<br><br>On April 11, 2024, at 3:09 p.m., during a concurrent interview and review of CNA 2's Employee Onboarding File, with the Infection Preventionist (IP), the IP stated, CNA 2 was not offered the COVID-19 vaccine and was not educated on COVID-19 immunization upon hire. The IP further stated, she is responsible for offering the COVID-19 vaccination to facility staff upon hire and annually.<br><br>The IP stated, she should have offered CNA 2 the COVID-19 vaccination and provided education on COVID-19 immunization. The IP further stated, offering Covid-19 vaccinations and educating staff were important to protect the vulnerable residents of the facility and prevent the spread of infections.<br><br>A reviewof the facility's policy and procedure titled, Coronavirus Disease (COVID-19) - Vaccination of Staff, dated May 2017, indicated, .Staff are educated about benefits and risk .of COVID-19 vaccine .Staff are offered vaccination against COVID-19 .Each staff member is provided with education regarding the benefits and risks .If the vaccination requires multiple doses of vaccine, staff are again provided with education regarding the benefits . |