VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 1, 2023

Ms. Teresa Isabelle, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701-4832

Dear Ms. Isabelle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 5, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475012	A. BUILDING _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	9 HAYWOOD AVENUE RUTLAND, VT 05701

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E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced investigation of the facility's Emergency Preparedness Program on 4/5/2023. There were no regulatory findings related to this investigation.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However it is the facility commitment to demonstrate and maintain compliance	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and staff vaccination review was conducted by the Division of Licensing and Protection between 4/3 - 4/5/23. The following regulatory deficiencies were identified:	F 000	Date of Compliance is 5/10/2023	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/28/23

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.

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F 655	Continued From page 1 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident for 6 of 37 sampled residents (Residents #7, #10, #16, #71, #77, and #273). Findings include: 1. Record review reveals that Resident #7 was admitted to the facility on 4/15/2022 and has diagnoses that include: dementia, urge incontinence (sudden need to urinate that is difficult to delay), adult failure to thrive, dysphagia (difficulty swallowing), type 2 diabetes, and unsteadiness on feet. Resident #7's care plan for ADLs (activities of daily living) and risk for falls was created on 5/27/2022, 42 days after	F 655	F655 Specific Corrective Action 1. There were no negative impacts on resident #7, #10, #16, #71, #77 and #273. Care Plans for residents #7, #10, #16, #71, #77, #273 were corrected. 2. An audit was conducted on all baseline care plans for all residents.No other residents were affected. 3. Education was completed with licensed staff and IDT on baseline careplans and the complition of them timely. 4. DON/ Designee will conduct weekly audits x4 and then monthly x3 to ensure baseline care plans are completed within 48 hours of when patients admit. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 655 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 655	Continued From page 2 admission. 2. Record review reveals that Resident #10 was admitted to the facility on 2/11/2022 and has diagnoses that include heart failure, arthritis, stage 3 kidney disease, type 2 diabetes, abnormalities of gait and mobility, and the need for assistance with personal care. Resident #10's care plans for ADLs and risk for falls was created on 7/5/2022, 144 days after admission. 3. Record review reveals that Resident #16 was admitted to the facility on 4/25/2022 and has diagnoses that include heart failure, COPD (chronic obstructive pulmonary disease), morbid obesity, acute kidney failure, obstructive uropathy (disorder due to obstructed urinary flow), frequent urinary tract infections, type 2 diabetes, and the need for assistance with personal care. Resident #16's care plan for ADLs was created on 5/4/2023, 9 days after admission. 4. Record review reveals that Resident #71 was admitted to the facility on 2/16/2023 and has diagnoses that include history of stroke, dysphagia, type 2 diabetes, and the need for assistance with personal care. Resident #71's care plan for ADLs was created on 2/26/23, 10 days after admission. 5. Record review reveals that Resident #77 was admitted to the facility on 7/1/2022 and has diagnoses that include end stage renal disease, polyneuropathy (nerve pain), cognitive communication deficit, heart failure, type 2 diabetes, contact dermatitis related to incontinence, and the need for assistance with personal care. Resident #77's admission Minimum Data Set (MDS; a comprehensive	F 655		

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F 655	Continued From page 3 assessment) dated 7/6/2022 reveals that s/he was admitted to the facility with bowel incontinence. Resident #77's care plan for ADLs was created on 7/6/2022, five days after admission, and bowel incontinence was created on 4/4/2023, 277 days after admission. 6. Record review reveals that Resident #273 was admitted to the facility on 2/24/2023 and has diagnoses that include heart failure, history of stroke, abnormalities of gait and mobility, and the need for assistance with personal care. S/He was admitted to the facility with an indwelling catheter. Resident #273's care plan for ADLs was created on 3/10/23, 14 days after admission, and s/he did not have a care plan for risk for falls or indwelling catheter care within 48 hours of admission. Facility policy titled "OPS416 Person-Centered Care Plan" states that "a baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient..." On 4/5/2023 at 7:46 AM, the Unit Manger confirmed that baseline care plans should include care plans for a resident's diagnoses, medications, ADLs, skin integrity, falls, and pain. On 4/5/2023 at 1:40 PM, the Director of Nursing confirmed that baseline care plans should include care needs, including catheter care, ADLS, and falls.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 4 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 5 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive care plan that is individualized and meets the needs identified on the resident's comprehensive assessment related to activities of daily living (ADL) for 6 Residents (Residents #7, #10, #16, #71, #77, #179 and #273), Dialysis needs for 1 Resident (Resident #179), and Bowel management for 1 Resident (Resident #58) in the sample of 31. Findings include: 1. Record review reveals that Resident #7 was admitted to the facility on 4/15/2022 and has diagnoses that include: dementia, urge incontinence (sudden need to urinate that is difficult to delay), adult failure to thrive, dysphagia (difficulty swallowing), type 2 diabetes, and unsteadiness on feet. Resident #7's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 1/30/2023 reveals that s/he requires a one person assist for dressing, toileting, and personal hygiene, and set up assistance for eating. Resident #7's care plan includes the following focus: "Patient requires assistance for ADL care related to: chronic conditions resulting in weakness and activity intolerance," created on 5/27/2022. Interventions include: "Assist with ADLs as needed," created on 6/6/2022. There are no interventions as to what type of assistance Resident #7 needs for dressing, toileting, personal hygiene, or eating in their care plan.	F 656	F656 Specific Corrective Action 1. There were no negative impacts on residents #7, #10,#16, #71, #77, #179, and #273. Care plans for these residents were corrected and updated. 2. An Audit was done on all comprehensive careplans. No other residents were affected. 3. Education completed with licensed staff and IDT regarding the completion and process of comprehensive careplans. 4. DON/Designee will conduct weekly audits x4, and monthly x3 to ensure that new orders, diagnoses, and ADLs are incofrporated into comprehensive careplans within 7 days. Compliance and results will be reviewed at QAPI meeting for further review and recommendations. **Tag F 656 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 656	Continued From page 6 2. Record review reveals that Resident #10 was admitted to the facility on 2/11/2022 and has diagnoses that include heart failure, arthritis, stage 3 kidney disease, type 2 diabetes, abnormalities of gait and mobility, and the need for assistance with personal care. Resident #10's MDS dated 1/24/2023 reveals that s/he requires a one person assist for transfers, dressing, toileting, and personal hygiene, and set up assistance for bed mobility and eating. Resident #10's care plan includes the following focus: "Resident is at risk for decreased ability to perform ADLs, recent MI [heart attack]," created on 7/5/2022. Interventions include: "assist with ADL's as needed," created on 7/5/2022. There are no interventions as to what type of assistance Resident #10 needs for transfer, mobility, dressing, toileting, personal hygiene, or eating in their care plan. 3. Record review reveals that Resident #16 was admitted to the facility on 4/25/2022 and has diagnoses that include heart failure, COPD (chronic obstructive pulmonary disease), morbid obesity, acute kidney failure, frequent urinary tract infections, type 2 diabetes, and the need for assistance with personal care. Resident #16's MDS dated 2/20/2023 reveals that s/he requires a two person assist for dressing, toileting, and personal hygiene, eating, and a one person assist for eating. Resident #16's care plan includes the following focus: Resident requires assistance for ADL care related to: weakness, limited mobility," created on 4/30/2022. Interventions include: "Assist with ADL's as needed," created on 5/4/2022. There are no interventions as to what type of assistance Resident #10 needs for dressing, toileting, personal hygiene, or eating in their care plan.	F 656		

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F 656	Continued From page 7 4. Record review reveals that Resident #71 was admitted to the facility on 2/16/2023 and has diagnoses that include history of stroke, dysphagia, type 2 diabetes, and the need for assistance with personal care. Resident #71's MDS dated 2/20/2023 reveals that s/he requires a one person assist for transfers, dressing, toileting, and personal hygiene, a two person assist for bed mobility, and set up assistance for eating. Resident #71's care plan includes the following focus: "Patient is at risk for decreased ability to perform ADL(s) related to: Recent hospitalization, CVA [stroke]" created on 2/26/23. Interventions include: "Assist with ADL's as needed," created on 2/26/23. There are no interventions as to what type of assistance Resident #71 needs for transfer, mobility, dressing, toileting, personal hygiene, or eating in their care plan. 5. Record review reveals that Resident #77 was admitted to the facility on 7/1/2022 and has diagnoses that include end stage renal disease, polyneuropathy, cognitive communication deficit, heart failure, type 2 diabetes, contact dermatitis related to incontinence, and the need for assistance with personal care. Resident #77's MDS dated 3/21/2023 reveals that s/he requires a one person assist for bed mobility, dressing, toileting, and personal hygiene, and set up assistance for eating. Resident #77's care plan includes the following focus: "Patient is at risk for decreased ability to perform ADL(s) related to chronic illness requiring HD [hemodialysis] and weakness," created on 7/6/2022. Interventions include: "Provide assist with ADL's as needed," created on 7/6/2022. There are no interventions as to what type of assistance Resident #77 needs	F 656		

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F 656	Continued From page 8 for bed mobility, dressing, toileting, personal hygiene, or eating in their care plan. 6. Record review reveals that Resident #273 was admitted to the facility on 2/24/2023 and has diagnoses that include heart failure, history of stroke, spinal stenosis, abnormalities of gait and mobility, and the need for assistance with personal care. Resident #273's MDS dated 2/28/2023 reveals that s/he requires a two person assist for bed mobility, dressing, toileting, and personal hygiene, and set up assistance for eating. Resident #273's care plan includes the following focus: "Resident/Patient is at risk for decreased ability to perform ASL(s) related to: Recent fall, hospitalization," created on 3/10/23. Interventions include: "Assist with ADL's as needed," created on 3/31/23. There are no interventions as to what type of assistance Resident #273 needs for bed mobility, dressing, toileting, personal hygiene, or eating in their care plan. Facility policy titled "OPS416 Person-Centered Care Plan" states that "the interdisciplinary team, in conjunction with the patient and/or patient representative, as appropriate, will establish expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. Documentation will show evidence of ...Patient's status in triggered Care Area Assessments (CAAs) [CAAs are key issues identified from the MDS used to identify areas for care planning]; Development of care planning interventions for all CAAs triggered by the MDS." Per interview on 4/4/2023, at 4:17 PM, the Director of Nursing stated that the ALD	F 656		

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F 656	Continued From page 9 intervention "assist with ADLs as needed" is used as an ADL intervention so staff could decide what type of assistance they needed, and that staff should know what type of assistance is needed by their transfer status. S/He confirmed that the care plans did not describe what type of assistance is needed for all ADL care for the above residents. On 4/5/2023 at 9:25 AM, a Licensed Nursing Assistant stated that s/he knows what type of assistance a resident needs for ADL care by asking a nurse, looking at a binder, meal ticket slip, or previous charting if it is not on the Kardex [a quick reference of care plan interventions]. S/He stated it would be beneficial to have that information in the Kardex. 7. Per record review on 4/5/23, there is no care plan to address Resident # 179's needs related to dialysis. Resident # 179 was admitted on 3/20/23 and receives hemodialysis every Monday, Wednesday and Friday. On 04/05/23 at 08:38 AM the Unit Manager stated that there should be a care plan to address Resident # 179's needs related to dialysis and confirmed that there was no care plan to address those needs. 8. Per record review Resident #58 did not have a documented Bowel Movement for seven days January 1st to January 7th 2023, and four days from January 23rd to January 27th 2023. At that time, the Resident was admitted to the hospital with a diagnosis of bowel obstruction. Record review reveals that during these episodes of constipation, resident was not administered the laxatives that were ordered for constipation. Constipation is generally described as having fewer than three bowel movements a week.	F 656		

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F 656	Continued From page 10 Review of The Facility Continence Management Guide: process section states "Develop a treatment plan..." Review of residents #58's care plan reveals that there was no care plan for constipation in place prior to hospitalization, and was not implemented after the return from the hospital. On 4/4/23 at 2:06 PM, interview with Licensed Practical Nurse Unit Manager confirms that S/he would expect that a care plan that address the Residents bowel status and management would be in place for resident #58. S/he also confirmed that there is no care plan in place.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679		

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F 679	Continued From page 11 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interviews, observations, and record review the facility failed to provide, based on the preferences of each resident, an ongoing program to support residents in their choice of activities, for (2) residents, (resident #46, and #96) of 31 sampled residents. Findings include: Per interview on 04/03/23 at 11:52 AM Resident #46 stated s/he has had, "no activities offered in or out of my bedroom since I got here." This resident also stated, "I haven't been out of my room since I got here." Upon record review Resident #46 was admitted to the facility on 02/28/23. The resident's Problem List shows current diagnoses to include a recent below the knee amputation of the left lower extremity, a current urinary tract infection, history of a stroke, and Type II Diabetes. The resident's progress notes read, "Resident has positive affect, cooperative with staff. (S/he) is alert and oriented x3. Patient able to make needs known". The medical record reveals a BIMS score of 15 (the BIMS score is a Brief Interview for Mental Status, used as an assessment tool to identify cognitive impairment). A BIMS score of 15 indicates the resident is cognitively intact. An interview was performed on 04/04/23 at 1:08 PM with the Unit Manager on the Dogwood Unit where Resident #46 resides. The Unit Manager was asked if this resident has been offered activities either in a group, or one-on-one in the resident's bedroom. The Unit Manager stated	F 679	F679 Specific Corrective Action 1. Resident #46 and #96 have been offered activities based on their likes and choice of activities. 2. An audit of all resident careplans to ensure resident specific interventions are in place. 3. Education of resident participation logs and completion of the logs has been done with activities staff. MVC has re-designed their partner program to meet the needs of residents and include questions to follow resident engagement. 4. Administrator or designee will conduct audits weekly x4, monthyl x3 on the resident participation logs. Administator or designee will coduct audits weekly x4 monthly x3 on the complition of the partner program. Administrator or designee will conduct audits weekly x4, monthly x3 on the comprehensive careplans for residents. Any Concerns/trends identified will be addressed in real time and discussed in QAPI. **Tag F 679 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 679	Continued From page 12 Resident #46 "refuses to get out of bed and refuses activities outside of the room". The unit manager further stated the resident refuses a multitude of activities such as participating in physical therapy and eating in the unit's dining room. S/he showed documentation of Resident #46's refusal of physical therapy. When asked if activities were offered in the residen'ts room, the Unit Manager stated this surveyor would need to ask the Activity Director for more information specific to activity program participation. On 04/05/23 at 12:11 PM the resident's Activity Participation Record for the month of March was reviewed with the Activity Director and the Administrator. In reviewing the March Activity Participation Record, the record reveals Resident #46 was offered and accepted the activity "Manicure/Aromatherapy/Massage/Painting Nails/Salon/Spa" three times in the month. The record reads the resident was recorded to have participated in the independent activity of "Relaxing/Looking out the window/Resting/Thinking" twice in the month. There were four documented refusals of activities offered, and the rest of the month was blank except for zeros recorded on eleven days out of the month indicating the resident was not in the building on those days. When the Activity Director was asked what the process is for documenting the offering of and refusal of activities, s/he stated they would be recorded on the Activity Participation Record. On 04/05/2023 at 12:15 PM the Administrator and Activity Director confirmed the lack of documentation specific to activity participation or refusal of activity program participation. It was confirmed that a lack of socialization and	F 679		

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F 679	Continued From page 13 participation in a resident's preferred activity program, whether group or independent, has the potential for a negative psychosocial impact on Resident #46, which this resident voiced during the interview process. 2. Per observations made over the three days of survey Resident #96 was seen throughout the days sitting in a wheelchair in the dining/activity area. During these observations s/he was not engaged in activity. On 4/3/23 at approximately 11:15 AM the Resident was observed at a table in the dining /activity area. Staff were preparing for lunch. At 3:15 PM Resident #96 was sitting at a table with four other Residents. Staff members offered the Residents fluids but then exited the room. Residents were talking with each other and periodically arguing. One resident was crying and asking for help to get out of there. Another Resident was saying "don't let them bully you. I'll shoot them right in the head. Be proud of yourself and don't let them bully you." The television had been on same channel with a fishing show playing loudly since arrival to unit at approximately 11:15 AM. At 3:59 PM Resident #96 was still sitting at the table. On 4/04/23 at 8:26 AM Resident #96 was again observed in the dining/activity area, s/he had just finished breakfast. The television was up loud on the history channel. S/he was sitting in her/his wheelchair sleeping. At 12:50 PM staff were assisting Residents in and out of the room but there was no activity other than a very loud cartoon on the television. At 1:24 PM the television remained on. There was no staff present to engage Residents in the dining/activity room. At 3:47 PM a cartoon movie (Abominable) was on the television very loud. Resident #96 was	F 679		

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F 679	Continued From page 14 at a table occasionally watching the movie. At 3:55 PM Resident #96 was still sitting at a table with no staff present in the room with the Residents. At 4:16 PM the Residents were being assisted by staff with hand washing. A Spiderman cartoon movie was on the television playing loudly. Per record review Resident #96 has a diagnosis of Alzheimer's disease and resides on the Dementia Unit. Review of the Activity Participation Record reflects that her/his activities preferences and interests include movies/TV, outside/gardening/ nature/tanning, reading/auto books, and socializing/socials/talking on phone/visits/sending cards. The Participation Record documentation for 4/1 - 4/4/23 reflects that the only activities that the Resident independently participated in were movie/TV on 4/1 and reading audio books on 4/2. Per interview with the Unit Manager (UM) on 4/5/23 at approximately 10:15 AM staff should be interacting with the Residents who are in the dining/activity room. The UM confirmed that lack of activity throughout the day can have a negative impact on the Residents and cause increased behaviors. Per interview on 4/5/23 at 11:22 AM the facility Administrator and the Director of Therapeutic Recreation, activities occur in the primary activity room and all Residents on the Cherry Tree Unit are invited. There are usually activities on the Cherry Tree Unit however, the staff member who is assigned to Cherry Tree has been out. There have been some activities such as coffee and doughnuts but not as much as usual.	F 679		

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F 684	Continued From page 15	F 684		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice related to proper wheelchair positioning and follow through on physical therapy recommendations for 1 resident (Resident #87) and failed to identify and provide needed care and services regarding bowel management to prevent rehospitalization for 1 Resident (Resident #58) in a sample of 31 Residents. Findings include: 1. Per record review of the facility January Bowel Record reveals that resident #58 had no documented bowel movements from 1/1 - 1/7/2023 and 1/23 - 1/27/2023. The Resident experienced untreated constipation resulting in a 15 day rehospitalization. Physician orders written on 10/4/2022 state: Milk of Magnesia Suspension 400mg/5ml (Magnesium Hydroxide) Give 30 ml (milliliters) by mouth as needed for constipation, give at bedtime if no BM (Bowel Movement) in 3 days. Bisacodyl Rectal Suppository 10mg. Insert 1 application rectally every 24 hours as needed for constipation if no result from MOM (Milk of	F 684	F684 Specific Corrective Action 1. There were no negative impacts on the residens #58 and #87. Treatment and care for these residents were reviewed. 2. An audit was conducted and no other resdients were affected. 3. Education was completed with direct care staff regarding consitpation management and wheelchair positioning 4. DON/Desginee will conduct weekly audits x4 and monthly x3 to ensure that patients with no/small bowel movements for 3 days have the bowel protocol implemented. Also, will conduct weekly x4 and monthly x3 to ensure that patients with screens for wheelchair positioning have recommendations that have been offered/ implemented. Compliance and results to be reviewed and QAPI meeting for further review and recommendations. **Tag F 684 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 684	Continued From page 16 Magnesia). Fleet Enema Rectal Enema (Sodium Phosphates). Insert 1 application rectally as needed for constipation if no result from bisacodyl within 2 hours. However, the Resident's Medication Administration Record (MAR) for the month of January reveals that during the 7-day period from January 1st to January 7th and the 5 day period between 1/23- 1/27/23 the resident did not receive any of the above ordered medications. A Nurse progress note written on 1/21/23 at 4:51 AM states that resident #58 "had been complaining of stomachache and cramps all during the night and had had an episode of vomiting with am and no further complaints". S/he was sent to the hospital later in the day with abdominal pain and was admitted. The Resident returned to facility on 1/23/23. On 1/26/2023 at 5:12 PM the resident was vomiting, and claimed s/he had not had a recent bowel movement. The nurse listened to the resident's bowel sounds and they were present in all quadrants, and her/his abdomen was soft and non-tender. On 1/27/23 the Resident continued to complain of nausea and vomiting, and received Milk of Magnesia. At 10:40 AM the Resident was transferred to the hospital with the diagnosis of bowel obstruction (a serious problem that happens when something blocks your bowels, either your large or small intestine). Review of the hospital Emergency Documentation dated 1/27/2023 the Resident's last bowel movement was 1/22/23 and is experiencing coffee ground emesis (vomit that looks like coffee grounds). While at the hospital the Resident underwent a computed tomography	F 684		

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F 684	Continued From page 17 scan (CT Scan, a medical imaging technique used to obtain detailed internal images of the body), a nasogastric tube was placed for decompression, the Resident received intravenous fluids, and laxative suppositories resulting in bowel movements. The resident returned to the facility on 2/10/23, 15 days later. Per interview on 04/04/23 at 2:05 PM with the Unit Manager (UM), Licensed Practical Nurse (LPN) the facilities process for bowel management includes the night nurse is to check all the resident's bowel movement records and make a bowel list every night (a list of residents that have no had a bowel movement in 3 days or more). This list is given to the day shift nurse who starts the bowel protocol. The bowel protocol follows Milk of Magnesia on day 3 of no bowel movement, Bisacodyl suppository to follow on the 4th day of no bowel movement, Fleet enema on 5th day of no bowel movement. The UM confirmed that there was no documentation that the Resident had a bowel movement during 1/1 - 1/7 and 1/23-1/27 and that the facility bowel management protocol had not been followed. The UM also confirmed that the resident should have received the as needed laxatives as ordered but did not. 2. On 04/03/2023 Resident #87 was observed in the common area of the Dogwood Unit positioned in his/her wheelchair as follows: leaning towards the right with no lateral support, the resident's right arm was pressed against the right armrest of the wheelchair putting pressure just below his/her shoulder, and the resident's bilateral lower extremities were noted to be dangling above the floor with no foot pedals attached to the wheelchair. Resident #87 has contractures of	F 684		

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F 684	Continued From page 18 his/her left arm, left hand, and bilateral feet. Resident #87 was interviewed on 04/03/2023 at 1:53 PM and stated that s/he has "some discomfort" of his/her right upper arm associated with his/her positioning in the wheelchair. The resident stated s/he was, "possibly getting a new wheelchair and support for my right side, I've been waiting 8 months." Record review on 04/03/2023 shows Resident #87 was admitted to the facility on 07/09/2020 with diagnoses to include: Parkinson's disease, osteoarthritis, unspecified muscle weakness (generalized), age-related osteoporosis, flexion deformity of left finger joints, scoliosis, acquired deformities of the right foot, acquired deformities of the left foot, abnormal posture, flexion deformity of the left wrist, flexion deformity of the left elbow, and adult failure to thrive. This resident's BIMS score (a BIMS score is a Brief Interview for Mental Status, used as an assessment tool to identify cognitive impairment) was recorded as fifteen, which indicates the resident's cognition is intact. This resident was alert, and able to clearly voice concerns upon interview. Upon interview on 04/04/2023 the Dogwood Unit Manager (UM) was asked if Resident #87 complained of discomfort due to wheelchair positioning to her/him or other staff members of which s/he was aware. The UM replied that Resident #87 usually sits in the communal area on the Dogwood Unit where s/he is easily observed and can access staff and voice his/her needs but, "has not complained of discomfort" to her/him. This surveyor asked the UM when the last time Resident #87 was referred to therapy for	F 684		

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F 684	Continued From page 19 wheelchair positioning or other therapy needs, s/he referred me to the therapy department for further information as s/he had no recent evaluation or treatment record s/he could access in the electronic medical record. When asked if this resident could self-propel in his/her wheelchair s/he stated the resident "used to be able to but hasn't in months." An interview with a Physical Therapy/Occupational Therapy Assistant (PTA) on 04/04/2023 at 01:20 PM reveals that Resident #87 was evaluated by Physical Therapy in April of 2022 which resulted in an order being placed for adjustable height armrests for this resident's wheelchair. A follow-up to ensure proper positioning and functionality was going to be completed once the equipment was obtained. After the PTA reviewed therapy records, the staff member stated, "It looks like the armrests were never followed up on." The PTA stated he/she " ...remember the armrests were going to cost about $150.00 but I don't know why they weren't received and why there was no follow-up". The PTA also stated, "The nursing department was supposed to notify the therapy department when the armrests arrived." The PTA then went to the Dogwood unit to observe the resident's positioning in his/her wheelchair and to confirm the adjustable height armrests were not on the chair. Upon returning from the unit s/he confirmed the armrests were not adjustable and stated the resident's positioning in the wheelchair "was horrible." The PTA printed out and provided this surveyor with the PT Initial Evaluation Form from April of 2022 for review. The PTA then went to administration for help in determining the cause of oversight in providing this resident with adjustable height armrests, which also resulted in	F 684		

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F 684	Continued From page 20 a lack of re-evaluation for proper functionality and positioning in the resident's wheelchair for the past year from April of 2022 through April of 2023. Review of the Physical Therapy Initial Evaluation Form dated for the period of 04/01/2022-04/30/3022 revealed that Resident #87 was, "Referred for PT (physical therapy) due to new complaints of R UE (right upper extremity) discomfort during W/C (wheelchair) mobility. Pt (patient) presents with severe posture abnormalities and L UE and BL LE (left upper extremity and bilateral lower extremity) deformities ...Pt would benefit from PT services to assess for optimal W/C seating system to support the above postural abnormalities to promote decreased R UE pain during W/C propulsion ...and promote maximal independence with W/C propulsion ... Pt demonstrates good rehabilitation potential ...Pt reports recent R UE discomfort due to height of W/C armrest". At the time of this therapy evaluation, records show Resident #87 could self-propel for approximately 10 minutes using her/his right upper extremity and bilateral lower extremities but would then experience discomfort as high as a five on a pain scale of 1-10, with ten being the worst pain. Records show the pain would limit further propulsion and risk injury to the right upper extremity. On 04/05/2023 at 08:30 AM The Administrator confirmed the armrests were not obtained and Resident #87 has not had follow-up from the therapy department for wheelchair positioning and functionality for the past year as was the documented plan of action in the Physical Therapy Initial Evaluation Form dated in April of 2022. It was confirmed this oversight resulted in poor wheelchair positioning since April of 2022,	F 684		

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F 684	Continued From page 21 discomfort, and the inability for self-propulsion in the current wheelchair for Resident #87. The administrator stated, "I didn't work in the facility at the time of the PT evaluation last year so I don't know why the armrests weren't received, but a new wheelchair will be ordered for this resident immediately. The physical therapy screen was already placed (to determine the chair that best meets the resident's needs)." Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott, Williams & Wilkins, pg 17.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 31 sampled residents (Residents #34, #7, and #10) remained free of accident hazards as possible regarding implementing interventions to reduces hazards and risks and assessing interventions for effectiveness. The facility also failed to provide a safe, and functional environment for residents in five rooms, and ensure that a heating register located in a common area was maintained at a safe temperature to prevent burns. Findings include: Findings include:	F 689		

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F 689	Continued From page 22 1. Record review reveals that Resident #34 was admitted to the facility on 3/15/2018 and has diagnoses that include Parkinson's, dementia, history of falling, dysphagia (difficulty swallowing), and the need for assistance with personal care. Resident #34's Minimum Data Set (MDS; a comprehensive assessment) dated 2/10/2023 reveals that s/he requires a two person assist for transfers, dressing, toileting, and personal hygiene, and bed mobility. Resident #34's care plan includes the following focus: "[Resident #34] is at risk for falls: H/O [history of] repeat falls, mild cognitive impairment, pain in left hip, low back pain, and dx [diagnosis] of glaucoma," created on 3/16/2018. Per review of facility incident reports, Resident #34 had falls on 10/23/2022, 11/8/2022, 11/22/2022, 2/2/2023, 3/30/2023. There were no revisions made to the fall care plan after any of the above falls. 2. Record review reveals that Resident #7 was admitted to the facility on 4/15/2022 and has diagnoses that include: dementia, urge incontinence (sudden need to urinate that is difficult to delay), adult failure to thrive, dysphagia, type 2 diabetes, and unsteadiness on feet. Resident #7's MDS dated 1/30/2023 reveals that s/he requires a two person assist for transfers, and a one person assist for dressing, toileting, and personal hygiene. Resident #7's care plan includes the following focus: "Resident is at risk for falls related to deconditioning," created on 5/27/2022. Per review of facility incident reports, Resident #7 had a fall on 11/15/2022. There were no revisions made to the fall care plan on or after 11/15/2022. 3. Record review reveals that Resident #10 was	F 689	F689 Specific Corrective Action 1. There were no negative impacts on residents, #7, #10, #34. Careplans for these residents were updated. Toilet saftey bars were replaced in rooms, 105, 109, 517, 413 and 520. The electric baseboard heater was removed and a new ceiling wall mount heater was ordered. 2. An audit was conducted for residents with falls, no other residents were affected. An audit was conducted for all other toilet safety bars and temps of all heaters. All loose safety bars have been replaced and heaters are within regulartory range of 71-81 degrees. 3. Education was completed with direct staff regarding fall interventions, toilet safety bars, and electric baseboard heat. 4. DON/Designee conduct weekly audits x4, monthly x3 to ensure patients that fall have a new fall intervention documented in their care plan. Any concerns or trends will be addressed in the moment and brought to QAPI for review. Administator/Designee will conduct weekly x4, monthly x3 audits on toliet safety bars, to ensure resident safety. Any concerns or trends will be addressed real time and will be brought to QAPI for review. **Tag F 689 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 689	Continued From page 23 admitted to the facility on 2/11/2022 and has diagnoses that include heart failure, arthritis, stage 3 kidney disease, type 2 diabetes, abnormalities of gait and mobility, and the need for assistance with personal care. Resident #10's MDS dated 1/24/2023 reveals that s/he requires a one person assist for transfers, dressing, toileting, and personal hygiene. Resident #10's care plan includes the following focus: "Resident is at risk for falls: impaired mobility," created on 7/6/2022. Per review of facility incident reports, Resident #10 had a fall on 8/4/2022. There were no revisions made to the fall care plan on or after 8/4/2022. Facility policy "NSG215 Falls Management" states under practice standards that staff are to "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Adjust and document individualized intervention strategies as patient condition changes." Per interview on 4/5/2023 at 8:33 AM, the Director of Nursing stated that care plans should be updated with new interventions after every fall. S/He confirmed that care plans were not updated with new interventions to prevent falls for Residents #7, #10, and #34. 4. Per observation by two surveyors on 04/04/23 at 11:46 AM, in room #109, and #105 on the TCU unit, toilet safety bars over resident toilets were loose, creating an unsafe environment. Metal and plastic toilet safety bars were attached to the back of the toilet, but not attached to the floor. The safety bars are hinged with the ability to raise up and down. The bars were very loose and were able to move more than one foot from side to side creating a potential for injury to the residents.	F 689		

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F 689	Continued From page 24 Each room was occupied with residents who utilized the toilets with assistance from staff. On 04/05/23 at 01:27 PM, a Licensed Nursing Aide (LNA) confirmed that the toilet safety bars were "very loose". On 04/05/23 the Administrator also confirmed the toilet safety bars on the Dogwood Unit in rooms #517, #413, and #520 were "very loose". On 04/05/23 at 11:00 AM, the Administrator and Director of Maintenance confirmed the toilet safety bars were loose and could potentially lead to resident injury. 5. On 4/4/23 at 3:00 PM an electric baseboard radiator located in the Cherry Tree Unit dining/activity room was noted to be hot to the touch. Using an infrared thermometer this surveyor obtained a temperature reading of 146 degrees Fahrenheit. At 140 degrees, a first-degree burn will occur in approximately 3 seconds. This temperature corresponds to the threshold between maximum pain and numbness, as well as the threshold between reversible injury and possible irreversible injury (ASTM International Standard C1055-03, titled Standard Guide for Heated System Surface Conditions that Produce Contact Burn Injuries. American Society for Testing and Materials (ASTM) Standard C 1055 -03). At 3:11 PM this surveyor and the Director of Environmental Services (DES) checked the radiator using two separate infrared thermometers obtaining a reading of 143 degrees Fahrenheit, The DES confirmed that the register was above acceptable heat range and posed a danger to the Residents who sit at the table. S/he immediately turned the heat down and removed	F 689		

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F 689	Continued From page 25 the control dial. Per continued interview the DES stated that all other radiators in the facility are connected to a wall mounted control that is regulated. On 4/4/2023 at 3:45 PM the Administrator reported that the facility contracted electrician had been called and will be coming in to add a wall mounted control for that register.	F 689		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide the necessary care and services to support the Resident's highest practicable level of physical, mental, and psychosocial well-being by not identifying risks, underlying causes of behaviors, or Resident specific interventions for two of seven residents in the sample (Residents #96, and #20). Findings include: 1. Per record review Resident #96 was admitted to the facility on 2/16/23 with diagnoses that include: Alzheimer's disease, unspecified Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, repeated falls, cerebral infarct, and major depressive disorder. Review of the Resident's February Medication Administration Record revealed that on 2/16/23 an order for Zyprexa	F 744		

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F 744	Continued From page 26 5mg by mouth every 12 hours as needed for anxiety/agitation was written. The MAR further revealed that Zyprexa was administered on 2/17, 2/18, 2/22, 2/23, 2/25, and 2/26. Progress notes reveal that the resident experienced behaviors including exit seeking leading to the use of the as needed Zyprexa. Review of the Resident's care plan revealed that there is no consideration of the risk of behaviors or identification of underlying causes or interventions specific to preventing or decreasing behavior expressions. Care plan focuses include impaired/decline in cognitive function or impaired thought process related to a condition other than delirium: Alzheimer's disease, Resident is at risk for distressed/fluctuating mood symptoms related to depression and anxiety. During interview on 4/5/2023 at 2:32 PM the Unit Manager (UM) confirmed that Resident # 96's care plan does not identify specific behavior or anxiety triggers, underlying causes of distress, or Resident specific interventions. 2. Per record review Resident #20 was admitted to the facility on 3/14/22 with diagnoses that include Lewy Body Dementia, Restlessness and Agitation, violent behavior, major depressive disorder, Delusional disorder, anxiety disorder, and psychosis. Nursing progress notes reflect that the resident exhibits behaviors that include hitting, biting, exit seeking, crying, and yelling. Per review of the Residents medication administration record for the month of March Resident #20 received Haldol 2mg 14 times and received Lorazepam 0.5mg 30 times for aggressive behaviors, exit seeking, and anxiety. Care plan focuses include impaired cognition, risk for	F 744	F744 Specific Corrective Action 1. There were no negative impact on resident #20, and #96. Treatment and care for these residents was reviewed 2. An audit was conducted and no other residents were affected. 3. Education was completed with direct care staff regarding non-pharmacological interventions added to careplans. 4.DON/Designee will conduct weekly audits x4, monthly x3 on as needed psychotrpic medication administrations to ensure non-pharmacological interventions were attempted prior to the use of pharmacological interventions. Compliance and results will be reviewed at QAPI meeting for further review and recommendations. **Tag F 744 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 744	Continued From page 27 distressed/fluctuating mood related to depression and anxiety, and risk for complications related to the use of psychotropic drugs; Haldol-Delusional disorder, psychosis, Seroquel- Delusional disorder, psychosis, Sertraline-anxiety, depression, Lorazepam- Anxiety. Further review of the Residents care plan reveals that there are no identified triggers, risks, or underlying causes of distress. Nor are there specific interventions identified to assist staff to manage the Resident's behavior expressions. Per interview with the UM on 4/5/23 at 2:20 PM the Resident has a fear of being left alone. The UM stated that some things that are triggers for the Resident's behaviors include after family comes in to visit then leaves, and when s/he gets over tired. The UM also stated that when s/he reverts back to when s/he was is a kid s/he triggers. The UM confirmed that the Resident's care plan does not address these triggers or any others, and the care plan does not address non-pharmacological interventions.	F 744		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interveiw, and record review the facility failed to ensure that its medication error rates were not 5 percent or greater.	F 759		

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F 759	Continued From page 28 Findings include: On 04/04/2023 at approximately 10:00 AM, a medication administration pass was observed on the Dogwood Unit. The medications being administered were ordered for a 7:00 AM administration time; they were administered outside of the practice standard for medication administration parameters of administration being within one hour before or one hour after the time they were ordered to be administered. The RN administering the medications stated the medication pass is "heavy" and by the time s/he gets to the end of the pass it becomes challenging to get all of the medications administered within the required timeframe. Record review of the Physician's orders shows the medication administration time for the following medications to be 7:00 AM. Review of the Medication Administration Audit Report shows the medications were administered to Resident #50 at the following times: 10:11AM Finasteride 5MG (milligrams), one tablet 10:13AM Metoprolol Succinate ER (extended release) 25MG, 1/2 tablet 10:13AM Midodrine 5MG, one tablet 10:13AM Nitrofurantoin 50MG, one tablet 10:14AM Tamsulosin 0.4MG, one tablet 10:15AM Cholecalciferol 125 MCG/5000 Units, one capsule This resulted in 6 medication errors recorded in a sampling of 31 medication observations. This medication error rate is 19.35%. On 04/05/2023 at 10:09AM The Director of	F 759	F759 Specific Corrective Action 1. There was no negative on resident #50. Treatment and care for resident #50 was reviewed. 2. An audit was conducted on medication administration times, adjustments were made appropriately to meet parameters. 3. Education completed with licensed staff regarding medication administration. 4. DON/Designee will conduct weekly audits x4 and monthly x3 to ensure medications are administered at the appropriate times. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 759 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 759	Continued From page 29 Nursing confirmed the medication administration times were out of compliance with the practice standard for medication administration, which is to administer medications within the two-hour timeframe of one hour before, or one hour after the ordered administration time. The DNS confirmed the medications should have been given no later than 8:00 AM.	F 759		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		

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F 883	Continued From page 30 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each resident receives optimal protection against the pneumococcal infection by not vaccinating eligible residents with the pneumococcal vaccine(s) for 4 of 5 sampled residents (Residents #61, #72, #75, and #99). Findings include: Review of Residents #61, #72, #75, and #99's vaccination history revealed that they were not up to date with the recommended pneumococcal vaccinations. In December 2022, the above	F 883	F883 Specific Corrective Action 1. There were no negative impacts on residents #61, #72, #75 and #99. Consents were reviewed and vacciens were administered to these residnets. 2. An audit was conducted on other Pneumococcal Immunizations and no other residents were affected. 3. Education was completed for licensed nursing staff regarding patient immunizations. 4. DON/Designee will conduct weekly audits x4 and monthly x3 to ensure that residents that have not received the penumococcal vaccination do not have a consentfor the vaccination on file. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 883 POC accepted on 4/29/23 by S. Freeman/P. Cota**	

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F 883	Continued From page 31 residents and/or their representatives signed a form consenting to the administration of the pneumococcal vaccine. There was no evidence in their medical records that the vaccine was administered to these residents. Facility policy "IC601 Pneumococcal Vaccination," last revised on 11/15/22, states the following: "2. Based on the patient's pneumococcal vaccination history, offer (unless the vaccination is medically contraindicated or the patient has already been vaccinated) the appropriate vaccination following the recommended schedule. 3. Patient/Resident representative signs the Pneumococcal Consent form. 4. Administer the vaccine." Per interview on 4/4/2023 at 3:23 PM, Infection Preventionist confirmed that Residents #61, #72, #75, and #99 were not up to date with pneumococcal vaccines and the vaccines had not been administered prior to 4/4/2023.	F 883		