STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	11/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(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 11/25/19 and concluded 11/27/19.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post preceding years of survey results with plans of correction or post a notice of	F 577	1. In order to meet the requirements of 483.10, NCC will post the results of the current and three preceding surveys in a	1/1/20

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

Electronically Signed | 12/18/2019

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F 577	Continued From page 1 the availability of the survey results for residents, family members, and/or legal representatives for 3 of 3 days of survey. Failure to post or make available the Health and Life Safety Code survey results for the prior three years is an infringement of the residents' rights. Findings include: Observations on November 25-27, 2019 showed the recent Life Safety Code survey, completed on 09/18/19 and Federal/State Health survey completed on 11/15/18, posted on a bulletin board located in the resident dining hallway. The facility failed to include the Life Safety Code and Federal/State Health surveys from 2016 and 2017 or post a notice of their availability. During an interview on 11/27/19 at 11:29 a.m., an administrative staff member (#1) acknowledged the facility had not posted the preceding years of 2016 and 2017 Health and Life Safety Code survey results or a notice of their availability.	F 577	place readily accessible to residents, family members, and legal representatives of the residents. 2. All residents, family members and resident representatives will have access to the current and three preceding years surveys. 3. The current years' survey will be posted on the bulletin board in the resident dining hallway. The previous three year's surveys will be displayed in a binder next to the bulletin board located in the resident dining hallway. 4. Monitoring of the availability of the surveys will be monitored monthly by the facility administrator. The administrator will report the results in both the monthly QA meeting and board of directors meeting. 5. Completion date: 1-1-2020	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 12 sampled residents (Resident #3 and #28) and 1	F 641	NCC will provide accurate entry for resident's status. 1. Accurate assessments for resident #3, #28 and #29 will be updated. Assessment dated 8/15/19 for resident #3, section N, N0410 is modified and updated. Assessment dated 11/20/19 for	1/1/20

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F 641	Continued From page 2 supplemental resident (Resident #29). Failure to accurately complete Section K (Swallowing/Nutritional Status) and Section N (Medications) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI User's Manual, revised October 2018, page K-5-6 stated, ". . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available . . . Code 2, yes, not on physician prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days and the weight loss was not planned and prescribed by a physician . . ." - Review of Resident #28's medical record occurred on all days of survey. The resident's current MDS, dated 11/06/19, identified weight loss. Resident #28's weight at the time of the MDS was 169 pounds (lbs.) (One month prior, on 09/05/19, Resident #28's weight was 172.0 lbs (a loss of 1.8%, not significant). Six months prior, on 05/10/19, Resident #28's weight was 180.0 lbs (a loss of 6.7%, not significant). - Review of Resident #29's medical record	F 641	resident #29,section K, K0300 is modified and updated. Assessment dated 11/06/19 for resident #28, section K, K0300 is modified and updated. 2. All resident will have accurate assessments. 3. I have educated myself (MDS Coordinator) on tag F641 and have made the needed and necessary updates. I have familiarized myself with the corrections for F641 and how to complete the assessments in the future without errors. I have informed the dietary manager and the charge nurse who assist with the MDS of these errors and we have reviewed/discussed ways to avoid these errors in the future. Reviewed sections N0410 and K0300 and the definitions in the RAI manual. 4. NCC will monitor residents #3, #28, and #29 in addition to a random sample of NCC residents that their MDS assessments are completed/coded accurately monthly for 3 months and then quarterly by the dietary manager and MDS coordinator. The QA data will be reported to and reviewed by the QA committee and board of directors. 5. Completion date 1/1/2020.	

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F 641	Continued From page 3 occurred on all days of survey. The resident's current MDS, dated 11/07/19, identified weight loss. Resident #29's weight at the time of the MDS was 208 lbs. (One month prior, on 10/09/19, Resident #29's weight was 213.0 lbs (a loss of 2.4%, not significant). Six months prior, on 05/10/19, Resident #29's weight was 222.0 lbs (a loss of 6.4%, not significant). SECTION N: MEDICATION The Long-Term Care Facility RAI User's Manual, revised October 2018, page N-6 and N-7, stated, ". . . Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)." - Review of Resident #3's medical record occurred on all days of survey. An annual MDS, dated 08/15/19, identified an anticoagulant administered on seven days of the seven day look back period; however, the resident's medical record lacked evidence of anticoagulant administration during that time. During an interview on 11/27/19 at 10:50 a.m., an administrative nurse (#6) agreed she failed to code the above sections of the MDS accurately.	F 641		
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-	F 686		1/1/20

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F 686	Continued From page 4 (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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #80) with a pressure ulcer. Failure to routinely assess, monitor, and measure pressure ulcers and ensure appropriate treatment may result in delayed healing of a pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcer Stages and Intervention" occurred on 11/27/19. This undated policy stated, ". . . All stage 2 and greater pressure ulcers will result in documenting in [name of electronic medical record] program for that resident on a weekly basis using the NCC [Napoleon Care Center]-weekly observation tool. . . . " The NCC Wound - Weekly Observation Tool included the following instructions: "To be completed by a Licensed Nurse on each wound weekly. . . . Use the following definitions for staging of pressure ulcers: . . . Stage II - Partial thickness loss of dermis presenting as a	F 686	NCC will provide comprehensive assessments of our residents to ensure the residents receive care consistent with professional standards, to prevent pressure ulcers, and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. 1. Comprehensive pressure ulcer assessments will be completed weekly for resident #80. 2. All residents who develop pressure ulcers will have comprehensive ulcer assessments completed weekly. 3. Education was provided to nurses, CNA's, and CMA's on December 17, 2019 and December 18, 2019 on our pressure ulcer policy and standing order guidelines on pressure ulcer care. FNP was educated by DON re: he is to notify the charge nurse and DON if he is dictating that a wound is a pressure ulcer, and if the pressure ulcer stage is worsening on his assessment, so appropriate treatment is put into place. 4. NCC will monitor resident #80 in	

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F 686	Continued From page 5 shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. . . . Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. . . . VISIBLE TISSUE . . . Epithelial tissue present (pink) . . . Granulation tissue present (beefy red) . . . Slough tissue present (yellow, tan, white, stringy) . . ." Observation on 11/25/19 at 5:20 p.m. showed a certified nurse aide (CNA) (#4) provided Resident #80 perineal cares while in bed. Observation showed an ulceration to the subcutaneous tissue in the area between the right buttock and the right upper posterior thigh, approximately the size of a quarter (2.5 centimeters), with a tan base and dark pink wound edges. The CNA applied a moisture barrier cream and a 2x2 gauze to the ulcer and placed pillows under the resident's legs. Review of Resident #80's medical record occurred on all days of survey. A FNP's [Family Nurse Practitioner] progress note, dated 10/08/19, stated, ". . . this resident [#80] is refusing repositioning while in bed as well as depends [incontinent brief] change at night. She has a small pressure ulcer below her right buttock cheek. . . ." An order, dated 10/08/19, stated, "[Brand of moisture barrier cream] ointment twice daily to skin cracks in the crack of her buttock until healed. . . ." The care plan, dated 10/14/19, stated, "SKIN: The resident has Actual impairment to skin integrity of the Right buttock as of 9/17/19. . . .	F 686	addition to a random sample of other residents diagnosed with pressure ulcers for proper comprehensive weekly assessments and appropriate pressure ulcer treatment is in place weekly x 4 (starting in December), then monthly x 3, then quarterly by an office nurse or QA coordinator. When QA data is being collected if any concerns arise they will be directed to the DON to address by reviewing/re-educating necessary staff. The QA data will be reported to and reviewed by the QA committee and board of directors. 5. Completion date 1/1/2020.	

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F 686	Continued From page 6 Follow facility protocols for treatment of injury. . . . Identify/document potential causative factors and eliminate/resolve where possible. . . . Provide treatment for skin breakdown per provider orders & as needed. . . . Res. [resident] is to be assisted out of w/c [wheelchair] and repositioned in bed 1-2 times a day as she is not able to complete consistent full or partial weight shifts for pressure relief and has a history of skin breakdown on her seated surface. . . ." The care plan, dated 11/13/19, stated, "PRESSURE ULCER: The resident has (Stage 2) pressure ulcer (R [right] lower buttock) r/t [related to] disease process, Hx [history] of ulcers, Immobility . . . Administer treatments as ordered and monitor for effectiveness. . . . Assess/record/monitor wound healing per facility policy. . . . Avoid positioning the res. incontinence product on the right buttock wound. . . . Follow facility policies/protocols for the prevention/treatment of skin breakdown. . . . The resident needs to turn/reposition at least every 4 hours, more often as needed or requested. Res. has refused 2 hours repositioning as per facility policy. . . . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. . . ." Resident #80's nurses' notes or assessments showed the following: * 09/17/19 at 5:30 p.m., The nurse noted "2 very superficial open areas each measuring approximately 0.3 cm [centimeters] with red scratch like areas surrounding area" to the base of the right buttock. * 9/25/19 at 11:37 a.m., ". . . lower right buttock	F 686		

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F 686	Continued From page 7 crease skin conts [continues] to be sore and open 0.5cm oval shape . . ." * 10/09/19 at 9:53 a.m., "NURSING MEASURE: SKIN NOTE REQUIRED WEEKLY TO ASSESS LOWER R BUTTOCK CREASE SKIN BREAKDOWN NOTED ON 9/17/19. . . . sore to crease of buttocks and thigh conts to be present unchanged in condition, pink center, no surrounding redness noted, no drainage. [Name of moisture barrier cream] applied . . ." The nurse failed to measure and stage the wound, now identified as a pressure ulcer by the FNP. * 10/16/19 8:16 a.m., "NURSING MEASURE: SKIN NOTE REQUIRED WEEKLY TO ASSESS LOWER R BUTTOCK CREASE SKIN BREAKDOWN NOTED ON 9/17/19. . . . opening appears deeper with pink/yellow center no surrounding redness, no pain with cleansing, [name of moisture barrier cream] and 2x2 applied." The nurse failed to measure the pressure ulcer. * 10/23/19 12:09 p.m., ". . . Right upper posterior aspect of thigh area continues to be monitored for further breakdown due to res persistent resistance to cares/repositioning. Area is chronically scarred in nature with no s/s [signs or symptoms] of infection. [Name of moisture barrier cream] applied w/ [with] cares, along w/continued monitoring." The nurse failed to measure the pressure ulcer. * 10/30/19 7:29 a.m., "NURSING MEASURE: SKIN NOTE REQUIRED WEEKLY TO ASSESS LOWER R BUTTOCK CREASE SKIN BREAKDOWN NOTED ON 9/17/19. . . . Sore to right buttocks is worsening in condition, deeper, more fleshy, with serosanquineous [sic] drainage, no pain with cleansing wound, resident with minimal feeling in area, does not want to listen to	F 686		

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F 686	Continued From page 8 staff about laying on side instead of back, wound in crease of buttock and thigh. Informed staff to leave brief elastic out of area." The nurse failed to measure the pressure ulcer. * 11/07/19 at 9:00 p.m., [returned from two day hospital stay] ". . . When this nurse asked to do a skin assessment she stated ,'I refuse' repeatedly. . . . she does get a bath tomorrow. Will continue to monitor." * 11/11/19 at 10:00 a.m., "FNP shown the sore to right buttock thigh area which is healing and with decreased depth serousy drainage small amount. orders recd [received] to reposition resident q [every] 4hours while in bed. [Name of resident] informed FNP 'I am not turning at night and you can't make me,' also to continue using the [name of moisture barrier cream] and 2x2's and having it changed q4 hours and PRN [as needed]." The nurse failed to measure the pressure ulcer from November 8-11 after the resident's refusal on the 7th. * 11/13/19 at 10:04 a.m. and 11/21/19 at 1:04 p.m., On both dates, a nurse completed the NCC Wound - Weekly Observation Tool and identified a facility-acquired Stage 2 pressure ulcer to the right buttock/thigh area, which originated as a Stage 2 pressure ulcer on 10/08/19, with unchanged appearance with moist epithelial tissue present (pink), small amount serous drainage, measuring length of 1.8 cm, width of 2.0 cm and depth of 0.2 cm, with no tunneling or undermining and white periwound tissue with no redness, and evaluated the pressure ulcer as "healing." The facility lacked data to ensure the pressure ulcer was "healing" based on the assessments from November 13-21, 2019, as the facility failed	F 686		

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F 686	Continued From page 9 to obtain measurements for the five-week period from October 8 - November 13 to compare to the ulcer's current status. During an interview on 11/26/19 at 4:00 p.m., an administrative nurse (#3) stated the resident's skin issue on the right buttock started as an abrasion, and when the nurse practitioner (NP) assessed the area on 10/08/19, the NP called the wound a pressure ulcer. On 11/27/19 at 7:55 a.m., the nurse (#3) agreed the moisture barrier cream was not an appropriate treatment for this pressure ulcer and the nurses should have done full assessments of the wound when the facility determined the wound was a pressure ulcer versus an abrasion.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interview, the facility failed to provide adequate assistance for 1 of 3 sampled residents (Residents #17) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift, including use of the leg strap, placed Resident #17 at risk of experiencing pain/discomfort and/or possible accidents with/without injury.	F 689	NCC will ensure our resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. 1/2. NCC will provide adequate assistance and ensure proper use of the sit to stand lift, including the use of the leg strap. Resident #17-has passed away at	1/1/20

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F 689	Continued From page 10 Findings include: Review of the facility policy titled "Policy for Mechanical Standing Lift Use" occurred on 11/27/19. This policy, dated August 2019, stated, ". . . 2. Proper use of sit to stand mechanical lift: a. Apply the harness to the resident. b. Pull the lift up to the resident, place their feet on the foot plate. c. Attach the harness straps to the lift. d. Strap resident legs on the foot plate with the foot strap [strap legs to the shin support pad with the leg strap]. . . ." Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . ADLS [activities of daily living]: The resident has an ADL self-care performance deficit r/t [related to] Confusion, . . . [history of] TIAs [transient ischemic attacks], Impaired balance . . . TRANSFER/AMBULATION: The resident requires Mechanical Lift [brand name] with (1) staff assistance for ALL transfers. Left hand weakness d/t [due to] CVA [cerebral vascular accident] 2017. W/C [wheelchair] PRIMARY as res. [resident's] legs become weak. . . ." Observation on 11/25/19 at 5:30 p.m. showed a certified nurse aide (CNA) (#2) wheeled Resident #17 into the bathroom. The CNA applied a sit-to-stand mechanical lift harness and chest safety strap to the resident and lifted the resident out of the wheelchair. The resident failed to support herself on her legs which resulted in her body bent at an angle at the waist with her arms horizontal to the floor, elbows bent and pointed upward, and her lower legs pulled away from the	F 689	this time, all residents will have adequate assistance and proper use of the sit to stand lift, including the use of the leg strap. 3. Education was provided by reviewing the policy on mechanical lift transfers to the nurses, CMA's, and CNA's at the staff meetings on December 17, 2019, and December 18, 2019. 4. Due to resident #17 passing away, NCC will monitor a random sample of residents who use the sit to stand lift for proper transfers including the use of the leg strap weekly x 4 (starting in December) then monthly x3, then quarterly by an office nurse or QA coordinator. When QA observations/data is being collected any concerns will be reported to the DON to address with staff by re-educating/reviewing the mechanical lift transfer policy as needed. The QA data will be reported to and reviewed by the QA committee and board of directors. 5. Completion date 1/1/2020.	

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(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 689	Continued From page 11 shin support pad. The CNA (#2) failed to apply the leg strap to secure Resident #17's legs to the shin support pad. The CNA lowered the resident on the toilet. When the resident finished, the CNA cued her to hold the lift handles, raised the resident with the mechanical lift from the toilet to a half-way sitting/standing position, therefore bearing no weight, with her arms straight out from her sides and her elbows bent and pointed upward. The resident was unable "to stand nice and tall" as the CNA instructed. The CNA (#2) completed perineal cares and transferred Resident #17 into her wheelchair. Observation showed the leg strap unused. During an interview on 11/27/19 at 7:50 a.m., a nurse administrator (#3) stated staff are to use the leg strap with a stand-lift transfer per protocol.	F 689		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		1/1/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	11/27/2019

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F 883	Continued From page 12 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 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:	F 883		

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F 883	Continued From page 13 Based on record review, review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccination for 4 of 4 sampled residents (Resident #3, #5, #12, and #17) and 1 supplemental resident (Resident #6) reviewed for immunization status. Failure 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 CDC: Vaccines and Preventable Diseases webpage(https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html), last reviewed December 6, 2017, stated, ". . . CDC recommends pneumococcal vaccination (PCV13 or Prevnar13, and PPSV23 or Pneumovax23) for all adults 65 years or older: Give a dose of PCV13 to adults 65 years or older who have not previously received a dose. Then administer a dose of PPSV23 at least 1 year later. If the patient already received one or more doses of PPSV23, give the dose of PCV13 at least 1 year after they received the most recent dose of PPSV23. . . ." - Review of Resident #3's medical record	F 883	NCC will develop policies and procedures to ensure that each resident is offered the pneumococcal immunizations according to CDC recommendations. 1. NCC will offer the Prevnar 13 booster immunization to resident #3, #5, #12 if they meet the CDC guidelines. (resident #17- has passed away) 2. NCC will offer the Prevnar 13 booster immunization to all residents who meet the CDC guideline. 3. NCC will update the influenza/pneumococcal vaccine policy to include the Prevnar 13 booster guideline. Education will be provided to all existing residents (who meet the guideline) and their representatives, if consent is received, the immunization will be administered. Upon new NCC admissions, it will be the policy to offer and follow the CDC recommendations of the Pneumococcal 23 and Prevnar 13 vaccines. 4. NCC will review resident #3, #5, and #12's medical record that education was provided if they meet the CDC guidelines and the Prevnar 13 booster was given if consent was obtained. A random sample of new admissions will have a chart review that the CDC recommendation of pneumococcal vaccine administration was followed correctly monthly x 3, then quarterly by an office nurse or QA coordinator. If any concerns arise during data collection it will be reported to the DON so staff can be re-educated as needed. The QA data will be reported to	

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F 883	Continued From page 14 occurred on 11/24/19. The resident was admitted in February 2018. The record showed Resident #3 received the PPSV23 vaccine on 12/31/15 (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 their legal representative. - Review of Resident #5's medical record occurred on 11/24/19. The resident was admitted in March 2015. The record showed Resident #5 received the PPSV23 vaccine on 03/10/15 (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 their legal representative. - Review of Resident #6's medical record occurred on 11/24/19. The resident was admitted in September 2018. The record showed Resident #6 received the PPSV23 vaccine on 09/04/18 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 their legal representative. - Review of Resident #12's medical record occurred on 11/24/19. The resident was admitted in August 2018. The record showed Resident #12 received the PPSV23 vaccine on 03/01/18 (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 their legal representative.	F 883	and reviewed by the QA committee and board of directors. 5. Completion date 1/1/2020.	

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F 883	Continued From page 15 - Review of Resident #17's medical record occurred on 11/24/19. The resident was admitted in June 2019. The record showed Resident #17 received the PPSV23 vaccine on 10/03/16 (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 their legal representative. The facility failed to follow the CDC recommendations for pneumococcal vaccine administration. During an interview on 11/27/19 at 10:40 a.m., two administrative nurse (#3 and #5) verified the facility failed to assess residents for pneumococcal immunization and/or follow the CDC recommendations for the pneumococcal vaccinations.	F 883		