STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135116	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Plaza Health and Rehabilitation of Cascadia	2870 Juniper Drive Lewiston, ID 83501

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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 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. Based on observation, review of the FDA Food Code, and staff interview it was determined the facility failed to follow sanitary requirements for food safety, including an appropriate hand washing sink, food sanitation, and appropriate cleaning and storage for resident's freezers. This was true for 76 residents who received food plated and delivered by the facility's meal serving room, and whose personal foods were stored in the residents freezer's. This deficient practice created the potential for harm by placing residents at risk for foodborne illnesses and/or adverse health outcomes. Findings include:1. The FDA Food Code Section 2-301.14 When to Wash documented food employees shall clean their hands immediately before engaging in food preparation including working with exposed food, clean equipment and utensils . (H) before donning gloves to initiate a task that involves working with food.On 6/25/26 at 11:55 AM, the facility's Dietary Manager (DM) brought in the hot food cart and donned gloves without handwashing. He moved the hot food into the steam table and then began to take food temperatures without washing hands between tasks or before donning gloves.On 6/25/26 at 12:00 PM, the Dietitian and DM stated hands should be washed between tasks and prior to donning gloves.2. The FDA Food Code Section 3-303.12 documented packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water.a. On 6/22/26 at 1:03 PM, in residents' Freezer #2, physical therapy ice was stored alongside food ice packs. On 6/25/25 at 12:40 PM, the Dietitian stated that physical therapy ice should not be stored with food ice.b. On 6/25/26 at 12:04 PM, it was observed that ice cubes were directly placed on the resident's juice cup lids. Hospitality aides were seen removing the ice from the juice lids before placing them on the resident's meal trays. On 6/25/26 at 12:34 PM, the Dietitian and DM stated ice cubes should not be stored directly on the juice cup lids, and the juice cups should be placed on top of or around the ice instead. 3. The FDA Food Code Sections 5-205.11, 6-301.12, 6-301.14, and 6-301.20 documented a handwashing sink must not be used for any other purpose than handwashing; handwashing sinks must have individual, disposable towels, or a continuous towel system that supplies the use of a clean towel; handwashing signage must be clearly visible and the area must have a waste receptacle. On 6/25/26 at 11:50 AM, the handwashing sink in the facility's meal dispensing area was observed to have dirty dishes in the sink, a reusable cup was stored next to the sink, without disposable towels, a trash can, and lacking employee handwashing signage.On 6/25/26 at 12:05 PM, the Dietitian and DM stated the handwashing sink did not contain disposable towels, a trash can, employee handwashing signage, nor should it contain dirty dishes or be a storage area for personal employee cups.

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

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents and/or their representatives were provided with complete facility discharge information. This was true for 3 of 6 residents (#4, #5, and #46) whose records were reviewed for hospital discharges. This failure placed the residents at risk for psychosocial harm, advanced directive misunderstandings, and a lack of medical history if the transferring facility did not receive a completed resident discharge record. Findings include:1. Resident #4 was re-admitted [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD-a progressive lung disease that blocks airflow and makes breathing difficult), congestive heart failure (CHF-a chronic condition where the heart's muscle becomes stiff or weak preventing it from pumping blood efficiently), and depression. On 2/10/26 the facility initiated an emergent discharge/transfer to hospital which identified what paperwork was sent to the hospital. Review of the Communication for Emergent Discharge/Transfer to Acute, the following documents were not included in the hospital transfer documents: -Resident Transfer Form -Face Sheet with Diagnosis -Care plan goals -Physician H&P -Advance directives -POST/POLST -Notification of resident family/resident advocate On 6/26/26 at 10:10 AM, the Administer brought in packet of the paperwork sent for Resident #4, and stated, This is everything the facility sent. The facility was unable to provide documentation the items listed above were sent with Resident #4. 2. Resident #5 was readmitted to the facility on [DATE], with multiple diagnoses including congestive heart failure, respiratory failure with hypoxia (a critical condition where lungs cannot transfer enough oxygen to the bloodstream, resulting in dangerously low blood oxygen levels), diabetes, kidney disease, and dementia. On 3/12/26, the facility initiated an emergent discharge/transfer to acute [facility] which identified what paperwork was sent to the receiving location [hospital]. Upon review of the paperwork the following documents were not included in the hospital transfer paperwork: -Resident Transfer form -Treatment Administration Record (TAR) (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Care plan goals -Physician H&P -Advanced Directives -Notification of residents' family and/or advocate 3. Resident #46 was admitted to the facility on [DATE], with multiple diagnoses including CHF, hypertension (a condition where the force of blood pushing against artery walls is consistently too high), and vascular disease (any condition affecting the circulatory system). On 6/23/26, the facility initiated an emergent discharge/transfer to acute [facility] which identified what paperwork was sent to the receiving location [hospital]. Upon review of the paperwork the following documents were not included in the hospital transfer paperwork: -Resident Transfer Form -Face sheet with diagnosis -Order summary with report -TAR -Care plan goals -Physician H & P -Advanced Directives -POST -Verbal report with transport staff -Notification of residents' family and/or advocate -Notices signed for transfer and bed hold On 6/23/26, a review of Resident #46's record included a Resident's Notice of Transfer and Bed Hold that were signed, but not checked off on the Communication for Emergent Discharge/Transfer to Acute checklist. On 6/25/26 at 8:36 AM, the CNO stated the checklist form is provided to prove we have sent the information; however, it appears there are documents that were not sent with the patient as it is not checked off on the forms for Resident #5 and Resident #46.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on the review of the Facility's Arbitration agreement, CMS SOM Appendix PP, and staff interview, it was determined the facility failed to ensure the facility's arbitration agreement provided the selection of a venue that is convenient to both parties. This was true for all residents who reside in the facility who signed an Arbitration Agreement. This failure created the potential for residents to be inconvenienced or the inability to participate during the arbitration process. Findings include:On 6/24/26 at 4:15 PM, after review of the arbitration agreement and the federal regulation requirement the Administrator stated the arbitration agreement was missing the regulatory requirement of a convenient location of arbitration for both parties.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review and staff interview, it was determined the facility failed to ensure residents were offered the opportunity to create an advance directive. This was true for 1 of 10 residents (Resident #13) whose advance directive was reviewed. This failure created the potential for Resident #13 to not have their wishes met if they were to require end of life care. Findings include: Resident #13 was re-admitted [DATE], with multiple diagnoses including hypertension, chronic kidney disease (a progressive condition where damaged kidneys lose their ability to filter waste and fluid from the blood), and mild cognitive impairment.On 6/24/26, review of Resident #13's medical record revealed the resident did not have an advance directive on file. On 6/25/26 at 2:43 PM, the Social Service Director stated she did not have documentation education was provided to Resident #13, nor were there attempts to obtain an advance directive.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure a resident was free from abuse. This was true for 1 of 3 residents (Resident #63) reviewed for abuse. This failure placed Resident #63 at risk for psychosocial harm when a video recording was taken of them during a sensitive moment and the video was shared with people not privileged to Resident #63's protected information. Findings include: Resident #63 was admitted to the facility on [DATE] with multiple diagnoses including dementia with behavioral disturbances, hypertension, and chronic kidney disease. Review of the State Agency Long Term Care Reporting Portal, on 8/12/25 at 9: 50 PM, Resident #63 was video recorded by 1 staff with another staff present. The facility's investigation report documented the description of the video as follows: At approximately 10:00 AM on August 13, 2025, a staff member from the Assisted Living unit at [facility name] presented a video to the Administrator of [Skilled Nursing Facility Name]. The video, approximately seven seconds in length, depicted [Resident #63] standing fully clothed in the shower, holding the shower head and spraying water into the bathroom and adjoining room. Certified Nursing Assistant [CNA #5] was visible in the video, laughing for the last couple seconds of the video.The investigation documented CNA #5 identified CNA #10 as the person who recorded the video. The staff from the Assisted Living facility stated they received the video from CNA #5. Resident #63 was interviewed and was unable to recall the incident. The state agency attempted to contact CNA #5 and CNA #10 during the investigation, and the CNA's did not return the state agency's calls. The facility was unable to provide the name or phone number of the staff who worked for the neighboring Assisted Living facility and showed the Administrator the video, for interview. Following the incident, the facility took the following actions: -Resident #63 was assessed for psychosocial harm by the Medical Director, no psychosocial harm evidence was identified-Both CNA's were suspended pending the investigation-The incident was reported as an allegation of abuse to the State Agency-Staff and residents were interviewed about abuse and HIPAA (Health Information and Accountability Act- laws which keep personal information safe)-The facility's cell phone policy was updated-The facility retrained all staff on HIPAA and abuse On 6/24/26 at 4:04 PM, the Administrator stated, the CNA's should not have video recorded Resident #63 during a sensitive moment and although the video was not recorded with malicious intent, the video should not have been shared with people who were not privileged to know about Resident #63's protected information. There was sufficient evidence the facility corrected the non-compliance as of 8/21/25, as there was no further incidents of staff recording residents after this date. At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, CMS SOM Appendix PP, and staff interviews, it was determined the facility failed to create a comprehensive care plan. This was true for 2 of 18 residents (#9 and #19) reviewed for care plan development. This deficient practice had the potential for harm if their care plans were not developed to ensure Resident's and/or their representatives, and facility staff were educated on individual diagnoses, treatment interventions, and treatment outcome goals specific for each resident. Findings include:1. Resident #19 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including anemia, nutrition deficiency, anorexia, dementia, and depression.A review of Resident #19's care plan dated 1/7/26, included treatment interventions for nutrition decline, but did not include treatment or interventions related to Resident #19's diagnosis of unspecified anemia.On 6/25/26 at 3:01 PM, the CNO stated Resident #19's anemia diagnosis and treatment interventions were not included in his care plan, and it should have been.2. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including PTSD (Post Traumatic Stress Disorder), anxiety, depression, mood disorder, dementia, and Alzheimer's disease.A review of Resident #9's care plan dated 6/6/23, documented Resident #9 had mood problems due to past trauma, depression, and anxiety. PTSD Interventions were included but did not address specific PTSD triggers experienced by Resident #9 and what interventions or redirections were needed by staff to assist Resident #9.On 6/25/26 at 3:09 PM, the CNO stated Resident #9's care plan was not comprehensive and did not include specific PTSD triggers and/or education/redirection for the staff and the resident or the resident's representative.

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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 record review and staff interview, it was determined the facility failed to ensure quality care was provided related to medication administration. This was true for 1 of 7 residents (Resident #35) whose medication regimen records were reviewed. This failure placed Resident #35 at risk for harm if they were to suffer adverse effects from receiving a medication outside the physicians prescribed parameters. Findings include: Resident #35 was admitted to the facility on [DATE] for care following a fall with fracture, with multiple diagnoses including chronic respiratory failure with hypoxia and hypercapnia (high blood carbon dioxide), and hypertension. Resident #35's June 2026 MAR documented the following physicians order, dated 6/12/26:-Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 50 mg by mouth in the morning related to essential (primary) hypertension, HOLD FOR SBP [systolic blood pressure - less than] 100 OR DBP [diastolic blood pressure - less than] 60 (systolic is the top number and diastolic is the bottom number in a blood pressure reading). Resident #35's blood pressure records documented they had a SPB less than 100 or a DPB less than 60 on June 13, 14, 17, 18, 20, 21, 22, 23, 24, and 25. Resident #35's MAR documented the blood pressures were out of parameter, and the Losartan blood pressure medication was administered on June 20, 22, and 23. On 6/25/26 at 5:14 PM, the CNO stated Resident #35's blood pressures were out of parameters according to the physician order and the doses of Losartan on June 20, 22, and 23 should have been held, and they were administered in error.

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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 observation, record review, and staff interview, it was determined the facility failed to ensure residents were provided respiratory services consistent with professional standards of practice. This was true for 1 of 2 residents (Resident #4) whose respiratory device was not stored properly; and 1 of 2 residents (Resident # 56) reviewed for physician orders for oxygen therapy. This deficient practice created the potential for residents to develop infection and to receive too little or too much oxygen. Findings include: The facility's policy titled, Oxygen Administration, Safety, Storage and Maintenance, revised 10/10/25, stated, The facility will administer, store and maintain oxygen safely in accordance with current standard of practice and licensed practitioner orders. 1. Resident #56 was admitted [DATE] with multiple diagnoses including congestive heart failure, hypertension, and pulmonary hypertension (high blood pressure in the arteries of the lungs).Resident #56's physician's orders included the following:-Oxygen at 2 LPM (liters per minute) per nasal cannula continuously via O2 (oxygen) concentrator, dated 8/28/25.On 6/22/26 at 5:25 PM, Resident #56 was observed with nasal cannula in her nares, oxygen on at 1 liter per minute.On 6/22/26 5:31 PM, RN #2 came into Resident #56's room and verified the oxygen was set at 1 LPM. RN #2 checked order and stated, Resident #52's oxygen should be set at 2 LPM. 2. Resident #4 was re-admitted [DATE], with multiple diagnoses including CHF, COPD, and muscle weakness. Resident #4's physician's orders included the following:-Oxygen at 1-3 LPM intermittently per nasal cannula to maintain oxygen saturations at greater than 88%, via O2 concentrator/or tank with humidification, dated 6/15/26.On 6/23/26 at 2:20 PM, Resident #4 was observed in his bed with nasal cannula directly on his nightstand. RN #4 confirmed the nasal cannula was on the nightstand and should be stored in a bag.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, staff interview and record review, it was determined the facility failed to ensure that expired medication was removed from medication storage area and discarded in accordance with professional standards and facility policy. This was true for 1 of 2 medication carts reviewed for medication storage and cart review. This deficient practice had the potential to affect the strength, quality and purity of the medication. Findings include:The facility's policy titled Medication Storage and Labeling, released [DATE] stated, The facility will ensure that medications are stored and labeled in accordance with CMS regulations, state law and acceptable professional principles to ensure safety, efficacy, and compliance. It further stated, Expired or discontinued medications must be removed promptly and disposed of per facility policy and DEA guidelines to prevent diversion.On [DATE] at 10:04 AM, during medication storage and cart review, the surveyor in the presence of RN #3, found a bottle of liquid lorazepam for Resident #2, dated with an expiration of [DATE].On [DATE] at 10:05 AM, RN #3 acknowledged medication was expired. RN #3 stated, the medication must be removed from the cart and discarded immediately.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure resident records were complete and accurate. This was true for 1 of 7 residents (Resident #68) whose medication regimen was reviewed. This failure created the potential for poor continuity of care for Resident #68. Findings include: Resident #68 admitted to the facility on [DATE], with multiple diagnoses including CHF, and bacteremia (the presence of bacteria in the bloodstream). a. Resident #68's June 2026 MAR documented the following physician orders, dated 6/20/26:-Crestor Oral Tablet 10 MG (rosuvastatin calcium) Give 10 mg by mouth at bedtime related to hyperlipidemia-Rosuvastatin Calcium Oral Tablet 10 MG (rosuvastatin calcium) Give 10 mg by mouth at bedtime relatedto hyperlipidemia The order for Crestor was signed as administered on June 20, 21, 22, 23, and 24. The order for rosuvastatin was signed as held due to duplicate therapy on June 20, 21, and 24; on the 22nd and 23rd, the medication was signed as administered. On 6/25/26 at 4:20 PM, the CNO verified the pharmacy had delivered 1 card of rosuvastatin medication for Resident #68 on 6/20/26. The CNO verified the medication card had 5 doses administered, indicating Resident #68 had not received the same medication twice on June 22nd and 23rd. On 6/25/26 at 4:35 PM, the CNO stated, Resident #68 had two of the same medication order, Crestor and rosuvastatin transcribed to their MAR in error, and on June 22nd and 23rd, the MAR documented they received the medication twice in error. b. Resident #68's June 2026 MAR documented the following physician order, dated 6/19/26:-Cefepime HCl Intravenous Solution 2 GM/100ML (Cefepime HCl) Use 2 gram intravenously every 8 hours related to bacteremia for 30 Administrations until finished Resident #68's MAR, on June 21, at 9:00 PM, the IV antibiotic, Cefepime was not signed as administered and there was a blank in the MAR. On 6/25/26 at 5:02 PM, the CNO verified how many doses of Cefepime had been delivered from the pharmacy for Resident #68 and verified the correct number of doses had been administered based on the number of doses remaining. On 6/25/26 at 5:06 PM, the CNO stated, the nurse who administered Resident #68's Cefepime at 9:00 PM on June 21 should have signed for it, and the MAR was left blank in error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, the facility failed to ensure the facility staff followed proper infection control practices and glove change protocols. This was true for 1 of 18 residents (Resident #6) when staff failed to perform hand hygiene when going from a dirty environment to a clean environment. This deficient practice placed residents at risk for cross-contamination, and the spread of healthcare associated infections. Findings include: The facility's policy titled Hand Hygiene, revision date 9/15/25, stated, Hand hygiene is recognized as a cornerstone of effective infection control and is essential in preventing the transmission of healthcare-associated infections (HAIs). All healthcare workers should perform hand hygiene at critical moments during resident care, according to CDC guidelines:-Immediately before and after touching a resident.-Before moving from work on a soiled body site to a clean body site on the same resident.-After contact with objects and surfaces in the resident's environment.-After contact with blood, body fluids, or visibly contaminated surfaces.Resident #6 was re-admitted [DATE], with multiple diagnoses including type 2 diabetes, hypertension and chronic pain syndrome.On 6/24/26 at 12:17 PM, RN #3 was observed doing a glucose finger stick on Resident #6 with clean gloves on, then removed the dirty gloves and put on clean gloves without performing hand hygiene.On 6/26/26 at 10:02 AM, the IP stated hand hygiene should be performed when changing gloves and when going from a dirty environment to a clean environment.

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Royal Plaza Health and Rehabilitation of Cascadia	2870 Juniper Drive Lewiston, ID 83501

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 policy review, CDC guidelines, record review, and staff interview, it was determined the facility failed to ensure immunizations were offered and/or provided as indicated. This was true for 2 of 5 residents (#2 and #13) reviewed for pneumococcal immunization. This deficient practice placed residents at risk of developing pneumococcal pneumonia and developing serious, potentially life-threatening complications. Findings include:The CDC webpage titled, Pneumococcal Vaccination accessed on 6/25/26, documented there are two types of pneumococcal vaccines. They are Pneumococcal conjugated vaccines (PCV) and Pneumococcal polysaccharide vaccine. The CDC recommended pneumococcal vaccination for:-All adults 50 years or older.-Adults 10 through [AGE] years old with certain risk conditions. 1. Resident #2 was re-admitted [DATE] with multiple diagnoses including, peripheral vascular disease (a progressive circulation disorder characterized by narrowing, blockage or spasms in blood vessels outside the heart), diabetes type 2, and vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain).Resident #2's Immunization Information, documented she refused to receive the pneumococcal vaccine, no dates listed.There was no documentation in Resident #2's record she and/or her representatives was offered and educated regarding the risk and benefits of having pneumococcal vaccines.2. Resident #13 was admitted [DATE], with multiple diagnoses including HTN, glaucoma (an eye disease that damaged the optic nerve due to abnormally high ocular pressure), and chronic kidney disease (damaged kidneys that cannot filter blood as they should).Resident #13's Immunization Information, documented she refused to receive the pneumococcal vaccine no dates listed.There was no documentation in Resident #13's record he and/or his representatives was offered and educated regarding the risk and benefits of having pneumococcal vaccines.On 6/26/26 at 10:01 AM, the IP stated she was unable to find documentation Resident #2 and Resident #13 were offered or educated of the risks and benefits of the pneumococcal vaccination.