STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145950	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations at Rock Island	2545 24th Street Rock Island, IL 61201

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50962 Based on record review and interview the facility failed to provide the resident and the resident's representative the facility's written bed hold policy within 24 hours of transfer for two of two residents (R50 and R60) reviewed for bed holds in a total sample of 31. Findings include: The facilities Bed Hold Policy dated 3/2023 documents, Under Normal circumstances, if you leave the facility for a hospitalization , you will be readmitted to the first available bed in a semi-private room. Under certain conditions, we can reserve your existing bed for you, at your request, so when you return to the facility, you will have the same bed if you are hospitalized . If you are a private pay, Medicare, or Medicaid resident, we will hold your same bed and room for you as long as you wish, at a charge to you as established in the resident contract signed on admission. If your care is being paid for by the Veteran's Administration, we will hold your bed for 48 hours unless prior approval for a longer period has been received from the VA (Veteran's Administration) that initiated your contract. Per the NHCA (Nursing Home Care Act), this facility will hold a bed for a maximum of ten days when you are hospitalized . On the 11th day, the facility will no longer hold a bed for you, but as you are still a resident, you will receive the next available bed when you are ready to return, even if there is a waiting list. There is no requirement under the NHCA to hold a bed for ten days during a therapeutic home visit. However, you are still considered a resident and will be given the next available bed when you are ready to return, even if there is a waiting list. After the thirtieth (30th) day, the resident will be formally discharged from the facility's roster. At this time, the resident can reapply for admission to the facility. 1) R50's medical record documents hospitalization s on 10/14/23, 2/22/24, 5/28/24, and 6/10/24. R50's progress notes dated 10/14/23, 2/22/24, 5/28/24, and 6/10/24 has no documentation that facility's bed hold policy was given or reviewed with R50 or family. On 08/29/24 3:01 PM V1 (Administrator) stated that bed hold policy was not sent or gone over with R50 or his family on 10/14/23, 2/22/24, 5/28/24, and 6/10/24. 30899 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident Census Record indicates R60 was transferred to the hospital on the following dates in 2024: 1/4/24, 2/11/24, 4/16/24, 4/30/24, 5/27/24, 6/7/24, 6/13/24, 7/27/24, 8/2/24 and 8/21/24. Facility Transfer/Discharge Status Form which includes Bed Hold Notices were only provided for transfers to the hospital in 2023, no Bed Hold Notices were found or presented for any of R60's transfers in 2024. On 8/29/24 at 10:30am R60 stated he did not recall receiving a bed hold form when discharged to the hospital. On 8/29/24 at 10:45am V1 (Administrator) stated R60 did not get a bed hold when transferred to the hospital.

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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. 34131 Based on observation, interview, and record review, the facility failed to develop a care plan to include a resting hand splint for one (65) of one resident reviewed for devices in a sample of 31. Findings include: R65's current orders for August 2024, documents LUE (left upper extremity) RHS (resting hand splint) wearing schedule: Patient should wear LUE RHS two hours prior to each meal and at night. Splint off during hygiene/bathing and feeding. If red or white spots are present, discontinue use and contact therapy. Before Meals and At Bedtime 07:30 AM, 11:30 AM, 04:30 PM, 08:00 PM. On 8/27/24 at 11:20 AM and 8/29/24 at 10:40 AM, R65's hand splint was sitting on a shelf in her room. R65's current care plan does not have R65's resting hand splint documented. On 8/29/24 at 4:01 PM, V8 (Registered Nurse/Care Plan Coordinator) verified R65's care plan needed updated.

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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. 34131 Based on observation, interview, and record review, the facility failed to revise a care plan to remove checking an AV/Arteriovenous fistula site; failed to include who to contact for emergencies/complications, failed to include a target weight; failed to have an assessment and care of the central dialysis port; and failed to include resident specific dialysis orders for two (R13 and R50) of 18 residents reviewed for care plan revisions in a sample of 31. Findings include: The facility's Comprehensive Care Plans policy dated 4/2017 documents, To develop a comprehensive, person-centered plan of care, consistent with the resident's rights, that includes measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs. The comprehensive care plan will include: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, psychosocial well-being while preventing decline when possible, and areas of potential risk to the resident with interventions to eliminate or reduce risk. Care Plans are revised as changes in the resident's condition dictates, but no less than on a quarterly basis. 1. R13's medical record documents the following diagnoses: End stage renal disease; Dependence on renal dialysis. R13's medical record documents R13's AV fistula was discontinued, and his right chest dialysis port was put in 4/1/24. On 8/27/24 11:30 AM, R13 was in his room, alert and oriented, and had a right chest long central catheter port wrapped in gauze. At that same time R13 stated I go to dialysis five days a week here. R13's left upper arm had a scar that was healed and R13 stated I had a shunt there for dialysis, but it got infected, so they had to remove it and put in this chest catheter for dialysis. R13's current care plan has no specific dialysis orders related to the type of dialyzer, flow rate, and length of time; target weights; who to contact for emergencies/complications; or care or assessment of the dialysis port. R13's current care plan has R13's left upper arm AV/Arteriovenous fistula site still documented. On 8/29/24 at 4:01 PM, V8 (Registered Nurse/Care Plan Coordinator) stated V13's care plan was not updated to remove R13's left arteriovenous catheter. V8 also confirmed R13's Care Plan did not address complications, emergencies, target weight, nephrologist, or assessment of the right chest catheter site. V8 stated R13's Care Plan, needs updated. 50962 2. R50's physician orders, dated 6/20/24, documents site (left upper inner thigh): HD (Hemodialysis) Catheter- Monitor site for bleeding and signs and symptoms of infection. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 11:20 AM, R50's dialysis catheter observed in left upper, inner thigh. R50's Current Care Plan, as of 8/29/24 at 1:00 PM, has not been revised to reflect dialysis catheter to left inner, upper thigh. On 08/29/24 01:50 PM V8 (Registered Nurse/Care Plan Coordinator) and V9 (Licensed Practical Nurse/Restorative Nurse) stated R50's current care plan does not show documentation that R50 has a dialysis catheter to his left inner, upper thigh.

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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** 30899 Based on interview and record review the facility failed to follow physician's orders to flush an indwelling urinary catheter and failed to identify and document changes in urine output/characteristics for one resident (R76) of four residents reviewed for urinary catheters in the sample of 31. Findings include: Facility Policy/Change in a Resident's Condition or Status dated 3/2023 documents: The nurse will notify the resident's attending physician or physician extender when: There is need to alter the resident's treatment significantly; deems necessary or appropriate in the best interest of the resident. The nurse will record in the resident's medical record any changes in the resident's medical condition or status. R76's Physician Order Report indicates R76 was admitted to the facility on [DATE]. R76 is [AGE] years old and has diagnoses that include Diabetes Mellitus with Chronic Diabetic Kidney Disease, Stage 3 Chronic Kidney Disease, Personal History of Urinary Tract Infections, Polyneuropathy and Acute Cystitis without Hematuria. Physician Orders indicate R76 had an indwelling urinary catheter (order date 12/7/23) with the following orders: Order Date 5/17/24: acetic acid solution 0.25%, 60 ml (milliliters) irrigation; Special Instructions: Flush catheter with 60ml daily AND (as needed) for increased sediment/mucus or blockage. Order Date 5/17/24: Normal Saline Flush 0.9%, 60ml. Special Instructions: Flush catheter with 60ml daily AND (as needed) for increase sediment/mucus blockage. Diagnosis: Neuromuscular Dysfunction of Bladder. R76's Medication Administration Record (MAR) dated 8/1/24 to 8/8/24 indicates that R76 was transcribed for R76 to only receive (as needed) acetic acid and Normal Saline irrigation/flushes of her indwelling urinary catheter despite the MAR indicating the Special Instructions documented Daily and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 1:04pm V6 (Registered Nurse/RN) stated that during report (on 8/7/24/evening shift) she was receiving report from the off-going, evening shift nurse (V7) who told her that R76 was having possible catheter problems and indicated the problems had to do with R76's urine output. V7 (Licensed Practical Nurse/LPN) reported that R76 had no output on evening shift, had not looked into the problem and suggested irrigating R76's catheter. V6 stated that V7 reported that she was unsure if R76's catheter was blocked or R76 just didn't have any output. V7 reported that she did not irrigate R76's catheter on her shift. V6 also stated that during initial rounds to get the residents' oxygen readings - including R76 - she found R76 was sleeping comfortably. V6 stated that approximately 45 minutes later, R76 was yelling, and she went immediately to R76's room along with a CNA (Certified Nurse Assistant). V6 stated they changed R76's position however R76 continued to indicate she was uncomfortable. V6 stated that she noticed R76's urine in the catheter tubing at that time was mucus(y), milky and amber colored. V6 stated that was not what R76's urine usually looked like. V6 stated that she then flushed R76's catheter and then did a bladder scan to determine if R76's low urine output was due to the catheter being clogged and to determine how much urine was in R76's bladder. V6 stated that when she was talking to the day shift nurse the following morning (8/08/24) she was told that R76 also had no output during the previous day (9/07/24). V6 stated I was not aware of that until the following morning, the evening shift nurse (V7) did not report that. V6 also stated My rule of thumb is if there is no output in 8 hours, that is abnormal. If there is no output and if there are orders to flush, that's what should be done and also bladder scan - which is what I did. Progress Note dated 8/8/24 at 2:31am indicates This nurse heard (R76) yelling out from the hallway, and the CNA and myself ran down to (R76's) room to find (R76) in distress and pointing at her back/butt, indicating that she wanted to be turned. We turned (R76) and this seemed to be effective at that time. Note indicates R76 had reportedly had catheter issues/inadequate urine output on the previous shift and had 300 ml of opaque, milky, amber-colored urine in her drainage bag at this time. Note indicate V6 proceeded to irrigate (R76's) catheter and perform a bladder scan. Note indicates R76 was not yelling at that time and seemed to be relaxed while she was performing the bladder scan. Note indicates the scan resulted in 000 ml as the reading. On 8/29/24 at 2:15pm V7 (LPN) stated (on 8/7/24) R76 did have low urine output and told staff to push fluids. V7 stated R76 had approximately 300ml urine output on that evening, but usually has about 800ml out. V7 stated that R76's urine was yellow/amber with sediment. V7 stated I didn't think about irrigating (R76's catheter). (R76) used to have orders to flush her catheter every evening but then the order changed. (V6) suggested flushing (R76's) catheter not me. V7 stated she forgot to document R76's urine output (on 8/7/24) on the MAR. No progress notes from day shift or evening shift on 8/7/24 were found or presented to indicate R76's low or absent urine output or characteristics of urine that may have indicated a blockage or infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 12:45pm V9 (LPN) stated that she spoke with V11 (Nurse Practitioner/NP) who changed R76's orders to (as needed) only because she thought maybe the flushes were causing R76's UTI's (urinary tract infections). V9 stated I forgot to change the Special Instructions to take out the daily flushes. At that time V9 was asked if she had made a progress note regarding her conversation with V11 about the changes to R76's orders - V9 responded that she would check. V9 returned later with a progress note dated 5/17/24 at 12:45pm that indicated This nurse spoke with (V11) about UTI. (V11) voiced concern about flushes (and) gave NO (Nursing Order) for acetic acid from scheduled to (as needed). MAR updated to reflect changes. Progress Note dated 5/17/24 at 12:45pm Progress Note Details indicates R76's Progress Note dated 5/17/24 was created on 8/29/24 at 2:48pm. This creation date was not included in the progress note V9 provided earlier. On 8/30/24 at 10:32am V1 (Administrator) stated I don't know why (V9) put that note in there. No one told her to do that. I think she put it in after she realized her mistake. She shouldn't have done that. On 8/30/24 at 9:00am V11 (Nurse Practitioner) stated I don't recall changing the order or discussing it with the nurse. (R76) had chronic UTI's because she had a catheter. I don't recall changing the order because of the reason you're telling me. (R76) was followed by Urology. I don't know who originally ordered the daily flushes. R76 did have good fluid intake and urine output so it would be a change for her to have a decrease. NP Note dated 5/9/24 indicates R76 was seen by V11 on that date. Note indicates R76's urine in catheter was clear yellow. Note did not indicate any concern for catheter flushes causing R76's UTI's. Physician Note dated 5/14/24 indicates R76 was seen by the physician on that date. Note did not indicate any concern for catheter flushes causing R76's UTI's. On 8/30/24 at 9:40am V2 (Director of Nursing) stated It's up to the nurse's discretion when to flush the catheter. It would depend on what the urine looks like, not just on output. But according to V6 (RN) (R76's urine) was cloudy. V6 did the right thing by trying to flush and scanning. R76's Care Plan (edited 7/17/24) indicates R76 has an indwelling urinary catheter; has acetic acid solution flush daily for catheter. Care Plan indicates to avoid obstructions in drainage; document urinary output every shift/record amount, type, color, odor.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 34131 Based on observation, interview, and record review, the facility failed to apply a resting hand splint for one (R65) of one resident reviewed for devices in a sample of 31. Findings include: Facility Splint-Brace Assistance, reviewed 6/24, documents When splints and other contracture devices are part of the plan, therapy will instruct nursing staff on their use and recommend a schedule for applying and removing the device. Facility Certified Nursing Assistant, updated 10/2013, documents Carry out assignments for resident care including restorative nursing procedures. R65's current orders for August 2024, documents LUE (left upper extremity) RHS (resting hand splint) wearing schedule: Patient should wear LUE RHS two hours prior to each meal and at night. Splint off during hygiene/bathing and feeding. If red or white spots are present, discontinue use and contact therapy. Before Meals and At Bedtime 07:30 AM, 11:30 AM, 04:30 PM, 08:00 PM. R51's Treatment Record for August 2024 has no documentation of R65's application of her resting hand splint. R51's medical record has no charting in the CNA (Certified Nursing Assistant) charting of R65's resting hand splint. On 8/27/24 at 11:20 AM and 8/29/24 at 10:40 AM, R65 was in bed and does not have her left resting hand splint on. R51's hand splint was sitting on a shelf in her room. 08/29/24 3:32 PM - Observations of R65's room, R65 lying in bed with fall mat on right side of bed, wheelchair in corner of the room with foot pedals in the seat, metal trough with thick foam on shelf, hand splint on shelf. R65 states the trough pinches her arm and she doesn't like to wear it, It doesn't help anyway. 08/29/24 3:44 PM V12 (CNA) stated she is unfamiliar with R65's arm splints and referred to the nurse. 08/29/24 3:50 PM V7 (Licensed Practical Nurse) walked into R65's room and observed the trough and hand splint. V7 stated R65 does not like to wear the trough because it's uncomfortable, but she typically gets her to wear it. V7 stated she doesn't know what the hand splint is, she's never seen it before. 08/30/24 10:15 AM V14 (Physical Therapist) stated RHS stands for resting hand splint and confirmed R65 should be using both the trough and resting hand splint as ordered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34131 Based on observation, interview, and record review, the facility failed to have specific dialysis orders related to the type of dialyzer, flow rate, and length of time; target weights; and care of the dialysis port for two (R13 and R50) of two residents reviewed for dialysis in a sample of 31. Findings include: Facility Care of Dialysis Resident policy, revised 5/17, documents To prevent complications pre and post dialysis treatment and to provide a safe environment. Monitor access site, identify any problems with site and report to physician and dialysis center. All physician orders are to be followed. 1. On 8/27/24 11:30 AM, R13 was in his room, alert and oriented, and had a right chest long central catheter port wrapped in gauze. At that same time R13 stated I go to dialysis five days a week here. R13's medical record documents the following diagnoses: End stage renal disease; Dependence on renal dialysis. R13's medical record has no specific dialysis orders related to the type of dialyzer, flow rate, and length of time; target weights; or care of the dialysis port. On 8/29/24 at 11 AM, V17 (Licensed Practical Nurse/LPN) stated they have a communication form from dialysis, but it does not state any specifics on the dialysate from dialysis, no specific orders for dialysis except R13 goes to dialysis five days a week, no target weight, and care of the dialysis port is done by dialysis. On 8/29/24 10:03 AM, V15 and V16 (Registered Nurses/RNs) on the dialysis unit both stated they are contracted by the facility, facility does not have access to their records for specific resident orders for dialysis and expect the staff to observe and be aware of any concerns with resident's dialysis access sites. 50962 2. R50's physician orders dated 6/20/24 documents Dialysis 5 times a week. R50's physician orders as of 8/29/24 has no documentation of an individualized dialysis prescription. On 08/29/24 at 2:00 PM, V3 (Assistant Director of Nursing) stated R50's current physician orders do not have an individualized dialysis prescription, dialysis unit keeps specific orders. V10 (Registered Nurse) stated that specific individualized dialysis orders are kept in the dialysis unit because they administer the dialysis. Facility orders for dialysis patients are generic with additional orders to monitor sites and vital signs after treatment. V10 stated that dialysis communication sheets are sent with patient to dialysis and return with documentation from dialysis.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 34131 Based on interview and record review, the facility failed to have an Infection Preventionist that has specialized training in infection prevention and control. This has the potential to affect all 79 residents residing in the facility. Findings include: Facility Infection Preventionist Nurse job description, reviewed November 2021, documents Maintains current knowledge of federal, state, and local regulations. Understands and complies with infection control, and safety procedures and regulations. Online https://www.cdc.gov/long-term-care-facilities/hcp/training/index.html, dated MARCH 28, 2024, documents Nursing Home Infection Preventionist Training At a glance- This course is for individuals responsible for infection prevention and control (IPC) programs in nursing homes. Participants can complete the 23 modules and sub-modules in any order and over multiple sessions. On 8/29/24 at 10:27 AM, V4 (Infection Preventionist/IP) stated, I thought I had my IP certificate done. V4 verified she had 15 of the 23 modules done and went into the CDC/Centers for Disease Control program and showed the surveyor where she had not completed the training or taken the posttest (2 tries to pass) and got her certificate. At that same time, V4 stated I have been in this position since December 2023, I work Monday thru Friday full time as the IP, and I need to finish this. Facility provided V4's IP certificates of 15 modules completed of the 23 modules for IP training. Facility Resident Census and Conditions of Residents form, dated 8/27/24, documents 79 residents reside in the facility.

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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** 34131 Based on interview and record review, the facility failed to have pneumonia vaccination records documented in the resident record and failed to offer pneumonia vaccinations for two (R13 and R65) of five residents reviewed for pneumonia vaccinations in a sample of 31. Findings include: Facility Immunizations, revised 7/2022, documents It is the policy of this facility to offer Influenza and Pneumococcal vaccinations to all residents. Pneumococcal vaccine will be offered to all residents upon admission unless they report prior immunization. Facility will make best efforts to validate prior immunization. 1. R13's medical record documents V13 was admitted to the facility on [DATE], and has no documentation R13 has received, or was offered the pneumonia vaccine. On 8/27/24 after surveyor spoke to V4 (Infection Preventionist/IP), V4 IP documented a progress note in R13's medical record of the following: Resident offered PNA (pneumonia) vaccine and he reports that he will take. Informed resident that the clinic will be 10/5/24 and I will return with a consent for him to sign and he was agreeable. 2. R65's medical record documents R65 was admitted to the facility on [DATE], and has no documentation R65 has received, or was offered the pneumonia vaccine. On 8/27/24 after surveyor spoke to V4, V4 documented a progress note in R65's medical record of the following: Resident offered PNA vaccine and declined. On 8/27/24 at 11:00 AM, V4 stated there is a vaccination clinic scheduled for October 15th for the flu/pneumonia vaccination for staff and residents. On 8/28/24 at 12:40 PM, V4 stated, I missed getting their immunizations on admission, and they did not have as a prior vaccination when I asked them yesterday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145950	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations at Rock Island	2545 24th Street Rock Island, IL 61201

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131 Based on interview and record review, the facility failed to have Covid-19 vaccination records documented in the resident record and failed to offer Covid-19 vaccinations for three (R13, R61 and R65) of five residents reviewed for Covid-19 vaccinations in a sample of 31. Findings include: Facility Covid Vaccine Policy, undated, documents The facility has made arrangements with a pharmacy to provide Covid vaccines to residents. The facility will continue to promote, encourage, and provide vaccination for all residents. 1. R13's medical record documents V13 was admitted to the facility on [DATE], and has no documentation R13 has received, or was offered the Covid-19 vaccine. On 8/27/24 after surveyor spoke to V4 (Infection Preventionist/IP), V4 documented a progress note in R13's medical record of the following: Resident offered Covid-19 vaccine and he reports that he will take. Informed resident that the clinic will be 10/15/24 and I will return with a consent for him to sign and he was agreeable. 2. R65's medical record documents R65 was admitted to the facility on [DATE], and has no documentation R65 has received, or was offered the Covid-19 vaccine. On 8/27/24 after surveyor spoke to V4, V4 documented a progress note in R65's medical record of the following: Resident offered Covid-19 vaccine and declined. 3. R61's medical record documents R61 was admitted to the facility on [DATE], and has no documentation R61 has received, or was offered the Covid-19 vaccine. On 8/27/24 after surveyor spoke to V4, V4 documented a progress note in R61's medical record of the following: Resident offered Covid-19 vaccine and declined stating I don't believe in that stuff. On 8/27/24 at 11:00 AM, V4 stated there is a vaccination clinic scheduled for October 15th for the flu/pneumonia vaccination for staff and residents. On 8/28/24 at 12:40 PM, V4 stated, I missed getting their immunizations on admission, and they did not have as a prior vaccination when I asked them yesterday.