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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 05/13/24.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 12 residents with one resident reviewed for treatment and services to prevent pressure ulcers (localized injury to the skin and underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 2's low air loss mattress was set at the appropriate setting for R2's weight, who was prone to pressure-related injury. This placed R2 at increased risk for the development of pressure	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/13/2024

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ulcers and the development of new pressure ulcers.

Findings included:

- R2's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness)with Lewy body's, neurocognitive disorder (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) psychotic disorder (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and hypertension (HTN-elevated blood pressure).

The " Significant Change in Status Minimum Data Set" (MDS) dated 04/01/24 for R2 documented a Brief Interview of Mental Status (BIMS) score of zero. The MDS documented R2 was at risk for developing pressure ulcers. The MDS documented R2 was dependent on staff for all activities of daily living (ADLs).

The "Pressure Ulcer Care Area Assessment" (CAA) dated 04 /01/24 documented R2 was at risk for pressure injury. The CAA documented a Braden (a tool developed to foster early identification of patients at risk for forming pressure ulcers) and pressure ulcer risk screening was completed. R2 had no skin issues at that time.

R2's "Care Plan" dated 04/04/24 documented R2

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was at risk for pressure ulcers and other skin impairments. The plan of care documented that every nursing shift would check to ensure a low-loss air mattress was plugged in and inflated. The plan of care for R2 dated 04/30/24 documented that every nursing shift would check the redness on R2's left gluteal (pertaining to the buttocks or buttocks muscles) area and apply barrier cream after incontinence care. The plan of care did not indicate the setting for a low-air loss mattress.

R2's EMR under the "Orders" tab dated 04/01/24 revealed the following physician orders:
Every nursing shift to check and ensure the air mattress was plugged in and inflated.

R2's EMR under the "Weights/Vital Sign" tab revealed her current weight was 140.50 pounds on 05/05/24.

On 05/29/24 at 01:35 PM R2 laid in her bed, turned to her left side. She had a washcloth on her forehead. R2's low air loss mattress was set at 210 pounds.

On 05/30/24 at 07:07 AM R2 laid in her bed on her back with her eyes shut. R2's low air loss mattress was set at 210 pounds.

On 05/08/24 at 09:41 AM, Licensed Nurse (LN) G stated the adjustments for setting on R2's bed were not in the EMR. She stated the order directed nursing to check to ensure the bed was plugged in and the mattress was inflated. LN G stated she thought checking settings was part of the order. LN G said she thought the setting on the mattress should be closer to R2's weight, but she was unsure.

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F 686	Continued From page 3 On 05/08/24 at 12:44 PM, Administrative Nurse D stated the facility did not take care of the low air loss mattress settings. He stated the settings were adjusted when the hospice set up the mattress. Administrative Nurse D stated facility staff had an order to check the mattress, not the settings. He stated the facility was working on putting something in place to ensure the settings were correct on mattresses that had weight settings. The facility's "Skin Integrity" policy revised on 10/22 documented that all residents are considered to some risk for the development of pressure ulcers and injuries. Nursing staff will evaluate skin integrity and tissue tolerance, implement preventative measures as indicated, and treat skin breakdown. The primary care provider admission orders authorize approval to begin using established skin and wound treatment guidelines. Dressing changes are performed by a licensed nurse. Licensed nurses may delegate minor skin tear treatments and preventative treatments in closed areas. The facility failed to ensure the low air loss mattress was set at the appropriate setting for R2's weight, who was prone to pressure-related injury. This placed R2 at increased risk for the development of pressure ulcers and the development of new pressure ulcers.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		

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needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 35 residents. The sample included 12 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 27's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner to decrease exposure and contamination. This deficient practice placed R27 at an increased risk of developing respiratory infection.

Findings included:

- R27's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), pulmonary nodule, and obstructive sleep apnea (a disorder of sleep characterized by periods without respirations).

The "Significant Change Minimum Data Set" (MDS) dated 12/22/23 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition.

The "Quarterly MDS" dated 03/18/24 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R27 used a

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non-invasive mechanical ventilator during the observation period.

R27's "Activities of Daily Living (ADLs)Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 01/04/24 documented R27 required extensive assistance with her ADLs.

R27's "Care Plan" dated 03/26/24 documented R27 was to wear her CPAP at night with no oxygen.

R27's EMR under the "Orders" tab revealed the following physician orders:
CPAP at night for obstructive sleep apnea dated 01/03/24.

On 05/06/24 at 10:20 AM R27 lay on her bed. Her CPAP mask laid directly on her bedside table unbagged.

On 05/08/24 at 09:07 AM R27 laid on her bed as she watched TV. R27's CPAP mask laid directly on the bedside table unbagged.

On 05/08/24 at 10:25 AM, Certified Nurse Aide (CNA) O stated she believed the CPAP mask should be stored in a plastic bag like oxygen was stored when R27 was not wearing it. CNA O stated she had never removed R27's CPAP mask in the morning, R27 was usually awake when she entered R27's room.

On 05/08/24 at 10:35 AM, Licensed Nurse (LN) G stated R27's CPAP mask should be bagged when not in use. LN G stated R27's daughter replaced the CPAP mask and cleaned the mask periodically when she visited her mother.

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F 695	Continued From page 6 On 05/08/24 at 12:44 PM, Administrative Nurse D stated CPAP masks should be stored in a container on the table, along with a cleaning solution. Administrative Nurse D stated the nursing staff should clean the CPAP mask. The facility was unable to provide a policy related care of respiratory equipment. The facility failed to ensure R27's CPAP mask was stored in a sanitary manner to decrease exposure and contamination. This deficient practice placed R27 at an increased risk of developing respiratory infection.	F 695		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 12 residents and five Certified Nurse Aides (CNAs) reviewed for performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure two of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included:	F 730		

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F 730	Continued From page 7 - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA N, hired on 01/10/14 had no yearly performance evaluations upon request. CNA M, hired on 05/26/22 had no yearly performance evaluations upon request. On 05/08/24 at 12:44 PM, Administrative Nurse D stated in August 2023, he started to get all the nursing staff's yearly performance reviews up to date. Administrative Nurse D stated he had not completed CNA M and CNA N at this time. Administrative Nurse D stated he had not received the self-performance paperwork back from CNA M and CNA N. Administrative Nurse D stated he started a performance improvement plan on the topic in December 2023. The facility's "Staff Competency" policy last reviewed on 10/11/21 documented all staff would receive education and training applicable to their position and job description. Checklists, Relias courses, and competency testing would be used to ensure staff are appropriately trained for the position. All clinical employees must complete the competency test at their annual review. The facility failed to ensure two of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 35 residents.

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F 732	Continued From page 9 Based on observation, record review, and interviews, the facility failed to retain the daily posted nursing staffing data for the 18 months as required. Findings included: - Review of the daily posted nursing staffing data provided by the facility lacked any posted nursing staffing data for December 2023 (31 days). On 05/08/24 at 12:44 PM, Administrative Nurse D stated the nursing staff scheduler was responsible for ensuring the daily posted nursing hours form was retained for the required 18 months. Administrative Nurse D stated the previous staff member who was responsible for maintaining the posted nursing staff hours had not retained the forms as required. The facility ' s "Daily Nurse Staffing Report" policy last reviewed on 10/11/21 documented that the nursing service was to provide each resident admitted to the health care center with the appropriate level of care to attain his/her optimum level of functioning. Nursing service was staffed, organized, and equipped to provide nursing care on a 24-hour-a-day basis. Daily resident census and staffing information was available to the public. The facility would maintain the Daily Nurse Staffing Form for a minimum of 18 months and file it in the business office. The facility failed to retain the daily posted nursing staffing data for the 18 months as required.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended

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beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure nonpharmacological interventions were attempted and documented prior to administration of an antipsychotic (class of medications used to treat a mental disorder characterized by a gross impairment testing) medication for Resident (R) 2, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications.

Findings included:

- R2's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness)with Lewy body's, neurocognitive disorder (a type of progressive dementia that leads to a decline in thinking, reasoning, and

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independent function), psychotic disorder (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and hypertension (HTN-elevated blood pressure).

The " Significant Change in Status Minimum Data Set" (MDS) dated 04/01/24 for R2 documented a Brief Interview of Mental Status (BIMS) score of zero. The MDS documented R2 received antipsychotic drugs during the observation period.

R2's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 04/01/2024 documented a psychotropic drug medication side effect screening on 03/15/24, and psychotropic drug use side effects will be part of the plan of care.

R2's "Care Plan" dated 04/04/24 documented R2 took Seroquel (antipsychotic medication) for Parkinson's psychosis. Staff would monitor for potential side effects such as urinary retention, skin changes, slurred speech, mental status, and behavioral changes. Staff would report side effects to the charge nurse for further evaluation.

The "Physician's Order" dated 12/18/23 directed to give Seroquel 50 milligram (mg) tablet once daily for psychotic disorder with delusions.

R2's EMR lacked documentation or evidence of nonpharmacological symptom management interventions that were implemented and failed before starting Seroquel.

On 05/08/24 at 09:41 AM Licensed Nurse (LN) G stated that antipsychotic medications were ok to give to a resident with a dementia diagnosis. She

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stated residents with a diagnosis of psychosis needed antipsychotic medication. LN G stated she would try nonpharmacological interventions first if that was possible.

On 05/08/24 at 12:44 PM Administrative Nurse D stated a nonpharmacological approach would be the best approach. He stated he would do talk therapy, but he had no residents who needed the therapy yet. He stated residents came into the facility on an antipsychotic and the facility tried to get the residents to the lowest dose. Administrative Nurse D stated the facility worked closely with physicians and pharmacists to ensure the resident was on the lowest dose of each medication.

The facility's "Psychotropic Medication Use policy," revised on 07/22 documented that psychoactive medications will not be used for discipline or convenience and will not be used unless necessary to treat medical symptoms. Residents receiving psychoactive medications will be monitored and observed for improvement or decline in functional status, target behaviors, and side effects. For any of the types of antipsychotics, gradual dose reductions and behavioral interventions will be done per physician orders, unless clinically contraindicated in an effect to discontinue the medication or to reach the lowest effective dose. Psychotropic medications are given to treat a specific condition diagnosed and documented in eh clinical record.

The facility failed to ensure nonpharmacological interventions were attempted prior to the administration of an antipsychotic medication for R2, who had a diagnosis of dementia. This placed the resident at risk for unnecessary

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F 758	Continued From page 14 psychotropic medications and related complications.	F 758		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to	F 849		

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provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

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(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those

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residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a

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description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 35 residents. The sample included 12 residents with one resident reviewed for hospice. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider. This deficient practice created a risk for missed or delayed services and impaired care for Resident (R)32.

Findings included:

- R32s Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), hearing loss, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dysphagia (swallowing difficulty).

The "Significant Change Minimum Data Set" (MDS) dated 04/15/24 documented R32 had severely impaired cognition, and never or rarely made decisions. The MDS documented R32 was dependent on two staff assistants for all activities of daily living (ADLs). The MDS documented R32 received hospice services during the observation period.

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R32's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 04/15/24 documented R32 was unable to participate in a Brief Interview of Mental Status (BIMS) assessment; the causes included general decline, advanced age, dementia, and cognitive communication deficit. R32's risk factors include falls, agitation, behaviors, weight loss, and communication.

R32's "Care Plan" dated 04/25/24 documented the facility would coordinate R32's care and services with the hospice provider. The plan of care directed the facility to communicate with hospice regarding R32's preferences, care concerns, and needs. The plan of care documented a nurse would visit weekly to assess for changes, symptoms management, pain, discomfort, dyspnea (difficulty breathing), air hunger, mobility, and skin and recommend and implement changes. The hospice aide was to have one-on-one visits with reading, music, personal hygiene, preventative skin care, eating, drinking, and toileting.

A review of the communication binder provided by the hospice revealed R32 was admitted to hospice services on 04/15/24. The hospice communication binder lacked the plan of care for R32 and the physician-signed terminal diagnosis for admission to hospice. The last documentation of hospice care was dated 05/02/24.

On 05/08/24 at 09:35 AM Certified Nursing Aide (CNA) P stated there were binders in the front halls by the nursing station that contained hospice information. CNA P stated the binders contained R32's care needs. CNA P stated he was unsure what to look for in the binder and stated there

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F 849	Continued From page 20 were tabs with different instructions for nursing staff. On 05/08/24 at 09:41 AM Licensed Nurse (LN) H stated all hospice binders were kept in the cabinet next to the nursing charting station. LN H stated the facility had its care plan for communication of care, and hospice also had a care plan for each resident. R32 ' s care would be found in both care plans. On 05/08/24 at 12:44 Administrated Nurse D stated the facility had care plans for everyone. He stated R32 ' s "Care Plan" was found in medical records; the document had been scanned into his file instead of being put in the hospice binder. Administrative Nurse D stated the facility collaborated with hospice through the care plans. He stated all hospice providers were welcome to attend the weekly care plan meetings. The facility was unable to provide a policy related to hospice services. The facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider. This deficient practice created a risk for missed or delayed services and impaired care for R32.	F 849		
F 883 SS=D	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,	F 883		

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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.

§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

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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:
The facility identified a census of 35 residents. The sample included 12 residents with five residents reviewed for pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to obtain a signed consent or declination for pneumococcal vaccination Prevnar 20 (PCV20) for Resident (R) 2, R25, and R86. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.

Findings included:

- R2's clinical record documented she received Prevnar 13 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 13 serotypes of Streptococcus pneumoniae [bacteria that causes pneumonia]) on 04/01/15 and Pneumovax 23 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 23 serotypes of Streptococcus pneumoniae) on 05/01/17. R2's clinical record lacked evidence she received Prevnar 20 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by

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20 serotypes of Streptococcus pneumoniae) or had a signed declination for Prevnar 20 vaccination.

R25's clinical record documented she received Pneumovax 23 on 01/01/97 and Prevnar 13 on 01/01/16. R25's clinical record lacked evidence she received Prevnar 20 or had a signed declination for Prevnar 20 vaccination.

R86's clinical record documented she received Pneumovax 23 on 01/01/07 and Prevnar 13 on 10/09/18. R86's clinical record lacked evidence she received Prevnar 20 or had a signed declination for Prevnar 20 vaccination.

On 05/08/24 at 10:28 AM, Licensed Nurse (LN) H stated when a resident was admitted to the facility, she asked them about their immunizations and the dates they were immunized or reviewed their admission records for their immunization history. She stated that was all she did with immunizations on admission.

On 05/08/24 at 10:31 AM, Administrative Nurse E stated when a resident was admitted to the facility, if they had received Pneumovax 23 but not the Prevnar 13 or Prevnar 20, the resident was asked if they wanted to receive the vaccination. She stated if a resident had not received Prevnar 20, staff called the physician for immunization verification or to get an order to give the vaccination. She stated the resident or their representative then signed the consent form. Administrative Nurse E stated if the resident or their representative refused the vaccination, they signed a declination.

On 05/08/24 at 10:57 AM, Administrative Nurse E

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stated the facility received the guidance on Prevnar 20 last week but she had heard the guidance was happening, so she started looking at who needed Prevnar 20 in April. She stated the facility received an order for R25 to receive Prevnar 20 on 05/01/24. Administrative Nurse E stated R2 was receiving end-of-life care and the facility did not receive an order to give Prevnar 20 yet.

On 05/08/24 at 01:00 PM, Administrative Nurse D stated Administrative Nurse F was in charge of immunizations. He stated the facility found out about four weeks ago that Prevnar 20 was important and they started working on it two weeks ago. Administrative Nurse D stated the pharmacy informed the facility of new immunization guidance and if corporate received new guidance, they sent it to the facility too.

On 05/08/24 at 01:03 PM, Administrative Nurse F stated when a resident was admitted to the facility, she looked through their immunization record or obtained their records for their immunizations. She stated she reviewed for Prevnar 13 and Pneumovax 23 but the guidance just changed to include Prevnar 20. Administrative Nurse F stated if a resident received Prevnar 13 or Pneumovax 23 over five years ago, it was recommended the resident receive Prevnar 20 with a physician order and family approval. She stated she tried to get consent or declinations within a couple of weeks after admission.

The facility's "Immunization- Pneumococcal" policy, last revised 01/31/22, directed residents were provided the opportunity and were encouraged to receive the pneumococcal

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F 883	Continued From page 25 vaccination(s). The policy directed the facility to provide educational material regarding risks and benefits to residents and obtained the resident's consent for, or refusal of, each pneumococcal vaccination(s). If vaccination status was unknown, the pneumococcal vaccinations were offered upon admission. The facility failed to obtain a signed consent or declination for the PCV 20 for R2, R25, and R86. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.	F 883		