STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted 06/21/23 through 06/23/23. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 26O011.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted 06/21/23 through 06/23/23. The following intake was investigated NC00203116. 1 of the 3 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		7/19/23

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

Electronically Signed | 07/14/2023

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to promote dignity while dining when Nurse Aide #1 was observed standing over the bedside feeding 2 of 2 residents (Resident #2, #5) who required total dependent care and were reviewed for resident rights. A reasonable person has the expectation of being treated with dignity while dining. Findings included. a.) Resident #5 was admitted to the facility on 08/23/22. A care plan revised 03/29/23 revealed Resident	F 550	F550 Resident #2 no longer resides in the facility. Resident #5 was assessed by the social worker on 7/12/2023 to ensure there were no signs of mental anguish as a result of the dignity violation. No issues were identified. All alert and oriented residents will be educated by the Facility Administrator or designee and provided with a copy of their Resident Rights by 7/14/2023. All residents that are dependent for feeding will be assessed by 7/14/2023 by the	

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F 550	Continued From page 2 #5 had an ADL (activities of daily living) self-care deficit related to dementia. The goal of care included Resident #5 would be assisted by staff with ADLs. Interventions included to assist with ADLs including eating and to promote independence and dignity and provide positive reinforcement for all activities. The Minimum Data Set (MDS) assessment dated 03/31/23 revealed Resident #5 had severely impaired cognition. She required extensive assistance with eating. During an observation of the lunch meal on 06/21/23 at 12:30 PM. Resident #5 was observed lying in bed in her room. She was assisted with eating her lunch meal by Nurse Aide #1 who was standing up at the bedside feeding Resident #5. b.) Resident #2 was admitted to the facility on 05/08/22. A care plan revised 05/19/23 revealed Resident #2 had an ADL (activities of daily living) self-care deficit related to impaired mobility, left side hemiplegia (paralysis), a left-hand contracture, and impaired cognition. The goal of care included Resident #2 would be assisted by staff with ADLs. Interventions included Resident #2 must be fed when unable to feed herself, and to promote independence and dignity and provide positive reinforcement for all activities. The Minimum Data Set (MDS) assessment dated 05/12/23 revealed Resident #2 had severely impaired cognition. She required extensive one-person assistance from staff with eating.	F 550	Social Worker or a member of the administrative nursing team to ensure there are no signs of mental anguish as a result of a dignity violation. The Director of Nursing/designee will education all staff on resident dignity, with special attention to sitting while feeding residents and Resident Rights by 7/14/2023. All newly hired staff will be educated on Resident Rights and Dignity during orientation. The Facility Administrator or designee will do walking rounds during meal times 3x week for 12 weeks to ensure staff are sitting while feeding residents. Any violation will be corrected immediately, the staff member will receive immediate re-education, disciplinary action for repeated offense and the resident will be assessed by the social worker to ensure the resident has no symptoms of mental anguish. The audits will be reviewed monthly in the Quality Assurance Performance Improvement meeting. The Quality Assurance team may change the plan of correction or extend the audits to ensure ongoing compliance.	

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F 550	Continued From page 3 During an observation of the lunch meal on 06/21/23 at 12:45 PM Resident #2 was observed lying in bed in her room. She was assisted with eating her lunch meal by Nurse Aide #1 who was standing up at the bedside feeding Resident #2. During an interview on 06/21/23 at 2:30 PM Nurse Aide #1 stated she had worked at the facility for two years and didn't realize she could not stand up to feed residents. She stated it was uncomfortable for her to sit at the bedside while feeding a resident, and she never sat down to feed residents in their rooms. She stated she would never disrespect a resident but didn't know that was "not allowed". During an interview on 06/23/23 at 11:30 AM the Director of Nursing (DON) stated all staff were educated on Resident Rights which included maintaining dignity when assisting a resident with care including eating. She stated staff should be providing care to residents while promoting and maintaining dignity. She stated staff had been educated regarding sitting at eye level and not standing beside of the resident when assisting a resident with eating. She stated further education would be provided.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		7/19/23

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F 684	Continued From page 4 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews the facility failed to administer two topical antibiotic ointments prescribed for treatment of a chronic autoimmune disorder according to the physician orders for 1 of 1 resident (Resident #1) reviewed for quality of care. Findings included. Resident #1 was readmitted to the facility on 05/31/21 with diagnoses including, Bullous Pemphigoid (a chronic autoimmune blistering skin disorder). A physicians order dated 11/04/22 for Resident #1 revealed Gentamicin 0.1% topical (antibiotic) ointment apply to both legs four times a day. (Bullous Pemphigoid) A physicians order dated 11/04/22 for Resident #1 revealed Mupirocin 2% topical (antibiotic) ointment apply to both legs four times a day. (Bullous Pemphigoid) A review of the physician orders dated 12/15/22, 01/13/23, 02/16/23, and 03/16/23 for Resident #1 revealed to continue Mupirocin ointment and Gentamicin ointment as ordered. The Minimum Data Set (MDS) assessment dated 03/14/23 revealed Resident #1 was cognitively intact. He exhibited no behaviors, and no rejection of care. He required extensive two-person assistance with bed mobility and	F 684	F684 Resident #1 no longer resides in the facility. The Director of Nursing or wound care nurse will review the most recent progress note from the facility MD/NP, in house wound care provider if applicable and outside wound care provider if applicable and verify the current treatment orders are correct by 7/14/2023. Any issues identified will be clarified and corrected. The wound care nurse and unit managers will be re-educated by the Director of Nursing by 7/14/2023 on reviewing all wound care notes after each provider visit to ensure all treatment orders are current. The Director of Nursing or designee will review all progress notes from the in house wound provider as well as outside wound providers weekly for 12 weeks to ensure treatment orders are correct. Any issues identified will be clarified and corrected. The audits will be reviewed monthly in the Quality Assurance Performance Improvement meeting. The Quality Assurance team may change the plan of correction or extend the audits to ensure ongoing compliance.	

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F 684	Continued From page 5	F 684		

transfers, and extensive one person assistance with activities of daily living (ADLs). He had no pressure wounds but had other open lesions and received wound care.

A care plan revised 03/23/23 revealed Resident #1 had impaired skin integrity with blisters on his upper and lower extremities (bullous blisters). The goal of care included, the areas would show improvement and signs of healing without complications. Interventions included in part; to administer medications as ordered.

Review of Resident #1's Medication Administration Record (MAR) dated 11/01/22 through 04/05/23 revealed the Mupirocin and Gentamicin was administered as ordered.

Review of Resident #1's MAR dated April 2023 revealed the Mupirocin ointment and Gentamicin ointment were both discontinued on 04/06/23.

Review of Resident #1's medical record from 03/16/23 through 04/06/23 revealed no order from the prescribing physician to discontinue the Mupirocin ointment or the Gentamicin ointment.

A physicians order dated 04/26/23 for Resident #1 revealed to continue Mupirocin ointment 2-4 times daily and continue Gentamicin ointment 2-4 times daily.

Review of Resident #1's MAR dated 04/26/23 through 05/22/23 revealed the Mupirocin ointment and the Gentamicin ointment were not administered 2-4 times daily as ordered.

During an interview on 06/22/23 at 10:30 AM the Wound Treatment Nurse stated Resident #1 was

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F 684	Continued From page 6	F 684		

no longer in the facility and initially had blisters on his legs, feet, and groin related to the autoimmune disorder Bullous Pemphigoid. She stated over the course of several weeks the blisters spread to his arms, chest, underarms, back, neck, eyelids, and face. He was followed by Dermatology who directed his treatment plan and who wrote the orders for the Mupirocin and Gentamicin ointment. She stated Resident #1 went to the Dermatologist monthly for follow up since November 2022. She stated Resident #1 had opened blistered areas and also scabbed areas with green drainage noted when pushing on the scab and he received oral antibiotics long term as well as the topical antibiotics. She stated she spoke with Nurse Practitioner #1 and asked her if they could start Xeroform (mesh gauze with antimicrobial properties) instead of using the Mupirocin or Gentamicin ointments for Resident #1 because she didn't think the ointments were helping him very much. She stated Nurse Practitioner #1 gave her a verbal order on 04/06/23 to discontinue the Mupirocin ointment and the Gentamicin ointment and start Xeroform gauze. She stated she was not aware that Resident #1 had orders dated 04/26/23 from the following monthly Dermatology visit to continue both the Mupirocin and Gentamicin ointment and therefore she did not clarify the order with Nurse Practitioner #1 or the Dermatologist. She stated Resident #1 did not receive either the Mupirocin or Gentamicin ointment as ordered after 04/05/23.

During an interview on 06/22/23 at 1:00 PM Nurse Practitioner #1 stated she had worked at the facility for one year and was familiar with Resident #1 and evaluated him on several occasions. She stated Resident #1 had Bullous

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F 684	Continued From page 7	F 684		

Pemphigoid resulting in opened blistered areas covering most of his body. She stated he was followed by Dermatology who directed his treatment and who ordered the Mupirocin and Gentamicin ointment. She stated she did have a conversation with the Wound Treatment Nurse regarding adding the Xeroform gauze to his treatment plan but stated she must have misunderstood the wound nurse and thought the Xeroform would be added to his treatment plan along with continued use of the Mupirocin and Gentamicin ointments. She stated she did not intend for the Mupirocin or Gentamicin to be discontinued. She stated she would have consulted with the Dermatologist before discontinuing any of his treatment orders and she did not do that. She stated she thought Resident #1 continued to receive the Mupirocin and the Gentamicin as ordered by Dermatology. She stated the error was due to miscommunication between her and the Wound Treatment Nurse. She stated Resident #1 received a long-term oral antibiotic as well and she did not feel that not receiving the Mupirocin or Gentamicin topical ointments had any effect on the outcome of his wounds.

During an interview on 06/23/23 at 11:30 AM the Director of Nursing (DON) stated Resident #1 had chronic blistering areas related to an autoimmune disorder and was followed by Dermatology. She stated the Dermatologist should have been consulted prior to discontinuing the topical antibiotic treatment and the order received on 04/26/23 should have been reviewed upon receipt and clarified if Resident #1 was not receiving the medication and unfortunately that didn't occur.

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F 806	Continued From page 8	F 806		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to honor food preferences for 1 of 2 residents reviewed for nutrition (Resident #2). Findings included: Resident #2 was admitted to the facility on 04/03/15 with diagnoses including Non-Alzheimer's dementia, Cerebral Vascular Accident (CVA) and dysphagia (difficulty swallowing foods or liquids). A physicians order dated 08/22/22 revealed Resident #2 was to receive a regular diet, with pureed texture, thin consistency, and large dinner portions. A care plan dated 02/17/23 revealed Resident #2 had an increased nutrition and hydration risk related to diagnoses of dementia, dysphagia, and the need for altered consistency with recent weight loss. The goal of care was that Resident #2 would tolerate the ordered diet and texture	F 806	F806 Resident #2 no longer resides in the facility. The preferences for each resident in the facility will be re-evaluated by the Dietary Manager or designee by 7/14/2023. Education will be provided to the dietary staff by 7/14/2023 on Tray card accuracy and honoring resident food preferences by the Dietary Manager or designee. The dietary manager or designee will audit 10 resident meal trays weekly for 12 weeks to ensure resident dislikes are being honored based on the tray cards. The dietary manager or designee will also interview 5 residents each week to ensure their food preferences are being met. The audits will be reviewed monthly in the Quality Assurance Performance Improvement meeting. The Quality Assurance team may change the plan of	7/19/23

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F 806	Continued From page 9	F 806		

within the limits of end stage illness through the next review. Interventions included; to use adaptive equipment as needed and provide diet as ordered.

The Minimum Data Set (MDS) quarterly assessment dated 05/12/23 revealed Resident #2 had severely impaired cognition. She required total care for activities of daily living and extensive one person assistance with eating. She had no weight loss at the time of assessment and received a mechanical diet.

A meal observation on 06/21/22 at 12:30 PM revealed Resident #2 was served a pureed diet, the meal ticket listed food preferences which included "nothing green on plate". The observation revealed Resident #2 was served pureed green beans and broccoli, along with pureed vegetable lasagna.

During an interview on 06/21/23 at 12:30 PM Nurse Aide #1 who was the assigned nurse aide stated Resident #2 required assistance with eating which she provided and stated Resident #2 only ate 1-2 bites of lunch because she did not like green beans, broccoli, or the pureed vegetable lasagna. She stated she ate most of her ice cream cup. She stated Resident #2 could not voice her needs due to confusion but indicated she did not want anything else to eat when asked by the nurse aide. Nurse Aide #1 stated she did not look at the meal ticket when assisting Resident #2 with eating but if a resident did not want what was served on the meal tray, or if a food item was served on the residents dislike list, she would notify the Kitchen.

During an interview on 06/22/23 at 10:45 AM the

correction or extend the audits to ensure ongoing compliance.

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Dietary Manager stated he just started working at the facility the day prior on 06/21/23. He stated he was made aware by the Regional Dietary Manager that Resident #2 received greens on her lunch plate yesterday. He stated "no greens" on the meal ticket meant no green foods including vegetables. He stated he could not speak on behalf of who plated the food yesterday but indicated it was missed. He stated there was work to be done to ensure meal tickets were read accurately and he was planning to implement a new process to ensure food preferences were honored.

A meal observation on 06/22/23 at 12:45 PM revealed Resident #2 was served pureed green peas during the lunch meal. Resident #2 did not eat the green peas.

During an interview on 06/22/23 at 1:00 PM Nurse Aide #1 who was the assigned nurse aide stated Resident #2 required assistance with eating which she provided. She indicated she did not read the meal ticket.

During an interview on 06/22/23 at 12:55 PM Dietary Staff #2 stated she was the cook and was the dietary manager until yesterday. She stated their process was the dietary aide would read the meal ticket to her and she plated the food. She stated she relied on the dietary aides to read the meal tickets correctly and tell her what each residents food preferences were. She stated she did not look at the meal ticket to confirm preferences. She stated the green vegetables added to Resident #2's lunch plate on both occasions was done in error.

During an interview on 06/23/23 at 12:30 PM the

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F 806	Continued From page 11 Administrator stated a new Dietary Manager was hired and started work yesterday. He stated Resident #2's food preferences should have been honored. He indicated the dietary aides as well as the nurse aides who assisted the residents with eating should be reviewing the meal ticket for food preferences. He indicated Nurse Aide #1 should have notified the kitchen on both occasions that Resident #2's dislikes were served on her meal tray and an alternate food provided. He stated a new process would be put in place to ensure meal tickets were read accurately and food preferences were honored.	F 806		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		7/19/23

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F 867	Continued From page 12	F 867		

will be used to develop and monitor performance indicators.

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

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

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

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

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 13 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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F 867	Continued From page 14 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the focused infection control survey on 07/29/20 and 02/23/21, the complaint investigation and revisit survey on 04/28/21, the focused infection control and complaint investigation survey on 06/03/22, and the recertification and complaint investigation survey on 12/09/22, These were for four deficiencies in the areas of Resident Rights (F550), Quality of Care (F684), Dietary Services (F806), and Infection Control (F880) which were subsequently recited on the current focused infection control and complaint investigation survey of 06/23/23. The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings Included. This tag is cross referenced to: F550: Based on observations, record review, and staff interviews the facility failed to promote	F 867	F867 Quality Improvement Activities Facility failed to maintain an effective Quality Assurance Performance Improvement process to implement systemic changes to effect: Resident Rights, Quality of Care, Dietary Services and Infection Control. (F550) All alert and oriented residents will be educated by the Facility Administrator or designee and provided with a copy of their Resident Rights by 7/14/2023. All residents that are dependent for feeding will be assessed by 7/13/2023 by the Social Worker or a member of the administrative nursing team to ensure there are no signs of mental anguish as a result of a dignity violation. (F684) The Director of Nursing or wound care nurse will review the most recent progress note from the facility MD/NP, in house wound care provider if applicable and outside wound care provider if applicable and verify the current treatment orders are correct by 7/14/2023. Any issues identified will be clarified and corrected. (F806) The preferences for each resident in the	

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F 867	Continued From page 15 dignity while dining when Nurse Aide #1 was observed standing over the bedside feeding 2 of 2 residents (Resident #2, #5) who required total dependent care and were reviewed for resident rights. A reasonable person has the expectation of being treated with dignity while dining. During the focused infection control survey and compliant investigation on 06/03/22 the facility failed to maintain the dignity of residents by serving meals in disposable containers. During an interview on 06/23/23 at 12:30 PM the Administrator indicated the previous deficiency regarding resident rights pertaining to meal service had been resolved and a new Dietary Manager was hired this week and therefore continued improvements would be made. He stated staff should always promote dignity and respect when providing resident care and staff had received training on resident rights including promoting dignity while assisting residents with eating. He stated further education would be provided to all staff regarding resident rights. F684: Based on record review, staff and Nurse Practitioner interviews the facility failed to administer two topical antibiotic ointments prescribed for treatment of a chronic autoimmune disorder according to the physician orders for 1 of 1 resident (Resident #1) reviewed for quality of care. During the complaint investigation and revisit survey completed on 04/28/21 the facility failed to assess and obtain orders for treatment of a right-hand skin tear and abrasion and failed to follow the Nurse Practitioners order to obtain a	F 867	facility will be re-evaluated by the Dietary Manager or designee by 7/14/2023. (F880) The Director of Nursing and the Infection Control Preventionist will review all cultures ordered since 6/1/2023 by 7/14/2023 to ensure appropriate Transmission Based Precautions are place if still applicable. The RDCS reviewed the medical records for all residents that had been prescribed antibiotics since January 1, 2023, calculated the rates of infection and identified two infection trends on 6/22/2023 The Facility Administration was inserviced by the Regional Director of Clinical Services on 7/14/2023 on the Saber Quality Assurance Performance Improvement Program. To monitor ongoing Quality Assurance Performance Improvement, the Regional Director of Clinical Services or the Regional Director of Operations will review monthly Quality Assurance Performance Improvement meeting to assure pertinent items are included and worked on monthly for 3 months.	

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urinalysis.

During the recertification survey and the complaint investigation completed on 12/09/22 the facility failed to complete a neurological assessment to include a) current vital signs with each neurological assessment recorded and b) assessment of hand grasps and observation of changes in behavior.

During an interview on 06/23/23 at 12:30 PM the Administrator indicated the previous deficiency regarding neurological assessments continued to be reviewed daily and discussed in the clinical meetings. He stated he felt that issue had resolved. He stated the Wound Treatment Nurse was very detail oriented and took ownership in her work, and the miscommunication regarding the physician orders should not have occurred but was done in error. He stated further education would be provided to the nursing staff regarding quality of care including following the physician orders.

F806: Based on observations, record review, and staff interviews the facility failed to honor food preferences for 1 of 2 residents reviewed for nutrition (Resident #2).

During the recertification survey and the complaint investigation completed on 12/09/22 the facility failed to honor food preferences.

During an interview on 06/23/23 at 12:30 PM the Administrator indicated the he thought the previous deficiency regarding honoring food preferences had been resolved. He stated a new Dietary Manager was hired this week and there would be changes made and new processes

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implemented including making sure dietary staff were reviewing the meal tickets and plating the food correctly. He indicated there had been staff turnover in the kitchen since the last recertification survey and more education was needed. He stated continued improvements would be made and further education would be provided.

F880: Based on record review, staff and Nurse Practitioner interviews the facility failed to a.) Implement Contact Precautions for a resident whose lab result was positive for MRSA (methicillin-resistant staphylococcus aureus- a multidrug resistant organism) for 1 of 1 resident (Resident #1) reviewed for infection control. b.) Implement a system of surveillance to investigate infection trends identified during the monthly review of resident infections, including data analysis and process surveillance of direct care staff regarding resident care practices which was reviewed for establishment of an infection prevention and control program. This deficient practice had the potential to effect residents in the facility.

During the focused infection control survey and complaint investigation on 07/29/20 the facility failed to implement the facility's Transmission-Based Precautions Policy by not wearing the personal protective equipment (PPE) required when providing care and services.

During the focused infection control survey on 02/23/21 the facility failed to: implement their Entry Screening for COVID-19 Policy, document or report a new onset of a symptom and provided services to residents prior to testing positive for COVID-19, implement the facility's Enhanced

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Droplet Isolation Policy, and implement the Hand Hygiene/Handwashing Policy.

During an interview on 06/23/23 at 12:30 PM the Administrator indicated staff should be following infection control guidelines. He stated Contact Precautions should have been implemented for the resident when the positive wound culture was reported. He stated the Infection Control nurse began her role in November 2022 and was responsible for ensuring the recommended guidelines and practices were being followed. He indicated he was not certain why there was a process failure causing repeated infection control deficiences. He stated more work was needed to ensure infection control practices were being followed.

This interview with the Administrator continued. He stated he began working in the facility as the Administrator in February 2023. He stated he came in at the end of the 12-week self-audit period for the corrective action plans for the deficiencies cited on the 12/09/22 recertification and complaint investigation survey. He stated after the 12 weeks of audits regarding the deficiencies that were cited that the processes used to prevent deficient practice didn't continue. He stated it seemed as though after the audits ended staff relaxed their approach in these areas. He stated new processes along with further education, and audits would be implemented to correct the deficient practice. He stated human error would always be a factor. He stated the results of the ongoing monitoring would be discussed in the monthly Quality Assurance meetings and he hoped that moving forward repeat deficiencies would not occur.

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F 868	Continued From page 19	F 868		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.	F 868		7/19/23

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F 868	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to maintain a quality assessment and assurance (QAA) committee that included participation of the Infection Preventionist to report on the Infection Prevention and Control Program. This deficient practice had the potential to impact facility residents as the Infection Preventionist was not involved in reporting of incidents within the program including outcome surveillance, outbreaks, or control measures. Findings included. The facility policy "Quality Assurance and Performance Improvement (QAPI) Program Policy revised 03/17/23 read in part; The purpose of QAPI in the facility is to take a proactive approach to continually improving delivery of care and services and to engage residents, care givers and other partners in maximizing quality of life and quality of care. The Infection Preventionist is a required participating member of the facility's QAA committee and reports to the committee on the Infection Prevention and Control Program on a regular basis. During an interview on 06/22/23 at 3:00 PM the Infection Preventionist stated she had assumed the role of the Infection Preventionist in November 2022. She stated she had not been attending the monthly or quarterly QAA meetings until the month of May 2023. She stated she was not aware until that time that she was to be included in the monthly or quarterly meetings. She stated she was just invited to attend in May 2023 by the Administrator. She stated she had never been told that she had to attend the	F 868	F868 The Infection Control Preventionist was informed of the upcoming Quality Assurance Performance Improvement meeting scheduled on 6/27/2023. The Infection Control line listings, infection rates and trends identified from January 1, 2023 - May 31, 2023 were reviewed in the June Quality Assurance Performance Improvement meeting. The Infection Control Preventionist was in attendance. On 7/14/2023 the RDCS will provide education to the facility administrator and the Infection Control Preventionist on the role and participation of the IFCP on the QAPI committee. To monitor ongoing Quality Assurance Performance Improvement, the Regional Director of Clinical Services or the Regional Director of Operations will review monthly Quality Assurance Performance Improvement meeting to ensure the Infection Control Preventionist attendance and that IFC is being discussed monthly for 3 months.	

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F 868	Continued From page 21 meetings and report on the Infection Control Program. During an interview on 06/23/23 at 12:30 PM the Administrator stated he began working in the facility in February 2023 and was not aware until May 2023 that the Infection Preventionist was not participating in the monthly or quarterly QAA meetings. He stated when that was realized he notified her of the responsibility to attend the QA meetings. He stated she would be required to be an active participant on the committee moving forward.	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an 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 §483.70(e) and following accepted national standards;	F 880		7/19/23

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F 880	Continued From page 22 §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 (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.	F 880		

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F 880	Continued From page 23 §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 record review, staff and Nurse Practitioner interviews the facility failed to a.) Implement Contact Precautions for a resident whose lab result was positive for MRSA (methicillin-resistant staphylococcus aureus- a multidrug resistant organism) for 1 of 1 resident (Resident #1) reviewed for infection control. b.) Implement a system of surveillance to investigate infection trends identified during the monthly review of resident infections, including data analysis and process surveillance of direct care staff regarding resident care practices which was reviewed for establishment of an infection prevention and control program. This deficient practice had the potential to effect residents in the facility. Findings included. Review of the "Transmission Based Precautions Policy" revised 02/03/23 revealed Contact Precautions were intended to prevent transmission of infectious agents that were spread through direct or indirect contact. Contact Precautions would apply where there was presence of excessive wound drainage, urine or fecal incontinence, or other discharge from the body suggesting an increased potential for environmental contamination and risk of contamination. Personal Protective Equipment (PPE) included gloves, gown, limiting transport and movement, use of disposable resident care equipment and room placement. Facility staff	F 880	F880 Resident #1 no longer resides in the facility. The Director of Nursing and the Infection Control Preventionist will review all cultures ordered since 6/1/2023 by 7/14/2023 to ensure appropriate Transmission Based Precautions are place if still applicable. The RDCS reviewed the medical records for all residents that had been prescribed antibiotics since January 1, 2023, calculated the rates of infection and identified two infection trends on 6/22/2023. Education will be provided to the Director of Nursing and the Infection Control Preventionist on obtaining all lab results, ensuring appropriate Transmission Based Precautions are being implemented and the process of identifying and correcting identified trends by the Regional Nurse on 7/14/2023. Education will be provided by the Director of Nursing and the Infection Control Preventionist by 7/14/2023 to all clinical staff on hand hygiene, peri-care, incontinent care and showers. The antibiotic line listing will be reviewed weekly for 12 weeks to ensure labs are being collected and appropriate	

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F 880	Continued From page 24 providing care for the resident will be notified by the Infection Preventionist and/or charge nurse regarding needed precautions based on the infectious agent. a.)Resident #1 was admitted to the facility on 05/31/21 with diagnoses including, Bullous Pemphigoid (a chronic autoimmune blistering skin disorder). Review of Resident #1's medical record revealed a lab report with a collection date of 04/27/23 and a reported date of 05/03/23. The lab report revealed Resident #1 was ordered to have a wound culture and sensitivity collected. The wound culture final report revealed an abnormal finding of MRSA. The sensitivity report revealed antimicrobial susceptibility to four named antibiotics including Trimethoprim/Sulfamethoxazole (Bactrim). Review of Resident #1's physician orders from 05/03/23 through 05/22/23 revealed no order to implement Contact Precautions due to newly identified MRSA. A nursing note dated 05/04/23 at 9:25 PM revealed Resident #1 had multiple open areas on his back that were weeping (fluid oozing from a wound). Resident #1 refused to turn, and the nurse was unable to fully evaluate the areas. Review of the Infection Log of residents with any type of infection in the facility from 05/01/23 through 06/21/2023 revealed no additional residents with a diagnoses of MRSA infection. During an interview on 06/22/23 at 10:30 AM the Wound Treatment Nurse stated Resident #1 was	F 880	Transmission Based Precautions are being implemented. The Quality Assurance Performance Improvement team will review the rates of infections as well as any infection trends monthly to ensure trends are being identified and addressed. The audits will be reviewed monthly in the Quality Assurance Performance Improvement meeting. The Quality Assurance team may change the plan of correction or extend the audits to ensure ongoing compliance.	

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no longer in the facility and initially had blisters on his legs, feet, and groin related to the autoimmune disorder Bullous Pemphigoid. She stated over the course of several weeks the blisters spread to his arms, chest, underarms, back, neck, eyelids, and face. He was followed by Dermatology who directed his treatment plan. She stated Resident #1 had opened blistered areas and also scabbed areas with green drainage noted when pushing on the scab and he received antibiotics. She stated during the month of May 2023 Resident #1 was only on regular standard precautions. She stated she always used gloves when providing wound care but did not use a gown when providing his wound care since he was not on any type of Transmission Based Precautions. She indicated she was not made aware by the Infection Control Nurse or any other staff that Resident #1 had newly identified MRSA during the month of May 2023. She indicated there were no other residents that were positive for MRSA currently or during that time that she was aware of.

During an interview on 06/22/23 at 1:00 PM Nurse Practitioner #1 stated she had worked at the facility for one year and was familiar with Resident #1 and evaluated him on several occasions. She stated Resident #1 had Bullous Pemphigoid resulting in opened blistered areas covering most of his body. She stated he was followed by Dermatology who directed the treatment for him and who ordered the wound culture. She indicated Resident #1 should have been placed on Contact Precautions for MRSA once the lab report was received at the facility. She indicated she reviewed the lab reports of the residents that she evaluated through the electronic medical records. She stated she was

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uncertain if Resident #1 was placed on Contact Precautions during that time.

During an interview on 06/22/23 at 3:00 PM the Infection Control Nurse stated Resident #1 was no longer in the facility, but she was not aware he was positive for MRSA in May 2023 until today. She stated she never saw the lab report that was received by the facility but stated if the report showed Resident #1 had MRSA, then Contact Precautions should have been implemented. She indicated she was not certain if Resident #1 was ever placed on Contact Precautions for MRSA. She indicated there was no documentation to support that he was placed on precautions.

During an interview on 06/23/23 at 11:30 AM the Director of Nursing (DON) stated she did not recall Resident #1 being on Contact Precautions for MRSA. She stated when a lab report comes though the main fax line it is given to the primary nurse who should review the report then send it to the provider for any new orders. She indicated she was uncertain who the primary nurse was when the report was received by the facility since it was not initialed by a nurse. She indicated unfortunately that process was not followed so that orders could have been received and Resident #1 placed on Contact Precautions. She indicated Resident #1 did not have a roommate during that time, and there were no residents that were positive for MRSA during or since that time.

b.) The "Infection Prevention and Control Program Policy" revised 05/11/23 read in part; the facility policy was to maintain an organized, effective facility wide program to prevent, identify, control, and reduce the risk of acquiring and

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transmitting infections, and to conduct surveillance of communicable disease and infectious outbreaks. The Infection Preventionist responsibilities included in part; conducting surveillance of staff and residents for facility associated or community associated infections and/or communicable diseases. To inform and educate staff members on their role in any action plans developed based on surveillance data and identified trends.

Review of the Monthly Infection Log on 06/22/23 revealed during the month of January 2023, 7 residents were diagnosed with urinary tract infection (UTI), 2 residents with yeast (candidiasis-fungal infection) infection, 2 residents with oral candidiasis, and 3 residents with eye infections.

Review of the Monthly Infection Log on 06/22/23 revealed during the month of February 2023, 4 residents were diagnosed with urinary tract infection (UTI), 2 residents with yeast infection, 1 resident with oral candidiasis.

Review of the Monthly Infection Log on 06/22/23 revealed during the month of March 2023, 9 residents were diagnosed with urinary tract infection (UTI), 2 residents with yeast infection, 3 residents with oral candidiasis.

Review of the Monthly Infection Log on 06/22/23 revealed during the month of April 2023, 10 residents were diagnosed with urinary tract infection (UTI), 3 residents with yeast infection, and 6 skin/wound infections.

Review of the Monthly Infection Log on 06/22/23 revealed during the month of May 2023, 4

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residents were diagnosed with urinary tract infection (UTI), and 1 resident with candidiasis.

Record review of the Monthly Infection Log on 06/22/23 revealed no documentation to support surveillance was conducted and data analysis of infection trends, or process surveillance such as direct care staff observations to determine if additional interventions or education was needed to reduce the occurrence rate of infection in the facility.

Observations were conducted from 06/21/23 through 06/23/23 of direct care staff performing hand hygiene, and donning/doffing gloves when needed. Hydration interventions were in place with water cups observed at the bedside. Urinary catheter bags were observed without any concerns identified.

During an interview on 06/22/23 at 3:00 PM the Infection Control Nurse stated she tracked monthly infections in the facility and recorded the data on a spreadsheet which included the residents name, admission date, type of infection, onset date, signs or symptoms, lab results, antibiotic name, date, dose, and duration, and if a change was made in the antibiotic, or if a resident was placed on isolation. She stated she counted the number of cases of infections each month but that was all of the data analysis that she did. She indicated she did not accurately calculate rates of various infections or analyze the data to identify trends or do any type of process surveillance such as observing direct care staff practices such as performing hand hygiene, donning gloves, providing incontinence care, observing hydration measures, ensuring baths and showers were given, or observing to ensure urinary catheter

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F 880	Continued From page 29 care was performed adequately for those residents with infections. She indicated she did not conduct surveillance to assess the need for intervention strategies to reduce the occurrence of infection, or to implement additional interventions, and monitor the effectiveness of the interventions. She stated data analysis or surveillance was not done to determine if additional infection control education was needed. She stated staff received annual infection control training, but she had not conducted any additional staff training. She stated since she had not looked at process surveillance, she could not determine if the increased or clusters of infections were related to direct care staff practices. She stated she began the role as the facility Infection Control Nurse in November 2022, and she did not feel as though she received enough training and education to fully understand what the duties of the Infection Control Nurse required. During an interview with the Director of Nursing (DON) on 06/23/23 at 11:30 AM she stated the Infection Control Nurse assumed the position in November 2022 and received training on the role and responsibilities of the Infection Control Nurse. She indicated she was not aware there was any concern regarding the Infection Control Nurse not understanding the requirements and her responsibilities in managing the infection control program. She stated she was not aware that infection surveillance was not being conducted according to standards. She indicated the Infection Control Nurse should be conducting surveillance and data analysis to help in reducing the occurrence of infections in the facility. She stated more education would be provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations	F 883		7/19/23

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F 883	Continued From page 30 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 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	F 883		

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F 883	Continued From page 31 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 record review and staff interviews the facility failed to provide education on the pneumococcal vaccine regarding the benefit and potential side effects and offer the vaccine to 2 of 5 residents (Resident #3, #4) who were reviewed for immunizations. Findings included. A review of the "Resident Vaccination Policy" revised 05/18/22 read in part; Residents and/or their Responsible Party will be asked about prior vaccinations on admission. Prior doses of the pneumococcal and other vaccines will be documented in the electronic health record. The pneumococcal vaccine will be offered to all residents and administered per order. The date of historical vaccinations will be documented in the health record on admission and as information comes in. If historical vaccination information is not known the resident/representative will provide	F 883	F883 Facility obtained pneumococcal vaccine consent and educated resident #3 (declined) and resident #4 (received) on (7/13/2023). The Director of Nursing and the administrative nursing team reviewed each medical record on (7/14/2023) to determine who was qualified to receive the pneumococcal vaccination. Consents or Declines along with education will be completed on each qualified resident by 7/14/2023. The vaccinations will be administered as soon as they arrive from Omnicare pharmacy. Education was provided to the Infection Control preventionist and the facility Unit Managers by the Director of Nursing on	

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their best estimate of dates of prior vaccinations. Education will occur before administration of the vaccine.

The Centers for Disease Control (CDC) guidelines dated 02/13/23 recommended routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults 65 years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown.

a.) Resident #3 was admitted to the facility on 03/04/21 with diagnoses including Renal Disease and Heart Failure.

The Minimum Data Set (MDS) assessment dated 03/10/23 revealed Resident #3 was cognitively intact. She was over the age of 65 and the pneumococcal vaccine was not up to date and not offered.

A review of the facility Immunization Report dated 06/21/23 revealed Resident #3 was ineligible to receive the pneumococcal vaccine.

A review of Resident #3's medical record revealed no documentation regarding education, or the administration of the pneumococcal vaccine since the last recertification survey on 12/09/22. There was no documented information regarding a contraindication in receiving the vaccine, and no historical data of previous vaccination.

An interview was conducted on 06/23/23 at 10:00 AM with Resident #3. She was alert and oriented and stated she did not recall speaking with any staff member regarding the vaccine. She

7/14/2023 on obtaining immunization records on admission, documentation process, obtaining consent and providing resident education.

New admissions will be audited weekly for 12 weeks to ensure vaccination history is obtained on admission, documented accurately, consent/decline obtain and education has been completed and recorded. Any errors in the process will be corrected and re-education will be provided. The audits will be reviewed monthly in the Quality Assurance Performance Improvement meeting. The Quality Assurance team may change the plan of correction or extend the audits to ensure ongoing compliance.

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indicated she did not think she had ever received the pneumococcal vaccine and stated she would receive the vaccine if it was offered to her.

b.) Resident #4 was admitted to the facility on 06/05/21 with diagnoses including Diabetes, Heart failure, and Lung Disease.

The Minimum Data Set (MDS) assessment dated 05/10/23 revealed Resident #4 was cognitively intact. She was over the age of 65 and the pneumococcal vaccine was coded as up to date.

A review of the facility Immunization Report dated 06/21/23 revealed Resident #4 was ineligible to receive the pneumococcal vaccine.

A review of Resident #4's medical record revealed no documentation regarding education, or the administration of the pneumococcal vaccine since the last recertification survey on 12/09/22. There was no documented information regarding a contraindication in receiving the vaccine, and no historical data of previous vaccination.

An interview was conducted on 06/23/23 at 10:30 AM with Resident #4. She was alert and oriented and stated she did not recall speaking with any staff member regarding the vaccine. She indicated she did not think she had ever received the pneumococcal vaccine and stated she would receive the vaccine if it was offered to her.

During an interview on 06/23/23 at 11:30 AM the Infection Control Nurse stated she became the Infection Control Nurse in November 2022. She stated after becoming the Infection Control Nurse she reviewed the Immunization Report and stated

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over time she thought she had talked with all of the residents who were eligible to receive the pneumococcal vaccine and if they had not, she would offer the vaccine. She stated Resident #3 or Resident #4 had not received the pneumococcal vaccine at the facility and indicated there was no documented contraindication in receiving the vaccine in the medical record for either resident. She stated she provided verbal education regarding the pneumococcal vaccine but there was no documentation in the residents medical record of the education that she provided. She stated if ineligible was listed on the Immunization Report that meant the resident or Responsible Party (RP) must have indicated they had received the vaccine.

During an interview on 06/23/23 at 11:45 AM the Admissions Coordinator stated she does not discuss vaccines with residents or their Responsible Party on admission. She stated she only pulled the vaccine information from the residents' hospital record and puts that in the admission packet.

During an interview on 06/23/23 at 12:00 PM the Director of Nursing (DON) stated the Infection Control Nurse was responsible for education and offering vaccines, and keeping track of residents that were eligible to receive the pneumococcal vaccine. She stated she was not aware the pneumococcal vaccines were not up to date for all eligible residents. She indicated the Infection Control Nurse should be reviewing the Immunization Report to determine if all residents are up to date and providing education and offering the vaccine if indicated.