STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21E104	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph's Nursing Home	1222 Tugwell Drive Catonsville, MD 21228

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews with facility staff, it was determined that the facility failed to manage expired food items. This deficiency was observed in the facility's kitchen during the recertification survey.The findings include:On 1/21/26 at 7:45 AM, the surveyor conducted an initial tour of the kitchen with Staff #24 (Cook). The facility's refrigerator contained opened food items with marked expiration dates that had passed. The surveyor noted the following expired items:-One opened bag of bagels (5 remaining) with an expiration date of 9/13/25.-One bag of raisin cinnamon bread with an expiration date of 12/03/25.-One bag of pumpernickel bread (20% remaining) with an expiration date of 11/28/25.-One bag of white bread with an expiration date of 1/13/26.-One bag of Hawaiian bread with an expiration date of 12/18/25.During a subsequent observation of the basement walk-in freezer at 8:00 AM on 1/21/26, the surveyor identified two foil-wrapped packs of ribs dated 11/22/25 and two 5-pound packs of low chicken dated 6/28/25. Staff #24 stated, Those items were for the sisters; I don't know how long they can be kept or used. When the surveyor asked how staff distinguished between food intended for the sisters and food for the residents, Staff #24 stated he did not know.On 1/21/26 at 8:45 AM, the surveyor interviewed Staff #25 (Certified Dietary Manager/Certified Food Protection Professional). She explained that all food items are marked with expiration dates and that staff are instructed to use freshly delivered bread first. According to Staff #25, when bread nears its expiration date, staff move it to the freezer. She noted that the bread items found in the refrigerator had been moved there from the freezer for use. However, when asked how long bread remains viable in the refrigerator after being moved from the freezer, Staff #25 stated she did not know.On 1/22/26 at approximately 10:00 AM, Staff #25 provided a policy titled HACCP: Bread from the Freezer. The policy required that:-Store-bought bread must be placed in the freezer before the labeled expiration date.-Bread removed from the freezer must be labeled with the date of removal.-Once defrosted, bread must be used within 3 days or discarded.-Quality guidelines: 3 months for best quality (USDA recommendation) and up to 6 months for store-bought bread if well-wrapped.While the surveyor reviewed the policy, Staff #25 admitted that she had researched and created the policy only after the surveyor brought the expired bread to her attention. The surveyor shared their concerns regarding food safety and oversight, which Staff #25 validated.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of pertinent documentation and interviews with facility staff, it was determined that the facility failed to have a system in place to ensure that the Resident Council was provided with responses, actions, and rationale taken regarding their concerns and to demonstrate the facility's response and rationale for such concerns. The Findings include: The Resident Council is a group of residents that meets regularly on the behalf of all residents in the facility to discuss concerns about facility policies and procedures affecting residents' care, treatment, and quality of life. Facility staff are required to consider resident and family group views and act upon grievances and recommendations. This may include developing or changing policies affecting resident care and life. Facility staff should discuss their decisions with the residents and/or family group and document their response and rationale in writing. The facility must be able to demonstrate their response and rationale. On 1/22/26 at 9:23 AM in an interview with the Director of Nursing (DON) she provided 1 sheet of lined paper titled, Resident Council News. No date was observed. When asked if she knew when the minutes were from, she stated no. She also provided 7 sheets of paper that she stated she had typed up after receiving the minutes on scrap pieces of paper. When asked how long the Resident Council had been holding meetings, she stated about August of last year (2025). On 1/22/26 at 9:28 AM review of the documentation revealed from 1 of the 7 typed papers, Thank you, Thank you, Thank you!! Lots of ideas from the Resident Council for the ideas, suggestions, and concerns slipped into our little pink bag on this bulletin board in these past months. Please feel free to continue making suggestions! Our next meeting is on Tuesday, October 21st, so we will discuss any new issues you may want to bring to our attention. The review of all 7 papers failed to reveal any of the concerns slipped into our pink bag. Additionally, the review failed to reveal any documentation of the facility's response to such concerns.On 1/22/26 at 9:46 AM in an interview with the DON she showed the survey team an organizational folder that on the left side had a list of the original Resident Council members. On the right hand side, she pointed to a paper that had Dates of Meetings with the first one documented as 1) 3/29/25. She pointed out and stated this was the first Resident Council meeting. Additionally, she provided 2 more handwritten Resident Council meetings minutes.On 1/22/26 at 12:27 PM in an interview with DON when asked what her understanding of the purpose/function of the Resident Council was, she stated, I think they [residents] feel empowered by having a say. It gives them a voice here. It might be as easy as they don't want pea soup or that they want a picnic. They had a summer picnic on the 4th of July. They wanted different food instead of just cheese balls. They wanted their parties later in the day. This is what we want to improve, and this is what we feel is good. They felt tickled about making care packages to welcome new residents. They've made an impact and it means a lot to them. They really like the bulletin board and have a suggestion box. During the interview when asked if there was documentation of issues/concerns residents and/or families shared and the facility's response to those issues, she stated, That would be something we need to do in the future. It certainly is worked on and is certainly done; it's just not in writing. The surveyor shared this was a concern and the DON acknowledged understanding of the concerns.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of medical records and interview with facility staff, it was determined that the facility failed to notify the provider of blood in a resident's stool and urine and weakness leading to the resident needing to be fed their meals. This was evident for 1 (Resident #5) of 16 residents reviewed during the facility's recertification survey.The findings include:On 1/22/26 at 10:54 AM review of Resident #5's medical record revealed:-12/14/2025 6:43 AM Resident was assisted with toileting this morning. He/she was observed by GNA (Geriatric Nursing Assistant) to be straining, and he/she had some BM (bowel movement) mixed with a moderate amount of blood in the toilet.-12/14/2025 11:42 AM Around 7:30 AM private aide reported that resident had a moderate amount of blood on his/her depends, also resident, also blood was observed in the toilet after bowel movement.-12/14/2025 11:56 AM Before lunch nurse aid reported that resident needs more help with transferring (is weaker) and probably he/she will need to use mechanical lift (next time when toileting).-12/14/2025 6:58 PM Resident is displaying change in condition. He/she was observed during dinner and was not able to feed him/herself or raise his/her eating utensils to his/her mouth. Resident also is letting his/her right arm hang down on the side of his/her wheelchair and when prompt to raise his/her arm up he/she becomes confused on what to do. Resident received full assistance with eating this evening. Resident is noted to have blood in his/her stool when using the bathroom, he/she is also becoming more tired than usual.-12/15/2025 6:50 AM Resident alert and verbal. He/she had a BM this morning mixed with a moderate amount of blood. Resident appears very weak.-12/15/2025 12:14 PM Resident was very weak this morning. Needed to be fed unable to feed him/herself due to his/her right-sided weakness but seems to have improved as the day went on. Still smiling and responsive.-12/15/2025 2:02 PM Resident verbal, alert. Resident was assisted by GNA with activities of daily living. Resident is not able to feed him/herself, so he/she was fed for both breakfast and lunch by staff members. When fed 100% of meal eaten. When taken to the bathroom, only stain of blood noticed on the depends (incontinence brief) and a few drops of blood noticed in the toilet. Resident has difficulties to stand up, need assistance of two people or need for mechanical lift.-12/15/2025 9:03 PM Care-staff also reported he/she had a trickle amount of blood in his/her urine while on the toilette this evening.-12/16/2025 2:14 PM Aide came in to stay with [resident's name] today. Care was given and he/she was fed. He/she is still weak and not moving his/her arms to assist with taking his/her medications. All vital signs were WNL (within normal limits). His/her sister was called today to make her aware of the changes in resident. Mr./Ms. [resident's name] is still bleeding in stool. He/she was in the activity room today and also in the dining room.-12/16/2025 8:04 PM Resident is still noted to have small amounts of blood with stool when using the bathroom this evening, he/she denies having any pain or discomfort at this time and states that he/she feels tired.-12/17/2025 12:33 PM CBC (complete blood count) results received with low HGB (hemoglobin) (8.3) and low HCT (hematocrit) (26.8). Of note, H&H marginally increased from last CBC on 10/22/25. Daughter/POA notified of results. She stated she plans to return to visit her [family member] this afternoon and will make a decision regarding his/her care. Doctor (D #29) notified of results via fax and confirmed receipt of fax with his office.-12/18/2025 15:40 Lower right arm shows signs of swelling. DON (Director of Nursing) delivered sling to keep arm elevated. Nurse Practitioner (NP #13) examined resident today. No new orders at this time.Resident #5's care plan was reviewed on 1/21/26 at 1:51 PM. The review revealed a care plan for hematological status. The goal was documented as I will remain free of complications related to altered hematological status through the review date (Target Date: 04/18/2026). The following interventions documented in the care plan to reach the above goal were : Monitor for blood in stool. Monitor/document/report PRN following s/sx (signs and symptoms) of anemia: Pallor; Fatigue; Dizziness; Syncope; Headache; Palpitations; Weakness; Feeling of cold; Low Hgb/hct (hemoglobin/hematocrit); SOB (shortness of breath) on (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exertion; Sore tongue; Chest pain; Tinnitus; Headache; Changes in mental status.On 1/28/26 at 12:27 PM in an interview with the Director of Nursing (DON) when asked the expectation if a resident was noted to have a change in condition such as blood in their stool, urine, incontinence brief, and/or the toilet, she stated, To report it to the charge nurse who usually calls the doctor right away. During the interview when asked the time frame she would expect the provider to be notified, she stated, In that shift, the provider would be notified. The surveyor shared the concern that there was no evidence in the medical record the provider was notified after Resident #5 was noted to have blood in their stool, urine, toilet and incontinence brief or after the resident was noted with weakness that progressed resulting in the resident being unable to feed themself. The DON stated, I gotcha and acknowledged understanding of the concern.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on a review of medical records and interviews with facility staff, it was determined that the facility failed to notify the physician regarding the status of a resident's indwelling Foley catheter. Specifically, staff failed to obtain physician orders for the replacement of dislodged catheters and failed to document these re-insertions in the medical record. This evident one resident (Resident #7) of one resident reviewed for urinary catheter care during this recertification survey.The findings include:A Foley catheter is an indwelling urinary catheter (IDC) that drains urine from the bladder into a collection bag.During a review of Resident #7's medical records from November 2025 to January 2026 on 1/22/26 at 1:08 PM, it revealed that progress notes indicated the catheter was found dislodged or came out on six separate occasions: 11/13/25, 11/20/25, 11/26/25, 12/04/25, 12/16/25, and 1/15/26. While notes indicated the catheter was re-inserted each time, there was no evidence that the physician was notified or that an order was obtained for re-insertion.Further review of the Treatment Administration Record (TAR) on 1/22/26 at 2:00 PM it revealed that TAR contained an order ?to change the 16 French/10cc balloon catheter every 30 days for hygiene and infection control.' Although the monthly changes were initialed on 11/10/25, 12/10/25, and 1/15/26, there were no TAR entries or supporting clinical records for the five additional re-insertions that occurred between November and December.On 1/23/26 at 10:35 AM, the Director of Nursing (DON) stated that a provider's order is required for the re-insertion or change of a Foley catheter. She further stated that these events must be documented in both the progress notes and the TAR. Upon reviewing Resident #7's records with the surveyor, the DON validated that the re-insertions were not documented in the TAR and that there was no evidence of physician notification or obtained orders.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews with facility staff and review of medical records and facility policy, it was determined that the facility failed to address pharmacy recommendations in a timely manner. This was evident for 2 (Resident #2 and Resident #11) of 5 residents reviewed for unnecessary medications during the facility's recertification survey. The findings include: The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. Irregularity refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences. 1) On 1/23/26 at 11:43 AM in an interview with the Director of Nursing (DON) when asked about the facility's MRR process, she stated the pharmacist completed the review and emailed the report. During the interview when asked who received the report, she stated, As far as I know, only me. When asked the process for the physician responding to the recommendations, she stated, I'll either fax it to the physician or if it's urgent I will call them. I also print a copy of any recommendations that need to be addressed. Occasionally, I've had physicians who won't fill them out. Additionally, she stated she put the recommendations that need to be addressed in the rolling cart in the charting room. She stated that it had any documentation that needed to be addressed by the physicians and they knew that. Furthermore, she stated it was the expectation for the physician to make a decision and check either agree, disagree, or other. If they disagreed with the recommendation, she stated there should be a documented rationale with the reason. The DON stated, Do they always, no but it is expected. During the interview she stated that the expectation was for them to sign and date the recommendation and put the completed form put back in the folder. Finally, the charge nurse was responsible for creating, discontinuing or revising orders. On 1/23/26 at 1:53 PM review of Resident #2's MRR's revealed: -9/30/2025 09:58 Pharmacy monthly review Late Entry: Note Text: Medication regimen review completed. Recommendation(s) to MD. (The recommendation was as follows: Please complete this order by adding a dose per application.generally 2gm (grams) for upper body and 4gm for lower body. Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)). Apply to left wrist topically every 8 hours as needed for wrist pain.) -12/31/2025 10:00 Pharmacy monthly review Late Entry: Note Text: Medication regimen review completed. Recommendation(s) to MD. (The recommendation was as follows: Please complete this order by adding a dose per application.generally 2gm for upper body and 4gm for lower body. Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)). Apply to left wrist topically every 8 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours as needed for wrist pain.) On 1/23/26 at 2:13 PM review of the 9/30/25 recommendation and 12/31/25 recommendation revealed they were the exact same recommendation; however, there was no documentation that the physician had addressed the 9/30/25 recommendation. The documentation from 12/31/25 revealed in the Physician/Prescriber Response section that the provider had checked agree and written in the comments section 2 gm to affected area (wrist) Q8h (every 8 hours) PRN (as needed). The documentation was signed and dated 1/13/26. Underneath the signature and date was handwritten, Fixed in PCC on 1/14/26. On 1/23/26 at 2:20 PM review of Resident #2's medical record revealed the Diclofenac Sodium External Gel 1 % order with a revision date of 1/14/26 with the following revision: Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)). Apply to left wrist topically every 8 hours as needed for wrist pain. Apply 2gm. On 1/23/26 at 3:01 PM review of the facility's Medication Regimen Review Policy revealed, For non-urgent recommendations, the Facility and Attending Physician must address the recommendation(s) in a timely manner that meets the needs of the resident- but no later than their next routine visit to assess the resident- and the Attending Physician should document in the medical record: a. What irregularity has been reviewed, b. What action has been taken to address the issue, c. The pharmacy recommendation itself can be used as a tool to document in the medical record, or a notation may make in the medical record/EHR (electronic health record). 2) On 1/23/26 at 10:05 AM, the surveyor reviewed the MRR for Resident #11. Records showed that on 12/31/25, the pharmacist recommended a correction to an order for Tylenol oral capsule 325 mg (milligrams), 2 capsules by mouth at bedtime. The pharmacist's note asked: Is the resident receiving capsules or tablets? Please correct the order if the resident is actually receiving tablets. The MRR for Resident #11 contained a handwritten response stating, capsules per order, but it lacked both a date and a signature. On 1/23/26 at 11:45 AM, the surveyor and Registered Nurse (RN #26) inspected Resident #11's medication package in the medication cart. The package contained Tylenol 325 mg tablets, despite the order for capsules. RN #26 stated, The order is for capsules. Why did the pharmacy deliver tablets instead? During an interview at 11:51 AM, the Director of Nursing (DON) explained that after providers review and sign the MRR, charge nurses (primarily Staff #28) are responsible for following and addressing the orders. At 12:06 PM, the DON claimed that Staff #23 (RN) had just shown her Resident #11's Tylenol capsules. However, when the DON and the surveyor re-verified the medication cart, they confirmed the package still contained tablets. Ten minutes later, the DON presented a package of Tylenol 500mg capsules. Upon verification, the surveyor and DON noted these 500mg capsules were for a separate PRN (as needed) order, not the bedtime order in question. The surveyor expressed concerns that the pharmacist's recommendation was not appropriately addressed or resolved. The DON validated this finding.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to ensure medications were ordered with an adequate indication for use. This was evident for 1 (Resident #8) out of 5 residents reviewed for unnecessary medications during the facility's recertification survey.The findings include: Adequate Indication for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals, and after any safer treatments have been deemed clinically contraindicated.On 1/23/26 at 10:54 AM review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Further review revealed the resident was ordered:-Candesartan Cilexetil Oral Tablet 16 MG (milligrams) Give 1 tablet by mouth one time a day. -Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day. -Novolog Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject 20 unit subcutaneously before meals.-Timolol Maleate Ophthalmic Solution 0.5 % Instill 1 drop in both eyes in the morning.-Lumigan Ophthalmic Solution 0.01 % (Bimatoprost). Instill 1 drop in both eyes at bedtime. Review of Resident #8's above orders failed to reveal an adequate indication for any of the medication orders.On 1/23/26 at 12:17 PM in an interview with the Director of Nursing (DON) when asked if medications should have an indication, she stated yes. The surveyor shared the concern that 5 out of 8 medications for Resident #8 did not have an indication. The DON stated, Oh, that's not good. and verbalized and acknowledged understanding of the concern.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility records and interview with facility staff, it was determined the facility staff failed to ensure the required committee members consistently attended monthly Quality Assurance and Performance Improvement (QAPI) meetings.The findings include:On 1/28/26 at 1:09 PM review of the facility's QAPI monthly attendance records for 1/2025 to 12/2025 revealed the following:-The Medical Director failed to attend 5 of 12 meetings (May 2025, August 2025, September 2025, November 2025, December 2025).-The Nursing Home Administrator failed to attend 1 of 12 meetings (May 2025).On 1/28/26 at 1:36 PM in an interview with the Infection Preventionist/Staff Educator/QAPI Secretary (IP/SE/QAPIS #1) when asked how long she had participated in QAPI meetings, she stated she had been in the QAPI Secretary role for about 2 years. During the interview the 2025 QAPI attendance sheets were reviewed by IP/SE/QAPIS #1, and she reviewed, verified and confirmed the surveyor's findings. The surveyor shared this was a concern and she acknowledged understanding of the concern.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and medical record review, it was determined that the facility failed to ensure maintaining an effective infection control program by failing to order contact precautions in a timely manner. This deficiency was identified for one resident (Resident #19) out of three reviewed for infection control during the annual recertification survey.The findings include:During the tour of the facility on 1/21/26 at 10:18 AM, the surveyor observed the contact precaution signage posted on the wall of Resident #19's room entrance.On 1/22/26 at 10:38 AM, the surveyor reviewed the records of three randomly residents currently receiving antibiotics. The review revealed that Resident #19 was diagnosed with Shingles (Herpes Zoster) by the attending provider on 1/19/26. Shingles is a painful, blistering rash caused by the reactivation of the varicella-zoster virus; per the Centers for Disease Control and Prevention (CDC), contact precautions are required to prevent the spread of the virus. However, no order for contact precautions was placed for Resident #19 until 1/20/26.During an interview on 1/22/26 at 2:00 PM, the Infection Preventionist (IP #1) stated that contact precautions are required for any resident diagnosed with Shingles and that the precaution order should be implemented simultaneously with the diagnosis. The surveyor shared concerns regarding the delay in Resident #19's contact precaution order, and IP #1 validated the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21E104	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph's Nursing Home	1222 Tugwell Drive Catonsville, MD 21228

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 Level of Harm - Minimal harm or potential for actual harm 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. Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure that an employee's COVID-19 vaccination status was monitored and documented. This finding was evident for one of five staff members (Staff #17) whose immunization records were reviewed during the recertification survey.The findings include:The COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease.On 1/22/26 at 11:38 AM, the surveyor reviewed the health files of five randomly selected employees. The review revealed that Staff #17 (Dietary Aide), who was hired in October 2024, lacked documentation to support their COVID-19 vaccination status.During an interview on 1/22/26 at 1:45 PM, the Infection Preventionist (IP #1) explained that upon hire, the facility collects copies of vaccination records and reviews the immunization status of all new employees. She stated that these records should include Flu, MMR, Hepatitis B, Tdap, Varicella, Tuberculosis (TB), and COVID-19. Upon a joint review of Staff #17's health records with the surveyor, it was confirmed that the file did not contain COVID-19 vaccination status. IP #1 validated the finding.