STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 02/25/19 and concluded 02/27/19.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		4/5/19

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

Electronically Signed | 03/13/2019

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F 585	Continued From page 1	F 585		

(meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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F 585	Continued From page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on the resident council interview and review of Resident Council meeting minutes, the facility failed to actively seek a resolution to resident grievances related to dietary concerns for 7 of 7 residents (Resident A, B, C, D, E, F, and G) attending the Resident Council interview. Failure to address the residents' concerns in a timely manner resulted in continued dissatisfaction regarding their dietary concerns. Findings include: During the Resident Council interview on the afternoon on 02/26/19, Residents A, B, C, D, E, F, and G stated the food is cold and it takes a	F 585	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section	

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F 585	Continued From page 3 long time to deliver meal trays. The residents also stated staff failed to address dietary concerns and no changes are made. Review of the Resident Council Minutes from January and February 2019 showed: * ". . . Feels food is luke warm and pancakes were cold. . . ." * ". . . [Resident name] still voiced pancakes and French toast are cold at times. . . ." * ". . .Feels food is luke warm. . . ." The facility failed to make prompt efforts to resolve a grievance and to keep the residents appropriately informed of progress toward a resolution.	F 585	7305 of the State Operation Manual. Resident A, B, C, D, E, F and G have had their concerns related to cold food addressed by the Director of Food and Nutrition on 4/5/19. All residents have the potential to be affected by this deficient practice. GSS Resident Group policy and procedure was reviewed by Administrator and Department Heads. Future resident concerns brought forward during resident council meeting will be documented on Concern and Suggestion Form with investigation and follow up at next resident council by appropriate department head. Audits of resident council meeting minutes will be conducted with verification of concern and suggestion form completion, investigation and follow up. Audits will be conducted monthly X3 months, then quarterly X 3 quarters. Audit results will be submitted monthly to QAPI Committee for review and further recommendation if indicated.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		3/27/19

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F 676	Continued From page 4 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and resident interview, the facility failed to provide care and services to maintain or improve abilities in activities of daily living (ADLs) for 1 of 1 sampled resident (Resident #25) care planned for ambulation to meals. Failure of staff to ambulate the resident may result in decreased mobility.	F 676	Resident # 25□s care plan was updated on 3/13/19 to be ambulated TID with walker and assist of 1. All residents have the potential to be affected by this deficient practice. Facility reviewed residents care plans and updated who have a documented walking program in place. All nursing department staff were	

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F 676	Continued From page 5 Findings include: Review of Resident #25's medical record occurred on all days of survey. Diagnoses included altered mental status, osteoporosis, and difficulty in walking. The current care plan stated, ". . . Focus . . . The resident has an ADL self care performance deficit R/T [related to] weakness and needing reassurance . . . Interventions . . . AMBULATION: Walk to meals with FWW [front-wheeled walker] and limited assist of 1 . . ." During an interview on the afternoon of 02/25/19, Resident #25 indicated she is to walk to meals with a staff member and her walker, but staff do not always have time. She stated, "If they're not short staffed [they walk me to meals]." The resident also stated she gets "a little upset," and "I haven't walked yet today." Observation on 02/25/19 of the afternoon snack (approximately 2:00 p.m.) and evening meal (approximately 5:00 p.m.) showed Resident #25 self-propelled in her wheelchair to and from the dining room without ambulation assistance from staff. Observation on 02/26/19 of the morning meal (approximately 11:00 a.m.) and afternoon snack showed Resident #25 self-propelled in her wheelchair to and from the dining room without ambulation assistance from staff. On 02/26/19 at 4:29 p.m., observation showed Resident #25 in her wheelchair, self-propelling to the evening meal. She indicated she had not walked today, and stated, "I should have asked somebody but they're so busy."	F 676	re-educated by D.N.S on 3/20/19 or prior to their next scheduled shift on assisting residents with ADLs and assisting them in achieving or maintaining their highest level of function, C.N.A to nurse communication and completing an alert for care plan review if appropriate, updating care plan to meet resident□s needs, and C.N.As directed to look at resident kardex in kiosk at beginning of shift and to provide care as per care plan. Audits of the PCC documentation and observation of cares related ambulation/walking with residents on walking program will be completed on random sample of 4 residents with each audit. Audits will be done by DNS or designee twice weekly for 4 weeks than 1 time / week for 8 weeks. Audit results will be submitted monthly to QAPI Committee for review and further recommendation if indicated.	

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F 676	Continued From page 6 Observation on the morning of 02/27/19 showed an unidentified certified nursing assistant (CNA) assisted Resident #25 to ambulate to the morning meal using a walker. During an interview on the afternoon of 02/27/19, a supervisory nurse (#1) confirmed Resident #25 should walk to meals, but does not always wait for staff to assist her.	F 676		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		3/27/19

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F 756	Continued From page 7 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to ensure the consultant pharmacist reported drug regimen irregularities for 1 of 4 sampled residents (Resident #4) selected for drug regimen review. Failure to report drug regimen irregularities may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Psychotropic Medications" occurred on 02/27/19. This policy stated, ". . . Gradual Dose Reductions . . . Other Psychotropic Medications . . . After the first year, tapering should be attempted annually unless clinically contraindicated . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included unspecified dementia, bipolar disorder, and anxiety disorder. Current physician's orders included lorazepam (Ativan, an anxiolytic) 0.5	F 756	Resident # 4□s medical record was reviewed by consulting pharmacist on 3/7/19. The DNS and physician were notified of recommendations related to psychotropic use. No changes were made, documentation stating no GDR. All residents on psychotropic medications have the potential to be affected by this deficient practice. Medical record review completed and no other residents were out of compliance with gradual dose reduction. Consulting Pharmacist, Social Services, and DNS were re-educated on GSS Medication Regimen Review and Psychotropic Medication Policy and Procedures. The GSS Medication Regimen Review summary report will now be completed monthly and submitted to the QAPI Committee for review and further recommendations. Consulting pharmacist monthly regime review reports and monthly summary will be audited by Social Work Director or	

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F 756	Continued From page 8 milligrams (mg) at bedtime and 0.25 mg daily. A nurse's note, dated 01/17/18, stated, ". . . Communication/Visit with Physician . . . Upon looking at medication will try gradual dose reduction to lorazepam to 0.25 mg every AM and 0.5 mg every evening. No other changes at this time." Monthly pharmacy reviews since January 2018 showed the pharmacist failed to identify and recommend an annual GDR for Resident #4's Ativan.	F 756	Designee verifying DNS and Physician notification. Audits will be completed monthly X3 months, then quarterly X 3 quarters. Audit results will be submitted to QAPI Committee for review and further recommendation if indicated.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §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	F 758		3/27/19

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F 758	Continued From page 9 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 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: Based on record review and review of facility policy, the facility failed to ensure residents on psychotropic medications received a gradual dose reduction (GDR) for 1 of 4 sampled residents (Resident #4) selected for medication regimen review. Failure to attempt a GDR (or identify contraindications for a GDR) may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include:	F 758	Resident # 4□s medical record was reviewed by consulting pharmacist on 3/7/19 The DNS and physicians were notified of recommendations related to psychotropic use, documentation stating no GDR. All residents on psychotropic medications have the potential to be affected by this deficient practice. Medical record review completed and no other residents were out of compliance with gradual dose reduction. Consulting Pharmacist, Social Services,	

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F 758	Continued From page 10 Review of the facility policy titled "Psychotropic Medications" occurred on 02/27/19. This policy stated, ". . . Gradual Dose Reductions . . . Other Psychotropic Medications . . . After the first year, tapering should be attempted annually unless clinically contraindicated . . . Tapering is considered clinically contraindicated if: 1) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability . . . or 2) The resident's target symptoms returned or worsened after the most recent attempt at a gradual dose reduction within the location and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included unspecified dementia, bipolar disorder, and anxiety disorder. Current physician's orders included lorazepam (Ativan, an anxiolytic) 0.5 milligrams (mg) at bedtime and 0.25 mg daily. A nurse's note, dated 1/17/2018 at 1:13 p.m., stated, ". . . Communication/Visit with Physician . . . Upon looking at medication will try gradual dose reduction to lorazepam to 0.25 mg every AM and 0.5 mg every evening. No other changes at this time." The medical record/physician's progress notes lacked evidence of an annual GDR attempt (or contraindications) related to the use of Ativan since January 2018.	F 758	and DNS were re-educated on GSS Medication Regimen Review and Psychotropic Medication Policy and Procedures. The GSS Medication Regimen Review summary report will now be completed monthly and submitted to the QAPI Committee for review and further recommendations. Consulting pharmacist monthly regime review reports and monthly summary will be audited by Social Services Director or Designee verifying DNS and Physician notification. Audits will be completed monthly X3 months, then quarterly X 3 quarters. Audit results will be submitted to QAPI Committee for review and further recommendation if indicated.	

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F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident council minutes, and resident council interview, the facility failed to serve foods at palatable temperatures for 1 of 2 meals observed (Supper 02/27/19). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the Resident Council Minutes from January and February 2019 showed: * ". . . Feels food is luke warm and pancakes were cold. . . ." * ". . . [Resident name] still voiced pancakes and French toast are cold at times. . . ." * ". . . Feels food is luke warm. . . ." During the Resident Council interview on the afternoon on 02/26/19, Residents A, B, C, D, E, F, and G stated the food is cold and it takes a long time to deliver meal trays. The residents also stated staff failed to address dietary concerns and no changes are made.	F 804	Resident A, B, C, D, E, F and G have had their concerns related to cold food addressed by the Director of Food and Nutrition. All residents have the potential to be affected by this deficient practice. GSS Resident Group policy and procedure was reviewed by Administrator and Department Heads. Future resident concerns brought forward during resident council meeting will be documented on Concern and Suggestion Form with investigation and follow up at next resident council by appropriate department head. Dietary staff will be re-educated by Director of Food and Nutrition on GSS Food Temperature Policy and Procedure, education on steam table assembly and dietary staff will take and pass the GSS Online safe food handling training course. Dietary staff responsible for serving food with has Food Temperature Competency completed with accuracy by 3/15/19. Audits of food temperature logs for	4/5/19

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	355097	A. BUILDING _____ B. WING _____	02/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

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F 804	Continued From page 12 The surveyors received a supper test tray on 02/27/19 at approximately 5:40 p.m. The test tray consisted of meat loaf, sweet potatoes, and peas. 3 of 3 surveyors confirmed the food failed to maintain a palatable temperature. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804	documented temperatures, visual observation of temping food, and asking residents about palatability of food will be conducted by Dietary Manager or Designee 2 meals weekly X 4 weeks, then one meal weekly X 8 weeks, then one meal quarterly X 3 quarters. Audit results will be submitted to the QAPI Committee for review and further recommendation if indicated.	
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, 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	F 883		4/3/19

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F 883	Continued From page 13 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 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 policy review, review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, record review, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or legal representatives regarding the benefits and potential side effects of receiving the vaccination for 3 of 5 sampled residents (Resident #9, #10	F 883	GSS-Larimore realizes the importance to offer and receive pneumococcal (PPSV23 and PCV13) vaccination for residents. GSS Immunization Policy and procedure was reviewed. Resident # 9, 10, and 23 Immunizations were ordered and will be offered once received. All residents have the potential to be affected by this deficient practice. All	

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F 883	Continued From page 14 and #23) reviewed for immunization status. Failure to implement a process to offer pneumococcal vaccine to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contact pneumonia and also spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "IMMUNIZATIONS FOR RESIDENTS" occurred on 02/27/19. This policy, revised November 2016, stated, ". . . Upon admission, each resident and/or resident representative will receive the Vaccine Information Statement (VIS) for influenza and pneumococcal vaccines. Discuss the benefits and potential side effects of vaccinations with the resident and/or resident representative. . . . If the resident and/or representative consent to vaccinations for pneumococcal and annual influenza, follow the procedures below. Obtain written consent if required by state regulations. Scan the signed consent into Resident Spaces using the indexing category for Consent for Immunizations (Inside). . . . The Vaccination Information Statements can also be found on the Centers for Disease Control and Prevention (CDC) website: . . . www.cdc.gov/vaccines/hcp/vis/index.html. . . ." Review of the CDC: Vaccination Information Statements webpage (https://www.cdc.gov/vaccines/hcp/vis/index.html), last updated October 12, 2018, stated, " . . . Pneumococcal conjugate vaccine (called PCV 13) protects against 13 types of pneumococcal	F 883	current residents medical record was reviewed for documentation of education, consent and administration of pneumococcal vaccination. Licensed nurses received re-education on GSS Immunization Policy and Procedure. Pneumococcal immunization will be included in all new residents admission orders. All new residents will be provided education on immunizations. If consent obtained, the pneumonia immunization will be administered as per policy and procedure. Refusals will be documented. Immunization record audit will be completed on all residents reviewing for documentation of education, consent and administration or refusal. Audit will include verification of pneumococcal vaccination physician order. Audits will be completed by DNS or designee 1 X / week for 4 weeks, every other week for 2 months, then quarterly X 3 quarters. Audit results will be submitted to QAPI Committee for review and further recommendation if indicated.	

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F 883	Continued From page 15 bacteria . . . is also recommended . . . for all adults 65 years of age and older . . . Your doctor can give you details. . . . Pneumococcal polysaccharide vaccine (PPSV 23) protects against 23 types of pneumococcal bacteria. . . . PPSV23 is recommended for: . . . All adults 65 years of age and older . . . Your healthcare provider can give you more information about these recommendations. . . ." - Review of Resident #9's medical record occurred on 02/27/19. The record showed Resident #9, admitted on 05/29/18, received the PPSV23 vaccine on 01/19/16 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PCV13 immunization and/or provided education to the resident and/or legal representative. - Review of Resident #10's medical record occurred on 02/27/19. The record showed Resident #10, admitted on 03/01/18 received the PCV13 vaccine on 09/15/17 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PPSV23 immunization and/or provided education to the resident and/or legal representative. - Review of Resident #23's medical record occurred on 02/27/19. The record showed Resident #23, admitted on 12/31/15, received the PPSV23 vaccine on 12/20/15 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for PCV13 immunization and/or provided education to the resident and/or	F 883		

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F 883	Continued From page 16 legal representative. During an interview on 02/27/19 at 3:58 p.m., an administrative nurse (#2) confirmed the facility failed to assess and educate residents and/or legal representatives regarding immunizations for pneumococcal vaccinations. The facility failed to implement a process to ensure each resident was assessed, offered pneumococcal vaccinations, and provide education to the residents and/or their legal representative.	F 883		