STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Trace Health & Living Community	3701 Hodgin Rd Richmond, IN 47374

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 36942 Based on observation, interview, and record review, the facility failed to ensure residents were clinically appropriate to self-administer medications for 3 of 3 residents randomly observed with medications at the bedside. (Resident 2, 9, and 22) Findings include: 1. An observation conducted of Resident 2's room, on 5/8/24 at 3:18 p.m., of a labeled bottle that contained benzocaine. Resident 2 indicated she utilized the benzocaine for her sore gums. An observation conducted of Resident 2's room, on 5/10/24 at 10:48 a.m., of a labeled bottle that contained benzocaine. There was also a bottle of nasal spray. Resident 2 indicated she took the nasal spray at night. Her jaw had been hurting for a while and the benzocaine did help. The clinical record for Resident 2 was reviewed on 5/10/24 at 12:17 p.m. The diagnoses included, but were not limited to, herpes viral encephalitis, altered mental status, and mild cognitive impairment. There were no self-administration assessments for Resident 2's utilization of benzocaine and/or the nasal spray on 5/8/24. A progress note, dated 5/9/24 at 5:08 p.m., indicated the following, .During the residents care conference . Also resident has been having c/o [complaints of] jaw/teeth pain new orders for Hurricane gel and may have at bedside and self admin. [administer] A physician order, dated 1/8/24 and discontinued on 5/9/24, was noted for benzocaine gel every 4 hours as needed for jaw pain. There were no instructions on the order that indicated Resident 2 was to self-administer the medication. 2. An observation conducted of Resident 9's room, on 5/10/24 at 10:52 a.m., of 2 lidocaine patches, unopened, and located on the table past the doorway into her room. The clinical record for Resident 9 was reviewed on 5/13/24 at 1:37 p.m. The diagnoses included, but were not limited to, congestive heart failure and arthritis. There was no self-administration assessment in Resident 9's clinical record. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. An observation conducted of Resident 22's room, on 5/8/24 at 3:06 p.m., of a nasal spray located on the window. An observation conducted of Resident 22's room, on 5/9/24 at 10:19 a.m., of a nasal spray located on the window. The clinical record for Resident 22 was reviewed on 5/13/24 at 1:56 p.m. The diagnoses included, but were not limited to, nasal congestion and edema. There were no self-administration assessments conducted for Resident 22's nasal spray. A physician order, dated 2/14/24, indicated the use of Flonase nasal spray; 1 spray in each nostril daily as needed. An interview conducted with the DON, on 5/14/24 at 4:24 p.m., indicated a self-administration assessment was to be conducted for the residents to determine their ability to self-administer medications and have them at the bedside. A policy titled Beside Medications and Self-Administration of Medications, undated, was provided by Clinical Specialist on 5/13/24 at 11:49 a.m. The policy indicated the following, .Each resident who desires to self-administer medication will be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility 3.1-11(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 30344 Based on interview and record review, the facility failed to obtain a resident's preference for bathing frequency for 1 of 1 resident reviewed for choices. (Resident 24) Findings include: The clinical record for Resident 24 was reviewed on 5/8/24 at 12:04 p.m. Her diagnoses included, but were not limited to: dementia, mood disorder, psychotic disorder with delusions, and anxiety. She resided on a secured unit of the facility. The ADL (activities of daily living) care plan, last reviewed/revised 4/23/24, indicated Resident 24 was unable to independently perform late loss ADLs related to weakness and debility. The 10/19/22 care plan, last reviewed/revised 4/23/24, indicated Resident 24 was cognitively impaired and unable to voice preferences regarding ADLs (activities of daily living.) The goal was for her to have her needs met. An approach, with a start date of 10/19/22 and end date of 6/1/24, read, Resident unable to state bathing preference. To be offered shower, per facility shower schedule. Staff to observe for any indication that resident may prefer to have shower done at another time of day and to inform IDT [Interdisciplinary Team] if this occurs. The 3/13/24 Quarterly MDS (Minimum Data Set) assessment and 4/20/24 Quarterly MDS assessment both indicated Resident 24 was cognitively intact. An interview was conducted with Resident 24 on 5/8/24 at 12:05 p.m. She indicated she would like to receive showers every other day, but didn't receive them that often in the facility. An interview was conducted with SSD (Social Services Director) 10 on 5/10/24 at 1:47 p.m. He indicated they discussed a resident's preference for bathing frequency upon admission and at care plan meetings. Nursing kept track and there were care plans for specific out of the norm preferences. The 10/26/20 Social History Assessment was reviewed. There was a section to document the resident's method of bathing as an adult to include type, frequency, day, etc. The response section was left blank, not completed. The 1/26/24 care conference observation did not reference Resident 24's bathing frequency preference. An interview was conducted with SSD 10 on 5/10/24 at 2:45 p.m. He referenced Resident 24's 10/19/22 cognitively impaired and unable to voice preferences regarding ADLs care plan and indicated he was unaware of any documentation or verification that Resident 24's bathing frequency preference was obtained. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/10/24 at 12:53 p.m., the DON provided Resident 24's shower sheets from April 1, 2024 to present. They included sheets for the following dates: 4/1/24, 4/4/24, 4/8/24, 4/11/24, 4/15/24, 4/18/24, 4/22/24, 4/25/24, 4/29/24, 5/2/24, 5/6/24, and 5/9/24. These dates indicated Resident 24 was provided showers twice weekly on Mondays and Thursdays. An interview was conducted with the DON (Director of Nursing) on 5/13/24 at 11:01 a.m. She indicated bathing frequency was generally discussed and documented on admission, but that process was not in effect when Resident 24 was admitted in 2020. It was also discussed at care plan meetings, but she was unsure if social services was specifically documenting bathing frequency preferences at care plan meetings. This morning, the DON spoke with Resident 24 herself, at which time Resident 24 informed she'd like a shower every other day. She was unsure as to the accuracy of the care plan that indicated Resident 24's preferences were unable to be obtained. An interview was conducted with CNA 12 on 5/14/24 at 2:13 p.m. She indicated she spoke with Resident 24 about her shower schedule over the weekend. Resident 24 informed her she would like 3 showers a week in the morning. The Resident Rights policy was provided by the CS (Clinical Specialist) on 5/13/24 at 11:49 a.m. It read, Federal and state laws guarantee certain basic rights to all residents of our community. These rights include the resident's right to: .5. Self-determination; .37. Receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. 38. Receive care in accordance with personal preference. 3.1-3(u)(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45291 Based on interview and observation, the facility failed to promote a clean and homelike environment for 1 of 4 residents reviewed (Resident 37) and 2 of 5 units reviewed for a clean and homelike environment. Findings include: The clinical record for Resident 37 was reviewed on 5/14/2024 at 1:22 p.m. The medical diagnosis included dementia with behaviors. An annual minimum data set assessment, dated 1/28/2024, indicated that Resident was cognitively intact. An interview and observation on 5/8/2024 at 11:45 a.m. indicated that the baseboard strip from the door to the kitchenette cabinets was missing. Resident 37 stated that it had been missing for a while. An observation on 5/8/2024 at 12:03 p.m. indicated that along the handrails on the 300 hall, debris was noted to include general debris in the inside corners of the handrails, paper wrappers from straws, a dead insect, and a paper clip. An observation on 5/9/2024 at 10:45 a.m. indicated a thumb tack inside the handrails on the 200 hall. An observation and interview on 5/10/2024 at 2:00 p.m. indicated the general debris in the 300 hall handrails remained. Housekeeper 8 cleaned some debris from the handrails and indicated that it is part of the assignment to clean the handrails weekly, but sometimes when they are cleaning them that the debris gathers in the corners and not everyone cleans it all out. An observations on 5/14/2024 at 2:30 p.m. with DON indicated that the baseboard stripping in Resident 37's room was still missing. A policy entitled, Quality of Life - Homelike Environment, was provided by the DON on 5/14/2024 at 2:45 p. m. The policy indicated, .Residents are provided with a safe, clean, comfortable and homelike environment .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 36942 Based on interview and record review, the facility failed to ensure accuracy of a resident's MDS (Minimum Data Set) assessment for 1 of 1 resident reviewed for dialysis. (Resident 50) Findings include: The clinical record for Resident 50 was reviewed on 5/13/24 at 10:22 a.m. The diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. A dialysis care plan, dated 2/14/24, indicated Resident 50 received hemodialysis due to end stage renal disease. A physician order, dated 3/13/24, indicated Resident 50 received dialysis. A Significant Change Minimum Data Set (MDS) assessment, dated 2/16/24, indicated no dialysis being marked. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the MDS Coordinator conducted the significant change MDS assessment due to Resident 50 starting dialysis. She was unsure why it was not marked on the MDS assessment.

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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. 45291 Based on interview and record review, the facility failed to develop care plans for diabetic medications, antiplatelet medication, medication used to aid in sleep, and gastroesophageal reflux disease (GERD) medication for Resident 53, failed to implement a care planned intervention of care in pairs for Resident 53, and failed to develop a care plan for Resident 89's impaired communication. This deficient practice affected 2 of 24 residents reviewed for care planning. Findings include: 1. The clinical record for Resident 53 was reviewed on 5/14/2024 at 1:20 p.m. The medical diagnoses included diabetes, congestive heart failure, insomnia, GERD, and restless leg syndrome. A Quarterly Minimum Data Set Assessment, dated 3/5/2024, indicated that Resident 53 was cognitively intact. A care plan, dated 12/14/2023, indicated that Resident 53 was to be a care in pairs for all care provided. An interview with Resident 53 on 5/14/2024 at 11:00 a.m. indicated that since yesterday when she raised a concern with her care that they have been utilizing care in pairs with her. She stated prior to 5/13/2024, the facility did not utilize care in pairs. When asked about a concern related to a lab draw on 5/11/2024, Resident 53 indicated that only one staff member was present during that time. An interview with DON on 5/14/2024 at 11:30 a.m. indicated that she obtained the lab draw on 5/11/2024. She indicated that she did not utilize care in pair with Resident 53 due to having a good report with her. A physician order, dated 5/2/2024, indicated Resident 53 to receive medication for treatment of restless leg syndrome. A physician order, dated 5/2/2024, indicated Resident 53 to receive medication for treatment of her insomnia. A physician order, dated 5/2/2024, indicated Resident 53 to receive an oral medication for treatment of her diabetes melilites. A physician order, dated 5/2/2024, indicated for Resident 53 to receive an injectable medication for treatment of her diabetes mellitus. A physician order, dated 5/2/2024, indicated for Resident 53 to receive antiplatelet medications for treatment of her chronic heart failure. A physician order, dated 5/2/2024, indicated Resident 53 to receive medication to treat her GERD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plans for the aforementioned medications for Resident 53 were provided by the DON on 5/15/2024 at 12:50 p.m. The provided care plans were dated and/or revised on 5/15/2024. 30344 2. The clinical record for Resident 89 was reviewed on 5/8/24 at 12:15 p.m. His diagnoses included, but were not limited to, expressive language disorder. The 3/28/24 nurse's note indicated he was admitted to the facility for stroke and left sided weakness. He was non-verbal and used a communication board. The 4/1/24 Admission MDS (Minimum Data Set) assessment indicated he had unclear speech. An observation of Resident 89 was made on 5/8/24 at 12:22 p.m. He was not able to communicate verbally, but laughed, grunted a bit, and gave the thumbs up. He did not have a communication board, note pad, or anything else visible in his room to use for communication. Resident 89 did not have a communication care plan. An observation of Resident 89 in the activity room was made on 5/14/24 at 10:44 a.m. during a craft activity. A staff member informed him his project looked good and asked if he'd like to add anything else to it. Resident 89 shook his head no, grunted a bit, and waved his hand over his project. No communication board was observed for use with Resident 89 at this time. An interview was conducted with CNA (Certified Nursing Assistant) 13 on 5/13/24 at 2:09 p.m. She indicated she only worked with Resident 89 once the previous day. She assisted him with getting off the commode. He pressed his call light for help and cued to her by pointing to his bottom and moaning. An interview and observation was conducted with CNA 12 on 5/14/24 at 2:15 p.m. in Resident 89's room. Resident 89 was not in his room at this time. CNA 12 indicated Resident 89 had a communication board and picked it up from the night stand near his bed. There were multiple laminated pages with pictures of various objects on each page. CNA 12 indicated, to her knowledge, he didn't really use it, but it was usually located on his bedside table. An interview was conducted with SSD (Social Services Director) 10 on 5/14/24 at 2:29 p.m. He indicated the Veterans Affairs was working on getting an I-Pad for Resident 89. He was unsure if he should have a care plan regarding his communication, but there were a few other residents on another unit with expressive problems and they all had care plans. An interview was conducted with SSD 10 on 5/14/24 at 3:13 p.m. He indicated Resident 89 did not have a communication care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plans policy was provided by the CS (Clinical Support) on 5/13/24 at 11:49 a.m. It read, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; .g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; .i. Reflect currently recognized standards of practice for problem areas and conditions. 3.1-35(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on observation, interview, and record review, the facility failed to ensure physician notification of a 3-pound (lb.) weight gain over a 24-hour period for 1 of 1 resident reviewed for edema (Resident 9) and 1 of 1 resident reviewed for dialysis (Resident 50). The facility failed to ensure ACE wraps were applied as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident 11) The facility failed to administer creams to a skin impairment without compounding medicated creams for 1 of 3 residents reviewed for skin impairments (Resident 33). The facility failed to verify a urinalysis was reordered after the results of a probable contamination, ensure vancomycin was given as ordered, and had no verification of catheter care being provided for eight days after return from a hospitalization for 1 of 3 residents reviewed for urinary tract infection (Resident 58). Findings include: 1. The clinical record for Resident 9 was reviewed on 5/13/24 at 1:37 p.m. The diagnoses included, but were not limited to, congestive heart failure, edema, and weakness. A care plan for nutrition, dated 3/26/22, indicated history of weight loss and diuretic therapy. The approach was listed to monitor/record weights and notify the physician of any significant changes. A physician order, dated 2/25/24, indicated daily weights to be obtained and contact the physician if more than 3 lbs. of weight gain within one day and/or more than 5 lbs. of weight gain within a week. The electronic medication administration record (EMAR) for April and May of 2024 were reviewed. The following date(s) were noted to where Resident 9 had weight gain of more than 3 lbs. over one day without physician notification located in the clinical record: 4/12/24 of 3.2 lbs., 4/25/24 of 3.4 lbs., 5/4/24 of 5.4 lbs., & 5/9/24 of 3.1 lbs. 2. The clinical record for Resident 50 was reviewed on 5/13/24 at 10:22 a.m. The diagnoses included, but were not limited to, end stage renal disease, edema, and congestive heart failure. A care plan for fluid volume, dated 2/17/21, indicated Resident 50 was at risk for fluid volume excess/exacerbation related to congestive heart failure. The approach was listed to assess and report fluid excess like weight gain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 3/13/24, indicated daily weights to be obtained and contact the physician if more than 3 lbs. of weight gain within one day and/or more than 5 lbs. of weight gain within a week. The electronic medication administration record (EMAR) for April and May of 2024 were reviewed. The following date(s) were noted to where Resident 50 had weight gain of more than 3 lbs. over one day without physician notification located in the clinical record: 4/7/24 of 6.4 lbs., 4/9/24 of 5.3 lbs., 4/11/24 of 3.2 lbs., 4/17/24 of 3.3 lbs., 5/3/24 of 3 lbs., & 5/6/24 of 12.9 lbs. A policy titled Change in a Resident's Condition or Status, revised April 2007, was provided by the DON on 5/14/24 at 9:20 a.m. The policy indicated the following, .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status .e. A need to alter the resident's medical treatment significantly .i. Instructions to notify the physician of changes in the resident's condition 3. The clinical record for Resident 11 was reviewed on 5/10/24 at 11:51 a.m. The diagnoses included, but were not limited to, Parkinson's disease, edema, pain, and weakness. A physician order, dated 3/26/24, indicated the use of ACE wraps on in the morning and off at night. An observation conducted of Resident 11, on 5/9/24 at 10:55 a.m., of being up in his wheelchair during an activity. He was wearing nonskid socks but no ACE wraps. An observation conducted of Resident 11, on 5/10/24 at 10:54 a.m., of being up in his wheelchair during an activity. He was wearing tennis shoes and did not have ACE wraps. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the expectations are to follow the physician orders as written and notify the physician when it's indicated. 3.1-37(a) 45291 4. The clinical record for Resident 33 was reviewed on 5/10/2024 at 11:30 a.m. The medical diagnosis included Alzheimer's disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Minimum Data Set Assessment, dated 3/8/2024, indicated that Resident 33 was independent with choices of his daily living, needed assistance of staff for dressing and hygiene needs, and had skin impairments. A physician order, dated 5/9/2024, indicated for Resident 33 to have Silvadene cream applied to sacrum twice a day. A physician order, dated 5/9/2023, indicated for Resident 33 to have nystatin-zinc-triamcinolone topical cream applied to sacrum twice a day. An interview with LPN 9 on 5/14/2024 at 10:50 a.m. indicated that Resident 33 had a skin impairment to his bottom and utilized two creams to the area. She showed the two topical creams in separate containers then stated that when she applied them, she would mix them together in her glove and then apply them to his sacrum. An observation on 5/14/2024 at 11:00 a.m. indicated that LPN 9 provided wound care to Resident 33's sacrum. During this observations, she took nystatin-zinc-triamcinolone cream from one container and then Silvadene from another, mixed the two creams together in her gloved hand then applied the compounded mixture to Resident 33's sacrum. An interview with the Clinical Specialist on 5/14/2024 at 2:10 p.m. indicated that the facility did not have policy about compounding medications at the bedside, but she had reached out to their consulting pharmacist. The consulting pharmacist had directed that one medicated cream should be applied and then the second should be applied on top of the first cream's application, but they should not be mixing the creams prior to application. An interview with the Clinical Specialist on 5/14/2024 at 3:35 p.m. indicated upon additional conversation with the consulting pharmacist that there is no adverse reaction to mixing the creams, but the pharmacy could not fully compound the ingredients into a single cream due to the fully compounding cream of nystatin-zinc-triamcinolone and Silvadene would affect billing. 30344 5. The clinical record for Resident 58 was reviewed on 5/9/24 at 11:15 a.m. Her diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, hypertension, and diabetes mellitus type II. An interview was conducted with Family Member 20 on 5/8/24 at 2:00 p.m. She indicated Resident 58 had a fall with fracture on 4/7/24. She came to see Resident 58 a few days later and her oxygen saturations were low, so she insisted she be sent to the emergency room . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/7/24, 7:27 a.m. nurse's note read, CNA [Certified Nursing Assistant] observed resident sitting in front of her wheelchair on the hallway floor, this nurse and CNA took residents vitals and assisted back into wheelchair. This nurse asked the resident what they were doing, resident said she was going to stand up because she wanted to resident is visibly confused, has required redirection most of the evening prior to this incident. Resident stated that she wanted to stand, there were girls in her room and her legs hurt, she said they would not support her anymore. This nurse took residents vitals : 209/75 [blood pressure,] 16 [respiration rate,] 113 [pulse rate,] 98% RA [oxygen saturation on room air,] 97.3 [temperature,] resident denies pain, no visible injuries, resident states she did not hit her head, residents daughter, and [name of provider] contacted. The 4/7/24, 9:45 p.m. nurse's note read, Granddaughter - [name of granddaughter] - called expressing concern over her grandmother and requested on call to be contacted [Name of provider] contacted order for UA&CS [urinalysis & culture & sensitivity] and to call urologist and inform him of change in condition. Urine obtained via straight cath [catheter,] urine is cloudy, sediment noted and foul odor. Collection cup and tubes labelled [sic] and placed in REV specimen refrigerator. Granddaughter called back and informed of orders. The 4/8/24, 10:09 a.m. IDT (Interdisciplinary Team) Post Fall Assessment note read, Fall on 04/07/2024: Resident was observed on floor in hallway close to power chair. Resident stated she was trying to stand up prior to fall. Staff last saw resident in her room in her wheelchair. Vital signs and neuro [neurological] checks were initiated. No injuries noted at time of fall. Root cause of fall is that resident was attempting to independently transfer from wheelchair to power chair. Resident has had a noted change in lethargy and weakness. Immediate intervention was to assist resident back in to wheelchair and start 15 minute checks. Intervention initiated by IDT is to complete labs and UA/C&S [urinalysis/culture & sensitivity] per MD orders r/t [related to] increase in weakness. Care plan updated. The 4/8/24, 1:15 p.m. nurse's note read, Seen by NP [nurse practitioner] N/O [new order] for labs UA & xRAYS D/T [due to] new ONSET of weakness LAbs & UA obtained this am Xray of back over the weekend were neg [negative] continues on Neuro's d/t recent fall denies any new issues Grand daughter updated. The 4/9/24, 10:25 a.m. physician note indicated Resident 58 was being seen today for increased confusion, being found on the floor by a member of the facility's staff and to review and address, if necessary, any recent labs or diagnostic testing. It read, Confusion .4/9/24-blood work is nonacute. Urinalysis is pending. Continue supportive treatment. Monitor for problems. The 4/11/24, 7:49 p.m. nurse's note read, Res [Resident] resting in recliner. Res was previously at bingo Alert and oriented with no distress noted. The 4/11/24, 10:27 a.m. UA/C&S results indicated the specimen was received in the lab on 4/9/24 at 4:23 p. m. She flagged positive with a result of 2+, MODERATE for leukocytes and abnormal amounts of blood and protein in urine. The microbiology report at the bottom indicated there was growth in the urine at 48 hours that was greater than 3 colony types isolated suggesting probable contamination. It read, If clinically indicated, recollection using a method to minimize contamination, with prompt transfer to urine culture transport tube is recommended. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no information in the clinical record to indicate another UA/CS was completed after the above 4/11/24 results. The 4/11/24, 3:44 p.m. NP note, recorded as a late entry on 5/14/24 at 3:45 p.m. and electronically signed by NP 15's Medical Scribe, included the 4/9/24 UA results, but did not include a comment on their review or plan to address the results. An interview was conducted with NP (Nurse Practitioner) 15 on 5/14/24 at 10:39 a.m. She indicated it looked to her like the 4/11/24 UA/CS results for Resident 58 were contaminated, so she did not move forward with treatment because of that. Typically speaking, if there was a contaminated UA and the resident was not symptomatic, then she wouldn't order a follow up UA. As far as ordering a redraw for Resident 58, perhaps she did and it fell off. The 4/13/24, 5:30 p.m. nurse's note read, QMA [Qualified Medication Aide] called this writer to res [resident's] room. Res was laying in bed lethargic but responded some with slurred speech. BP 160/74 P 68 T 97.9 02 74% RA R 14 Shallow deep breathing. Res was reaching in the air for things that wasn't there. Unable to answer questions fully. As VS [vital signs] were taken [name of PO-power of attorney] POA walked in and ask for res to be sent to ER. Called 911. EMT [Emergency Medical Technicians] arrived and took res to [NAME] [name of hospital.] Gave paper work to daughter to take to [name of hospital.] DON notified and [name of medical provider] was contacted and notified of transfer to hospital. Res daughter took res glasses to hospital. [Name of hospital]called and gave report to [name of ER staff] in the ER. The 4/17/24 hospital discharge summary indicated her principal problem was a UTI (urinary tract infection) with an active problem of sepsis due to UTI. It read, .was admitted from ECF [extended care facility] with increased confusion. She was diagnosed with acute metabolic encephalopathy thought to be secondary to Enterococcus faecalis UTI. She improved with antibiotics. Given microbiology results and risk of interaction between Zyvox and Sinemet she will be discharged on 1 additional dose of IV [intravenous] vancomycin Patient also had urinary retention which certainly contributed to her agitation and encephalopathy. She is therefore discharged with a Foley catheter in place. The START taking these medications section of the discharge summary indicated to take vancomycin 1.25 gram/250 mL injection into the vein 1 time for 1 dose on 4/19/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Urinary Retention section of the 4/17/24 hospital After Visit Summary read, Urinary retention means you are having trouble urinating. In some cases you may not be able to pass any urine at all. This condition occurs even though your bladder is full. Causes - For girls and women, the most common cause of urinary retention is a bladder infection .Treatment - This condition is treated by putting a tube (catheter) into the bladder to drain the urine. This gives relief right away. The catheter may need to stay in place for a few days Home Care - If you were given antibiotics to treat a bladder infection, take them until they are used up. Or take them until your healthcare provider tells you to stop. It's important to finish the antibiotics even if you feel better. This is to make sure your infection has cleared. If a catheter was left in place, it's important to keep bacteria from getting into the collection bag. Don't disconnect the catheter from the collection bag. Use a leg band to secure the drainage tube, so it does not pull on the catheter. Drain the collection bag when it becomes full using the drain spout at the bottom of the bag. Don't pull on or try to take out your catheter. This will harm your urethra. The catheter must be removed by a healthcare provider. Follow-up care - .If a catheter was left in place, it can often be removed in 3 to 7 days. Some conditions require that thee catheter stays in longer. Your provider will tell you when to come back to have the catheter removed. The 4/17/24, 4:21 p.m. nurse's note indicated Resident 58 returned from the hospital. The April, 2024 facility physician's orders included the order for the one dose of vancomycin to be given on 4/19/24, but did not include any orders regarding her catheter until 4/25/24. They were to apply leg bag for Foley catheter twice a day, starting 4/25/24; to change urinary catheter and drainage bag as needed for occlusion/dislodgement starting 4/25/24; and to provide urinary catheter care every shift, starting 4/25/24. The April, 2024 MAR (medication administration record) indicated Resident 58 did not receive the one dose of vancomycin on 4/19/24. They indicated the orders regarding her catheter did not begin being provided until 4/25/24. An interview was conducted with the DON (Director of Nursing) on 5/14/24 at 12:25 p.m. and 5/14/24 at 1:54 p.m. She indicated Resident 58 did not receive the dose of vancomycin on 4/19/24, as ordered. They caught the error the following week and the nursing staff involved were disciplined. They were providing catheter care as a standard of practice after her return from the hospital on 4/17/24 through 4/25/24, but did not have orders, documentation of the care, or any other verification to verify that. An interview was conducted with CNA 12 on 5/14/24 at 1:52 p.m. She indicated she worked with Resident 58 often. Since her hospitalization , she had been declining. She wasn't eating as well anymore and was sleeping more often. An interview was conducted with CNA 13 on 5/14/24 at 1:54 p.m. She indicated she worked Resident 58 and she was declining and very tired. The Urinary Catheter Care policy was provided by the DON on 5/14/24 at 2:45 p.m. It read, The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual giving the catheter care. 3. All assessment data obtained when giving catheter care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on observation, interview, and record review, the facility failed to ensure a transfer with utilization of a gait belt and the utilization of a Hoyer (mechanical lift) lift for 2 of 2 randomly observed residents (Resident 36 and Resident 71) and ensure fall interventions were in place for 2 of 7 residents reviewed for accidents (Resident 36 and Resident 62). Findings include: 1. The clinical record for Resident 62 was reviewed on 5/8/24 at 12:20 p.m. His diagnoses included, but were not limited to, dementia. An interview was conducted with Family Member 21 on 5/8/24 at 2:24 p.m. He indicated Resident 62 fell about a month ago and fractured his pelvis. He was in his room around 2:00 p.m. and tried to get up and walk. The staff had told him many times to use his walker or wheel chair. The 4/18/24 post fall assessment indicated Resident 62 had an unwitnessed fall on 4/18/24 at 2:00 p.m. He was found in a supine position, outside of the bathroom door. Prior to the fall he was sitting in his wheel chair. The 4/18/24, 2:29 p.m. nurse's note read, Resident found on floor unable to make sense of what happened, c/o [complains of] right hip pain, MD notified, new order for right hip x ray, family aware. The 4/18/24, 6:31 p.m. nurse's note read, Results from X-ray reveal pelvic fracture with mild displacement, oncoming nurse notified M.D. of results, Order to sent resident out to ER [emergency room] obtained. The 4/19/24, 2:29 a.m. nurse's note read, Resident returned to facility via [name of hospital] transport. VSS [Vital Signs Stable.] Resident diagnosed with Closed displaced fracture of right acetabulum, and pelvis. Acute Cystitis without hematuria. Resident c/o pain in legs and pelvis. prn [as needed] pain medication given. Referral placed with [name of orthopedic provider], they will call facility with appointment time. Resident must remain weight bearing and can sit as tolerated. N.O. [New order] for cephalexin 500mg QID [4 times daily] x [times] 7 days and Norco 5-325mg q [every] 6h [hours] prn pain x 5 days. Resident is resting in bed with call light in reach and no other needs at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/19/24, 10:28 a.m. IDT (Interdisciplinary Team) note, recorded as a late entry on 4/24/24 at 10:33 p.m., read, IDT Post Fall Assessment Fall on 04/18/2024: Resident was observed on floor in room. Resident stated he was trying to take a leak prior to fall. Resident was not incontinent at time of fall. Staff last saw resident in his room. Vital signs and neuro checks were initiated. Injuries noted at time of fall was c/o [complaints of] pain to Rt [right] hip, nurse notified provider and NP [nurse practitioner] gave order to obtain a stat [immediately] X-ray. Root cause of fall is that resident was attempting to independently ambulate/transfer. Resident is cognitively impaired with poor safety awareness. Resident is also noted to be impulsive and resistant to the use of the call light. Immediate intervention was to bring to a supervised area and notify provider of pain. Intervention initiated by IDT is for resident to have individualized activities in the afternoon. Care plan updated. Observations of Resident 62 sitting in his wheel chair were made on the following dates and times: 5/8/24 at 12:21 p.m. alone in his room, 5/10/24 at 1:01 p.m. at a dining room table, 5/13/24 at 10:39 a.m. in his room with family, 5/13/24 at 12:33 p.m. at a dining room table, and 5/13/24 at 2:00 p.m. still at a dining room table. There was an antirollback device (device used to help prevent falls that attaches to the back of a wheel chair and grabs the tires when the user stands, preventing the chair from rolling backward) attached to the right side of his wheel chair, but it was missing the left side of the device. An interview was conducted with UM (Unit Manager) 17 on 5/13/24 at 2:05 p.m. at the nurse's desk while Resident 62 was sitting in his wheel chair at a dining room table. Resident 62 was easily visible from the nurse's station. UM 17 observed Resident 62's missing left antirollback and indicated she believed he was supposed have one on the left side, because she'd never known a resident to have one side and not the other. She called the therapy department at this time to let them know about the missing left antirollback. After getting off the phone, she indicated they instructed her to contact the Maintenance Supervisor. UM 17 indicated she didn't work on the unit enough to know whether Resident 62 had the left antirollback device attached to his wheel chair when he fell on [DATE]. To her knowledge, he's had that wheel chair since he's been back here, for months. An interview was conducted with RN (Registered Nurse) 18 on 5/13/24 at 2:05 p.m. She indicated Resident 62 had the ability to walk on 4/18/24 when he fell . He used his wheel chair to come to the dining room for meals and used his walker in his room. An observation and interview was conducted with the MS (Maintenance Supervisor) on 5/13/24 at 2:13 p.m. while he was working on Resident 62's wheel chair in the hallway in front of the nurses desk. The MS added the left side of the antirollback device and repositioned the right side of the antirollback device. He indicated the right antirollback was not in a position to prevent rollback, and no one informed him prior to today that the left antirollback was missing. An interview was conducted with the DON (Director of Nursing) on 5/13/24 at 2:33 p.m. She indicated she was unaware if the left antirollback was attached to Resident 62's wheel chair when he fell on [DATE]. They may not have paid much attention to the antirollback device, since it wasn't a fall intervention listed on his care plan. She wasn't sure if that was the same wheel chair he was in when he fell on [DATE] or not. 36942 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation was conducted of Resident 36 on 5/8/24 at 2:06 p.m. She was sitting on the leg rest to her recliner with her feet touching the floor. Certified Nursing Assistant (CNA) 4 and CNA 5 entered the room and put one of each of their arms underneath Resident 36's arms to lift her up and pivot her into her wheelchair. There was no utilization of a gait belt during the pivot transfer. A gait belt was located on top of Resident 36's walker in her room during the observation. A soft touch call light was located on the bedside table to the right side of the recliner. The call light was placed towards the back of the bedside table to where Resident 36 would have to reach backwards to reach the call light. An observation of Resident 36, conducted on 5/8/24 at 2:20 p.m., of her sitting up in her wheelchair at the nurses' station. There was no television or activities being provided. There was a bowling activity being conducted in the Taste of Town room of the facility. An observation of Resident 36's room, conducted on 5/8/24 at 2:54 p.m., of her call light that did not contain no neon tape around it by her bed. An observation conducted of Resident 36, on 5/8/24 at 3:28 p.m., up in her wheelchair at the nurses' station. There was no television or activities being provided. An observation conducted of Resident 36, on 5/9/24 at 10:11 a.m., up in her wheelchair at the nurses' station. There was no television or activities being provided. An observation conducted of Resident 36, on 5/9/24 at 10:54 a.m., up in her wheelchair at the nurses' station. There was a box of markers and coloring pages that were located on top of the box of markers but not set up for the resident to utilize. An observation conducted of Resident 36, on 5/10/24 at 10:45 a.m., up in her wheelchair at the nurses' station. There was no television or activities being provided. She was leaning to the left and a staff member placed a pillow underneath her left arm. The clinical record for Resident 36 was reviewed on 5/10/24 at 11:46 a.m. The diagnoses included, but were not limited to, Parkinson's disease, repeated falls, malnutrition, and cerebral infarction. A Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated severe cognitive impairment, the utilization of a walker and wheelchair, substantial/maximal assistance with toileting, bathing, upper and lower body dressing, personal hygiene, sit to stand, and chair to bed/bed to chair transfer. A fall care plan, updated 4/10/24, indicated Resident 36 was at risk for falling and fall related injuries. The approaches included, but were not limited to, offered diversional activities when up in high traffic areas such as snacks, people watching, puzzles, and at times coloring, offered assistance with transferring to bed or recliner, after meals and toileting, and brightly colored tape to call lights. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. An observation was conducted of Resident 71 on 5/8/24 at 1:59 p.m. She was slouched down in her wheelchair to where her legs were over the foot pedals and her buttocks was towards the front of her wheelchair cushion. Resident 71 had a lift pad underneath her. CNA 4 and CNA 5 entered the room and put one of each of their arm's underneath both of Resident 71's arms and their other arm towards the back of Resident 71 grabbing onto the back of her pants. CNA 4 and CNA 5 hoisted Resident 71 while underneath her arms and grabbing onto the back of her pants to move her backwards and repositioned in her wheelchair. CNA 5 indicated, at the time of the observation, that she was new to the facility and still undergoing orientation. The clinical record for Resident 71 was reviewed on 5/10/24 at 12:00 p.m. The diagnoses included, but were not limited to, encephalopathy, cerebral infarction, hemiplegia and hemiparesis. An Annual MDS assessment, dated 4/25/24, indicated severe cognitive impairment, dependent for chair to bed/bed to chair transfer, and utilized a wheelchair. A care plan for activities of daily living (ADLs), updated 3/21/24, indicated Resident 71 was unable to perform ADLs independently. Resident 71 required extensive/maximal assistance for bed mobility, transfers per Hoyer (mechanical) lift and 2 staff members. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the expectations are to follow the appropriate practices for the fall policy and utilization of a gait belt during transfers. A policy titled Fall Prevention Policy and Procedure, dated May 2016, was provided by the DON on 5/13/24 at 1:10 p.m. The policy indicated the following, .CARE PLANNING .Fall risk care plans will be kept current by the IDT [interdisciplinary team] and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, .PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION .3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under the belt .4. Assist the resident to stand on count of three .6. Stand to side and slightly behind resident while continuing to hold onto belt .PROCEDURE #26: TRANSFER TO WHEELCHAIR .2. Place wheelchair on resident's unaffected side .4. Stand in front of resident and apply gait belt around the resident's abdomen 3.1-45(a)(1) 3.1-45(a)(2)

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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. 36942 Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed-up with timely for 1 of 5 residents reviewed for unnecessary medications. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 5/13/24 at 2:17 p.m. The diagnoses included, but were not limited to, bradycardia, nasal congestion, and depressive episodes. A physician order, dated 7/13/23, was noted for Zoloft (antidepressant medication) 50 milligrams daily. A physician order, dated 2/14/24, was noted for Flonase nasal spray; 1 puff in each nostril daily as needed. The order was discontinued on 5/12/24. A pharmacy review, dated 11/16/23, indicated a gradual dose reduction (GDR) request for Resident 22's Zoloft. It was marked as agree for the Zoloft to be decreased from 50 milligrams to 25 milligrams. This recommendation was not implemented due to Resident 22 still receiving Zoloft 50 milligrams daily upon record review. A pharmacy review, dated 3/4/24, indicated the Flonase nasal spray to be scheduled for daily use. It was marked as agree to schedule the Flonase nasal spray to daily; 1 spray in each nostril. This recommendation was not implemented due to Resident 22 still having a physician order for Flonase nasal spray as needed upon record review. A pharmacy review, dated 4/1/24, indicated the Flonase nasal spray to be discontinued. It was marked as agree to discontinue to Flonase. This recommendation was not implemented due to Resident 22 still having a physician order for Flonase nasal spray upon record review. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the pharmacy recommendations were usually followed up with by the DON or the Assistant Director of Nursing (ADON). The process was not being implemented and it was in the process of being changed. A policy titled Medication Regimen Review, updated 3/09, was provided by the DON on 5/14/24 at 9:20 a.m. The policy indicated the following, .report in writing any potential irregularities and/or comments to the Director of Nursing Services .The recommendations MUST be addressed and appropriate action taken in a reasonable time frame 3.1-25(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Trace Health & Living Community	3701 Hodgin Rd Richmond, IN 47374

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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. 36942 Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during incontinence care (Resident 3), ensure personal protective equipment (PPE) was donned prior to incontinence care for a resident on enhanced barrier precautions (EBP) (Resident 3), and ensure hand hygiene in between residents during medication administration (Resident 68). Findings include: 1. An observation conducted of incontinence care for Resident 3 was conducted on 5/10/24 at 2:00 p.m. with Qualified Medication Aide (QMA) 2 and Certified Nursing Assistant (CNA) 3. CNA 3 proceeded to remove Resident 3's incontinence brief due to soilage. CNA 3 performed perineal care by utilizing disposable wipes. CNA 3 proceeded to wipe from front to back of the perineum but utilized the same soiled wipe to wipe Resident 3 twice. CNA 3 placed the soiled wipes within the soiled brief and discarded such. CNA 3 took a tube a cream and applied the cream to Resident 3's coccyx area with the same gloves that were soiled from performing incontinence care. Both CNA 3 and QMA 2 did not don PPE prior to conducting incontinence care for Resident 3. The clinical record for Resident 3 was reviewed on 5/13/24 at 10:10 a.m. The diagnoses included, but were not limited to, pressure ulcer of sacral region and diabetes mellitus. A care plan, dated 5/8/24, indicated Resident 3 requires enhanced barrier precautions related to her wound. The approach indicated to apply gown and gloves for high-contact care activities such as toileting needs, providing hygiene, and changing briefs/assisting with toileting needs. 2. An observation was conducted of medication administration, on 5/9/24 at 8:30 a.m., with QMA 2. She proceeded to prepare medications for Resident 45 and administer such medications. QMA 2 returned to the medication cart and started to prepare medications for Resident 68 without performing hand hygiene. There was a bottle containing hand sanitizer on the medication cart. After donning gloves to administer eye drops to Resident 68, QMA 2 doffed her gloves and performed hand hygiene. An interview conducted with QMA 2 during the observation, and she commented that makes sense when asked about the hand hygiene not being performed in between residents with medication administration. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated they reflect the policy regarding incontinence care, hand hygiene, and donning and doffing of PPE related to residents on enhanced barrier precautions. A policy titled Hand Washing/Hand Hygiene Policy, printed on March 24, 2016, was provided by the DON on 5/13/24 at 11:51 a.m. The policy indicated to perform hand hygiene before and after direct resident contact, before and after entering isolation precaution settings, before and after assisting a resident with personal care, and after contact with a resident's mucous membranes and body fluids or excretions, and after handling soiled or used linens, dressings, bedpans, catheters and urinals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled Bed Bath/Perineal Care, undated, was provided by the DON on 5/13/24 at 11:51 a.m. The document indicated the following, .Perineal care .For Females .Wash between and outside labia in downward strokes, alternating from side to side and moving outward on thighs. Use different part of washcloth for each stroke A policy titled Enhanced Barrier Precautions, revised 4/1/24, was provided by the DON on 5/13/24 at 11:51 a.m. The policy indicated the following, .EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [Multidrug-resistant Organisms] to staff hands and clothing 3.1-18(b)(2) 3.1-18(l)

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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** 36942 Based on interview and record review, the facility failed to ensure pneumococcal immunizations were offered and/or administered for 2 of 5 residents reviewed for immunizations. (Resident 36 and Resident 11) Findings include: 1. The clinical record for Resident 36 was reviewed on 5/14/24 at 10:15 a.m. The diagnoses included, but were not limited to, Parkinson's disease, cerebral infarction, and malnutrition. An immunization record, dated 12/1/21, was provided by the Assistant Director of Nursing (ADON) on 5/14/24 at 4:15 p.m. The document indicated the following immunizations administered: Pneumovax-23 (PPSV23) administered on 11/10/1997, & Prevnar-13 (PCV13) administered on 7/11/2017. An immunization consent form, dated 9/29/22, indicated consent was given for the influenza vaccine but not to the pneumococcal vaccine. Under the refusal column there was no indication of refusal for the pneumococcal vaccine. A Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated the pneumococcal vaccine was not up to date due to not offered. 2. The clinical record for Resident 11 was reviewed on 5/14/24 at 10:30 a.m. The diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus, edema, and weakness. Resident 11 was admitted to the facility on [DATE]. An immunization consent form, undated, was provided by the ADON on 5/14/24 at 4:15 p.m. The document indicated consent was given for the pneumococcal vaccine. There was no indication in Resident 11's clinical record that a pneumococcal vaccine was administered. A Quarterly MDS, dated [DATE], indicated the pneumococcal vaccine was not given due to it was offered and declined. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the Infection Preventionist is responsible for the immunization consents and follow-up regarding to the administration of immunizations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Pneumonia Vaccination Policy, dated 11/8/16, was provided by the DON on 5/14/24 at 2:45 p. m. The policy indicated the following, .both pneumococcal conjugate vaccine (PCV13, Prevnar 13, Pfizer) and pneumococcal polysaccharide vaccine (PPSV23, Pneumovax, Merck) should be administered routinely in a series to all adults age [AGE] years and older .In addition to adults age [AGE] years and older, adults age 19 through [AGE] years who have the conditions specified below and who have not previously received PCV13 should receive a PCV13 dose during their next vaccination opportunity .PPSV23 is recommended for all people who meet any of the criteria below .1. All adults age [AGE] years and older 3.1-13(a)