STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075135	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare Health Center	22 Masonic Avenue Wallingford, CT 06492

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on review of clinical records, review of facility policy/procedures and interviews for three of six sampled residents (Resident #18) reviewed for advance directives, the facility failed to ensure consents were obtained regarding the resident's wishes regarding advance directives and decisions related to cardiopulmonary code status from the resident/responsible party. The findings include: 1. Resident #18 was admitted to the facility in July/2024. The resident was sent out to the hospital on [DATE], and readmitted to the facility in September of 2024 with diagnoses that included metabolic encephalopathy, altered mental status, and cerebral infarction. The admission MDS assessment dated [DATE] identified Resident #18 had severely impaired cognitive function, did not display behaviors, required substantial/maximal assistance with bed mobility, dressing and personal hygiene and was dependent for transfers. The care plan dated [DATE] identified Resident #18 was at risk for impaired cognitive function related to disease process with interventions that included administer medications as ordered, ask yes or no questions, cue, reorient, and supervise as needed. Review of the clinical record identified an advance directive form with a [DATE] date. The form was signed by Resident #18's Responsible Party and denoted a code status of CPR, full code which indicates that in the event the resident's heart stops, cardiopulmonary resuscitation will be performed. A review of the resident's physical clinical record (paper) identified an advance directive form that identified do not attempt CPR, allow death to occur naturally DNR (Do Not Resuscitate). The form was incomplete in that it did not have the resident's date of birth filled in, there were no dates or signatures of nurses or providers. There was only a hand written message that identified that the Responsible Party had decided on a code status of DNR for Resident #18. The physician's order dated [DATE] directed to discontinue CPR, and directed a code status of DNR and RN may pronounce. The unit roster identified Resident #18 had a code status of DNR. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 2:00 PM with LPN #8 identified the electronic record identified Resident #19's [NAME] status was DNR. She further noted that the residents also have bracelets that reflect their code status, red bracelets are for DNR status, and white bracelets are for full code status. Interview on [DATE] at 2:30 PM with RN#6 (Unit Manager) identified advance directives are signed upon admission and scanned into the resident's electronic health record. You can find the code status in the header of the electronic record and a copy of the advance directive in the physical record. There are also bracelets utilized to indicate code status: however, you never want to go just off the bracelet when determining someone's code status. If a resident's power of attorney/responsible party gives a verbal agreement/decision via telephone call, then it should be signed by two nurses and then put in the binder for the APRN to sign, there should also be a date and time of the telephone call. Interview on [DATE] at 2:57 PM with the DNS identified the advance directive form should be completed upon admission, and signed by two nurses, as well as the APRN. Resident #18's advance directive was not completed correctly and was incomplete. Subsequent to surveyor inquiry on [DATE] a new advance directive form was completed indicating Resident #18 had a code status of full code indicating the wish to have CPR performed. Interview on [DATE] at 10:09 AM with Resident #18's Responsible Party identified that it had previously been his/her wish to make Resident #18 a DNR when readmitted to the faciality, however the facility reached out to him/her on [DATE] to clarify his/her wishes and he/she would like to have Resident #18 as a full code. Review of the advanced directive policy directed that on admission of a resident who is not competent, the resident's family or designated proxy should be asked whether the resident ever executed advance directives, if no written record of advance directive exists, attempts should be made to ascertain whether the resident has ever expressed wishes regarding resuscitation, life support and procedures and treatments, and if so, what were the terms. Within three days of admission the social worker will verify the presence of the advance directive in the resident's chart and discuss advance directives with the resident, allowing him/her to execute or change any advance directive if he/she so desires. Information will be documented in the resident's chart and communicated to the physician by the social worker or other members of the care team. The advance directives will be in the medical record. 2. Resident #22 was admitted to the facility in April of 2024 and had diagnoses that included Parkinson's disease, bipolar II disorder, and type 2 diabetes. The admission MDS assessment dated [DATE] identified Resident #22 was cognitively intact, dependent on care with toileting hygiene, dressing, transfers and moderate assistance with personal hygiene. The assessment further identified that the resident did not ambulate, utilized a wheelchair and dependent for wheelchair mobility. The physician's order dated [DATE] identified a code status of cardiopulmonary resuscitation (CPR). A CPR code status means if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physical chart and the electronic health record both failed to identify a signed Advance Directives Summary form/consent by the resident/resident representative indicating the resident's wishes for a code status. Interview and clinical record review with the Charge Nurse (LPN#7) on [DATE] at 2:30 PM identified that if Resident #22 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the clinical record at the physician's order, and the document/ miscellaneous tab to review the scanned Advance Directive Summary form/consent in the electronic health record. LPN #7 noted the physician's order directed CPR; the document/ miscellaneous tab failed to identify a copy of the signed Advance Directive Summary form. Additionally, LPN #7 identified that the physician's order should match the Advance Directive Summary consent form. LPN #7 identified the Advance directive form should be completed on admission by the resident/responsible party, then a physician's order is obtained, the copy goes into the doctor's book to be sign and scanned into the electronic health record. Interview with Resident #22 on [DATE] at 1:40 PM identified that he/she did not recall the facility having any discussion regarding his/her advance directive or code status wishes nor did he/she sign any documents since being admitted to the facility. Interview with the Director of Social Services (SW#1) on [DATE] at 9:15 AM identified that she obtains code status information from the advance directive consent form and the physician's order. Additionally, SW#1 identified she was not responsible for the completion of the Advance Directive Summary consent form with resident/responsible party. SW #1 identified that nursing is responsible for paperwork regarding advance directives. Interview with the Unit Manager (RN #4) on [DATE] at 1:05 PM identified the Advance Directive Summary consent form is completed and signed on admission. She identified the code status would be reviewed with residents who are capable and/or the responsible party would be contacted for residents who are not capable of completing the form. After the form is completed, a physician's order is obtained via telephone or written, the order is entered into the electronic health record, and the form is scanned into the electronic health record. RN #4 identified she contacted Resident #22's Responsible Party and spoke with Resident #22 and consent was obtained on [DATE]. RN #4 indicated that she is unable to state why Resident #22's consent was not obtained on admission. Interview with the DNS on [DATE] at 2:58 PM identified that Advance Directives are completed on admission and a copy of the form/consents should be uploaded into the electronic record and placed in the physical chart. Review of the Advance Medical Directives policy identified prior to admission, the facility's admission office shall include in the admission packet an explanation of Advance Medical Directives to the resident and his/her family. The policy further identified the resident will be asked if he/she has executed any Advance Directive, the resident or his/her proxy will indicate by signature, acknowledgment of receipt of the information about Advance Directive and that the facility has asked if the resident has executed any Advance Directive. 3. Resident #128 was admitted to the facility in [DATE] with diagnoses that included unspecified dementia, dysphagia, oropharyngeal phase, anxiety disorder and major depressive disorder. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #128 had severe cognitive impairment and was dependent on staff for all personal care/hygiene, transfers and mobility. The care plan dated [DATE] identified Resident #128 had a terminal prognosis related to dysphagia and was admitted to hospice services with interventions to encourage support of family and friends, keep the environment quiet and provide maximum comfort for the resident. The physician's orders for October, November, and December of 2024 directed a code status of do not resuscitate (DNR) and RN may pronounce. Review Resident #28's electronic health record and the physical clinical record on [DATE] at 10:00 AM failed to identify an advance directive form with documentation of the resident's/responsible party's wishes related to code status inclusive of dates and signatures. Interview on [DATE] at 11:00 AM with the Director of Quality Improvement identified the Advance Directives were part of the admission paperwork and there was not a facility policy on obtaining the admission signatures. She indicated that if the family/POA/Conservator was not able to come in to the facility to sign, they are able to email paperwork, and the nurse could take a verbal consent over the phone as long as it was witnessed by two nurses. Interview on [DATE] at 2:35 PM with LPN #5 identified that the facility was transitioning to all electronic records and items may not be present in the paper chart but should be scanned into the electronic health record. LPN#5 was not able to locate a physical or scanned copy of the written Advance Directive. Interview on [DATE] at 2:21 PM with RN#3 identified Resident #128 had physician's orders that directed the resident had a code status of DNR but failed to locate the written advance directives in the clinical record. RN#3 further identified that code status is reviewed and verified by the unit secretary and were just completed last Tuesday, or 7 days prior by the unit secretary. Interview on [DATE] at 2:25 PM with the Unit Secretary identified she verified the code status by looking in the electronic health record to see what was recorded under the advance directive header in the special instructions at the top of each electronic health record and verified this status matched the physician's order. Interview on [DATE] at 2:58 PM with the DNS identified that Advance Directives are obtained by hospital discharge paperwork if the resident is admitted from the hospital or if a resident is alert and oriented the paperwork is signed on admission. Nurses are able to get verbal consent by phone as long as two nurses witness it. Advance Directives are scanned into the resident's electronic health record as part of the admission process by the unit secretaries and many of the copies can be found in the previous electronic system, which we do not have access to. She indicated that if there were a code on the floor, the Advance Directive is listed on the resident face sheet. Additionally, the DNS confirmed there were no written advance directives for Resident #128 located in the resident chart. Subsequent to surveyor inquiry a nurse's noted dated [DATE] at 4:38 PM identified Resident #128's Responsible Party gave verbal consent for a code status of DNR. The advance directive form was completed with two nurse signatures and dates to verify the consent. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy for Advance Medical Directives identified the procedure for obtaining advance directive should be reviewed within the first three days of admission and annual review by social services included verifying the presence of the Advance Directive forms in the resident's chart. Additionally, the policy identified the resident's wishes will be noted in the chart and the Advance Directive documents will be located in the medical record. 47489 47900

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47489 Based on observation and interviews for the facility and 1 of 6 sampled residents (Resident #80) reviewed for Abuse, and for the facility reviewed for a safe, clean, comfortable and homelike environment, the facility failed to ensure residents resided in a safe, clean, comfortable environment. The findings included: Observation on 12/2/24 at 12:00 PM of the 3 Ramage unit North side identified a hole in the wall on the left side of the nurses' station with facility maintenance staff standing by it. The maintenance staff identified there had been a water leak and staff was standing by awaiting additional staff to replace the sheet rock. At that time this was the only active work being done. However, the base molding on the entire unit was not present. Observation on 12/4/24 at 11:05 AM of 3 Ramage North and South identified the walls in all the hallways were patched with spackle and sanded. The drywall residue/dust was clumped on the floor under the areas of sanding, spread across the floor of the hallway, across some resident room doorways, behind the barrier doors in the hallway, on the handrails throughout the hallway. Additionally, white footprints of drywall residue were noted to be in the North stairwell down the first set of stairs. Interview on 12/4/24 at 11:05 AM with the Facility Manager, Administrator, Unit Manager, and BFSI, subsequent to surveyor inquiry, identified that the secured unit 3 Ramage North and South had some work done in preparation for painting that was scheduled over the week. The facility manager identified that the staff performing the work should have cleaned up after themselves but failed to do so. Additionally, the residents of the unit had been walking or wheeling through the hallway and tracking the dust throughout the unit on the wheelchairs and feet. According to the Administrator there were no respiratory or other complaints related to the excessive drywall residue. The identified plan was to move all residents to the dining area and complete the necessary cleaning and painting. Observation on 12/4/24 at 11:59 AM identified residents, with exception of one resident, from 3 Ramage had been moved out of the resident rooms and placed in the dining room and the South end Lounge while a terminal clean of the hallway and resident rooms was completed. The barrier doors in the hallway were closed and the cleanup area was not accessible to the residents. Staff were vacuuming and wiping down the walls and handrails. Interview on 12/9/24 at 9:05 AM with the Facility Manager identified that the work crew should have swept up the mess, drywall residue, at the end of the day, so it was not left in the hallway and covering surfaces. Additionally, he indicated that an in-service was conducted to educate staff on work performed and impact on residents if areas are not cleaned. Observation on 12/2/24 at 11:05 AM identified Resident #80 in bed with bed in the lowest position. The window curtain was attached to the window track halfway with half of the curtain hanging down with the metal curtain hooks hanging and exposed in the resident room. The bedside privacy curtain was halfway drawn with several brownish, reddish colored splatters. Additionally, there was a cable wire protruding from the wall without a wall cover, so the inside of the wall was exposed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/3/24 at 2:35 PM of Resident #80's room identified the window curtain was attached to the window track halfway with half of the curtain hanging down with the metal curtain hooks hanging, exposed in the resident room. The bedside privacy curtain was halfway drawn with several brownish, reddish colored splatters. Additionally, there was a cable wire protruding from the wall without a wall cover, so the inside of the wall was exposed. Interview on 12/3/24 at 2:38 PM with LPN #5 identified the soiled bedside curtain would be changed by housekeeping and that a work order would be placed to fix the curtain and the wire protruding from the wall. Observation on 12/4/24 at 12:05 PM identified Resident #80's room with a soiled bedside curtain, a window curtain that is half attached to the window with exposed metal hooks, and a cable wire not secured to the wall and with the inside of the wall exposed. Interview on 12/04/24 at 12:18 PM with the Administrator who identified the window curtains would be fixed, the bedside curtain replaced due to being soiled, and the cable wire in the wall secured.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on observations, review of clinical records, review of facility policy and interviews for three of six sampled residents (Residents #13, #38, #82) who resided on a secured unit, the facility failed to ensure there was documentation of the clinical criteria met for placement in the unit and that the secured unit was the least restrictive setting for the residents. The findings include: 1. Resident #13's diagnoses included dementia, bipolar disorder and liver cancer. An Elopement Risk Evaluation dated 10/3/24 indicated Resident #13 was disoriented, and forgetful with intermittent confusion, had a diagnosis of a cognitive impairment (dementia) and was not appropriate for a wander guard device. The quarterly MDS assessment dated [DATE] identified Resident #13 had severe cognitive impairment, exhibited no behavioral symptoms, was totally dependent for transfers, grooming and toileting, was non-ambulatory, and utilized a manual wheelchair for mobility. Review of psychiatric progress notes from 6/1/24 through 10/8/24 identified Resident #13 had cognitive impairment, memory loss, good mood, no anxiety, restful sleep and a good appetite. Additionally, the psychiatric notes indicated the resident's present medications were effective in managing behaviors and mood, and that the resident was not a danger to self or others. The care plan dated 10/14/24 identified Resident #13 was at risk for elopement related to impaired safety awareness with interventions that included a wander guard. The physician's orders for November/2024 directed to monitor for behaviors including itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusals of care. Review of Nursing Progress Notes from 10/1/24 through 12/9/24 identified Resident #13 was alert, forgetful and confused at times. Additionally, Resident #13 was pleasant with no unwanted behaviors displayed. The review further identified; Resident #13 had difficulty with word finding at times but was easily redirected. Interview on 12/6/24 at 2:05 PM with Person #2 (Responsible Party), indicated there had been a discussion regarding the move from another unit at the facility to the secured unit. Person #2 was unable to recall if a consent form was signed specifically for the secured unit Observation on the secured unit on 12/9/24 at 2:22 PM identified Resident #13 seated in a manual wheelchair being assisted by staff to go to his/her room, and Resident #13 was noted to have the ability to move self-propel small distances. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility Assessment identified the facility had two secured memory care units. It also indicated the facility provided care and services based on the resident population, including the following, behavioral health issues, psychosocial support, mobility assistance, medication and medication management, wound care, infection control, rehab, respiratory therapy, incontinence prevention/care, assistance with activities of daily living, intravenous therapy, nutrition and therapeutic recreation. The facility assessment failed to identify criteria for placement on the secured units. Resident #13's clinical record failed to include the following: documentation by the physician of the clinical criteria met for placement on the secured unit, documentation by the interdisciplinary team of the impact and or reaction of the resident regarding placement on the secured unit, documentation to support the secured unit being the least restrictive setting/approach for the resident, involvement of the resident's responsible party in the decision to house the resident on the secured unit, and documentation in the care plan that the resident resided on a secured unit and the ongoing assessment of the resident's continued need to be on a secured unit. Interview on 12/9/24 at 10:11 AM with the Administrator identified the residents admitted to the secured unit have a dementia diagnosis, and may include behaviors like wondering, intrusiveness, or other behavioral issues. The Administrator further identified the interdisciplinary team at the facility discuss the residents in morning report every day regarding any behaviors or changes in condition. Including, residents who may be appropriate to be moved onto the secured unit or any resident that maybe appropriate to move to another unit in the facility, or who are no longer appropriate to be on the secured unit. Wandering assessments are completely quarterly and when there is a change in condition. When a resident has wandering behaviors or other behaviors like potential elopement, discussions occur with the family/representatives regarding moving to one of the secured units. Further, the Administrator noted there should be documentation of the discussions regarding any move to or out of the secured unit in the resident's clinical record. She noted physicians may not necessarily document in the clinical record regarding the secured unit, and noted that she expects the social worker, nurses, and or APRN would document in the clinical record regarding the residents on the secured unit. Review of the Mission and Guidelines of Memory Care Units policy dated 6/10/2024 directed, in part, to provide care for resident's who have dementia and need a secured specialized unit to provide a safe, structured and secure environment. Provide adaptive social programs and success-based activities specific to the need of each resident incorporating the resident's past interests, hobbies, accomplishments, ethnicity and culture. To maintain and promote the highest level of functioning for each resident as long as possible. To utilize structured assessment tools to trigger modifications to the resident's care plan and approaches to care when indicated. And to provide family members support, education, and update throughout their loved ones stay and duration of their illness. 2. Resident #38 diagnosis included dementia, difficulty swallowing, and falls. The annual MDS assessment dated [DATE] identified Resident #38 was severely cognitively impaired, had behaviors of hitting, kicking, pushing, scratching and or grabbing at others, was dependent for bed mobility, transfers, dressing and personal hygiene, and utilized a wheelchair for mobility. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Elopement Risk Evaluation dated 10/8/24 indicated Resident #38 was disoriented or had intermittent confusion, was combative or severely agitated, had a diagnosis of dementia, and was not appropriate for a wander guard. A psychiatric APRN note dated 10/7/24 identified Resident #38 required long-term care, was combative with care, and not a danger to self or others. The care plan dated 10/21/24 identified Resident #38 was at risk for alteration in mood related to dementia, with interventions that included medications as ordered, psychiatric follow up as needed and report/document behaviors. Observation on 12/2/24 at 11:50 AM identified Resident #38 on the secured unit, awaiting lunch service. The resident was awake, calm, cooperative. Staff moved the wheelchair closer to the table for lunch. The resident is unable to self-propel the wheelchair. The Facility Assessment identified the facility had two secured memory care units. It also indicated the facility provided care and services based on the resident population, including the following, behavioral health issues, psychosocial support, mobility assistance, medication and medication management, wound care, infection control, rehab, respiratory therapy, incontinence prevention/care, assistance with activities of daily living, intravenous therapy, nutrition and therapeutic recreation. The facility assessment failed to identify criteria for placement on the secured units. Resident #38's clinical record failed to include the following: documentation by the physician of the clinical criteria met for placement on the secured unit, documentation by the interdisciplinary team of the impact and or reaction of the resident regarding placement on the secured unit, documentation to support the secured unit being the least restrictive setting/approach for the resident, involvement of the resident's responsible party in the decision to house the resident on the secured unit, and documentation in the care plan that the resident resided on a secured unit and the ongoing assessment of the resident's continued need to be on a secured unit. Interview on 12/9/24 at 10:11 AM with the Administrator identified the residents admitted to the secured unit have a dementia diagnosis, and may include behaviors like wondering, intrusiveness, or other behavioral issues. The Administrator further identified the interdisciplinary team at the facility discuss the residents in morning report every day regarding any behaviors or changes in condition. Including, residents who may be appropriate to be moved onto the secured unit or any resident that maybe appropriate to move to another unit in the facility, or who are no longer appropriate to be on the secured unit. Wandering assessments are completely quarterly and when there is a change in condition. When a resident has wandering behaviors or other behaviors like potential elopement, discussions occur with the family/representatives regarding moving to one of the secured units. Further, the Administrator noted there should be documentation of the discussions regarding any move to or out of the secured unit in the resident's clinical record. She noted physicians may not necessarily document in the clinical record regarding the secured unit, and noted that she expects the social worker, nurses, and or APRN would document in the clinical record regarding the residents on the secured unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Mission and Guidelines of Memory Care Units policy dated 6/10/2024 directed, in part, to provide care for resident's who have dementia and need a secured specialized unit to provide a safe, structured and secure environment. Provide adaptive social programs and success-based activities specific to the need of each resident incorporating the resident's past interests, hobbies, accomplishments, ethnicity and culture. To maintain and promote the highest level of functioning for each resident as long as possible. To utilize structured assessment tools to trigger modifications to the resident's care plan and approaches to care when indicated. And to provide family members support, education, and update throughout their loved ones stay and duration of their illness. 3. Resident #82's diagnosis included dementia, heart failure, weight loss. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #82 was severely cognitively impaired, had no behaviors, was dependent for grooming, dressing, transfers and personal hygiene, and utilized a manual wheelchair for mobility. The Elopement Risk Evaluation dated 10/26/24, identified Resident #82 was disoriented, did not understand his/her surroundings, had difficulty with redirection, had a diagnosis of cognitive impairment/dementia and was not appropriate for a wander guard device. A psychiatric physician's note dated 10/29/24 indicated Resident #82 was not a danger to self or others, the resident was on medications that required behavior monitoring The care plan dated 11/4/24 identified Resident #82 was at risk for impaired thought process related to history of dementia with interventions that included cueing, reorienting and supervision as needed. The Facility Assessment identified the facility had two secured memory care units. It also indicated the facility provided care and services based on the resident population, including the following, behavioral health issues, psychosocial support, mobility assistance, medication and medication management, wound care, infection control, rehab, respiratory therapy, incontinence prevention/care, assistance with activities of daily living, intravenous therapy, nutrition and therapeutic recreation. The facility assessment failed to identify criteria for placement on the secured units. Resident #82's clinical record failed to include the following: documentation by the physician of the clinical criteria met for placement on the secured unit, documentation by the interdisciplinary team of the impact and or reaction of the resident regarding placement on the secured unit, documentation to support the secured unit being the least restrictive setting/approach for the resident, involvement of the resident's responsible party in the decision to house the resident on the secured unit, and documentation in the care plan that the resident resided on a secured unit and the ongoing assessment of the resident's continued need to be on a secured unit. Observation on 12/2/24 at 12:22 PM on the secured unit identified Resident #82 sitting up in a wheelchair being assisted with the lunch meal. The resident was unable to self-propel the wheelchair. (continued on next page)

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Masonicare Health Center	22 Masonic Avenue Wallingford, CT 06492

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/6/24 at 1:55 PM identified the entrance onto the third-floor secured unit is through double doors that lead to a telephone for entry onto the unit. Off the third-floor secured unit, is the second secured unit, which has a keypad for entry once through unlocked double doors. There are 3 other ways to exit the secured second unit. A fire exit behind the nurses' station, a door with keypad entry/exit in front of the nurses' station and a keypad entry/exit through the community room that leads to an unsecured 3rd floor rehabilitation unit. Interview on 12/9/24 at 10:11 AM with the Administrator identified the residents admitted to the secured unit have a dementia diagnosis, and may include behaviors like wondering, intrusiveness, or other behavioral issues. The Administrator further identified the interdisciplinary team at the facility discuss the residents in morning report every day regarding any behaviors or changes in condition. Including, residents who may be appropriate to be moved onto the secured unit or any resident that maybe appropriate to move to another unit in the facility, or who are no longer appropriate to be on the secured unit. Wandering assessments are completely quarterly and when there is a change in condition. When a resident has wandering behaviors or other behaviors like potential elopement, discussions occur with the family/representatives regarding moving to one of the secured units. Further, the Administrator noted there should be documentation of the discussions regarding any move to or out of the secured unit in the resident's clinical record. She noted physicians may not necessarily document in the clinical record regarding the secured unit, and noted that she expects the social worker, nurses, and or APRN would document in the clinical record regarding the residents on the secured unit. Review of the Mission and Guidelines of Memory Care Units policy dated 6/10/2024 directed, in part, to provide care for resident's who have dementia and need a secured specialized unit to provide a safe, structured and secure environment. Provide adaptive social programs and success-based activities specific to the need of each resident incorporating the resident's past interests, hobbies, accomplishments, ethnicity and culture. To maintain and promote the highest level of functioning for each resident as long as possible. To utilize structured assessment tools to trigger modifications to the resident's care plan and approaches to care when indicated. And to provide family members support, education, and update throughout their loved ones stay and duration of their illness.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, review of facility documentation, reviews of facility policy and interview for one of three sampled residents (Resident #169) reviewed for accidents, the facility failed to review and revise the resident care plan (RCP) to include interventions for accident prevention following a skin injury obtained during a transfer. The findings include: Resident #169 had diagnoses that included dementia, muscle wasting and atrophy, atrial fibrillation, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #169 with moderate cognitive impairment, dependence on staff for transfers, utilized a wheelchair for mobility, and was non-ambulatory. The nurse's notes dated 7/16/24 at 8:51 PM identified he was called to Resident #169's room related to an open area to the lower right lateral leg. The resident was unable to identify the cause of the injury to the lower right leg. Resident #169 was seated in his/her wheelchair and a was assisting Resident #169 back to bed when the injury was noted. A steri-strip (wound closure tape) was applied, and responsible party was updated. The electronic version of accident and incident summary report dated 7/16/24 identified Resident #169 had a skin tear to his/her right lower leg that measured 3cm in length by 1.5 cm in width and 0.1 cm in depth. The facility investigation identified Resident #169's skin tear occurred while the resident was being transferred to bed. The physician's orders dated 7/16/24 directed to keep steri-strips in place and covered with non-stick dressing and wrap with a stretch gauze daily. The RCP dated 7/17/24 identified Resident #169 was at risk for impaired skin integrity related decreased mobility and bowel incontinence. Care plan interventions directed to provide incontinent care each shift, monitor bony prominences, treatment as ordered to the lower right leg skin tear, and wound consult. The weekly wound assessment dated [DATE] identified Resident #169 had a skin tear to the right lower leg. The wound size was documented as 2.2 cm in length by 1.9 cm in width and 0.2 cm in depth and noted with intact steri-strip. Further review of the weekly wound assessment dated [DATE] identified Resident #169 skin tear to the right lower leg was resolved. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the ADNS on 12/5/24 at 10:30 AM identified that the unit manager/nursing supervisor is responsible for initiating the investigation of an accident/incident and for obtaining statements. He identified the multi-disciplinary team would discuss and develop an intervention to prevent accident/injury after it determined the cause. The ADNS further identified that the multi-disciplinary team determined the cause of Resident #169 skin tear to the lower right leg occurred when NA #3 was transferring Resident #169 back to bed. He identified that the care plan should have included that NA #3 was provided education pertaining to safe transfers of the resident. Additionally, he noted that they did not re-educate NA #3 for safe transfers after Resident #169 had a skin tear to the lower right leg that occurred during the transfer. Interview with RN #2 on 12/5/24 at 2:30 PM identified that he could not recalled the details of Resident #169 skin tear to the lower right leg. He identified that Resident #169's wheelchair was at the bedside, but he could not remember whether Resident #169 skin tear to the lower right leg was noted while the resident was sitting in his/her wheelchair, or it was noted after the resident transferred. He further identified that he did not notice any broken or sharp edges on the wheelchair. Attempts to interview NA #3 were unsuccessful. The Patient and Resident Care Plan policy identified the facility would develope a patient specific care plan for all residents. The care plan would be revised as appropriate for the residents.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46117 Based on review of employee files and staff interviews for one of three nurse aides (NA #4), the facility failed to complete an annual performance evaluation. The findings include: Review of NA #4 personnel file identified a hire date of 1/18/2010 and failed to identify that a yearly performance evaluation was completed for 2022, 2023, or 2024. Interview with administrator on 12/3/24 at 2:30 PM identified that each employee should have a performance review completed on an annual basis on the anniversary of their hire date. She identified that the unit manager on the floor was responsible for ensuring the performance evaluation were completed yearly and could not find documentation to identify that the performance evaluation was completed for NA #4. Although requested, policy for performance evaluation was not available.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for two of five sampled residents (Resident #120, and Resident #135) reviewed for unnecessary medications, the facility failed to ensure documentation of the provider's decisions and actions were noted on the pharmacist consultant's recommendation form and that the form was maintained as part of the clinical record. 1. Resident #120's diagnoses included unspecified dementia, anxiety disorder, and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #120 was severely cognitively impaired, required substantial/maximal assistance with bed mobility and dressing, was dependent on staff for transfers and personal hygiene, and utilized a wheelchair for mobility. The care plan dated 3/7/24 identified Resident #120 was at risk for behavioral changes related to psychotropic medications with interventions that included administer psychotropic medications as ordered and monitor for side effects. Th physician's order dated 3/12/24 directed Seroquel 25mg by mouth every twelve hours as needed for agitation. The pharmacist consultant's note dated 3/14/24 identified a medication recommendation was made, however no pharmacy consultant recommendation was located in the resident record. The pharmacy recommendation from 3/14/24 provided by the ADNS on 12/9/24 identified Resident #120 was recently admitted and did not have a clear diagnosis to support the use of Seroquel 25mg. Further review of the recommendation identified that it had not been addressed by the APRN/Physician. Interview with the ADNS at the time the recommendation was provided identified that she obtained the recommendation via email once the request was made by the surveyor to review the pharmacy recommendations. Interview on 12/9/24 at 3:04 PM with APRN#2 for Resident #120's unit identified that when she gets a medication review, she will sign it within the week, however she only reviews the paperwork that she is given to review and does not receive the pharmacy recommendations directly from the pharmacy consultant. Review of the Drug Regimen monthly policy directed the prescriber/licensed designee to act upon the recommendations in a time frame of 30 days or less and shall be maintained by the facility for review as part of the medical record. 2. Resident #135's diagnoses included unspecified dementia with agitation, psychotic disorder with delusions, and anxiety disorder. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual MDS assessment dated [DATE] identified Resident #135 was severely cognitively impaired, required substantial/maximal assist with bed mobility, was dependent on staff for transfers, dressing, and personal hygiene and utilized a wheelchair for mobility. The care plan dated 12/18/24 identified Resident #135 utilized psychotropic medications related to behavioral management with interventions that included administer psychotropic medications as ordered, monitor for side effects. The pharmacy consultant note dated 2/2/24 identified a medication review had been completed and a recommendation was made. A review of Resident #135's clinical record failed to identify a corresponding recommendation related to the pharmacy consultant's note dated 2/2/24. The ADNS provided a copy of the recommendation on 12/9/24 that identified a recommendation for a TSH (thyroid-stimulating hormone) level eight weeks after the Levothyroxine dosage change. Interview with the ADNS at the time the recommendation was provided identified that she obtained the recommendation via email once the request was made by the surveyor to review the pharmacy recommendations. Review of the clinical record identified a TSH level dated 5/3/24. Interview on 12/6/24 at 11:30 AM with ADNS/Unit Manager identified that the pharmacy medication reviews are received via email by the ADNS/DNS and sometimes the unit managers are on the email as well. These are usually received a day or two after the pharmacist comes into the building. It is the responsibility of the unit manager to follow up on the recommendation and then give it to the APRN to agree or disagree. Unless it is a nursing recommendation in which the nurse can follow up on. Then it is scanned into the chart. If there is a delay in the APRN receiving the review they may not be receiving the paper timely. Interview on 12/6/24 at 11:45 AM with Unit Secretary #2 for Resident #135 identified she scans the documents once they are signed into the medical chart and that all of the scanning was currently caught up for the unit. Interview on 12/9/24 at 10:53 AM with Pharmacist #2 identified the pharmacy consultant emails the recommendations usually the date of or day after they are completed, and they are email to the DON and the ADNS. If the issues was urgent then the Pharmacist would speak to someone at the facility or call if they were off site. The recommendations are then uploaded as part of the clinical record by the facility. Interview on 12/9/24 at 1:28 PM with APRN#1 for Resident #135's unit identified that she gets the medication reviews sporadically and although the ADNS is the unit manager for the unit she has never a recommendation from him. APRN#1 further identified that when she has received recommendations in the past, they have not always been timely and can occasionally receive them several months later. Review of the Drug Regimen monthly policy directed the prescriber/licensed designee to act upon the recommendations in a time frame of 30 days or less and shall be maintained by the facility for review as part of the medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. 47489 Based on review of clinical records, review of facility policy and procedure, the facility failed to ensure the medicaion error rate for observed medication administration was below 5%. The finding includes: The calculated medication error rate was 12%.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47489 Based on observations, review of facility policy, and interviews, the facility failed to ensure the medication adminstraion cart was secure. The findings include: Interview on 12/2/24 at 11:30 AM with NA#5 identified the unit as the locked down dementia unit. Observation on 12/2/24 at 11:37 AM identified LPN#4 had finished prepping medication and walked into the dining room to administer to a resident. The cart was located to the right side of the entrance to the dining room. As LPN#4 walked away from the cart, he failed to secure the cart and all drawers could be opened and medications accessed. LPN#4 then came back into the hallway where the cart was located and intercepted a confused resident who needed redirection. LPN#4 escorted the resident down the hallway to the resident's room which was approximately 50 feet down the hallway. LPN#4 entered the resident room and the medication cart was not within his line of sight. Observation on 12/2/24 at 11:46 AM identified LPN#4 returned to the medication cart. Interview on 12/2/24 at 11:47 AM with LPN#4 identified that the medication cart was supposed to be secured when not in attendance by the nurse, and that he just forgot to secure it. Interview on 12/2/24 at 11:48 AM with the ADNS identified that the medication carts should be secured when the nurse is not around. The ADNS indicated that even if he went into the dining room and could see the cart, it would need to be secured, and identified that this particular floor's residents had cognitive deficits. Review of the facility policy for Medication Ordering, Scheduling, and Administration identified that each medication cart will be maintained on the nursing unit in such a way as to provide for safety and security. Additionally, the policy identified that cart main locks will be secured whenever a nurse is not in attendance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47489 Based on observations, review of facility policy and interviews, the facility failed to ensure food items were dated when stored, were removed once out of date for use and failed to ensure kitchen staff with facial hair were supplied and wore beard guards. The findings included: Observations during the initial tour of the kitchen on 12/2/24 at 9:50 AM identified the following: Several staff with facial hair, to include the Executive Chef and [NAME] #5 hair did not have beard guards and [NAME] #5 was actively preparing foods. Interview on 12/2/24 at 10:00 AM with the Executive Chef and the Sous Chef identified that several staff who have facial hair do not have beard guards in place. The Executive Chef identified the facility does not have any and indicated they were ordered but had not been received. Observation on 12/2/24 at 10:30 AM of the walk-in prep refrigerator Identified the following prepared foods that had exceeded the amount of days to be used: Cheese Blitzes, full tray not covered, not dated with fruit that was turning brown Stuffed peppers with beef stuffing full tray dated 11/26 Meatballs and sauce full tray and dated 11/26 Ground meat 1/2 tray covered and dated 11/26 Metal Prep bin of turkey chunks, uncovered, and not labelled Interview on 12/2/24 at 10:35 AM with the Executive Chef and the Sous Chef identified the food should have been discarded within 3 days or by 11/29. Additionally, the Executive Chef identified that prepared foods should be covered and labelled when put in the preparation area. Observation on 12/2/24 at 10:53 AM of the #15 refrigerator identified a full tray of ham slices that were turning grey, with loose fitting saran wrap and dated 11/25. Observation on 12/3/24 at 11:15 AM identified [NAME] #4 in the food preparation area with a beard and no beard guard. Observation on 12/4/24 at 9:58 AM identified [NAME] #3, [NAME] #4, and [NAME] #6 who all present with facial hair, are present in the preparation area working with food and do not have beard guards in place. Interview on12/4/24 at 10:02 AM with [NAME] #3 and [NAME] #4 identified the facility never offered the employees beard guards. [NAME] #3 indicated he thought that if his beard was kept short, he didn't need to wear a beard guard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/4/24 at 10:45 AM with the Interim Food Service Director identified that the kitchen employees are aware they are supposed to wear beard guards if they have facial hair. The Interim Food Service Director identified the facility policy required beard guards and she indicated that they had been ordered. The FSD identified that she directs employees to wear a hair net over the beard if the beard guards are not available. Additionally, she identified she was made aware of the out of date food and indicated that weekend staff should have discarded the food. Observation on 12/5/24 at 10:12 AM identified the Sous chef, Cook#1, and Cook#2 had facial hair, were in the food preparation area, and did not have beard guards in place. Interview on 12/5/24 at 10:15 with the Sous Chef identified that the beard guards were not available. Observation on12/9/24 at 1:05 PM in the kitchen prep area identified Cook#5 had a beard, was preparing food, and did not have a beard guard in place. Interview on 12/9/24 at 1:06 PM with Cook#5 identified he was aware that facial hair needed to be covered and proceeded to put a hair net over his beard. Additionally, he indicated that the facility had not made beard guards available. Interview on 12/9/24 at 2:30 PM with Executive Chef identified the beard guards were ordered on 12/5/24, subsequent to surveyor inquiry, and were received in the facility on 12/9/24. Review of the facility Uniform Dress Code policy identified Associates working with food had to restrain all facial hair with a beard net/restraint. Review of the facility Food and Supply storage policy identified that the refrigerated storage life of foods, specifically unused portions of foods prepared on site, and deli meets should be discarded after 3 days from being opened or prepared.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47900 Based on review of facility documentation, review of facility policy/procedures, and interviews, the facility failed to ensure the water management plan was followed and failed to ensure positive legionella water sampling testing result was reported to the State Agency. The findings include: Review of the facility annual Water Management Plan meeting identified that legionella testing to be done monthly. A request was made to the Administrator and the Director of Maintenance on 12/6/24 at 3:15 PM for all Legionella testing completed from April 2022 to November 2024 and the Water Management Plan binder provided by the contracted company. On 12/9/24 the facility provided at 8:30 AM testing few testing results for the years 2023 and 2024 and annual water management plan meeting minutes. Another request was made to the Director of Maintenance on 12/9/24 at 9:15 AM for Legionella testing results for the year 2022 and the missing testing results for 2023 and 2024 the facility was unable to provide testing results of April 2022 through December 2022, December of 2023, January, February and October of 2024. Interview with the Director of Maintenance and the Administrator on 12/9/24 at 3:38 PM identified they were unable to provide the copies of the missing legionella water sampling testing results and the water management plan binder. The Director of Maintenance identified he was responsible for obtaining and keeping the copies of the Legionella water sampling results sent by the facility contracted water management company. The Administration identified the results are sent to the Director of Maintenance and the facility should maintain a copy of the results. Review of the facility's Water Management plan identified positive water sampling results of Legionella that the facility failed to report to the State Agency: Water sample collected in the month of January 2023 identified 3 testing location with a final result above 10 colony forming per milliliter or swab (CFU) of species Legionella pneumophila (serogroup 5). Water sample collected in the month of February 2023 identified 4 testing location with a final result above 10 colony forming per milliliter or swab (CFU) of species Legionella pneumophila (serogroup 5). Water sample collected in the month of March 2023 identified 7 testing location with a final result above 10 CFU of species Legionella pneumophila (serogroup 5). Water sample collected in the month of April 2023 identified 4 testing location with a final result above 10 CFU of species Legionella pneumophila (serogroup 5). Water sample collected in the month of May 2023 identified 8 testing location with a final result above 10 CFU of species Legionella pneumophila (serogroup 5). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Water sample collected in the month of July 2023 identified 6 testing location with a final result above 20 CFU of species Legionella pneumophila (serogroup 5). Water sample collected in the month of August 2023 identified 2 testing location with a final result above 10 CFU of species Legionella sp (not L. pneumophila). Water sample collected in the month of September 2023 identified 2 testing location with a final result above 20 CFU of species Legionella pneumophila (serogroup 5). Water sample collected in the month of November 2023 identified 6 testing location with a final result above 20 CFU of species 3 Legionella pneumophila (serogroup 5) and of species 3 Legionella sp (not L. pneumophila). Water sample collected in the month of March 2024 identified 6 testing location with a final result above 10 CFU of species Legionella sp (not L. pneumophila). Water sample collected in the month of April 2024 identified 4 testing location with a final result above 10 CFU of species 2 Legionella pneumophila (serogroup 2-14) and of species 2 Legionella sp (not L. pneumophila). Water sample collected in the month of May 2024 identified 5 testing location with a final result above 10 CFU of species Legionella sp (not L. pneumophila). Water sample collected in the month of August 2024 identified 1 testing location with a final result above 20 CFU of species Legionella pneumophila (serogroup 5). Water sample collected in the month of September 2024 identified 5 testing location with a final result above 10 CFU of species Legionella pneumophila (serogroup 2-14) and of species Legionella sp (not L. pneumophila). Review of the Water management Meeting dated 2/1/22 identified the facility completed chemical disinfectant, mixing valves have been installed under sink for additional control measures, numerous hyperchlorination completed, and flushing aggressively at the positive areas. Review of the Water management Meeting dated 2/14/23 identified the facility completed chemical disinfectant, mixing valves have been installed under sink for additional control measures, numerous hyperchlorination completed, and flushing aggressively at the positive areas. Review of the recommendation dated 10/2/24 provided by the water management company identified the water samples collected in September 2024 identified 14 samples with detectable legionella results and recommends increase flushing and replace aerators on the fixtures in the positive location. The Director of Maintenance provided a log of the increase flushes conducted in October and indicated that aerators were replaced as recommended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075135	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare Health Center	22 Masonic Avenue Wallingford, CT 06492

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Water Management Contractor on 12/9/24 at 12:38 PM identified he completes the monthly testing for the facility as it is apart of the facility's Water Management plan due to several positive Legionella detection. The Water Management Contractor identified that the facility is responsible for report Legionella positive results greater than 10 CFU to the Staff Agency. He indicated that the facility has a previous report to the State Agency in 2021 and thought there were continuing to report when the water sampling results were positive regardless of the species. The Water Management Contractor identified he sends recommendations via email to the Director of Maintenance when the Legionella water sample results were positive, and his recommendations were followed. He further identified his contract ended with the facility in June 2024 and the facility was provided with a copy of all water sampling testing results. Interview with the Director of Maintenance and Administrator regarding the Water Management Plan on 12/9/24 at 9:15 AM identified the Water Management Plan is the annual meeting document as it contains the updated information. The Director of Maintenance identified the facility Water Management Plan consist of monthly water sample testing, monthly flushes of the identified areas, weekly flushing of the eye wash stations and was unable to locate the binder provided by the water management company. Interview with the Director of Maintenance and Administrator on 12/9/24 at 12:45 PM identified the Administrator was responsible to report to the State Agency positive water sampling results. The Administrator indicated she was told only certain species would be reported to the State Agency and was not aware of all the positive water sampling positive results. The Director of Maintenance identified he was responsible to notify the Administrator of the positive water sampling results but failed to communicate all the positive results to the Administrator. The Administrator identified that the facility policy is to report positive results to the State Agency as required. Although a policy/plan related to water management plan and the reporting of positive water sampling result was requested, it was not provided. In an interview with the Administrator on 12/9/24 at 12:45 and Director of Maintenance on 12/9/24 at 9:15 AM identified it was the practice of the facility to report positive water sampling results to the State Agency as required and the annual meeting minutes contains the facility water management plan. Review of the facility Water management plan derived from annual Water Management Meeting identified sampling all healthcare wings on a monthly basis.

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	075135	A. Building B. Wing	12/09/2024

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Masonicare Health Center	22 Masonic Avenue Wallingford, CT 06492

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility documentation, review of facility policy/procedures, and interviews for two of five sampled residents (Resident #25 and Resident #144), reviewed for immunizations, the facility failed to administer the pneumococcal vaccine as requested by the resident upon admission and failed to offer the appropriate pneumococcal vaccine to the resident. The findings include: 1. Resident #25 was admitted to the facility in the month of January 2024 with diagnoses that included type 2 diabetes mellitus, major depressive disorder, and Wernicke's encephalopathy. The quarterly MDS assessment dated [DATE] identified Resident #25 was cognitively intact. The assessment further identified that the resident did not receive the pneumococcal vaccine as it was not offered. Review of the Informed Consent for Pneumococcal Vaccine Vaccination consent form identified Resident #25 gave the facility permission to administer the pneumococcal/Prevnar as recommended by current Centers for Disease Control and Prevention (CDC) guidelines on 1/25/2024. Review of Resident #25 clinical records failed to identify that he/she had received the vaccination at the facility or had change his/her decision. Interview with the Infection Preventionist (IP) nurse (LPN #6) and the Director of Quality (RN #1) on 12/9/24 at 11:18 AM identified the procedure for when resident/responsible party gives consent for a vaccine to be administer, that a physician's order is obtained, and the vaccine is administered to the resident. LPN #6 was unable to identify why the vaccine was not given when a consent was obtained. RN #1 further identified it was the responsibility of the Infection Preventionist nurse to track the resident's vaccine status. 2. Resident #144 was admitted to the facility in the month of June 2022 with diagnoses that included Alzheimer's disease, dementia and depression. The quarterly MDS assessment dated [DATE] identified Resident #144 had severely impaired cognition. Review of the pneumococcal consent form that was provided to Resident #144 legal representative identified a patient/resident consent for Pneumococcal Conjugate Vaccine (Prevnar 13) form on 5/6/22 instead of the Informed Consent for Pneumococcal Vaccine Vaccination form that included both pneumococcal/Prevnar vaccine as recommended by CDC guidelines. Review of Resident #144 Immunization Audit Report identified the resident had received the Prevnar 13 (pneumococcal vaccine) on 3/12/2015 and received the Prevnar 23 on 4/12/24 prior to his/her admission to the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Centers for Disease and Control (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommends that adults aged [AGE] years or older who have received both pneumococcal vaccine PCV13 and pneumococcal vaccine PPSV23 but have not yet received a final dose of PPSV23 at age [AGE] years or older are recommended to complete their pneumococcal vaccine series by receiving either a single dose of PCV20 or PPSV23. Interview with the Infection Preventionist (IP) nurse (LPN #6) and the Director of Quality (RN #1) on 12/9/24 at 11:18 AM identified that it was the responsibility of the previous IP nurse to offer the PCV20 vaccine to the resident on admission. LPN #6 identified Resident #144 was eligible to receive the PCV20 based on his/her prior pneumococcal vaccination history. She further identified she was unable to locate any other pneumococcal vaccine vaccination consent. Review of the Influenza and Pneumococcal Immunization policy identified to offer patients/residents pneumococcal immunizations as recommended by the Centers for Disease Control (CDC), provided that there are no medical contraindications and that the resident or resident's representative consents to any such immunizations after receiving education on the benefits and potential side effects. The policy further identified the facility will document in the resident's medical record at minimum that the resident received the pneumococcal immunization or did not receive the immunization due to medical contraindications or refusal.