STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E361	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Quad Cities	1403 9th Avenue Silvis, IL 61282

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33985 Based on record review and interview, the facility failed to provide a resident and resident's representative with a written notice of transfer (R6) and the facility failed to notify the facility Ombudsman monthly of resident transfers to the hospital. This failure has the potential to affect all 31 residents residing in the facility. Findings include: 1. R6's Nurses Notes, dated 9/6/2024, documents the following: At 3:45 PM, R6 is violently tremoring. Hospice is requesting a hold of medications for comfort as Hospice believes R6 is over medicated. V6/R6's POA/Power of Attorney notified and requests that R6 be sent out to the emergency room to be evaluated. Request granted. R6 was sent to the emergency room to be evaluated. R6's chart lacks the documentation to show that R6 and V6/R6's POA was notified in writing of the transfer/discharge to the emergency room . On 9/19/2024 at 10:00 AM, V2/DON (Director of Nurses) stated, I cannot find anywhere that a written notice of transfer was given to (R6 or V6/R6's POA (Power of Attorney). I know that V6 requested a transfer, but I cannot be sure V6 was notified in writing that R6 was transferred. 2. On 9/19/2024 at 12:30 PM, V1/Administrator stated, The last notice given to the Ombudsman for resident transfers was in 2021. It has not been updated for a long time. Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility.

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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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. 33985 Based on record review and interview, the facility failed to provide a copy of the bed hold policy for the resident discharging to the hospital for one of one resident (R6) reviewed for bed hold in a sample of 21. Findings Include: The facility policy named, Bed Hold Guarantee Policy, dated 8/1/2017, documents the following. The resident, resident family or legal representative will be given the appropriate Notice of Bed Hold Policy at the time of discharge or therapeutic leave, if possible, but notice will be given no longer than 24 hours after discharge or initiation of leave. R6's Short Transfer Form from a local hospital, dated 9/6/2024, documents R6 was seen in the emergency room for a diagnosis of End of Life care. R6's medical record, dated 9/6/2024, lacks the documentation to support that R6 or V6/R6's representative was given a written notice of the bed hold policy prior to discharge. On 9/19/2024 at 10:00 AM, V2/DON (Director of Nurses) stated, No (R6 or V6/R6's representative) did not get a copy of the bed hold policy prior to leaving the facility.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 33985 Based on record review and interview, the facility failed to obtain a new level one PASRR (Pre-Admission Screening and Resident Review) for 2 of 3 residents (R13 and R25) reviewed for pre-admission screenings in the sample of 21. Findings Include: The facility policy named, Resident Assessment- Coordination with PASRR Program, no date, documents, If a resident who stays in the facility longer than 30days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have a mental illness or intellectual disability to the appropriate state designated authority. The Social Service Director shall be responsible for keeping track of each resident's PASRR screening status and referring to the appropriate authority. 1. R25's Interagency Certification of Screening Results, dated 10/29/2020, documents the following: Date of admission to facility: 10/28/2020. Screening has indicated a nursing facility is appropriate. R25's Interagency Certification of Screening also documents that R25's screening is valid for only 90 days from the day of screening. R25's Medical Record lacks the documentation to show that a new Level I Screening was done. 2. R13's Interagency Certification of Screening Results, dated 9/14/2019, documents the following: Date of Admission to the facility: 9/9/2019. Screening has indicated supportive living services are appropriate. R13's Interagency Certification of Screening also documents that R13's screening is valid for only 90 days from the day of screening. R13's Medical Record lacks the documentation to show that a new Level 1 Screening was done. On 9/19/2024 at 9:30 AM, V10/SSD (Social Service Director) stated, I do not know who is responsible for taking care of the PASRR screening process. I am not sure what you are talking about. I will try and find out for you.

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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. 30899 Based on observation, interview, and record review, the facility failed to notify the physician and initiate treatment for a skin fold wound for one resident (R20) of one resident reviewed for skin impairments in the sample of 21. Findings include: Facility Policy/Skin Condition Monitoring dated 1/18 documents: It is the policy of this facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. Upon notification of a skin lesion, wound, or other skin abnormality, the Nurse will assess and document the findings in the nurses notes and complete QA (Quality Assurance) form for Newly Acquired Skin Condition. The Nurse will then implement the following procedure: Notify the physician and obtain treatment order. The treatment order will include: Type of Treatment Location of area to be treated Frequency of how often treatment is to be performed How area is to be cleaned Stop date - if needed Any skin abnormality will have a specific treatment order until area is resolved. PRN (as needed) orders should not be obtained for a skin abnormality. Once the skin abnormality is healed, the treatment may then be changed to PRN with a physician's order. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: Characteristics: Size, Shape, Depth, Odor, Color, Presence of granulation tissue. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 1:45pm, R20 was sitting in her wheelchair in her room and was noted to have a large fat pad protruding under her chin causing a deep skin fold between her chin and neck. Extending out from the skin fold was an inflamed reddened area. R20 stated one of the CNAs (Certified Nurse Assistants) noticed the red area during lunch in the dining room. R20 stated the area feels moist but is not painful. R20 stated she was going to tell the nurse but never told her. Current Physician's Orders indicates R20 has orders (date initiated 5/6/24) for Nystatin (anti-fungal) powder to abdominal/breast folds - but not for neck area. Progress Note dated 9/16/24 at 6:20pm indicates R20 has an angry reddened area under chin/neck and under both breasts. Nystatin powder applied. On 9/17/24 at 2:35pm V3, LPN (Licensed Practical Nurse) stated she was told about R20's red neck area in morning report. V3 stated that R20 received a shower today and they cleaned R20's neck really good. V3 stated that V5, PM shift nurse (on 9/16/24) Put some cream or something on it but I didn't see it on the treatment sheet. The treatment sheet only says for abdomen and under breasts. (R20's) Physician was here today, I don't know if he wrote some orders for her neck. So far haven't seen anything for her neck. I didn't feel comfortable putting a treatment on an area that did not have orders. R20's Current Care Plan has no focus area/problem to address R20's neck, abdomen, or breast fungal skin issues.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34131 Based on observation, interview, and record review, the facility failed to have sufficient staff available to provide nursing services to meet the residents' need in the facility. This has the potential to affect all 31 residents currently residing in the facility. Findings include: Facility Assessment Tool, reviewed 1/24/24, documents the following: Staffing plan- facility consults minimum staffing requirements to ensure facility meets the minimum requirements for staffing. Facility considers acuity, daily tasks, and resident needs to ensure staffing meets the needs of the residents. Nurse Aides total number needed (in a 24-hour period) eight. Staff Plan- Direct care staff ratio for days and evenings is three, and direct care staff ratio for nights is two. Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. Staff Daily Assignment postings, dated 8/23/24, 8/26/24, 8/31/24, 9/1/24, and 9/9/24, document for the night shift one CNA/Certified Nurse Aid and one nurse scheduled for the whole eight hours with an average census of 30 plus residents in the facility. No accommodations were made for coverage in the absence of a second CNA for night shift. On 9/17/24 at 1:19 PM, R20 stated We need two CNAs on night shift. I am a (mechanical) lift and require two people for cares. There have been times where there is only one CNA working at night and I have to wait a long time. At that time R20 was in a manual wheelchair sitting up straight in the wheelchair but appeared stiff and shoulders pulled back, had minimal movement of her arms, and a mechanical lift sling was in place under her body in the wheelchair. On 9/18/24 at 11:34 AM, V2 DON/Director of Nursing stated I take care of the staffing for the nursing home; nursing and CNA openings are posted in the nursing office for the staff to pick up the open shifts; nursing and CNA jobs are posted online (in a couple places) for hiring, we use three agencies for nurses and one agency for CNAs because corporate does not want us to use agency staff for CNAs; we are to use our own agency staffing service but there are never any staff available to work; ideally I would staff two CNAs on nights; we have residents who use (mechanical lifts) and require two people for personal cares; and I have had some days where there was only one CNA on night shift.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34131 Based on interview and record review, the facility failed to maintain and process pharmacist drug regimen review recommendations for one (R24) of 12 residents reviewed for drug regimen review in a sample of 21. Findings include: R24's Medication Regimen Review/MRR for July and September 2024 documents See report for any noted irregularities and/or recommendations. R24's medical record had no documentation, and the facility was unable to provide MRRs for July and September 2024 prior to the survey exit. On 9/19/24 at 12:48 PM, V2 DON/Director of Nursing stated I cannot find (R24's) MRR for July and September 2024. We keep them in the residents' medical record, but I don't know where (R24's) are.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to include the Infection Preventionist position or duties in the Facility Assessment. This failure has the potential to affect all 31 residents in the facility. Findings include: Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. Facility assessment dated [DATE] indicates Services provided by the facility include Infection Prevention and Control: Identification and Containment of infections and prevention of infections. Facility Assessment does not include Infection Preventionist position or duties listed under Nursing Services or any other area of the assessment. Infection Preventionist Job Description/Job Summary dated 3/3/23 indicates: The Infection Preventionist is accountable for decreasing the incidence and transmission of infectious diseases between residents, staff, visitors, and community. Through strategic planning, leadership, and consultation, you will lead and direct a robust team in the identification and implementation of infection prevention goals and objectives throughout the facility. On 9/19/24 at 12:45pm V1, Administrator stated the Infection Preventionist is a key nursing position and should be included in the Facility Assessment.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 34131 Based on interview and record review, the facility failed to develop, implement, and maintain documentation; and demonstrate evidence of its ongoing QAPI/Quality Assurance Performance Improvement program. This has the potential to affect all 31 residents currently residing in the facility. Findings include: Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. QAPI Plan for (facility), updated 4/1/24, documents The purpose of our Quality Assurance and Performance Improvement Program is to achieve and sustain a culture of excellence by using a fact based, team driven and decision-making model with a proactive approach to continual improvement of the way we care for those we serve. Key monitors are measured and trended on a quarterly basis. The team and committee have the responsibility for planning, designing, implementing and coordinating consumer care and service. The facility was unable to present a QAPI plan to the State Survey Agency no later than one year old. The facility was unable to provide any current documentation and evidence of its ongoing QAPI program. On 9/18/24 at 11:58 AM, V1 Administrator verified the last QAPI program implemented was in February 2023, and (V1) was not currently working on any QAPI plan. I have been here only a week; I have a lot of work to do.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34131 Based on interview and record review, the facility failed to develop and implement plans of action to make improvements to residents' quality of care and quality of life in its QAPI/Quality Assurance Performance Improvement program. This has the potential to affect all 31 residents currently residing in the facility. Findings include: Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. QAPI Plan for (facility), updated 4/1/24, documents The purpose of our Quality Assurance and Performance Improvement Program is to achieve and sustain a culture of excellence by using a fact based, team driven and decision-making model with a proactive approach to continual improvement of the way we care for those we serve. The QAPI Committee analyzes performance to identify and follow up on areas of opportunity. Identifies opportunities for improvement and uses criteria to prioritize opportunities. The team and committee have the responsibility for planning, designing, implementing, and coordinating consumer care and service. Facility will establish performance indicators for all designated goals. The facility was unable to provide a QAPI plan or PIP/Performance Improvement Project to the State Survey Agency conducted in the last year. On 9/18/24 at 11:58 AM, V1 Administrator verified the last QAPI/PIP program implemented was in February 2023, and (V1) was not currently working on any QAPI or PIP/Performance Improvement Projects. I have been here only a week, I haven't had time to develop a plan but know we need to work on some things, and I have a lot of work to do.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 30899 Based on interview and record review the facility failed to implement an ongoing infection prevention and control program (IPCP), failed to include an ongoing system of surveillance, and failed to implement a program to manage and minimize the risk of waterborne pathogens. This failure has the potential to affect all 31 residents. Findings include: Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. Facility Policy/Infection Control: Surveillance and Monitoring dated 5/2007 documents: It is the policy of the facility to do routine surveillance and monitoring of the facility to determine if compliance with work practices and care of protective clothing and equipment is maintained. No surveillance monitoring or tracking was found or presented for staff or resident illness. No antibiotic tracking, infection tracking/surveillance was found or presented for April, May, June, or July 2024. On 9/17/24 at 8:30am V1, Administrator stated We have no designated IP (Infection Preventionist) staff at the facility right now. The previous IP quit before I started. Our DON (Director of Nursing) does not have an IP certificate or training. The Regional IP nurse does not oversee this building, so we have no one at this time. The facility has not had a Certified Infection Preventionist since 9/27/23. On 9/19/24 at 10:23am V2, DON (Director of Nurses) stated she has worked at the facility for 2 years however has only been DON since August 1, 2024. V2 stated there have been no formal Infection Control In-services and no monitoring of infection control practices since they had an Infection Preventionist. V2 stated the last Infection Preventionist left in September 2023, and they never replaced her. V2 stated that during the COVID outbreak a few months ago, we had no formal in-services to review Infection Control practices or Transmission Based Precautions. V2 stated V11, (previous) Administrator took care of all the COVID monitoring But she wasn't even a nurse. V2 stated there has been no one doing monitoring of infection control processes like hand hygiene, catheter care, appropriate use of PPE (Personal Protective Equipment, etc. since the Infection Preventionist left. Facility Water Management Plan dated 11/4/19 documents: Maintenance Schedule: Daily - Ensure water cannot stagnate anywhere in the system; keep water tanks and cisterns covered, clean, and free of debris. Weekly - Random cold and hot water temps/record; flushing of non-used toilets, taps and shower heads. Quarterly - Clean and disinfect shower heads (disassemble); clean and disinfect faucet aerators. Annually - Risk assessment, cleaning water heaters and mixing valves; water system inspection, maintained and cleaned; servicing of boilers thermostatic mixing valves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Legionella Management Procedure dated 8/10/18 documents: Legionella Management Team is charged with the responsibility and duty to effectively control the risk from Legionella bacteria in its water systems. The Legionella Management Team comprises: Corporate Maintenance Director, Administrator and Maintenance Personnel. Corporate Maintenance Director and Administrator: Implementation and continuing review of this procedure. Ensure via appointed staff responsibility for the day-to-day delivery of the process and continuing audit. Maintenance Director: Carry out weekly/monthly checks as required. Update logbook with information gathered in weekly monthly checks. To attend training events as and when offered. A Legionella Risk Assessment shall be undertaken of all water storage tanks, calorifiers and associated pipework which are susceptible to colonization by Legionella. On completion of the risk assessment a monitoring regimen will be formatted and inserted in the site logbook. Sites shall have personnel who have been trained, instructed and who are competent to carry out weekly, monthly, quarterly monitoring regimes in-house. Suitable training and equipment will be provided to ensure the works are carried out correctly and safely. Training: Responsibility for Legionella training rests with the Corporate Maintenance Director and the Administrator. On 9/18/24 at 9:43am V4, Maintenance stated, I don't know anything about that book (Water Management Plan) or a water management program. I don't know what waterborne pathogens are. I've only been here since January (2024). I haven't had any training on any of that. I was told Housekeeping does the water temperatures and turns them into the Administrator.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 30899 Based on interview and record review the facility failed to develop and implement an ongoing facility-wide system to monitor the use of antibiotics and failed to include leadership support and accountability via the participation of an individual with designated responsibility for the infection control program (i.e., Infection Preventionist). These failures have the potential to affect all 31 residents in the facility. Findings include: Facility Policy/Assessment of Infections and Antimicrobial Usage dated 1/1/19 documents: Assessing antimicrobial use is essential for determining antimicrobial use trends. Antimicrobial use should be reviewed regularly to measure progress of antimicrobial stewardship activities. Additionally, the results are useful to identify gaps in communication, inconsistencies in documentation, and compliance with facility policies and evidence-based recommendations for antimicrobial prescribing. Align antimicrobial prescribing data and clinical documentation with published recommendations and facility policies. For each prescribed antimicrobial, determine whether the criteria were met as described by: Antimicrobial prescribing guidelines for long-term care residents. Infection surveillance definitions for long-term care facilities. Facility policies/protocols. Facility Policy/Antibiotic Stewardship Program dated 12/12/18 documents: Purpose: To improve the use of Antibiotics in healthcare, to protect residents and to reduce the threat of antibiotic resistance through a set of commitments and actions designed to optimize the treatment of infections while reducing adverse events associated with antibiotic use. This will be accomplished utilizing the Core Elements for Antibiotic Stewardship: Leadership Commitment - Demonstrates support and commitment for safe and appropriate antibiotic use. Accountability - Identify physicians, nurses and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities. Drug Expertise - Establish access to consultant pharmacists or other individuals with experience or training in antibiotic stewardship. Action - Implement at least one policy or practice to improve antibiotic use. Tracking - Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use. Reporting - Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff. Education - Provide resources to clinicians, nursing staff, resident and families about antibiotic resistance and opportunities for improving antibiotics. Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/17/24 at 8:30am V1, Administrator stated We have no designated IP (Infection Preventionist) staff at the facility right now. The previous IP quit before I started. Our DON (Director of Nursing) does not have an IP certificate or training. The Regional IP nurse does not oversee this building, so we have no one at this time. The facility has not had a Certified Infection Preventionist since 9/27/23. Pharmacy (Antibiotic) Therapeutic Class report dated 4/1/24 to 4/30/24 indicates R1, R3, R4, R5, R9, R13, R17 and R20 all received antibiotics in the month of April 2024. Pharmacy (Antibiotic) Therapeutic Class report dated 5/1/24 to 5/31/24 indicates R2, R5, R9, R13, R18 and R20 all received antibiotics in the month of May 2024. Pharmacy (Antibiotic) Therapeutic Class report dated 6/1/24 to 6/30/24 indicates R3, R6, R9, R20 and R27 all received antibiotics in the month of June 2024. Pharmacy (Antibiotic) Therapeutic Class report dated 7/1/24 to 7/31/24 indicates R3, R4, R6, R9, and R30 all received antibiotics in the month of July 2024. No antibiotic tracking, infection tracking/surveillance was found or presented for April, May, June, or July 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E361	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenues at Quad Cities	1403 9th Avenue Silvis, IL 61282

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 30899 Based on observation, interview, and record review, the facility failed to employ a Certified Infection Preventionist. This failure has the potential to affect all 31 residents in the facility. Findings include: Infection Preventionist Job Description dated 3/3/23 documents: Qualifications: Must have completed Specialty Training in Infection Prevention and Control through accredited continuing education such as: CDC (Centers for Disease Control) or APIC (Association for Infection Prevention and Control) Infection Preventionist. Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. On 9/17/24 at 8:30am V1, Administrator stated We have no designated IP (Infection Preventionist) staff at the facility right now. The previous IP quit before I started. Our DON (Director of Nursing) does not have an IP certificate or training. The Regional IP nurse does not oversee this building, so we have no one at this time. On 9/18/24 at 3:24pm V1, Administrator stated the previous IP's last day employed at the facility was 9/27/23. V1 stated the previous DON took over IP at that time until April 2024, but was unsure if was IP Certified. The current DON hire date is 8/1/24 but is not IP Certified. On 9/19/24 at 11:30am V2, DON provided three Infection Control training modules, all dated 1/20/22 for V7, Previous facility DON. No certification of a completed IP program was found or presented for V7 who took over the IP program from 9/27/23 to 4/2024. The facility has not had a Certified Infection Preventionist since 9/27/23.

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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 - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. 30899 Based on observation, interview, and record review the facility failed to ensure documentation in the resident's medical record of the administration or refusal of the Influenza and/or Pneumococcal vaccinations for three residents (R17, R26, R29) of five residents reviewed for Influenza and Pneumonia vaccinations in the sample of 21. The facility also failed to provide surveillance monitoring and tracking of immunizations for residents. This failure has the potential to affect all 31 residents. Findings include: Facility Policy/Immunization of Residents dated 1/23/20 documents: Review the residents Immunization Record, Physician order Sheet and Consent Form to verify timing of previous vaccinations, allergies, and contraindications. Document immunization on the resident's Medication Administration Record (MAR) and on the resident's Immunization Record. Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. R17's Influenza and Pneumonia Consent (undated) indicates R17 last received the Influenza vaccine 9/23/22. No documentation was found or presented to indicate if R17 was offered or refused the Influenza Vaccine in 2023. R26's Pneumonia and Influenza Vaccine Consents were signed on 11/20/23. Influenza Consent indicates R26 Already had this year. Consent does not indicate date received. MAR, Physician Orders, and Immunization Record do not indicate if R26 received the Pneumonia vaccine or if it was refused. R29's Immunization Record, MAR and Physician Orders does not include any vaccinations offered or administered. On 9/18/24 at 2:00pm V1, Administrator stated I took over as Administrator about one week ago. We have no Infection Preventionist, and I don't currently know who is monitoring and documenting the vaccination program. V1 also stated she has looked through multiple binders and could not find any resident or staff tracking or monitoring of vaccinations of any kind. V1 stated Someone should have been keeping a line list of resident vaccinations. On 9/19/24 at 1:45pm V2, DON (Director of Nursing) stated I've been DON since August 1st (2024). I don't know who was or is doing the vaccination program. The last Infection Preventionist was monitoring the vaccinations, but she left in September of last year (2023). No 'Line List tracking/monitoring of any immunizations was found or presented. No staff were identified as overseeing, monitoring, or tracking the vaccination program. Resident MARs did not contain vaccination information for any of the facility residents.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 30899 Based on interview and record review the facility failed to provide a surveillance system to identify possible communicable disease or infections, how and when to use Transmission Based Precautions and proper infection and prevention and control practices when performing resident care activities. This failure has the potential to affect all 31 residents. Findings include: Facility application for Medicare and Medicaid, dated 9/16/24, documents 31 residents reside in the facility. Facility Policy/Infection Control Surveillance and Monitoring dated 5/2007 documents: Monitoring the effectiveness of the facility work practices and protective equipment will be conducted by the Administrator and DON (Director of Nursing). This includes but is not limited to: Surveillance of the facility to ensure required work practices are observed and that protective clothing and equipment are provided and properly used. Improvement in training, work practices, or protective equipment to prevent reoccurrence. Infection Preventionist Job Description dated 3/3/23 documents: Job Summary: The Infection Preventionist is accountable for decreasing the incidence and transmission of infectious diseases between residents, staff, visitors, and community. Through strategic planning, leadership, and consultation, you will lead and direct a robust team in the identification and implementation of infection prevention goals and objectives throughout the facility. The Infection Preventionist reports to the Director of Nursing, QAA (Quality Assessment and Assurance) Committee and partners with the Medical Director to develop a system of care that promotes sound and scientific infection prevention practices and principles. Attends and participates in continuing educational infection control programs. Responsibilities: Authority and responsibility for ensuring appropriate intervention and education occurs with staff, volunteers, and medical staff when healthcare infection trends, outbreaks or non-compliance to infection control are identified. Ensures that education and counseling on infection prevention is available for staff, volunteers, medical staff, and residents. Facility Policy/Antibiotic Stewardship Program dated 12/12/18 documents: Purpose: To improve the use of Antibiotics in healthcare, to protect residents and to reduce the threat of antibiotic resistance through a set of commitments and actions designed to optimize the treatment of infections while reducing adverse events associated with antibiotic use. This will be accomplished utilizing the Core Elements for Antibiotic Stewardship: (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Education - Provide resources to clinicians, nursing staff, resident and families about antibiotic resistance and opportunities for improving antibiotics. Resident Infection Control/Antibiotic Use Log indicates tracking of infections and antibiotics was documented January, February, March, August, and September 2024. No antibiotic tracking, infection tracking/surveillance was found or presented for April, May, June, or July 2024. Inservice Attendance sheets for more than 6 months reviewed and found only one formal Infection Control related in-service: Hand Hygiene on 3/25/24. On 9/19/24 at 10:23am V2, DON (Director of Nurses) stated she has worked at the facility for 2 years however has only been DON since August 1, 2024. V2 stated there have been no formal Infection Control In-services and no monitoring of infection control practices since we had an Infection Preventionist. V2 stated the last Infection Preventionist left in September 2023, and they never replaced her. V2 stated that during the COVID outbreak a few months ago, we had no formal in-services to review Infection Control practices or Transmission Based Precautions.