STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345199	A. BUILDING _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROL WOODS	750 WEAVER DAIRY ROAD CHAPEL HILL, NC 27514

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 6/3/24 through 6/6/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #W7DG11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 6/3/24 through 6/6/24. Event ID #W7DG11.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		6/29/24

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

Electronically Signed | 06/28/2024

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 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare and Medicaid Services (CMS) database (Resident #1) and failed to electronically transmit to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, a 5 day assessment within 14 days of the completion date (Resident #16) for 2 of 9 residents reviewed for resident assessment. Findings Included: a.Resident #1 was admitted on 12/30/24. The	F 640	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed so as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an	

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F 640	Continued From page 2 discharge MDS assessment dated 3/5/24 was signed as completed on 3/8/24. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 6/5/24 did not indicate this assessment had been accepted. An interview was conducted on 6/6/24 at 10:22 AM with MDS Nurse #1. She indicated that she completed the assessment but was not sure why this was not transmitted and accepted correctly but she had been behind from being off the month of January 2024. An interview was conducted on 6/5/24 at 1:57 PM with the Director of Nursing. She indicated that she is not sure why the MDS Nurse #1 did not confirm that the assessment had been transmitted and accepted and that all assessments should be completed and submitted within the required timeframes. b.Resident #16 was admitted on 1/16/24. A review of Resident #16 5-day assessment with an Assessment Reference Date (ARD) of 1/18/24 was signed as completed on 2/1/24. The assessment was submitted to the QIES ASAP system on 3/13/24. An interview was conducted on 6/5/24 at 1:57 PM with the Director of Nursing. She indicated that she is not sure why the MDS Nurse #1 did not confirm that the assessment had been transmitted and that all assessments should be completed and submitted within the required timeframes.	F 640	admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected: The Director of Nursing audited records for all residents affected and successfully transmitted MDS on June 7, 2024 . 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was conducted by the Director of Nursing on all admissions dating back to June 3, 2023, cross referencing submissions from the Electronic Health Record and Simple LTC validation reports to ensure all MDS submissions were accepted. Submissions not accepted have been re-submitted and validated on June 28, 2024. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing (DON) in-serviced the MDS Coordinator on June 25, 2024 on completing and transmitting assessments within the required timeframe. The DON also in-serviced the MDS Coordinator on June 25, 2024 on running validation reports to ensure successful transmission of the assessment. The MDS Coordinator or designee will print transmission validation reports and will place them in the Validation Report binder. Director of Nursing or designee will conduct a weekly audit of 100% of transmissions for one month, followed by a weekly audit of 50% of transmissions for two months.	

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F 640	Continued From page 3 An interview was conducted on 6/6/24 at 10:22 AM with MDS Nurse #1. She indicated that she completed the assessment, but it was rejected and had to be resubmitted. She further revealed that she did not know why this was done late but that and that she had been behind from being off the month of January 2024.	F 640	4. How the facility plans to monitor its performance to make sure solutions are sustained: The Quality Assurance and Performance Improvement Team (QAPI) will review results of audits monthly for three months and make recommendations as needed.	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		6/29/24

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F 657	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise the care plan in the area of falls for Resident # 2. This was for 1 of 9 residents reviewed for care plans. The findings included: Resident #2 was admitted to the facility on 1/5/22 with diagnoses that included cerebral infarction and unsteadiness of feet. Resident #2's active care plan dated 10/24/23 revealed a focus that read resident was at risk for falls related to weakness and fall history. The care plan was initiated on 1/5/22. The active care plan has had no other updates or revisions since 10/24/23. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 3/27/24 indicated that Resident #2 was cognitively impaired and no falls since admission. A review of the nurse's progress note dated 4/2/24 and authored by Nurse #1, revealed Resident # 2 had attempted to go to the bathroom without calling for staff assistance and fell in her room. The progress note further revealed staff implemented more frequent checks on Resident #2 due to the possibility of her forgetting to call for staff assistance again. An interview was conducted on 06/05/24 at 12:07 PM with MDS Nurse #1. She indicated that Resident #2's falls care plan had not been reviewed or revised since 10/24/23 due to an oversight and the care plan should have been	F 657	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed so as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected: The care plan of the affected resident was reviewed and updated by the DON on June 5, 2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing conducted a 100% audit on care plans for all current residents related to falls to ensure all care plans are accurate and interventions updated. The DON has conducted a 100% audit on care plans for all current residents to ensure care plans have been reviewed and revised at least every 92 days. 3. What measures will be put into place or systemic changes made to ensure that	

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F 657	Continued From page 5 updated to reflect the fall that occurred in the facility. An interview was conducted on 6/5/24 at 12:39 PM with the Director of Nursing. She revealed that she does not know why Resident #2's falls care plan had not been reviewed or revised since 10/24/23 but the care plan should have been reviewed and revised to reflect the fall in the facility and that each care plan should be reviewed and or revised every 92 days and as needed.	F 657	the deficient practice will not recur: MDS Coordinator and Nurse Coordinators have been in-serviced by Director of Nursing on June 25, 2024 on ensuring interventions implemented post fall are incorporated into resident care plans. MDS Coordinator was in-serviced by DON on June 25, 2024 on reviewing and/or revising care plans every 92 days and as needed. The Director of Nursing or designee will monitor incident reports for falls to ensure care plans have been updated daily for one month, three times a week for one month, and one time a week for one month. Care plan assessment schedule/timeline tool will be utilized to audit care plans to ensure revision at least every 92 days. The Director of Nursing or designee will audit to ensure revisions made based on the care plan assessment schedule/tool three times a week for one month, two times a week for one month, and one time a week for one month. 4. How the facility plans to monitor its performance to make sure solutions are sustained: The Quality Assurance and Performance Improvement Team (QAPI) will review results of audits monthly for three months and make recommendations as needed.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		6/29/24

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F 812	Continued From page 6 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food items, and label and date food available for resident use in 1 of 1 walk-in cooler and 1 of 4 reach-in coolers in the main kitchen, in 1 of 1 walk-in cooler and in 2 of 3 reach-in coolers in building 4 kitchen, and in 2 of 4 nourishment room refrigerators (wren and blue bird pods' refrigerators) in the 3rd floor of building 4 where the nursing home residents resided. These practices had the potential to affect food and beverages served to the residents. Findings included: a. An initial tour of the kitchen on 6/3/24 at 11:05 am was made with the Dining Services Director, Master Chef and building 4 Kitchen Manager. An initial observation of the walk-in cooler on 6/3/24 at 11:10 am revealed an opened bag of large flour tortillas dated 4/23/24, a large tray of mushrooms labeled "Discard 5/28/24", a half	F 812	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed so as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected: All stored food was audited. Expired, undated or unlabeled items were discarded during inspection.	

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F 812	Continued From page 7 block of white cheese wrapped in plastic dated 4/30/24, an opened jar of blue cheese dressing without any date, an opened jar labeled with a marker "salad dressing 5/27/24 discard 5/30/24", an opened jar of cheese vinaigrette dressing labeled 5/16/24. b. An initial observation of the reach-in cooler in the main kitchen on 6/3/24 at 11:15 am revealed a medium tray labeled egg salad with a sticker date showing 5/24/24 and discard 5/27/24, and olives in a large tray with a sticker date of 5/24/24 and discard 5/27/24. The Dining Services Director stated they were mislabeled but should have been discarded after 7 days. The Master Chef stated the items in the main kitchen were used in preparation of food for residents in all buildings. c. An initial observation of the building 4 kitchen where the nursing home residents resided on 6/3/24 at 11:45 am revealed the walk-in cooler had an open carton of fat free milk dated 5/20/24, reach-in cooler #1 had a small tray of shredded cheese without any date, reach-in cooler #2 had a small tray of lettuce without any date and an opened bag of turkey slices dated 5/24/24. d. An initial observation of the nourishment refrigerators on 6/5/24 at 2:30 pm revealed an opened lemonade bottle without a date in the wren pod's refrigerator. The blue bird pod's refrigerator had 6 small cups of cottage cheese dated 3/17/24 with a marker and a small, opened bag of loaf bread dated 4/20/24. During an interview on 6/5/24 at 1:51 pm, the Dining Services Director stated the Master, and the Sous Chefs were responsible for checking labels and expiration dates in the main kitchen	F 812	2. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was performed in the main kitchen, satellite kitchen and nourishment refrigerators. All expired, undated, and unlabeled items were discarded during the audit. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Food service personnel were in-serviced on how to properly store, label and date food. The Dining Service Director or designee will complete a quality improvement audit of storing, labeling and dating of food, three times a day for one month, once a day for one month, and two times a week for one month. 4. How the facility plans to monitor its performance to make sure solutions are sustained: The Quality Assurance and Performance Improvement Team (QAPI) will review results of audits monthly for three months and make recommendations as needed. 5. Completion Date: 6/29/2024	

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F 812	Continued From page 8 twice daily. He stated one of them was off during the initial tour and the checks were not done yet. He stated there were a lot of new staff that needed to be trained in food storage. He stated the Kitchen Manager was responsible for checking food items in building 4 and she was new. The nourishment refrigerators were also checked by the Kitchen Manager and her staff. He stated they should be checked twice daily. During an interview on 6/5/24 at 3:24 pm, the Administrator stated she was aware of unlabeled and misdated food items found in the kitchen. She stated they will work on correcting the problem. During a follow up interview on 6/6/24 at 9:59 am, the Administrator stated she expected staff to follow their policy on labeling and storing food items.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and	F 851		6/29/24

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F 851	Continued From page 9	F 851		

services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

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F 851	Continued From page 10 §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to submit accurate payroll data, regarding 24-hour licenses nurse coverage, for 9 of 9 days reviewed (10/14/23, 10/28,23, 11/25/23, 11/26/23, 12/9/23, 12/16/23, 12/17/23, 12/23/23, 12/31/23) of the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) for the 1st quarter in fiscal year 2024. Findings included: The CMS submission report, PBJ Final File Validation Report for Fiscal Year 2024 (October 1 to December 31) showed the facility failed to have Licensed Nursing Coverage, 24 hours out of 24 hours for the days of 10/14/23, 10/28/23, 11/25/23, 11/26/23, 12/9/23, 12/16/23, 12/17/23, 12/23/23, and 12/31/23. Posted Nurse Staffing, nurse schedules, and the nursing staff's timecards for 10/14/23, 10/28,23, 11/25/23, 11/26/23, 12/9/23, 12/16/23, 12/17/23, 12/23/23, and 12/31/23 were reviewed and revealed there was 24-hour licensed nursing coverage for the 1st quarter of Fiscal Year 2024. During an interview with the Administrator on 6/6/24 at 11:35am she revealed that there was 24-hour licensed nursing staff working on 10/14/23, 10/28,23, 11/25/23, 11/26/23, 12/9/23, 12/16/23, 12/17/23, 12/23/23, and 12/31/23 but that the office must have not submitted the	F 851	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed so as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected: A review was done and corrections were completed for October, November, and December 2023. The facility is unable to resubmit these corrections to Payroll Based Journal based on Payroll Based Journal□s policy of not accepting corrections or revisions after the original file is submitted. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: A review was done and corrections were completed for January, February, and	

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	345199	A. BUILDING _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROL WOODS	750 WEAVER DAIRY ROAD CHAPEL HILL, NC 27514

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F 851	Continued From page 11 information incorrectly.	F 851	March 2024. The facility is unable to resubmit these corrections to Payroll Based Journal based on Payroll Based Journal□s policy of not accepting corrections or revisions after the original file is submitted. Corrections have been made for April and May 2024. June 2024 will be reviewed for accuracy. After this review, April, May, and June 2024 will be submitted to Payroll Based Journal. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Payroll Specialist was in-serviced on ensuring Payroll Based Journal information is complete and accurate prior to quarterly submission. After payroll is completed monthly, nurse schedule of hours worked and the Payroll Based Journal report will be audited by the Vice President of Human Resources or designee to ensure the Payroll Based Journal report accurately reflects nursing hours worked for the month. Prior to quarterly submission of the Payroll Based Journal report, the Administrator or designee will cross-reference the report with nursing hours worked to ensure the Payroll Based Journal submission is accurate. 4. How the facility plans to monitor its performance to make sure solutions are sustained: The Quality Assurance and Performance Improvement Team (QAPI) will review results of audits monthly for three months and make recommendations as needed.	

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F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		6/29/24

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F 883	Continued From page 13 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 resident and staff interviews the facility failed to follow their policy on pneumococcal vaccine and offer up to date pneumonia vaccines to 5 of 5 residents reviewed for immunization status (Resident #3, Resident #8, Resident #9, Resident #12, and Resident #123). The findings included: The facility's policy on pneumococcal vaccine last reviewed in July 2023 stated, "the administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendation at the time of the vaccination." a. Resident #3 was admitted to the facility on 1/30/24. Her diagnoses included rheumatic heart disease, hypertension and atrial fibrillation. Review of Resident #3's immunization record	F 883	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies cited in the CMS-2567. The statements made in this Plan of Correction are not an admission to and do not indicate an agreement with the alleged deficiencies. This Plan of Correction is written and executed so as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. Response to this Statement of Deficiencies does not constitute an admission that any deficiency is accurate. 1. What corrective action will be accomplished for residents affected: Residents identified during the survey have all received approval from their Provider to receive the updated	

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F 883	Continued From page 14 revealed she received PPSV23 on 10/16/14 and PCV13 on 2/1/16. Review of the quarterly Minimum Data Set (MDS) dated 5/8/24 revealed Resident #3 was cognitively intact, and her pneumococcal immunization was up to date. Review of Resident #3's medical record revealed no information that the Resident or their legal representative was provided education regarding the benefits and potential side effects of the 20-valent pneumococcal conjugate vaccine (PCV20). During an interview on 6/5/24 at 10:30 am, Resident #3 stated she did not know about pneumonia vaccine. She could not remember if a staff member talked to her about it. b. Resident #8 was admitted to the facility on 1/5/24. Her diagnoses included atherosclerotic heart disease, cholecystitis and hypertension. Review of Resident #8's immunization record revealed she received PPSV23 on 4/15/10 and a PCV13 on 10/4/16. Review of the quarterly MDS dated 4/13/24 revealed that Resident #8 was cognitively intact, and her pneumococcal immunization was up to date. Review of Resident #8's medical record revealed no information that the Resident or their legal representative was provided education regarding the benefits and potential side effects of PCV20 vaccine.	F 883	pneumococcal vaccination and have been inoculated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All remaining residents have been audited to determine current pneumococcal vaccination status. Residents wishing to receive updated pneumococcal vaccination with approval from their Provider have all been inoculated. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All Nurse Coordinators were in-serviced on the policy of offering all new admissions the pneumococcal vaccine based on current Center for Disease Control and Prevention guidelines and resident vaccination status. New admissions will be audited by the Director of Nursing or designee two times a week for the first month and one time a week for two months. 4. How the facility plans to monitor its performance to make sure solutions are sustained: The Quality Assurance and Performance Improvement Team (QAPI) will review results of audits monthly for three months and make recommendations as needed. 5. Completion Date: 6/29/2024	

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F 883	Continued From page 15	F 883		

During an interview on 6/5/24 at 10:40 am, Resident denied being offered a pneumonia shot and denied receiving one.

c. Resident #9 was admitted to the facility on 3/31/24. His diagnoses included chronic kidney disease, heart attack and stroke.

Review of Resident #9's immunization record revealed he received PPSV23 on 1/1/94 and a PCV13 on 4/22/16.

Review of the comprehensive MDS dated 4/7/24 revealed that Resident #9 was cognitively intact, and his pneumococcal immunization was up to date.

Review of Resident #12's medical record revealed no information that the Resident or their legal representative was provided education regarding the benefits and potential side effects of PCV20 vaccine.

Resident #9 was not available for interview.

d. Resident #12 was admitted to the facility on 10/6/22. His diagnoses included diabetes mellitus, hypertension and vascular dementia.

Review of Resident #12's immunization record revealed he received PPSV23 on 7/13/10 and a PCV13 on 2/26/16.

Review of the quarterly MDS dated 5/14/24 revealed that Resident #12 was severely cognitively impaired, and his pneumococcal immunization was up to date.

Review of Resident #12's medical record

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F 883	Continued From page 16	F 883		

revealed no information that the Resident or their legal representative was provided education regarding the benefits and potential side effects of PCV20 vaccine.

The resident's representative was not available for interview by telephone during the survey.

e. Resident #123 was admitted to the facility on 8/25/23. His diagnoses included hypertension, atherosclerotic heart disease and vascular dementia.

Review of Resident #123's immunization record revealed he received PPSV23 on 7/7/10 and a PCV13 on 4/3/15.

Review of the quarterly MDS dated 5/31/24 revealed that Resident #123 was cognitively intact, and his pneumococcal immunization was up to date.

Review of Resident #123's medical record revealed no information that the Resident or their legal representative was provided education regarding the benefits and potential side effects of PCV20 vaccine.

Resident #123 preferred not to be interviewed during the survey. During an interview on 6/5/23 at 3:50 pm, his representative stated she did not get any information on the update pneumonia vaccine for the resident.

During an interview on 6/5/24 at 2:24 pm, the Infection Preventionist stated she thought the residents did not need any more pneumococcal vaccines after they received the PPSV23. She stated she would check the current guidelines.

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F 883	Continued From page 17 During a follow up interview on 6/6/24 at 8:46 am, the Infection Preventionist stated she would discuss the current guidelines for the pneumococcal vaccine with the Medical Director. During an interview on 6/6/24 at 10:03 am, the Director of Nursing stated she expected staff to follow the facility's policy, current guidelines and immunization best practices for the residents.	F 883		