STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075163	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare at Bishop Wicke Health & Rehabilitation	584 Long Hill Ave Shelton, CT 06484

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #58) reviewed for food choices, the facility failed to provide the correct diet. The findings include:Resident #58's diagnoses included hypertension, gastro-esophageal reflux disease (GERD), and gout.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status score of 14 indicating intact cognition, was dependent with personal hygiene, rolling left and right and with chair/bed-to-chair transfers, and required set-up assistance with eating. A signed Physician order dated 2/29/2024 identified Resident #58 had an allergy to garlic. The Resident Care Plan (RCP) dated 5/30/2024 and in effect at the time of survey identified Resident #58 had a nutritional problem or potential nutritional problem related to diagnoses of hypertension, GERD, morbid obesity, constipation, gout, and a food allergy to garlic. Interventions included educating the resident on the importance of maintaining the ordered diet and to encourage the resident to comply, provide/serve diet as ordered, and the Registered Dietician was to evaluate and make dietary change recommendations.Signed Physician orders dated 6/22/2024 and through 9/15/2025 directed Resident #58 to receive a regular diet of regular texture and consistency.Review of the Multidisciplinary Care Conference note dated 8/25/2025 identified that the Registered Dietician attended and that Resident #58 had an allergy to garlic.The Registered Dietician Quarterly Assessments dated 8/28/2024, 11/18/2024, and 8/19/2025 identified Resident #58 had an allergy to garlic.Interview with Resident #58 on 9/10/2025 at 10:55 AM identified that he/she had an allergy to garlic, the facility continued to serve him/her food with garlic against his/her request, and he/she stated that eating garlic resulted in a stomachache and gastrointestinal issues.Observation on 9/15/2025 at 1:18 PM identified Resident #58's lunch tray sitting on the bedside table and had been served spaghetti and meatballs with squash.Interview and record review on 9/15/2025 at 1:21 PM with the Director of Dietary Services identified she was aware Resident #58 had food allergies to melon, shellfish, and bananas but failed to identify a documented allergy to garlic. Further, she identified that both the spaghetti and meatballs and garlic vegetables contained garlic as an ingredient and Resident #58 had been served spaghetti and meatballs with a double portion of garlic vegetables for lunch.Interview on 9/15/2025 at 1:25 PM with the Dietary Aide #1 identified that she was responsible for entering food allergies into the kitchen's resident census and believed the garlic allergy was not included due to a cloud syncing problem with her computer.Interview on 9/15/2025 at 2:07 PM with the Director of Nursing Services identified that the Dietary Manager had notified her that Resident #58 was served food that contained ingredients for which he/she had a documented food allergy, that nursing had been directed to conduct an evaluation of him/her, and Medical Doctor (MD) #1 was called and was performing an evaluation. Further she indicated she would be calling Resident #58's family member and reporting the incident to the State Agency.Interview with Resident #58 on 9/15/2025 at 2:19 PM identified that she had taken a bite of the spaghetti and meatballs but did not eat the entire meal, and that staff removed her spaghetti and meatballs and garlic vegetables and provided him/her with chicken noodle soup. Resident #58 indicated that he/she had eaten 100% of the (continued on next page)

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

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	soup.Interview on 9/15/2025 at 2:25 PM with [NAME] #2 identified that the chicken noodle soup was prepared on 9/14/2025 and was made with a powdered soup stock base that did not contain garlic as a listed ingredient. [NAME] #2 stated garlic had been added to the soup, and cooks usually added garlic to their soups during the cooking process.Subsequent to surveyor inquiry, a new Resident Nutrition Interview was conducted on 9/15/2025 and identified Resident #58 had food allergies to shellfish, bananas, and melon. Further, it was identified that he/she had a food intolerance to garlic with no difference in symptoms between fresh or garlic powder as both cause him/her gas.Interview with MD #1 on 9/16/2025 at 11:51 AM identified that he had evaluated Resident #58 on 9/15/2025 and determined that he/she did not have a garlic allergy but preferred not to receive garlic in his/her meals. Further, he stated that he was unaware prior to 9/15/2025 that he/she had garlic documented as a food allergy and was unable to identify why garlic had been listed in the physician orders as a food allergy. Subsequent to surveyor inquiry, MD #1 directed nursing to remove garlic from his/her allergy list.Interview on 9/17/2025 at 11:10 AM with the Assistant Director of Nursing Services (ADNS) identified that she was the person who removed the spaghetti and meatballs from Resident #58's room and delivered him/her chicken noodle soup (a second meal containing garlic.) The ADNS stated she was unaware the soup contained garlic, failed to ask anyone in the kitchen if there was garlic in the soup, and should have asked but didn't think of it.Review of the facility's Menu Planning policy identified that a dining census shall be used to identify residents' diets, allergies, adaptive equipment, special needs and any other dietary concerns. Upon arriving at the facility, an interview will be conducted by the dining team to discuss with each resident what their special needs/requests are as well as ethnic background, likes/dislikes and how they can be best served while at the facility. Further, members of the dining team will attend quarterly resident care plan meetings to assess the residents' likes/dislikes with the food served and discuss whether or not the facility is meeting the dietary wishes of the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and facility policy during a tour of the kitchen, the facility failed to ensure open food items were dated to include opened, expired, and used by dates, and failed to perform hand hygiene prior to placing gloves on during food preparation and food service. The findings include: 1. On 9/10/25 at 9:15 AM, during the initial brief kitchen tour and interview with the Food Service Director, identified in freezer #2, a previously opened and repackaged bag of raspberry turnovers with a handwritten best used by date of 6/7/25 and a previously opened and repackaged bag of apple turnovers, with a handwritten best used by date of 7/11/25. In the refrigerator on the second shelf was a thawed package of ground veal with a handwritten date of 9/2/25, indicating when it was thawed, along with a handwritten note for the veal to be used by 9/4/25. The Food Service Director stated that staff used the best used by date as the food's expiration date. Subsequent to the surveyor's inquiry, the Food Service Director noted she would dispose of the expired raspberry and apple turnover bags immediately and disposed of the expired ground veal. Further observations in the kitchen identified the following underneath the kitchen's prep counter: An unopened expired 16 oz Chili Powder container with a manufacturer's best buy date of 2/6/25 counter was observed. An opened 16 oz container of basil leaves, opened on 7/10/25 with no expiration date. Subsequent to this observation, the Food Service Director placed a best used date on the container for 7/10/26.An opened 16 oz container of cocoa powder, with no open date, and an expiration date of 8/29/25. Subsequent to observation, the Food Service Director discarded this container. An opened 16 oz container of granulated garlic without an opening date, and a manufacturer's expiration date of March 2029.An opened 16 oz container of granulated onion, without an opened date posted on the container, but did contain a handwritten received date of 7/30/25. The Food Service Director placed a best used date on the container for 7/30/26.An opened 16 oz container of Italian seasoning, dated to be opened on 6/5/25, without an expiration date, or used by date. The Food Service Director subsequently placed a best used by date of 6/5/26 on this container. In a large clear plastic covered storage bin was a 50 lb. bag of red velvet cake mix approximately 1/3 used, with a handwritten date opened January of 2025, along with a handwritten best used by date of March of 2025. The Food Service Director disposed of the Red Velvet Cake Mix. 2. On 9/15/2025 12:05 PM - During food service observation, with the Food Service Director in the kitchen, 5 staff members were noted to place and removed gloves without the benefit of sanitizing or washing their hands. [NAME] #1 failed to sanitize/wash 3 times, [NAME] #2 failed to sanitize/wash 2 times, Dietary Aides #4, #5 and #6 failed to wash/sanitize 2 times. Subsequent to surveyor inquiry, the Food Service Director immediately educated staff to the facility hand washing policy and the importance of hand washing or sanitizing prior to placing and following removal of gloves during food prep and food service. Review of the facility's Production Guidelines - Sanitation and Safety policy identified that hand contact with food shall be restricted. Proper hand hygiene shall be used. Plastic/vinyl, non-latex gloves should be used when contacting and preparing food.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical record, facility policy, and interviews for 1 of 3 sampled residents (Resident #87) reviewed for pressure ulcers, the facility failed to perform hand washing/sanitization during wound care. The findings include:Resident #87's diagnoses included peripheral vascular disease, dementia, and traumatic brain injury.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 had a Brief Interview of Mental Status (BIMS) score of 3 indicating severe cognitive impairment, was dependent for personal hygiene, rolling left and right, and chair/bed-to-chair transfers, and had an unstageable pressure ulcer presenting as a deep tissue injury (DTI).The Resident Care Plan (RCP) dated 9/10/2025 identified Resident #87 had a DTI on his/her left inner heel related to immobility and peripheral vascular disease. Interventions included administer treatments as ordered and monitor for effectiveness, initiate Enhanced Barrier Precautions (EBP) per orders, and follow facility policies/protocols for the prevention/treatment of skin breakdown.A nursing note dated 9/10/2025 identified Resident #87 had a new facility acquired pressure ulcer on his/her left heel, measuring 5.3 centimeters (cm) x 5.5 cm with no depth and a base of deep red, maroon, or purple in color.A physician order dated 9/10/2025 directed to maintain EBP to the pressure area every shift, and to apply skin prep to the pressure area of the left inner heel every day for 14 days.Interview on 9/15/2025 at 10:58 AM with Registered Nurse (RN) #1 (infection prevention nurse) identified that hand hygiene should be performed by staff when entering or leaving a resident room, before applying gloves, and after glove removal.Observation and interview on 9/15/2025 at 11:16 AM with Licensed Practical Nurse (LPN) #3 during Resident #87's wound care identified that he failed to perform hand hygiene before wound care and failed to perform hand hygiene when changing his gloves during wound care. LPN #3 indicated the reason he did not perform hand hygiene was because he did not think of it. Further, LPN #3 indicated he had not received training on and was unaware of the facility's policy on hand hygiene.Interview on 9/15/2025 at 12:00 PM with the Director of Nursing Service (DNS) identified that during wound care, nurses should perform hand hygiene at the beginning and end of wound care and when changing gloves. Further she identified that staff receive education on hand hygiene, but LPN #3 would not be required to attend the in-service on hand hygiene as he is employed through an agency and not the facility.Review of the facility's Hand Hygiene Policy identified in part that hands should be washed with alcohol-based hand sanitizer after removing personal protective equipment (gloves) and before and after giving care to each resident. The Hand Hygiene Policy failed to identify that alcohol-based hand sanitizer should be used before donning personal protective equipment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interviews, review of the clinical record, facility documentation, and policy for 1 of 8 sampled residents (Resident #93), reviewed for accidents, the facility failed to revise the Resident Care Plan (RCP) following a fall. The findings include:Resident #93's diagnoses included osteoarthritis, gout, and adjustment disorder.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #93 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition and required partial/moderate assistance for lower body dressing, and transfers. Additionally, the MDS identified Resident #93 had a fall in the month prior to admission.The Resident Care Plan dated 8/30/25 identified Resident #93 was at risk for falls related to weakness. Interventions included anticipating and meeting resident needs, appropriate footwear when ambulating, maintain a safe environment free of spills, clutter, adequate lighting, call light and personal items in reach, and keep the bed in low position.The Physician orders dated 8/20/25-9/15/25 did not include fall prevention measures.A review of the Accident Occurrence form dated 8/30/25 at 9:52 PM identified Resident #93 had an unwitnessed fall and was found lying on the floor next to the bed. The RCP included a new intervention.A review of the Accident Occurrence form dated 9/1/25 at 7:10 AM identified Resident #93 had an unwitnessed fall and was found on the window side of the bed, sitting on the floor. The RCP included a new intervention.A review of the Accident Occurrence form dated 9/4/25 at 8:05 PM identified Resident #93 had an unwitnessed fall and was found on the bathroom floor, he/she hit his/her head which resulted in a transfer to the Emergency Room. A review of the RCP failed to identify the RCP had been revised to include a new intervention following the fall.An interview, clinical record review, and review of the Accident Occurrence with Registered Nurse Supervisor (RN) #3 on 9/16/25 at 1:45 PM identified the facility policy directed the supervisor to initiate a new intervention after a resident fell. RN #3 indicated RCP interventions were only to be placed in the RCP and not in physician's orders, nurses' notes, or on the Accident Occurrence form. RN #3 further stated although she had put a new intervention in place for a non-slip mat, the intervention never was placed on Resident #93's RCP but should have been. An interview and record review with the Director of Nurses (DNS) on 9/16/25 at 2:22 PM identified the facility policy directed nursing staff to update the RCP with a new intervention following a fall. The interdisciplinary team reviewed falls the next morning and, if needed, they would amend the intervention. Although a review of Resident #93's falls occurring on 8/30/25 and 9/1/25 had new interventions on the RCP, there was no new intervention put in place following Resident #93's fall that led to a hospitalization on 9/4/25. The DNS stated that a new RCP intervention should have been put in place to prevent further falls, however, she was unable to explain why Resident #93's RCP failed to include a new intervention following the resident's fall. The Resident Care Planning Guidelines directed, in part, that the care planning process assures all members of the interdisciplinary team are caring for the individual patient/resident based on their specific needs. Additionally, the nurse on the floor and members of the interdisciplinary team update care plans as needed. The Resident Care Team Policy directed in part that the care plan needs to be updated to reflect day-to-day changes in the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interview for 2 of 2 sampled residents (Resident #49 and Resident #109) reviewed for skin issues, the facility failed to ensure neurological assessments were completed after falls. The findings include: 1. Resident #49 had diagnoses that included Alzheimer's disease, hypertension, and anxiety. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #49 was severely cognitively impaired, used a wheelchair, required setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility, and was dependent for transfers. The Resident Care Plan (RCP) dated 11/7/24 identified Resident #49 was at risk for falls related to poor safety awareness and medical conditions. Interventions included to ensure Resident #49's call light was within reach, ensure prompt, and review information on past falls and attempt to determine possible root causes of falls, and alter or remove any potential causes if possible. a. A nursing note dated 1/3/25 at 7:13 AM identified at 6:15 AM Resident #49 was observed on the floor of his/her room stating he/she was putting clothes away, turned too fast, and fell. Resident #49 was noted to have had increased restlessness throughout the night. A Reportable Event Occurrence form with investigation documentation dated 1/3/25 at 6:15 AM identified Resident #49 had an unwitnessed fall without injury and neurological checks were initiated per the protocol. Review of the Head Injury Flow Sheet dated 1/3/25 indicated neurological checks began at 6:15 AM and were to be performed every 15 minutes 4 times, every 1 hour 4 times, every 4 hours 6 times, and every 8 hours 6 times for a total of 20 opportunities. Out of 20 opportunities 3 neurological checks failed to be completed. b. A nursing note dated 4/4/25 at 3:33 PM identified Resident #49 had an unwitnessed fall at 2:50 PM and was heard yelling for help. Resident #49 was subsequently found lying on the floor on his/her left side in a fetal position. Resident #49 complained of pain to the left hip and back of his/her head where a large hematoma (bruise) was noted. A Reportable Event Occurrence form with investigation dated 4/4/25 at 2:50 PM identified Resident #49 had an unwitnessed fall. Review of the Head Injury Flow Sheet dated 4/4/25 indicated neurological checks began at 2:55 PM and were to be performed every 15 minutes 4 times, every 1 hour 4 times, every 4 hours 6 times, and every 8 hours 6 times for a total of 20 opportunities. Out of 20 opportunities 3 neurological checks failed to be completed. 2. Resident #109's diagnoses included hypertension, overactive bladder, and unspecified falls. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #109 had a Brief Interview Mental Status (BIMS) score of 5 indicating severe cognitive impairment and was dependent on 1 staff for transfers to a wheelchair/bed and toileting. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 7/29/25 identified Resident #109 was a fall risk. Interventions included monitoring for signs and symptoms of a urinary tract infection, follow the facility fall protocols, keep the bed in the lowest position, keep the resident in common areas as much as possible, anticipate needs, and provide physical therapy as needed. A physician's order dated 8/15/25 directed to ambulate Resident #109 with the assistance of 1 staff with a rolling walker and to transfer to a wheelchair with the assistance of 2 staff. a. A review of Resident #109's Reportable Event Occurrence form Report dated 9/4/25 at 9:00 AM identified Resident #109 had an unwitnessed fall attempting to ambulate to the bathroom. A physician's note dated 9/4/25 at 9:42 AM identified that Resident #109 had an unwitnessed fall in his/her room. Resident #109 complained of mild to moderate chest pain that worsened with palpation (touch) and deep breaths. The physician's assessment and plan indicated a contusion (bruise) to right front wall of his/her thorax (chest), to provide pain medications as needed and obtain a chest x-ray if the pain persisted. A nurse's note dated 9/4/25 at 11:27 AM identified that Resident #109 had an unwitnessed fall in his/her room attempting to self-toilet at 9:00 AM by getting out of bed unassisted. Resident #109 was incontinent of urine at the time of the fall, and no injuries were noted. Resident #109's RCP was updated on 9/4/25 to include a non-slip floor mat to the door side of the bed. A Fall Risk assessment dated [DATE] identified a fall risk score of 11 indicating Resident #109 was a high risk for falls. A Neurological Flow Sheet dated 9/4/25 indicated neurological checks began at 6:15 AM and were to be performed every 15 minutes 4 times, every 1 hour 4 times, every 4 hours 6 times, and every 8 hours 6 times for a total of 20 opportunities. Out of 20 opportunities 2 neurological checks failed to be completed. b. Resident #109's Reportable Event Occurrence form report dated 9/14/25 at 9:45 PM identified he/she attempted to get of bed, unattended, to use the bathroom and slipped onto the floor. The resident did not sustain any injuries. Resident #109's RCP was not updated with a new intervention for the fall on 9/14/25. The Neurological Flow Sheet dated 9/14/25 indicated neurological checks began at 9:45 PM and were to be performed every 15 minutes 4 times, every 1 hour 4 times, every 4 hours 6 times, and every 8 hours 6 times for a total of 20 opportunities. Out of 20 opportunities, 7 neurological checks failed to be completed. A Fall Risk assessment dated [DATE] identified a fall score of 14 indicating Resident #109 was a high risk for falls. Interview with Director of Nursing Services (DNS) on 9/17/25 at 10:56 AM and 12:35 PM identified that neurological checks should be completed for all residents who sustained an unwitnessed fall and hit their head and for cognitively impaired residents who had an unwitnessed fall. The DNS indicated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that when neurological checks were initiated, the form must be filled out completely for all indicated times. She indicated that the neurological assessments were incomplete, and the charge nurses were responsible to ensure all neurological assessments were thoroughly completed on his/her shift. Further, the DNS stated that when nursing supervisors were performing rounds on their shift, they should be looking at the Head Injury Flow Sheets to ensure no missing entries. The DNS could not explain why staff were not thoroughly completing the neurological assessments. Review of the Head Injuries policy directed, in part, the Head Injury Flow Sheet is utilized if a fall is unwitnessed and the resident is cognitively unable to articulate the circumstances of the event. The policy directed the nurse observes for neurological responses and neurological assessments will be done immediately after the injury occurs, following the times designated on the Head Injury Flow Sheet. The policy directed if there was a change anytime during the assessment, the physician should be notified.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of the clinical record, and facility policy for the only sampled resident (Resident #43) reviewed for communication difficulties, the facility failed to identify a change in communication ability had occurred and failed to provide appropriate services related to the change in status. The findings include:Resident #43's diagnoses included cerebral infarction, acquired deformity of head, left sided hemiplegia, and adjustment disorder with depressed mood.The annual Minimum Data Set assessment dated [DATE] identified Resident #43 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment, was independent with eating, required moderate assistance with oral hygiene, was dependent on chair/bed-to-chair transfers, and had obvious or likely cavities or broken natural teeth and clear speech with distinct intelligible words.The Resident Care Plan (RCP) dated 7/11/2024 identified he/she had oral/dental health problems related to some broken teeth and multiple teeth extracted. Interventions included consulting with the dietician and change his/her diet if chewing/swallowing problems were noted. The RCP failed to address a change in his/her ability to communicate.A. The hospital Discharge summary dated [DATE] indicated that Resident #43 was hospitalized for aspiration pneumonia. A follow up Speech Therapy (ST) care plan note dated 8/21/2024 identified that the resident was seen post hospitalization and had intact motor speech skills and did not require further assessment.Dental consultation notes dated 10/15/2024, 11/26/2024, 1/3/2025, 1/22/2025, and 6/18/2025 identified that Resident #43 had multiple surgical dental extractions resulting in the resident becoming completely edentulous (no teeth) following the last visit on 6/18/2025.The annual Long Term Care Evaluation (performed yearly to identify changes in resident status) dated 7/7/2025 failed to identify Resident #43 had any changes in his/her ability to communicate verbally.Observation and interview on 9/10/2025 at 11:03 AM with Resident #43 identified he/she had unintelligible, unclear speech when responding to questions requiring more than a yes/no answer. No Augmentative and Alternative Communication (AAC) devices (specialized communication devices/aides) were present at his/her bedside or utilized by Resident #43.Interview on 9/15/2025 at 1:48 PM with the Director of Therapeutic Recreation identified Resident #43 communicated with facial expressions or yes/no answers. Further she indicated he/she does not have any AAC devices available to use and during observed family visits, Resident #43 was quiet and did not communicate much. Interview and review of ST documentation on 9/16/2025 at 1:28 PM with ST #1 identified that she had treated Resident #43 from 11/13/2024 through 12/10/2024 for dysphagia (swallowing difficulty) management after a hospitalization for aspiration pneumonia. At that time, the physician order directed treatment for dysphagia, so ST #1 did not evaluate Resident #43's ability to speak/communicate. From 11/13/2024 through 9/17/2025, ST #1 indicated that Resident #43 communicated his/her basic wants and needs through answering yes/no questions, could follow commands, had unclear and unintelligible speech, and had dental extractions leaving him/her edentulous. ST #1 was unaware of any changes in Resident #43's ability to communicate, so she did not further evaluate the resident for the change or for an AAC device. Interview on 9/17/2025 at 9:41 AM with Person #2 (Resident #43's family member) identified when Resident #43 was admitted to the facility he/she could speak in complete sentences and experienced a change in speech each time after his/her teeth were extracted. Person #2 notified ST #1 of Resident #43's speech difficulties in July or August of 2025 and had mentioned it several times to staff in RCP meetings. Person #2 indicated that while at the meetings, he/she requested assistance as to how family members could make him/her more comfortable and how he/she could learn to help Resident #43 or make things easier with communication. As of now, no one had assisted with his/her request for help. Further, Person #2 stated, you are on your own here. I'm getting used to that. You can't keep asking the same things over and over with no answers. It's not easy getting there (to the (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility) and seeing him/her like that, it's hard. You want to do everything you can because he/she won't for themself. I really want help. He/she stated that the relationship between Resident #43 and family members had been negatively affected from Resident #43's change in speech. Resident #43 didn't speak to them anymore during visits and had to be forced to speak, which he/she found sad, and it bothered him/her. Interview on 9/17/2025 at 10:33 AM with the Director of Rehabilitation identified that Rehabilitation Services attended RCP meetings, but she was unaware of Resident #43's change in verbal communication. She indicated that the facility practice was for nursing to notify the Rehabilitation Department with any communication changes. Additionally, it was the responsibility of the speech therapist to review previous notes prior seeing a resident referred to speech therapy by the physician, and ST #1 should have done so in November 2024 post hospitalization. Once reviewed, if the notes indicated a change in speaking ability was noted from the previous information, ST #1 should have contacted nursing or the physician to make them aware of the change and to determine if further orders were required. The Rehabilitation Director stated that there was no policy for speech therapy to evaluate residents who have had tooth extractions as these are treated situationally.Interview on 9/17/2025 at 10:54 AM with Social Worker (SW) #1 identified that Person #2 regularly attended RCP meetings, visited the facility daily, and was happy with the care Resident #43 was receiving. SW #1 stated that Person #2 asked for help to make Resident #43's verbal communication easier, more comfortable during visits, and for methods that would help Resident #43's better. Although she had received the information, she failed to understand this was a request for assistance, failed to communicate the concern to nursing, and stated if she were aware that Person #2 was requesting assistance for Resident #43, she would have notified the Rehabilitation Department.Interview on 9/17/2025 at 12:01 PM with the Director of Nursing Services (DNS) identified that she was unaware that Resident #43 had a change in verbal communication following his/her dental extractions. Nursing staff on the unit attended Resident Care Plan meetings and the morning staff meetings. They were responsible to identify changes and act upon Person #2's concerns and changes in Resident #43's verbal communication ability, but no staff had made her aware. Further, Resident #43's tooth extractions should have been indicated in the Resident Care Plan, but the RCP was never revised.Review of the Facility's Communications Policy identified in part that upon admission, residents' ability to communicate with others is evaluated. Any resident with a suspected speech, language, or hearing problem will be referred to their physician for a referral to speech pathology for an evaluation as appropriate. The policy failed to identify the potential for resident evaluations after admission, including change in a resident's speech or a new edentulous status.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record review, and facility policy for 1 of 3 sampled residents (Resident #7) reviewed for pressure ulcers, the facility failed to set an alternating pressure mattress at the correct setting, per the physician order. The findings include: Resident #7?s diagnoses included Alzheimer's disease, vascular dementia, and unspecified systolic (congestive) heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 had a short-term and long-term memory problem and was dependent on staff for toileting hygiene, rolling left and right in bed, lying to sitting on side of bed, and transfers. Additionally, the assessment identified 1 stage 3 pressure ulcer that was not present upon admission/entry or reentry into the facility and that there was a pressure reducing device for the bed. The Resident Care Plan (RCP) dated 8/12/2025 identified Resident #7 had a pressure ulcer to the coccyx related to immobility and bowel/bladder incontinence. Interventions included administer treatments as ordered and monitor for effectiveness, assist with position changes approximately every two (2) hours and as needed, and an alternating mattress set at 150 pounds (lbs.). Resident #7's Braden Scale (predicting pressure ulcer risk evaluation) dated 6/14/2025 identified that he/she was at high risk for pressure ulcer development.A physician's order dated 9/15/2025 for Resident #7 directed to set the alternating pressure mattress at 150 lbs. and to check the mattress function and setting every shift.Observations on 9/10/2025 at 10:28 AM, 9/10/2025 at 1:26 PM, 9/12/2025 at 9:11 AM, and 9/15/2025 at 9:56 AM, identified Resident #7 was in bed with the pressure-relieving mattress set at 200 lbs.Observation, interview, and review of physician orders with Licensed Practical Nurse (LPN) #1 on 9/15/2025 at 10:08 AM identified Resident #7 was sleeping in bed on his/her left side, covered by a blanket, with the head of the bed slightly elevated. The alternating pressure mattress was observed to be set at 200 lbs. and had been set to 200 lbs. during 4 previous observations. The current physician order directed the alternating pressure mattress to be set at 150 lbs. and to check the function and setting every shift. LPN #1 identified that the alternating air mattress was incorrectly set according to the physician's order. LPN #1 stated that the facility policy directed to set the alternating air mattress per the physician order and that it was her responsibility as the unit nurse to check and ensure the correct setting. LPN #1 indicated that she had not checked the setting on Resident #7's alternating air mattress that shift but should have. Subsequent to surveyor inquiry, LPN #1 changed the setting on Resident #7's alternating air mattress from 200 lbs. to 150 lbs. per the physician's order. Interview with the Director of Nursing (DNS) and Assistant Director of Nursing (ADNS) on 9/15/2025 at 10:25 AM indicated that the facility policy directed setting pressure relieving mattresses per the physician order. The unit nurse was responsible to check mattresses for the correct physician ordered setting every shift. The DNS and ADNS indicated Resident #7's mattress should have been set according to the physician's order, at 150 lbs., and not at 200 lbs. as observed. Review of specialty mattresses policy dated 11/2021 directed, in part, that residents who are at high risk for, are admitted with, or develop a pressure area will receive an appropriate specialty mattress. The policy failed to identify how the specialty mattress should be set.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 2 of 8 sampled residents (Resident #16 and Resident #49) reviewed for accidents, for Resident #16, the facility failed to transfer a resident according to the plan of care resulting in a fall, and for Resident #49, the facility failed to implement new Resident Care Plan (RCP) interventions following falls, and failed to utilize wheelchair equipment according to the Resident Care Plan. The findings include: 1. Resident #16's diagnoses included pain in left hip, abnormalities of gait and mobility, Parkinson's disease, psychotic disturbance, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #16 had a Brief Interview for Mental Status score of 14, indicating no cognitive impairment and required a wheelchair/walker for mobility and needed partial/moderate assistance for bed mobility, toileting, and bathing transfers. A Facility Reported Incident (FRI) form dated 8/13/25 at 12:45 PM identified Resident #16 had reported to the speech therapist that he/she was pushed down by NA #5 while being transferred to the toilet. According to the investigation, Resident #16 indicated he/she did not believe NA #5 was intentionally attempting to hurt him/her but felt like he/she was being rushed. NA #5's statement identified that Resident #16 needed to use the bathroom and during the transfer his/her feet became twisted and were close to the bar next to the toilet, so NA #5 used the resident's brief to guide him/her onto the toilet. Resident #16 used the restroom and offered no complaints. NA #5 indicated that she did not observe Resident #16 hit the bar during the transfer. Resident #16's undated NA Resident Care Card (used to direct care) indicated that Resident #16 required the assistance of 2 with ambulation and transfers. Interview with Physical Therapist (PT) #1 on 9/16/25 at 1:25 PM, identified that, at the time of Resident #16's fall, he/she required the assistance of 2 for transfers. Interview and review of facility documentation with PT #2 (Rehabilitation Director) on 9/26/25 at 1:35 PM identified that although she had written a note in the unit's communication log on 7/17/25, alerting nursing staff that Resident #16 was able to ambulate to the bathroom with the assistance of 1, the resident still required the assistance of 2 for transfers. Attempts to reach NA #5 were unsuccessful. 2. Resident #49 had diagnoses that included Alzheimer's disease, hypertension, and anxiety. A Fall Risk Evaluation dated 10/20/24 identified Resident #49 had a score of 13 indicating a high fall risk. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #49 had a Brief Interview of Mental Status score of 4 indicating severely impaired cognition, required setup or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean-up assistance with eating, supervision or touching assistance with wheelchair mobility 50 ft. and dependent for 150 ft., substantial/maximal assistance with bed mobility, and was dependent for transfers. The MDS assessment further identified Resident #49 had not fallen since a previous assessment dated [DATE]. The Resident Care Plan (RCP) dated 11/7/24 identified Resident #49 was at risk for falls related to poor safety awareness and medical conditions. Interventions included to ensure Resident #49's call light was in reach, encourage use, and respond promptly, on the falling star program (intervention not to leave Resident #49 alone unless nurse was aware), place Dycem above and below the wheelchair cushion, physical therapy to evaluate and treat as ordered/needed, and review information on past falls to determine the possible root cause, and alter or remove any potential causes if possible. A. Review of the Reportable Event Occurrence form dated 1/3/25 at 6:15 AM identified Resident #49 had an unwitnessed fall and was found in his/her room sitting upright on the floor behind the door. The recommendation/preventative measures initiated were to obtain a urine dip and implementation of the Urinary Tract Infection (UTI) protocol. Review of the Reportable Event Occurrence form dated 4/4/25 at 2:50 PM identified Resident #49 had an unwitnessed fall in his/her room and was found lying on the floor, on their left side, with their head facing the door, calling for help. Additionally, Resident #49's wheelchair was by the bed, and the wheels were unlocked. The recommendation/ preventative measure was to place the resident back to bed for a nap after lunch. Review of a Reportable Event Occurrence form dated 5/1/25 at 3:40 PM identified Resident #49 had an unwitnessed fall in his/her room and was found lying on his/her back on the floor facing the door calling for help. Review of the clinical record identified on 5/1/25 all Resident #49's RCP interventions were reviewed and appropriate. No new intervention was implemented. Review of a Reportable Event Occurrence form dated 5/30/25 at 9:15 AM identified Resident #49 was found on his/her knees facing the bed, arms on the bed, and the wheelchair behind him/her with the wheels unlocked. Resident #49 was last seen at 8:30 AM self-propelling on and off the unit in his/her wheelchair. The recommendation/ preventative measure was to continue the fall prevention measures already in place. Review of the clinical record identified on 5/30/25 all Resident #49's RCP interventions were reviewed and appropriate. No new intervention was implemented. Review of a Reportable Event Occurrence form dated 6/9/25 at 3:15 PM identified Resident #49 had an unwitnessed fall in his/her room and was found lying on the floor next to the bed on his/her back. The recommendation/preventative measures indicated all interventions were reviewed and appropriate. Review of the clinical record identified on 6/9/25 all Resident #49's RCP interventions were reviewed and appropriate. No new intervention was implemented. A Reportable Event Occurrence form dated 6/10/25 at 12:55 PM was requested but not provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interim Nurses Notes Post Fall form dated 6/10/25 at 12:55 PM identified Resident #49 was found lying on the floor next to his/her bed wearing shoes and reporting that his/her head hurt. Potential alternative measures post fall were the initiation of the UTI protocol and placement of anti-rollback devices to Resident #49's wheelchair. Review of the clinical record identified a fall evaluation was completed on 6/10/25 with a score of 2 indicating a high fall risk. B. Observation on 9/17/25 at 11:40 AM identified Resident #49 in a wheelchair in the front lobby with a staff member and then at 11:50 AM was sitting at a table in the dining room. During both observations Resident #49 failed to have an anti-rollback device attached to the wheelchair. Interview, observation, and record review with Licensed Practical Nurse (LPN) #5 on 8/17/25 at 12:15 PM identified following a fall, 2 fall evaluations (Fall Risk and Post Fall) as well as a Reportable Occurrence form were completed by the charge nurse and the RN Supervisor. LPN #5 identified the process for initiating new interventions post fall was a bit of a mess. There were 2 RCP's, a fall risk and an actual fall RCP. LPN #5 indicated her RCP update would include the date, an explanation the fall, indicate if there were injuries, and a new intervention if appropriate. Upon the direction of the RN, she would update the RCP to indicate that all interventions were reviewed and appropriate if there was no new intervention being implemented. LPN #5 identified that unfortunately Resident #49 fell a lot and that Resident #49 was quick and quiet. On observation of Resident #49's wheelchair failed to have an anti-roll back device attached per the RCP intervention. LPN #5 identified that she hadn't actually observed that the anti-rollbacks were not in place, but she had thought something did not look right. LPN #5 stated if she had realized Resident #49 was in the wrong wheelchair earlier, she would have made the switch right away. Resident #49's wheelchair was subsequently found 2 rooms away in another resident's room. LPN #5 indicated that the NA may have put the resident in the wrong wheelchair and requested a NA to switch Resident #49 to the correct wheelchair. Interview and record review with the Director of Nursing Services (DNS) on 9/17/25 at 12:35 PM identified: A. After a resident fall the interventions should be reviewed and if there was an intervention already in place that met the circumstances of the fall it may not be necessary to initiate a new intervention. There were many interventions within the fall policy that nursing staff could use if they were having trouble thinking of a new intervention, however, if the resident fell doing the same type of activity then it was her expectation that a new intervention would be added, or the current intervention would be changed to prevent another fall with the same activity. The DNS identified that out of 6 falls, only 3 had new interventions. When Resident #49 had fallen 3 consecutive times while appearing to be trying to independently transfer to the bed, the nursing staff should have tried a new intervention, so she was unsure why nursing staff documented the fall interventions in place remained appropriate and did not add any new intervention. B. Review of the fall documentation dated 1/3/2025, 4/4/2025, 5/1/25, 5/30/25, 6/9/25, and 6/10/25 identified that of the 6 falls, only 1 had a post fall, Fall Risk assessment documented on 6/10/25. The DNS identified that it was facility policy to complete a fall risk assessment after every fall so Resident #49 should have had fall assessments completed on 1/3/2025, 4/4/2025, 5/1/25, 5/30/25, and 6/9/25. Review of the Resident Safety policy dated 8/2025 directed, in part, it is the policy of the facility to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide interventions that promote resident safety based on individual goals of care. The policy directed the following evaluations to be completed after a fall: Fall risk evaluation, Post Fall evaluation, and Registered Nurse post fall assessment (instituted 7/21/25). The policy directed after a fall the RCP is reviewed and new interventions added if deemed appropriate. The policy directed the Reportable Event Occurrence Form is given to the supervisor and/or the DNS for completion of the investigation and input regarding appropriate follow up intervention.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, and interviews, for the only sampled resident (Resident #68) reviewed for respiratory issues, the facility failed to change the resident's nebulizer mask and tubing per the facility policy. The findings include:Resident #68's diagnosis included: anemia, heart failure and chronic obstructive pulmonary disease.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #68 had a Brief Interview of Mental Status score of 13 indicating intact cognition and required substantial/maximal assistance with upper and lower body dressing, and transfers and partial/moderate assistance with bed mobility. A physician's order dated 8/25/25 directed to provide Ipratropium-Albuterol Inhalation Solution (0.5-2.5 MG/3ML) to be used with the resident's nebulizer as needed every 6 hours for complaints/feelings of shortness of breath while awakeObservations of Resident #68's nebulizer equipment identified that the tubing was dated 7/18/25 (indicating when first put into use) and stored uncovered, exposed to the environment on 9/10/25 at 11:15 AM on the bedside table, on 9/12/25 at 10:02 AM on the arm of the recliner chair, and on 9/15/25 on the seat of the recliner.Review of Resident 68's Medication Administration Record (MAR) identified that the resident last received a nebulizer treatment on Saturday 9/13/25 at 6:03 AM. Interview and observation with LPN #5 on 9/15/25 at 10:18 AM identified Resident #68's nebulizer mask and tubing was dated 7/18/25 and stored on the arm of the recliner. LPN #5 indicated that the policy directed nebulizer masks and tubing were to be replaced every Wednesday on the 11:00 PM to 7:00 AM shift. LPN #5 stated that she was responsible to replace the tubing it's my fault and that she should have checked the equipment to ensure a storage bag was present and that the tubing had been replaced per the facility policy. LPN #5 indicated that although the equipment should have been contained in a bag and there was no bag present, that Resident #68 was self-care and may have completely removed the bag from the room.Subsequent to surveyor inquiry, LPN #5 immediately removed Resident #68's old tubing and mask and replaced it with new equipment and dated it for 9/15/25.Review of the facility's policy statement in Department of Nursing Services - Cleaning of Respiratory Equipment, identifies oxygen cannulas and masks, and nebulizer masks are to be changed weekly.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on review of facility documentation, facility policy and interviews during a review of the infection control program, the facility failed to ensure documentation of a 48-to-72-hour review of antibiotic use and failed to ensure practitioners were documenting the rationale for continued antibiotic use when the antibiotic failed to meet the criteria. The findings include:Interview and review of the Antibiotic Stewardship Program on 9/14/25 from 11:00 AM through 12:30 PM with the Infection Control Nurse (ICN), Registered Nurse (RN) #1 and Assistant Director of Nursing Services (ADNS) identified that the facility used McGeer's criteria in determining if antibiotic use was appropriate for a suspected or diagnosed infection. Although the information was reviewed as a guide, the facility practice did not include documentation of the review. Additionally, it was identified that practitioners (physician/Advanced Practice Registered Nurse, APRN) were not consistently documenting the rationale for continuing the use of antibiotics when McGeer's criteria had not been met.A. RN #1 indicated that the facility followed the Centers for Disease Control (CDC) recommendations to determine the continued need for antibiotic use during the time out period (48 to 72 hours) after the initiation of antibiotic therapy. A review of the resident antibiotic use log failed to identify an area to document a 48 to 72 hour look back or any documentation that a look back had taken place to determine antibiotic necessity. RN #1 indicated that she did not conduct a 48 to 72-hour time out for resident antibiotic use stating the review was her responsibility, but she was unable to state why she had failed to conduct the review per the facility policy.B. RN #1 identified that the facility did not have any systems in place to ensure practitioners were documenting the rationale for the continued use of an antibiotic that was contraindicated. Any antibiotic use failing to meet the initial McGeers criteria or the criteria during the 48 to 72-hour look back period, or any antibiotic use based on the practitioner's judgement required documentation according to the facility policy. RN #1 was unable to identify how this was communicated to the practitioner or how the facility was ensuring compliance with practitioner documentation.Interview with APRN # 1 on 9/15/25 at 3:00 PM identified that the facility had never communicated an individual resident review of antibiotic use, or that there was a formal process in place at the facility since she started in March 2025. (6 months prior) APRN #1 indicated that she usually documented the rationale for continuing an antibiotic without direction from the facility. An interview with the Medical Director on 9/16/25 at 10:30 AM indicated that he prescribed antibiotics based on his assessment of the resident and did not determine the need for antibiotic use based solely on diagnostic testing. Although he indicated that he did not always document the rationale for continuing the use of an antibiotic. he stated that if it was the policy and recommended practice for antibiotic stewardship then the facility should be following the standard and policy.A review of the Antibiotic Stewardship Program Policy dated 1/25 directed, in part, the Stewardship Program is based on the CDC's core elements of Antibiotic Stewardship for nursing homes. The core elements are leadership, accountability, drug expertise, action, tracking, reporting and education. Nursing contacts providers for reassessment during the time out period for the ongoing need for and choice of antibiotics once more data is available including clinical response, additional diagnostic information, and alternate explanations for the status change which prompted the antibiotic start.

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	075163	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare at Bishop Wicke Health & Rehabilitation	584 Long Hill Ave Shelton, CT 06484

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 5 sampled residents (Resident #86 and #88) for vaccinations, the facility failed to ensure the pneumococcal vaccine was offered. The findings included:1.Resident #86's was admitted to the facility in January 2020. Resident #86's diagnoses included heart disease and hypertension.The quarterly Minimum Data Set assessment dated [DATE] identified that Resident #86 had a Brief Interview for Mental Status score of 15 indicating intact cognition and required moderate assistance with Activities of Daily Living (ADL).The Resident Care Plan dated 9/12/25 failed to address Resident #86's vaccination status. A review of Resident #86's clinical record for the pneumococcal conjugate vaccination (PCV) status identified that he/she received the PCV 13 in July of 2021. The Center for Disease Control (CDC) pneumococcal vaccination recommendation indicated that Resident #86 was to receive 1 dose of either the PVC20 or PCV21 one year after PCV13 was given. The clinical record failed to identify a consent to offer any further vaccinations, or that any further vaccinations had been administered. 2. Resident #88 was admitted to the facility March 2024. Resident #88's diagnoses included heart failure and type 2 diabetes.The quarterly Minimum Data Set assessment dated [DATE] identified Resident # 88 had a Brief Interview for Mental Status score of 4 indicating extreme cognitive impairment and was totally dependent on staff for ADLS.The Resident Care Plan dated 9/5/25 failed to address Resident #88's vaccination status. A review of Resident # 88's clinical record failed to identify a signed consent or nursing documentation of pneumococcal vaccination status. An unsigned, undated vaccination worksheet indicated that the PVC 23 pneumococcal vaccination had been declined. The form directed that educational and consent forms should be given to all residents and/or resident representatives, whether the resident choose to receive a vaccine or wished to consult in the future with their attending physician. Additionally, there was no information in Resident #88's clinical record of a pneumococcal vaccination history.Interview with RN #1 on 9/16/25 at 1:00 PM identified that the facility should have offered the opportunity to provide vaccinations to Resident #86 and Resident #88. She believed that the vaccination was offered to Resident #86, but he/she may have declined. Additionally, RN #1 was unable to find a consent form accepting or declining the vaccinations or documentation for either resident in the clinical record. RN #1 indicated that it was her responsibility to ensure the facility had offered vaccinations to Resident #86 and Resident #88 indicating it may have been an oversight. A review of the Pneumococcal Vaccine Policy dated 4/25 directed, in part, it is the policy of [NAME] Health Center to vaccinate all eligible residents against pneumococcal disease. A consent form is signed by the resident or party responsible. Eligibility for vaccination is determined by guidelines established by the CDC which are based on individual's age, prior vaccination status, and medical condition.