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| {F 000} | INITIAL COMMENTS<br><br>On 12/30/24, an unannounced on-site visit was conducted at Edgewood Rehabilitation and Living Center to follow up on the deficiencies cited at the annual Long Term Care Survey Process for Federal Recertification for 10/17/24. It was determined that Edgewood Rehabilitation and Living Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. | {F 000} | | |
| {F 584} SS=E | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition; | {F 584} | | |

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

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| {F 584} | Continued From page 1<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to maintain adequate housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior for 6 of 19 resident rooms for 1 of 1 environmental tour.<br><br>Findings:<br><br>On 12/30/24 from 11:15 a.m. to 11:30 a.m. an environmental tour was conducted with the Maintenance Director in which the following findings were observed:<br><br>1. Room #2- The walls around the entire room and in the bathroom were marred, chipped, and gouged creating uncleanable surfaces.<br>2. Room #2- Resident #24's Broda Chair had ripped/torn positioning pad for his/her right shoulder.<br>3. Room #3- The standing floor fan was heavily soiled with dust/dirt.<br>4. Room #4- The bathroom had a bed pan stored on the floor by the toilet. The room entrance door | {F 584} | | |

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| {F 584} | Continued From page 2<br>jamb had broken surface protectors.<br>5. Room #11- The walls around the entire room and bathroom were marred and chipped paint on the wall behind the privacy curtain.<br>6. Room #15- The room entrance door jamb had broken surface protectors.<br>7. Room #19- The room entrance door jamb had broken surface protectors.<br><br>On 12/30/24 at 11:30 a.m., in an interview with the Maintenance Director the above information was confirmed. | {F 584} | | |
| {F 655} SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§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-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline | {F 655} | | |

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| {F 655} | Continued From page 3<br>care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§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:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record review, the facility failed to ensure that a baseline care plan was developed and implemented within 48 hours, that included instructions needed to provide minimum healthcare information necessary to properly care for 2 of 5 residents reviewed for new admissions. (Resident #338 and #340)<br><br>1. Resident #338 was admitted to the facility on 12/10/24 with the diagnosis of Malignant Neoplasm of the bladder, Post-Traumatic Stress Disorder, Diabetes, Chronic Obstructive Pulmonary Disease, and Chronic systolic heart failure. His/her baseline care plan was not completed until 12/19/24.<br><br>2. Resident #340 was admitted to the facility on 12/11/24 with the admitting diagnosis of Post | {F 655} | | |

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| {F 655} | Continued From page 4<br>Polio Syndrome, Anxiety, Adult Failure to Thrive, and Pneumonia. His/her baseline care plan was not completed unitl 12/19/24.<br><br>On 12/30/24 at 1:06 p.m., during an interview with the Material Data Set Coordinator the above information was confirmed. | {F 655} | | |
| {F 684} SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy, record review and interviews, the facility failed to complete post fall neurological assessments along with appropriate fall assessments for 3 of 3 residents reviewed for falls (Resident #7, #17, #340).<br><br>Findings:<br><br>Section V. Procedure of the Fall Management Policy (dated 7/2019), subsection E states to, "Complete Post Fall Observation tool, following a fall" and subsection F states "Documentation must be completed in the nurse's note on each shift X3 following the fall".<br><br>The Neurological Assessment Policy (dated 1/2019) states, "Residents with suspected | {F 684} | | |

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| {F 684} | Continued From page 5 | {F 684} | | |

neurological compromise will have a neurological sign monitored and recorded for a minimum of 12 hours". Subsection III Procedures states "A neurological assessment following resident head injury will be completed for all residents sustaining head trauma or suspected head trauma. In EMR: Neuro Checks will be conducted-every 15 minutes x4, every 30 minutes x4, every 1 hr. x4, every 4 hr. x2, and every 8 hr. x1. Frequency of neuro checks after 24 hours is determined by resident's observed signs and symptoms of neurological compromise."

1. Review of Resident #7's medical record revealed that on 11/14/24 he/she had a Brief Interview of Mental Status (BIMS) of 8 of 15, indicating he/she has moderate cognitive impairment.

Review of Resident #7's record indicates he/she sustained an unwitnessed fall on 12/19/24. Further review of the medical record lacked evidence of the facility continuing to monitor him/her for further injuries and/or neurological changes after the unwitnessed fall.

2. Review of Resident #17's quarterly Minimum Data Set (MDS) dated 12/19/24 revealed Resident had a BIMS of 8 of 15, indicating he/she has moderate cognitive impairment.

Review of Resident #17's record shows he/she sustained 2 unwitnessed falls on 12/5/24. Further review of the medical record lacked evidence of the facility continuing to monitor him/her for further injuries and/or neurological changes after the unwitnessed falls.

3. Review of Resident #340's medical record

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| {F 684} | Continued From page 6<br>shows he/she sustained an unwitnessed fall on 12/24/24 resulting in a hematoma to his/her left forehead and left cheek. Further review of his/her medical record lacked evidence of the facility continuing to monitor him/her for further injuries and/or neurological changes after the unwitnessed fall.<br><br>On 12/30/24 at 12:15 p.m., during an interview with the Director of Nursing, the above findings were confirmed. | {F 684} | | |
| {F 689} SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure the resident environment remained as free of accident hazards, related to a patient lift on 1 of 1 units.<br><br>Findings:<br><br>On 12/30/24 at 9:04 a.m., a surveyor observed the Hoyer Lift Reliant 600 in the Long-Term Care hallway, available for use, with 2 missing safety springs. At 9:06 a.m., the Director of Nursing (DON) was notified of the missing springs.<br><br>At 9:11 a.m., 2 surveyors again observed the | {F 689} | | |

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| {F 689} | Continued From page 7<br>hoyer lift in the Long-Term Care hallway available for use, missing the 2 safety springs.<br><br>At 9:16 a.m., 2 surveyors observed CNA #2 with Resident #18 in his/her wheelchair and the hoyer pad underneath him/her. The hoyer pad was attached to the hoyer arms. At this time CNA #3 entered the room to assist with a hoyer transfer. During a brief interview with both surveyors, CNA #2 and CNA #3 discussed only having one hoyer available for use as the other one is currently not working, as the facility is waiting on batteries and were unaware of the safety concerns with the missing springs.<br><br>On 12/30/24 at 9:20 a.m., 2 surveyors spoke with the DON, alerting her to staff currently using the hoyer that has 2 missing safety springs. The DON stated, Maintenance is obtaining the safety clips now and immediately responded intervened with the CNA's.<br><br>On 12/30/24 at 9:25 a.m., during an interview, the DON confirmed the 2 missing safety clips were now in place. | {F 689} | | |
| {F 761} SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals | {F 761} | | |

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| {F 761} | Continued From page 8<br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy, record review and interviews, the facility failed to adequately ensure medications and biologics were monitored and stored at appropriate temperatures in 1 of 1 refrigerator observed and 2 of 2 months of medication refrigerator logs reviewed.<br><br>Findings:<br><br>Facility policy and procedure for "Omnicare Storage and Expiration of Medications, Biologicals, Syringes and Needles", revised 8/1/24 states, "Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance ... refrigeration: 36° to 46°F."<br><br>On 12/30/24 at 2:00 p.m., observation of the Unit A medication storage room refrigerator which contained 33 Novavax Vaccinations (COVID-19) | {F 761} | | |

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| {F 761} | Continued From page 9<br>and 6 Fluzone Vaccinations.<br><br>On 12/30/24 a surveyor reviewed the facilities "Daily Temperature Recording Chart" for the medication refrigerator for the months of November and December.<br><br>1. November 27th through November 30th lacked evidence of twice daily temperature readings for 4 out of the 4 days and temperatures were out of range for 2 out of the 4 days.<br><br>2. December 1st through December 29th lacked evidence of twice daily temperature readings for 12 out of 29 days and temperatures were out of range for 12 out of the 29 days.<br><br>On 12/30/24 at 12:15 p.m., during an interview, the above was confirmed with the Director of Nursing. | {F 761} | | |
| {F 812} SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | {F 812} | | |

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| {F 812} | Continued From page 10<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 1 of 1 kitchen tour and for 1 of 1 survey days (12/30/24). This has the potential to affect all residents.<br><br>Finding:<br><br>On 12/30/24 from 8:30 a.m. to 8:48 a.m., during an initial kitchen tour, a surveyor observed the dish room with a small wall mounted fan that was dirty and heavily soiled with dust.<br><br>On 12/30/24 at 9:05 a.m., during an interview with the Administrator and the Cook, the above finding was confirmed. | {F 812} | | |
| F 867 | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such | F 867 | | |

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information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems

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impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this

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| F 867 | Continued From page 13<br>section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for identified deficiencies from the annual Long Term Care Recertification Survey, dated 10/17/24, was effective. Several issues were again identified during the revisit survey, on 12/30/24.<br><br>Findings:<br><br>During the revisit survey on 12/30/24, it was determined the Federal citations: F584, F655, F684, F761, F812, F883 and F887 would be recited for the same following issues:<br>F584 The POC indicated the facility educated the Maintence and Housekeeping Director and audits to be completed. The facility failed to maintain adequate housekeeping and maintenance | F 867 | | |

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| F 867 | Continued From page 14<br>services to maintain a sanitary, orderly, and comfortable interior.<br>F655 The POC indicated the facility educated the MDS Coordinator regarding appropriate care plannning time frames. The facility failed to ensure that baseline care plans were developed and implemented within 48 hours, that included instructions needed to provide minimum healthcare information necessary to properly care for new admissions.<br>F684 The POC indicated that nursing staff was educted on the Neurological Assessment Policy and Fall Policy. The facility failed to to monitor residents after a fall.<br>F761 The POC indicated that nursing staff was educated on the Pharmacy policies/procedures regarding Medication Storage and appopriate temperatures and the need to record temperatures. The facility failed to adequately ensure medications and biologics were monitored and stored at appropriate temperatures.<br>F812- The POC indicated that the kitchen staff were educated and to complete audits. The facility failed to ensure the kitchen was maintained in a clean and sanitary manner.<br>F883 The facility failed to identify current resisdent who were not offered the vaccine.<br>F887 The POC indicated the Infection Preventionist was educated and current residents were offered the vaccine and educated. The faciliy to educate, offer and/or administer the updated 2024-2025 COVID -19 vaccines to residents.<br><br>On 12/30/24 at 3:45 p.m., the above concerns were discussed with the Administrator and Director of Nursing. | F 867 | | |
| {F 883} SS=E | Influenza and Pneumococcal Immunizations | {F 883} | | |

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| {F 883} | Continued From page 15<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(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;<br>(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;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(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;<br>(ii) Each resident is offered a pneumococcal | {F 883} | | |

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| {F 883} | Continued From page 16 | {F 883} | | |

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 the facility's immunization policy, record review and interview, the facility failed to implement their influenza and pneumococcal immunization policy for 6 of 9 residents whose immunization records were reviewed (#6, #18, #19, #337, #338, #339).

Findings:

The facility's "Immunization Policy" indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine, each resident, and/or resident's legal representative will receive education produced by the Maine and/or Federal Centers for Disease Control regarding the benefits and potential side effects of the vaccines for the current year. The resident's clinical record will include the following documentation: Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal consent may also be

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obtained if communication is done via a telephone conversation. Proof the resident either received the Influenza and/or the Pneumococcal vaccine, the vaccine(s) was contraindicated for medical reasons, or the resident refused the vaccine(s). Each resident will be offered a Pneumococcal Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. Vaccines will be given in accordance with the Maine Center for Disease Control. For Immunocompromised adults aged 65 years or older. A single dose of PCV 20 may be administered or administered 1 dose of PCV 15, if not previously administered, followed by 1 dose of 23 valent pneumococcal polysaccharide vaccine (PPSV23) at a minimum interval of 8 weeks between both doses. The vaccine administration will be documented on the vaccine record in the medication administration record.

The facilities "Immunization Consent Form" adopted 7/2024 states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)" This form allows the resident and/or representative to give or not give consent for the influenza vaccine, Prevnar 20 vaccine (PCV20) and the COVID-19 vaccine.

1. Resident #6's clinical record contained an immunization consent form, signed on 9/25/24, indicating he/she had given permission for the Influenza and COVID vaccines. The medical record lacked evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the PCV 20 vaccine.

2. Resident #18 was admitted to the facility on

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6/19/24. Review of the clinical records lacked evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the PCV 20 vaccine.

3. Resident #19's clinical record contained an immunization consent form, signed on 10/10/24, indicating he/she had given permission for the following vaccines: Influenza, Prevnar 20 and COVID (Coronavirus). Further review states he/she received the Influenza vaccine on 10/21/24 but did not receive the Prevnar 20 vaccine as of his/her discharge of 12/12/24.

4. Resident #337 was admitted to the facility on 12/17/24. Review of the clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the influenza and PCV 20 vaccine as of 12/30/24.

5. Resident #338 was admitted on 12/10/24. Review of the clinical record lacks evidence of a vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the influenza and PCV 20 vaccine as of his/her discharge on 12/20/24.

6. Resident #339 was admitted on 12/10/24. Review of the clinical record lacks evidence of a vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the influenza and PCV 20 vaccine as of his/her discharge on 12/21/24.

On 12/30/24 at 2:15 p.m., during an interview, the Infection Preventionist (IP) confirmed the above,

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| {F 883} | Continued From page 19<br>lack of offering and/or administration of the influenza and/or PCV 20 vaccine. At this time, both the surveyor and the IP reviewed the resident "Immunization Consent Form" which states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)". The Surveyor asked if the VIS sheets with the benefits and side effects are given to the resident and/or representative when she has them sign the immunization consent form. The IP stated she does not provide the VIS sheets. The surveyor asked how the resident and/or representative are educated on the benefits and side effects of the vaccine. The IP stated she does not educate the resident and/or representative. | {F 883} | | |
| {F 887} SS=E | COVID-19 Immunization<br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, | {F 887} | | |

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resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record review, observations and interview, the facility failed to offer the updated 2024-2025 COVID-19 vaccine

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doses for 5 of 5 residents reviewed. (#6, # 7, #18, #19, #21, #337, #338 and #339).

Findings:

The facility's policy, "Policy for Suspected or Confirmed Coronavirus (COVID-19)" revised 5/7/24 indicated under Vaccines: The facility will be required to educate residents and employees on vaccines and offer updated vaccines to all residents.

The facilities "Immunization Consent Form" for the influenza vaccine, Prevnar 20 vaccine (PCV20) and the COVID-19 vaccine, adopted 7/2024 states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)".

1. Resident #6's clinical record contained an immunization consent form, signed on 11/8/23 indicating he/she had refused the COVID-19 vaccine. Upon further review, his/her medical record contained an updated immunization consent form, signed on 9/25/24 indicating he/she had given permission for the COVID-19 vaccine. As of 12/30/24, he/she has not received the 2024-2025 COVID-19 vaccine.

2. Resident #7's last documented COVID-19 vaccination was on 12/21/23. As of 12/30/24, the clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine.

3. Resident #18's clinical record contained an immunization consent form, signed on 9/26/24, indicating he/she had given permission to receive the COVID-19 vaccine. As of 12/30/24, the

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clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine.

4. Resident #19's clinical record contained an immunization consent form, signed on 10/10/24, indicating he/she had given permission for the COVID-19 vaccine. The medical record lacked evidence that he/she was given the 2024-2025 COVID-19 vaccine as of his/her discharge on 12/12/24.

5. Resident #21's clinical record contained a signed immunization consent form indicating he/she had given permission for the influenza vaccine and the COVID-19 vaccine however, lacked a date. Further review states he/she received the Influenza vaccine on 10/17/24. As of 12/30/24, he/she has not received the 2024-2025 COVID-19 vaccine.

6. Resident #337 was admitted to the facility on 12/17/24. As of 12/30/24, the clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine.

7. Resident #338 was admitted on 12/10/24. Review of the clinical record lacks evidence of a vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine as of his/her discharge on 12/20/24.

8. Resident #339 was admitted on 12/10/24. Review of the clinical record lacks evidence of a

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| {F 887} | Continued From page 23<br>vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine as of his/her discharge on 12/21/24.<br><br>On 12/30/24 at 2:00 p.m., 2 surveyors observed 3 boxes of the 2024-2025 COVID-19 vaccines available in the facilities medication refrigerator.<br><br>On 12/30/24 at 2:15 p.m., during an interview, the Infection Preventionist (IP) confirmed the above, lack of offering and/or administration of the 2024-2025 COVID-19. At this time, both the surveyor and the IP reviewed the resident "Immunization Consent Form" which states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)". The Surveyor asked if the VIS sheets with the benefits and side effects are given to the resident and/or representative when she has them sign the immunization consent form. The IP stated she does not provide the VIS sheets. The surveyor asked how the resident and/or representative are educated on the benefits and side effects of the vaccine. The IP stated she does not educate the resident and/or representative and has the 2024-2025 COVID-19 vaccine in house. | {F 887} | | |