STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. BUILDING _____ B. WING _____	C 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

(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 A recertification survey was conducted by Healthcare Licensing and Surveys from 1/21/25 through 1/24/25. Also reviewed in the course of the survey were complaint intakes WY00003985, WY00004034, WY00004129, WY00004170, and WY00004180. The following common abbreviations are used throughout this document: CDC: Centers for Disease Control and Prevention BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F-623** **Notice Requirements Before Transfer/Discharge** **CFR(s): 483.15(c)(3)-(6)(8)** This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer for 1 of 2 sample residents (#4) reviewed for facility-initiated transfers. Corrective Action(s):	03/14/2025
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623	1)The Nursing Home Administrator has implemented a system for sending the notice of bed-hold notice to the resident or resident representative upon transfer. Nursing will notify the resident or resident representative verbally prior to the transfer and then send a physical copy of the forms. 2)Upon nursing staff initiating the Leave of Absence (LOA) in the Electronic Health Record (EHR), the Social Worker will be notified through the EHR of the LOA. Once alerted, the Social Worker will provide copies of the notices to the records department to be maintained in the EHR. As a backup, the Social Worker will follow up with nursing staff on the next business day to ensure the forms were sent.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine Szymanski	SNF Administrator	2/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623	**F-623 (Con't)** **Notice Requirements Before Transfer/Discharge** **CFR(s): 483.15(c)(3)-(6)(8)** 3)The facility completed an audit of all other resident records, and no other residents were affected by this practice from 2024 through the present. 4)The facility has reviewed the policy and processes related to Notice Requirements before Transfer/Discharge. 5)Nursing staff and Social Worker involved in this process were re-educated on their respective roles and responsibilities on 2/13/2025. How the Facility Will Identify Other Residents Being Affected: The Social Worker audited all other resident records and no other residents were affected by this practice. Measures to be Put into Place: The Nursing Home Administrator has implemented a system for sending the notice of bed-hold to the resident or resident representative upon transfer. Nursing will notify the resident or resident representative verbally prior to the transfer and then send a physical copy of the forms.	

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F 623	Continued From page 2 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 623	**F-623 (Con't)** **Notice Requirements Before Transfer/Discharge** **CFR(s): 483.15(c)(3)-(6)(8)** Upon nursing staff initiating the Leave of Absence (LOA) in the Electronic Health Record (EHR), the Social Worker will be notified through the EHR of the LOA. Once alerted, the Social Worker will provide copies of the notices to the records department to be maintained in the EHR. As a backup, the Social Worker will follow up with nursing staff on the next business day to ensure the forms were sent. Monitoring and Tracking: The Social Worker will conduct audits on the LOA tracking document twice monthly for three months. The results of these audits will be presented to and reviewed by the QAPI committee bi-monthly to determine progress and address any compliance issues. Responsible Person(s): Nursing Home Administrator, Director of Nursing, and Social Worker.	

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F 623	Continued From page 3 Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer for 1 of 2 sample residents (#4) reviewed for facility-initiated transfers. The findings were: 1. Review of a 12/16/24 nurse progress note showed resident #4 was transferred to the hospital for an acute change of condition. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative. 2. Interview with the social services director on 1/24/25 at 10:51 AM revealed she was unable to locate the transfer notice. 3. Review of the 10/28/24 Transfer or Discharge; notice of; Appealing and Emergency Discharge policy showed "...When a resident is temporarily transferred on an emergency basis to an acute care facility, the Social Worker, designee, or Nurse will provide verbal confirmation of transfer to the resident and family member or legal representative immediately or as soon as practicable. The resident and/or representative will also be notified by the Social Worker or designee in writing (i.e., a completed Notice of Resident Transfer or Discharge form) ..."	F 623	**F-625** **Notice of Bed Hold Policy Before/Upon Transfer** **CFR(s): 483.15(d)(1)(2)** This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide written information on the bed-hold policy for 1 of 2 sample residents (#4) reviewed for facility-initiated transfers. Corrective Action(s): 1) The Nursing Home Administrator has implemented a system for sending the notice of bed-hold to the resident or resident representative upon transfer. Nursing will notify the resident or resident representative verbally prior to the transfer and then send a physical copy of the form. 2) Upon nursing staff initiating the Leave of Absence (LOA) in the Electronic Health Record (EHR), the Social Worker will be notified through the EHR of the LOA. Once alerted, the Social Worker will provide copies of the notices to the records department to be maintained in the EHR. As a backup, the Social Worker will follow up with nursing staff on the next business day to ensure the forms were sent.	03/14/2025
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		

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F 625	Continued From page 4 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide written information on the bed-hold policy for 1 of 2 sample residents (#4) reviewed for facility-initiated transfers. The findings were: 1. Review of a 12/16/24 nurse progress note showed resident #4 was transferred to the hospital for an acute change of condition. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 2. Interview with the social services director on	F 625	**F-625 (Con't)** **Notice of Bed Hold Policy Before/Upon Transfer** **CFR(s): 483.15(d)(1)(2)** 3) The facility audited all other resident records, and no other residents were affected by this practice from 2024 through the present. 4) The facility has reviewed the policy and processes related to Notice Requirements before Transfer/Discharge. 5) Nursing staff and Social Worker involved in this process were re-educated on their respective roles and responsibilities on 2/13/2025. How the Facility Will Identify Other Residents Being Affected: The Social Worker audited all other resident records, and no other residents have been affected by this practice from 2024 to the present. Measures to be Put into Place: The Nursing Home Administrator has implemented a system for sending the notice of bed-hold notice to the resident or resident representative upon transfer. Nursing will notify the resident or resident representative verbally prior to the transfer and then send a physical copy of the forms.	

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F 625	Continued From page 5 1/24/25 at 10:51 AM revealed she was unable to locate the bed-hold notice. 3. Review of the 9/24/24 Bed Hold and Return policy showed "...a. Upon admission and prior to any transfer, residents and/or their representatives will be provided written information regarding State and facility bed hold policies, which address holding a resident's bed during periods of absence (hospitalization or therapeutic leave) ... "	F 625	**F-625 (Con't)** **Notice of Bed Hold Policy Before/Upon Transfer** **CFR(s): 483.15(d)(1)(2)** Upon nursing staff initiating the Leave of Absence (LOA) in the Electronic Health Record (EHR), the Social Worker will be notified through the EHR of the LOA. Once alerted, the Social Worker will provide copies of the notices to the records department to be maintained in the EHR. As a backup, the Social Worker will follow up with nursing staff on the next business day to ensure the forms were sent. Monitoring and Tracking: The Social Worker will conduct audits on the LOA tracking document twice monthly for three months. The results of these audits will be presented to and reviewed by the QAPI committee bi-monthly to determine progress and address any compliance issues. Responsible Person(s): Nursing Home Administrator, Director of Nursing, and Social Worker.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to arrange for specialized services to meet the resident's needs	F 644		

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F 644	Continued From page 6 as identified on the Preadmission Screening and Resident Review (PASARR) level II for 1 of 2 sample residents (#9) reviewed. The findings were: 1. Review of the 8/8/24 annual MDS assessment showed resident #9 was admitted to the facility on 8/22/23 from an inpatient psychiatric hospital. The resident was coded as having been evaluated by a Level II PASARR and determined to have a serious mental illness. The resident had a BIMS score of 3 out 15, which indicated severe cognitive impairment, with inattention and disorganized thinking. In addition, the resident had diagnoses which included anxiety disorder, depression, bipolar, and psychotic disorder. Review of the 1/13/23 PASARR Level II Determination Summary Report showed the resident met the state definition of mental illness and recommended rehabilitative services to be provided in the nursing facility to include a "minimum of annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatment plan." The following concerns were identified: a. Review of the resident's medical record showed the last psychiatric evaluation was completed on 2/1/21. b. Interview with the social services director on 1/24/25 at 9:56 AM confirmed an annual comprehensive psychiatric evaluation had not been completed as indicated on the PASARR Level II Determination Summary Report.	F 644	**F-644** **Coordination of PASARR and Assessments** **CFR(s): 483.80(e)(1)(2)** This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to arrange for specialized services to meet the resident's needs as identified on the Preadmission Screening and Resident Review (PASARR) level II for 1 of 2 sample residents (#9) reviewed. Corrective Action(s): The Social Worker will review and revise the SNF-Resident Assessment Instrument policy (Chapter 15 Section 03) to add that the facility will attempt to offer PASARR or other assessments to each resident or their representative. Any declination of a PASRR recommendation or other assessments will be documented in the EHR. How the Facility Will Identify Other Residents Being Affected: The Social Worker completed the audit on 2/14/25 of all residents who have PASRR II recommendations. During the audit, it was determined that other residents have PASRR recommendations.	03/14/2025
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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F 644	Continued From page 6 as identified on the Preadmission Screening and Resident Review (PASARR) level II for 1 of 2 sample residents (#9) reviewed. The findings were: 1. Review of the 8/8/24 annual MDS assessment showed resident #9 was admitted to the facility on 8/22/23 from an inpatient psychiatric hospital. The resident was coded as having been evaluated by a Level II PASARR and determined to have a serious mental illness. The resident had a BIMS score of 3 out 15, which indicated severe cognitive impairment, with inattention and disorganized thinking. In addition, the resident had diagnoses which included anxiety disorder, depression, bipolar, and psychotic disorder. Review of the 1/13/23 PASARR Level II Determination Summary Report showed the resident met the state definition of mental illness and recommended rehabilitative services to be provided in the nursing facility to include a "minimum of annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatment plan." The following concerns were identified: a. Review of the resident's medical record showed the last psychiatric evaluation was completed on 2/1/21. b. Interview with the social services director on 1/24/25 at 9:56 AM confirmed an annual comprehensive psychiatric evaluation had not been completed as indicated on the PASARR Level II Determination Summary Report.	F 644	**F-644 (Con't)** **Coordination of PASARR and Assessments** **CFR(s): 483.80(e)(1)(2)** Measures to be Put into Place: The Social Worker will attempt to offer PASRR recommendations or other assessments to each resident or their representative. Any declination of a PASRR recommendations or other assessments will be documented in the EHR Monitoring and Tracking: The results of the PASRR audits and recommendations will be presented by the Social Worker to the QAPI Committee bi-monthly for review and evaluation to determine progress and address any compliance issues. Responsible Person(s): The Social Worker.	
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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F 880	Continued From page 7 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880	**F-880** **Infection Prevention and Control** **CFR(s): 483.80(a)(1)(2)(4)(e)(f)** This STANDARD is not met as evidenced by: Based on staff interview and policy and procedure review, the facility failed to conduct an annual review of its infection prevention and control program (IPCP). The census was 13. Corrective Action(s): The Director of Nursing and Infection Preventionist Nurse reviewed and revised as necessary the SNF-Antibiotic Stewardship, Written Exposure Control Plan and Health Outbreak Guidelines, Vaccination of Residents, and Infection Prevention and Control policies to state the facility will attempt to offer vaccinations to each resident or their representative. The Policy Committee will review and implement these revised policies on 2/24/2025. Any declination of the offer for a vaccination will be documented in the EHR. How the Facility Will Identify Other Residents Being Affected: The Infection Preventionist Nurse will ensure that all infection policies are reviewed annually. Measures to be Put into Place: The Infection Preventionist Nurse will ensure that all infection policies and the infection program are reviewed annually.	03/14/2025

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F 880	Continued From page 8 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy and procedure review, the facility failed to conduct an annual review of its infection prevention and control program (IPCP). The census was 13. The findings were: 1. Review of the facility's IPCP policies showed the following concerns: a. The "Antibiotic Stewardship" policy showed it was approved on 3/11/22 with no evidence the policy had been subsequently reviewed. b. The "Written Exposure Control Plan & Health Outbreak Guidelines" policy was approved	F 880	**F-880 (Con't)** **Infection Prevention and Control** **CFR(s): 483.80(a)(1)(2)(4)(e)(f)** Monitoring and Tracking: The Infection Prevention Nurse will monitor and ensure the infection prevention policies and program are reviewed annually. The results of these audits will be presented to and reviewed by the QAPI committee bi-monthly to determine progress and address any compliance issues. Responsible Person(s): Director of Nursing, and the Infection Preventionist Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535058	A. BUILDING _____ B. WING _____	C 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW SKILLED NURSING COMMUNITY AT WLRC	8204 WYOMING STATE HIGHWAY 789 LANDER, WY 82520

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F 880	Continued From page 9 on 4/5/22 with no evidence the policy had been subsequently reviewed. c. The "Vaccination of Residents" policy was approved on 4/5/22 with no evidence the policy had been subsequently reviewed. d. The "Infection Prevention and Control policy was approved on 5/18/23 with no evidence the policy had been subsequently reviewed. 2. Interview with the DON on 1/24/25 at 12:47 PM confirmed the IPCP policies had not been reviewed annually as required.	F 880	**F-883** **Influenza and Pneumococcal Immunizations** **CFR(s): 483.80(d)(1)(2)** This STANDARD is not met as evidenced by: Based on medical record review, staff interview, policy and procedure review, and review of CDC immunization recommendations, the facility failed to ensure residents were offered pneumococcal immunizations based on CDC recommendations for 1 of 5 sample residents (#3) reviewed for immunizations.	
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	F 883	Corrective Action(s): The Director of Nursing and Infection Preventionist Nurse will track all resident vaccinations on a shared document quarterly. If a resident or their representative declines a vaccination, a declination form will be completed and recorded. The Director of Nursing and Infection Preventionist Nurse reviewed all residents eligible for Pneumococcal vaccines. All eligible residents and or guardians were sent VIS, consent, and declination on 2/14/2025. How the Facility Will Identify Other Residents Being Affected: The Director of Nursing and Infection Preventionist Nurse will audit all current residents to ensure they receive the required vaccinations.	03/14/2025

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F 883	Continued From page 10 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: Based on medical record review, staff interview, policy and procedure review, and review of CDC immunization recommendations, the facility failed to ensure residents were offered pneumococcal immunizations based on CDC recommendations for 1 of 5 sample residents (#3) reviewed for immunizations. The findings were:	F 883	**F-883 (Con't)** **Influenza and Pneumococcal Immunizations** **CFR(s): 483.80(d)(1)(2)** Measures to be Put into Place: The Director of Nursing will track all resident vaccinations quarterly. Monitoring and Tracking: The Director of Nursing will track all resident vaccinations quarterly. If a resident or their representative declines a vaccination, a declination form will be completed for our records. The results of these audits will be presented by the Infection Preventionist to the QAPI committee bi-monthly to determine progress and address any compliance issues Responsible Person(s): Director of Nursing, and the Infection Prevention Nurse.	

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F 883	Continued From page 11 1. Review of the 10/21/24 quarterly MDS assessment showed resident #3 was admitted to the facility on 7/16/24. The resident was 58 years old. The following concerns were identified: a. Review of Section O of the 10/21/24 quarterly MDS assessment showed the resident's pneumococcal vaccine was not up-to-date and had not been offered. b. Review of the resident's medical record showed no evidence the resident had been previously vaccinated. c. Interview with the DON on 1/24/25 at 12:47 PM confirmed the resident had not been offered the vaccine. 2. Review of the 4/5/22 "Vaccination of Residents" policy showed "All residents will be offered vaccines that aid in preventing infectious disease unless the vaccine is medically contraindicated or the resident has already been vaccinated." 3. According to the CDC Vaccines and Immunizations by age located at https://www.cdc.gov/vaccines/by-age/index.html (accessed on 1/30/25) showed "CDC recommends pneumococcal vaccination for all adults who never received a pneumococcal conjugate vaccine and are age 50 years or older."	F 883		