STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edwardsville Care and Rehab	751 Blake Street Edwardsville, KS 66111

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 94 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to provide written notification of facility-initiated transfers to the residents or their representatives for Resident (R)72 and R35. The facility also failed to send notification of facility-initiated discharges and transfers to the office of the State Long Term Care Ombudsman as required. This placed the residents at risk for impaired rights. Findings included: - R72's Electronic Medical Record (EMR) documented R72 had a diagnosis of acute (condition characterized by a relatively sudden onset of symptoms that are usually severe) and chronic (persisting for a long period) respiratory failure (a condition where you don't have enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood and asthma (disorder of narrowed airways that caused wheezing and shortness of breath). R72's Quarterly Minimum Data Set (MDS), 06/24/24, documented R72 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented the resident had shortness of breath. R72's Care Plan, revised 08/03/24, documented R72 had asthma and instructed staff to advise R72 to minimize contact with known offending allergens, administer R72 albuterol sulfate inhaler every four hours as needed, and assist R72 in identifying asthma triggers and strategies for prevention. The Progress Note, dated 01/16/2024 at 05:00 PM, documented R72 was admitted to the hospital. Review of R72's clinical record lacked evidence the resident or representative was provided written notice when she was transferred to the hospital. On 08/19/24 at 03:21PM R72 sat in a chair at the front entrance of the facility. On 08/21/24 at 08:30 AM, Administrative Staff B verified the facility had not provided a written notice of transfer/discharge to the resident when discharged to the hospital. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Edwardsville Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Blake Street Edwardsville, KS 66111	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 08:35 AM, Administrative Nurse D verified staff had not provided R72 or her representative with the bed hold policy when R72 was admitted to the hospital. Administrative Nurse D stated the nurse does the initial bed hold notice and social service follows up with family. On 08/20/24 at 3:30 PM, Social Service X verified the facility had not provided R72 a written notice when R72 was transferred to the hospital. Social Services X stated she used to notify the office of the Ombudsman in the past, but approximately two years ago she was told she no longer needed to notify them since the facility had no ombudsman coverage. The facility did not provide a policy. The facility failed to provide R72 or his representative written notice regarding R72's facility-initiated transfer to the hospital. This placed the resident and/or her representative at risk of uninformed care choices. 32360 - The Electronic Medical Record (EMR) for R38 had a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented R38 had intact cognition and was independent with all activities of daily living (ADLs). R38 received oxygen daily and was not short of breath. R38's Care Plan, dated 05/23/24 and initiated on 07/03/17, documented R38 received oxygen therapy due to COPD and directed staff to give medications as ordered by the physician, monitor for signs and symptoms of respiratory distress and report to the physician as needed. The plan directed staff to administer oxygen via a nasal cannula (a device that gives you additional oxygen through your nose) to maintain oxygen saturation (a measure of how much oxygen the blood carried as a percentage of the maximum it could carry) above 90% and explain the risk versus benefits should she remove her oxygen. The Progress Note, dated 06/29/24 at 09:33 AM, documented R38 was admitted to the hospital due to abnormality of her vital signs. R38's clinical record lacked evidence the resident was provided a written notice of transfer/discharge as soon as practicable when she was transferred to the hospital. On 08/20/24 at 11:45 AM, observation revealed R38 in bed with oxygen on per nasal cannula. On 08/21/24 at 08:30 AM, Administrative Staff B verified the facility had not provided a written notice to the resident when she was discharged to the hospital. On 08/21/24 at 08:35 AM, Administrative Nurse D verified staff had not provided R38 with written notification for transfer when R38 was transferred to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Edwardsville Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Blake Street Edwardsville, KS 66111	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 3:30 PM, Social Service X verified the facility had not provided R38 a written notice when R38 was transferred to the hospital. Social Services X stated she used to notify the office of the Ombudsman in the past, but approximately two years ago she was told she no longer needed to notify them since the facility had no ombudsman coverage. Upon request a policy for notice for transfer/discharge policy was not provided by the facility. The facility failed to provide R38 written notice regarding R38's facility-initiated transfer to the hospital. This placed the resident at risk of uninformed care choices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Edwardsville Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 751 Blake Street Edwardsville, KS 66111	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 94 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R)35, R19, R38, and R72 or their representative with written information regarding the facility bed hold policy when they were transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. Findings included: - R35's Electronic Health Record (EHR) revealed a diagnosis of cerebral atherosclerosis (a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of fatty deposits inside the artery walls), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and dysphagia (swallowing difficulty). R35's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R35 had moderately impaired cognition. The MDS recorded she required extensive assistance of one staff with bed mobility and transfers. The MDS lacked documentation the resident received hospice services. R35's Care Plan, dated 06/10/24, recorded R35 required staff assistance with most activities of daily living (ADL) care. R35's Care Plan lacked document the resident received hospice services due to a terminal prognosis. The Progress Note, dated 11/27/23 at 03:30 PM, documented R35 did not get up for breakfast or lunch and appeared lethargic (lack of energy and mental energy, and drowsiness) and had emesis (vomit) on her bed. Staff obtained the resident's vital signs and had an oxygen reading of 93% (normal 95% to 100%,) a heart rate of 71 (normal 60-100 beats per minute), and her blood pressure was 90/43 millimeters of Mercury (mm/Hg) (normal 120/80 mm/Hg). The physician was contacted, and the resident was sent to the hospital via ambulance. The Progress Note, dated 11/29/23 at 08:28 AM, documented the resident was admitted to hospital. The Progress Notes. dated 12/04/23 at 05:33 PM, documented the resident returned to the facility and was readmitted . A review of 35's clinical record lacked evidence the resident or representative was provided the bed hold policy when she was transferred to the hospital. On 08/20/24 at 11:45 AM, R35 sat in a wheelchair in her bedroom. Certified Medication Aide (CMA) S administered the resident's medications. On 08/21/24 at 08:30 AM, Administrative Staff B verified the facility had not provided the resident or her representative, the bed hold notice when she was discharged /transferred to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 at 08:35 AM, Administrative Nurse D verified the resident or her representative had not been provided the bed hold policy and should have been. Administrative Nurse D stated the nurse did the initial bed hold notice and that the social worker would follow up with the resident's family. The facility's Bed Hold policy, dated 06/24, documented the community staff shall inform residents upon admission and prior to a transfer for hospitalization or the therapeutic leave of the bed-hold policy. When an emergency transfer is necessary, the facility shall provide the resident and the representative with information concerning the bed hold policy per state laws as applicable. The bed hold information would include any charges that the resident may incur as well as the tie limit established by the state Medicaid plan for which the facility would reserve the resident's bed space. The facility failed to provide R35 or his representative with written information regarding the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. 26768 - R19's Electronic Medical Record (EMR) documented diagnoses of schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), hypertension (elevated blood pressure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), acute and pneumonia (inflammation of the lungs). The Annual Minimum Data Set (MDS), dated [DATE], documented a staff interview that indicated no memory problems. R19 was independent in decision-making and had disorganized thinking. The MDS documented R19 was independent with all activities of daily living. R19 was short of breath with any activity and used tobacco. R19 received antipsychotic medications (a class of medications used to treat major mental conditions that cause a break from reality). R19's EMR documented R19 had an unplanned discharge to an inpatient psychiatric hospital from 06/10 24 to 06/14/24. R19's clinical record lacked evidence the resident was provided a copy of the bed hold notice for the above transfer. On 08/20/24 at 07:35 AM, observation revealed R19 sat at the dining table with his walker in front of him and drank an orange soda. At 07:50 AM, he stood and ambulated with his walker through the dining room to the outside exit to the smoking area. He sat on a bench outside, ate a hard-boiled egg, and drank his coffee. On 08/21/24 at 08:30 AM, Administrative Staff B verified the facility had not provided a bed hold notice to the resident or their representative when he was discharged from the hospital. On 08/21/24 at 08:35 AM, Administrative Nurse D verified staff should have provided a bed hold notice and stated the nurse provided the initial bed hold notice and the social worker was supposed to follow up with the resident's family or representative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Bed Hold policy, dated 06/24, documented the community staff shall inform residents upon admission and prior to a transfer for hospitalization or the therapeutic leave of the bed-hold policy. When an emergency transfer is necessary, the facility shall provide the resident and the representative with information concerning the bed hold policy per state laws as applicable. The bed hold information would include any charges that the resident may incur as well as the tie limit established by the state Medicaid plan for which the facility would reserve the resident's bed space. The facility failed to provide a bed hold notice to R19 or his representative when R19 was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the facility. 32360 - The Electronic Medical Record (EMR) for R38 had a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented R38 had intact cognition and was independent with all activities of daily living (ADLs). R38 received oxygen daily and was not short of breath. R38's Care Plan, dated 05/23/24 and initiated on 07/03/17, documented R38 received oxygen therapy due to COPD and directed staff to give medications as ordered by the physician, monitor for signs and symptoms of respiratory distress and report to the physician as needed. The plan directed staff to administer oxygen via a nasal cannula (a device that gives you additional oxygen through your nose) to maintain oxygen saturation (a measure of how much oxygen the blood carried as a percentage of the maximum it could carry) above 90 % and explain the risk versus benefits should she remove her oxygen. The Progress Note, dated 06/29/24 at 09:33 AM, documented that R38 was admitted to the hospital due to abnormality of her vital signs. R38's clinical record lacked evidence the resident was provided the bed hold policy when she was transferred to the hospital. On 08/20/24 at 11:45 AM, observation revealed R38 in bed with oxygen on per nasal cannula. On 08/21/24 at 08:30 AM, Administrative Staff B verified the facility had not provided a bed hold notice to the resident when discharged to the hospital. On 08/21/24 at 08:35 AM, Administrative Nurse D verified staff had not provided R38 with the bed hold policy when R38 was admitted to the hospital. Administrative Nurse D stated the nurse does the initial bed hold notice and social service follows up with the resident or family. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Bed Hold policy, dated 06/2024, documented the community staff shall inform residents upon admission and prior to a transfer for hospitalization or the therapeutic leave of the bed-hold policy. When an emergency transfer is necessary, the facility shall provide the resident and the representative with information concerning the bed hold policy per state laws as applicable. The bed hold information would include any charges that the resident may incur as well as the tie limit established by the state Medicaid plan for which the facility would reserve the resident's bed space. The facility failed to provide R38 with a bed hold notice which specifies the duration of the bed hold when she was transferred to the hospital. This placed R38 at risk of not being permitted to return and resume residence in the facility. 32358 - R72's Electronic Medical Record (EMR) documented R72 had a diagnosis of acute (a condition characterized by a relatively sudden onset of symptoms that are usually severe) and chronic (persisting for a long period) respiratory failure (a condition where you don't have enough oxygen in the tissues in your body or when you have too much carbon dioxide in your blood and asthma (disorder of narrowed airways that caused wheezing and shortness of breath). R72's Quarterly Minimum Data Set (MDS), 06/24/24, documented R72 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented the resident had shortness of breath. R72's Care Plan, revised 08/03/24, documented R72 had asthma and instructed staff to advise R72 to minimize contact with known offending allergens, administer R72 albuterol sulfate inhaler every four hours as needed (prn), and assist R72 in identifying asthma triggers and strategies for prevention. The Progress Note, dated 01/16/2024 at 05:00 PM, documented R72 was admitted to the hospital. R72's clinical record lacked evidence the resident or representative was provided notice of the facility bed hold policy when she was transferred to the hospital. On 08/19/24 at 03:21 PM, R72 sat in a chair at the front entrance of the facility. On 08/21/24 at 08:30 AM, Administrative Staff B verified the facility had not provided a bed hold notice to the resident when discharged to the hospital. On 08/21/24 at 08:35 AM, Administrative Nurse D verified staff had not provided R72 or her representative with the bed hold policy when R72 was admitted to the hospital. Administrative Nurse D stated the nurse does the initial bed hold notice and social service follows up with the family. The facility's Bed Hold policy, dated 06/24, documented the community staff shall inform residents upon admission and prior to a transfer for hospitalization or the therapeutic leave of the bed-hold policy. When an emergency transfer is necessary, the facility shall provide the resident and the representative with information concerning the bed hold policy per state laws as applicable. The bed hold information would include any charges that the resident may incur as well as the tie limit established by the state Medicaid plan for which the facility would reserve the resident's bed space. (continued on next page)

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Edwardsville Care and Rehab	751 Blake Street Edwardsville, KS 66111

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide R72 or his representative the bed hold notice when R72 transferred to the hospital. This placed the resident and/or her representative at risk of not returning to the facility in the same room.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 94 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to complete the required Significant Change Minimum Data Set (MDS) for Resident (R) 81. This placed the resident at risk for inappropriate care and unmet needs. Findings included: - R81's Electronic Medical Record (EMR) included diagnoses of schizoaffective disorders (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings of sadness), deaf nonspeaking, pneumonia, lack of coordination, pain, and drug-induced secondary Parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). R81's Annual Minimum Data Set (MDS), dated [DATE], documented R81 had intact cognition, hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and exhibited no behaviors. R81 was independent with bed mobility, walking in the room, locomotion on and off the unit, required limited assistance from one person for transfers, dressing, and personal hygiene, had no functional range of motion impairment, and used a wheelchair for mobility. The MDS further documented R81 was frequently incontinent of urine and bowel, had pain, and received as-needed (PRN) pain medication. R81 also received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and hypnotic (a class of medications used to induce sleep). The Quarterly MDS dated [DATE], documented R81 had moderately impaired cognition, delusions, and rejected evaluation of care which occurred one to three days of the observation period. R81 had functional range of motion impairment upper and lower extremities of both sides and used a wheelchair for mobility. The MDS further documented R81 required substantial/maximal assistance with eating, toileting, upper and lower body dressing, and personal hygiene. R81 required partial/moderate assistance with sitting to standing, chair to bed, and toilet transfers. Received scheduled and PRN pain medications, antipsychotics, and antidepressants. The MDS lacked documentation that R81 had a condition or chronic disease that may result in a life expectancy of less than six months or hospice care (care that focuses on the care, comfort, and quality of life who are approaching end-of-life). R81's Care Plan, dated 07/07/24, documented R81 used medication to help manage some health problems that may cause adverse reactions and directed staff to notify the doctor if any adverse reactions occurred. The care plan lacked end-of-life or hospice care and services interventions. The Physician Order, dated 11/06/23, informed facility staff R81 admitted to hospice as of 10/25/23. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 11/14/23 at 03:05 PM, documented hospice had been notified of the need for over-the-counter cream three times a day for 14 days of treatment. On 08/20/24 at 07:49 AM, observation revealed R81 in the dining room, dressed for the day. R81 sat in a high-backed wheelchair and was fed by staff. Staff communicated with the resident by using sign language. On 08/21/24 at 09:38 AM, Certified Medication Aide (CMA) R reported R81's hospice information is in a book at the nurse's station. CMA R stated hospice provided incontinent briefs and pads, a Certified Nurse Aide (CNA) twice a week for showers and a nurse comes when facility staff calls with concerns. On 08/20/24 at 03:53 PM, Administrative Nurse E stated a significant change is usually done when residents are admitted to hospice, significant change MDS was overlooked and not completed. The facility's Comprehensive Assessment policy, dated 08/2022, documented a comprehensive assessment of the resident's needs, strengths, goals, life history and preferences will be completed utilizing the RAI specified by CMS. A comprehensive assessment will be completed with a defined significant change. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conducts timely resident assessments and reviews according to the following schedule: when there has been a significant change in the resident's condition. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairment in functional capacity. Information derived from the comprehensive assessment enables staff to plan care that allows the resident to reach his/her highest practicable level of function. The facility failed to complete the required significant change MDS for R81 who had obtained services for end-of-life/hospice care, which placed the resident at risk for inappropriate care and unmet needs.

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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 32360

The facility had a census of 94 residents. The sample included 19 residents, with three reviewed for smoking. Based on observation, record review, and interview, the facility failed to follow the plan of care for smoking for one resident, Resident (R) 6, and failed to assess R53 for safe smoking. This placed the residents at risk for preventable accidents and injury.

Findings included:

- The Electronic Medical Record (EMR) for R6 had diagnoses of cerebral infarction (occurs as a result of disrupted blood flow to the brain), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), paranoid schizophrenia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and abnormal involuntary movements (unintended, uncontrollable movements of the body).

The Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had intact cognition and was dependent upon staff for transfer, required substantial assistance for toileting, personal hygiene, and mobility. R6 had functional impairment on her upper body on one side and lower impairment on both sides.

The Smoking Evaluation, dated 06/06/24, documented R6 had no cognitive loss, could not light her cigarette, and required a smoking apron.

R6's Care Plan, dated 07/03/24, initiated on 04/17/17, documented R6 was at risk for smoking injury and directed staff to assist her to and from the designated smoking area as needed, complete a smoking safety assessment, observe R6 for unsafe smoking behaviors or attempts to obtain smoking materials from outside sources and provide a smoking apron while smoking. The update, dated 01/27/23, directed staff to provide R6 with a smoke apron while she was smoking.

On 08/18/24 at 03:54 PM, observation revealed R6 had a splint on the left arm/hand. Her right arm was outstretched in front of her with a cigarette in her hand. She was not wearing a smoking apron.

On 08/20/24 at 11:45 AM, Certified Nurse Aide (CNA) M stated R6 required assistance with most of her activities of daily living, and staff were to provide her with a smoke apron when she was outside smoking.

On 08/21/24 at 08:30 AM, Administrative Nurse D verified R6 should have a smoke apron on as she was at risk for injury.

The facility's Accident Prevention-Smoking policy, dated 08/24, documented the facility shall establish and maintain safe resident smoking practices, and any smoking-related privileges, restrictions, and concerns shall be noted on the care plan and all personnel caring for the resident shall be alerted to these issues per community protocol.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide R6 with a smoking apron per her plan of care. This placed the resident at risk for accidents and injuries. 26768 - R53's Electronic Medical Record documented diagnoses of nicotine (an addictive, poisonous chemical found in tobacco) dependence, and drug-induced subacute dyskinesia (causes repetitive, involuntary movements). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R53 was independent for all activities of daily living, had no range of motion impairment, no falls, no pain, and no burns. R53's Care Plan, dated 07/04/24, directed staff to offer smoking cessation (stopping) information, initiated 01/27/23. Ensure R53 was aware of the facility smoking policy, initiated on 01/27/23. Encourage R53 to wear a smoking apron, however it was not required, initiated 01/27/23. The plan directed R53 was R53 to adhere to the rules, regulations, and safety procedures of the building 100 percent of the time, initiated 02/05/024. Show R53 where smoking was allowed and how to access it, initiated 01/27/23. The Smoking Assessment, dated 01/24/23, documented R53 had no cognitive loss or visual deficit, no dexterity problem, and could light his cigarettes. The assessment stated R53 required staff supervision and a smoking apron. R53's medical record lacked further assessment of his smoking abilities or privileges. The Progress Note, dated 04/23/24 at 04:28 PM, documented staff found R53 smoking in his room in the morning. The Progress Note, dated 06/27/24 at 10:11 AM, documented staff found R53in his bathroom smoking with his roommate and one other resident. The Progress Note, dated 07/13/24 at 03:31 PM, documented staff found R53 smoking unsupervised outside this morning and around 02:00 PM. On 08/19/24 at 03:15 PM, observation revealed R53 independently ambulated to the dining room and sat at a table. He was one of the first smokers out the door for the 03:30 PM smoking time. Staff lighted his cigarette for him and he was not wearing a smoking apron. On 08/19/24 at 03:24 PM, Licensed Nurse (LN) G showed the smoking cart with all residents' cigarettes in separate drawers. She stated if a resident was required to use an apron, the drawer would have an A on it. R53's drawer showed no apron and no extender. On 08/20/24 at 01:00 PM, Certified Nurse Aide (CNA) N stated R53 would grab an apron if there was one available when he walked out to smoke. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edwardsville Care and Rehab	751 Blake Street Edwardsville, KS 66111

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 01:07 PM, LN G stated a smoking assessment should be done quarterly and the computer system triggers an alert when they are due. She verified R53 had not been assessed for smoking safety for the past 18 months. On 08/20/24 at 01:50 PM, Administrative Nurse D verified staff should have assessed the resident for smoking safety quarterly. The facility's Smoking policy, dated 12/07/22, stated the policy was to establish expectations designed to help residents who decide to smoke be able to enjoy privilege in a safe and peaceful environment. The facility would hold, track, and maintain all resident smoking or tobacco items. The facility's Smoking Policy, dated 08/2024, stated residents who wish to smoke would be evaluated for safe smoking per community protocol. The staff would review the status of a resident's smoking privileges periodically per community protocol. The facility failed to routinely assess R53 for safety while smoking, placing R53 at risk for accidents or injury while smoking.

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NAME OF PROVIDER OR SUPPLIER Edwardsville Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Blake Street Edwardsville, KS 66111	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 94 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to discard Resident (R)22, R51, and R82s' insulin (a hormone that lowers the level of glucose in the blood) flex pens when outdated and failed to discard expired stock medications. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On [DATE] at 08:00 AM, observation of the facility's A hall treatment cart revealed the following: R22's Novolog (fast-acting insulin) flex pen was not labeled with an open or expired date. R51's Basaglar (long-acting insulin) flex pen was not labeled with an open or expired date. R82's Novolog flex pen was labeled with an open date of [DATE] (expired on [DATE], 28 days) On [DATE] at 08:05 AM, observation of the facility's A hall medication cart revealed one bottle of Vitamin D3, 30 tablets, expiration date ,d+[DATE]. On [DATE] at 08:15 AM, observation of the A hall Medication Room revealed the following: R51's Ozempic (long-acting insulin) flex pen was labeled with an open date of [DATE] (expired on [DATE], 56 days) On [DATE] at 08:30 AM, Licensed Nurse (LN) I verified the nurses were supposed to date the flex pens when opened and discard the outdated insulin and outdated stock medication. On [DATE] at 09:30 AM, Administrative Nurse D verified the nurses should label and date the flex pens with the resident's name and discard outdated insulin and outdated stock medication. Medlineplus.gov directs open, unrefrigerated Lantus (basaglar and glargine) can be used within 28 days; after that time, they must be discarded. Medlineplus.gov directs open, unrefrigerated Ozempic can be used within 56 days: after that time, they must be discarded. The facility's Storage of Medication policy, dated ,d+[DATE], documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to discard the resident's outdated insulin flex pens, and outdated stock medication placing the residents at risk for ineffective medication.

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 32358 The facility had a census of 94 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 94 residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 08/20/24 at 10:00 AM, a review of the noon meal consisted of meatloaf, Capri vegetables, a dinner roll, and strawberry cake. On 08/20/24 at 11:30 AM, observation revealed Dietary Manager (DM)BB in the kitchen overseeing the preparation of the noon meal. On 08/19/24 at 11:32 AM, DM BB verified she was not a certified dietary manager. Dietary Staff BB stated she had finished the classes but had not scheduled a date to take the test. On 08/20/24 at 02:33 PM, Administrative Staff A verified DM BB had no dietary manager certification. The facility's Food Service Staffing Policy, revised 10/2022, documented that if the facility dietitian was not full-time, then the facility would employ another qualified nutritional professional to serve as the Dietary Manager. The dietary manager must meet one of the following qualifications: A certified dietary manager, A certified food service manager, Had a similar certification in food service management and safety from a national certifying body, Had an associate or higher degree in food services management or in hospitality, if the course study includes food service or restaurant management from an accredited institution of higher learning, had two or more years of experience in the position of dietary manager in a nursing facility setting and had completed a course of study in food safety and management, by no later than October 1, 2023, that included topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving and met the states established standards if applicable. The facility failed to employ a full-time certified dietary manager for 94 residents who resided in the facility and received meals from the kitchen. This placed the residents at risk of not receiving adequate nutrition.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32358 The facility had a census of 94 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, in one of one kitchen. This placed the residents who received their meals from the facility's kitchen at risk for foodborne illness. Findings included: - On 08/20/24 at 11:29 AM, observation in the kitchen revealed the following A white upright freezer had approximately three-quarters-inch thick ice buildup on the inside including the shelves, sides, top, and bottom. The middle section of the three-door silver refrigerator had four uncovered, undated, unlabeled bowls of cantaloupe verified by Dietary Staff (DS) CC, who stated they should be covered, dated, and labeled. DS CC discarded the cantaloupe. The serving window had numerous different-sized areas with missing Formica. The wall located underneath the place where the dirty dishes came into the dishwasher area had numerous different-sized blackish streaks running down to the floor, which extended approximately two to three feet wide from the disposable to the dishwasher. The caulking, approximately six feet long, located between the dish table and the wall had a black substance. The ceiling located between the oven hood and the wall had a missing piece of sheet rock approximately three feet long by one foot wide, covered with a taped piece of plastic. The floor located in front of the refrigerators had an approximately two-foot by one-foot piece of missing tile. The August 2024 refrigerator/freezer logs lacked temperature documentation on the following dates: The bread refrigerator - 08/08 and 08/16 in the morning (AM), 08/12,08/13, and 08/18 in the afternoon (PM). The walk-in freezer -08/13 and 08/18 in the PM. The walk-in refrigerator 08/13 and 08/18 in the PM. The white upright freezer 08/13, 08/16, and 08/18 in the AM. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/20/24 at 12:00 PM, Dietary Manager (DM) BB verified the issues in the kitchen and stated staff should cover, label, and date food items placed in the freezer. DM BB stated she was unaware of why the missing area of sheet rock was covered with plastic; she assumed the kitchen pipes above it had a leak at some point in time. DM BB stated staff should clean the wall underneath the dishwasher and she would get maintenance to replace the caulking by the dishwasher table. DM BB stated staff should check the temperatures of the refrigerators and freezers twice a day and document them on the log sheet. On 08/20/24 at 02:33 PM, Administrative Staff A verified the missing piece of ceiling sheetrock and stated at one time there was a leak in the pipe above the area, but it had been fixed and the plastic should have been removed and replaced with sheetrock. The facility's Supervision, Maintenance Services Policy, revised 09/2023, documented the maintenance director was responsible for scheduling preventive maintenance service. The facility's Sanitation Policy, revised 10/2022, documented the food service area would be maintained in a clean and sanitary manner. The facility's Food Safety Requirements Policy, revised 10/23, documented that all foods stored in the refrigerator or freezer would be covered, labeled, and dated. The functioning of the refrigeration and food temperatures would be monitored at designated intervals throughout the day by the food service manager or designee and documented according to state-specific requirements. The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the 94 residents who received their meals from the facility's kitchen. This placed the 94 residents at risk for foodborne illness.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 94 residents. The sample included 19 residents with two reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)35 and R81. This placed R35 and R81 at risk for inappropriate end-of-life care. Findings included: - R35's Electronic Health Record (EHR) revealed diagnoses of cerebral atherosclerosis (a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of fatty deposits inside the artery walls), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and dysphagia (swallowing difficulty). R35's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R35 had moderately impaired cognition. The MDS recorded she required extensive assistance of one staff with bed mobility and transfers. The MDS lacked documentation the resident received hospice services. R35's Care Plan, dated 06/10/24, recorded R35 required staff assistance with most activities of daily living (ADL) care. R35's Care Plan lacked document the resident received hospice services due to a terminal prognosis. A review of R35's medical records revealed the resident was admitted to hospice care on 04/04/24 but lacked evidence of coordination of care. There was a hospice communication book at the nurse's station. On 08/20/24 at 11:45 AM, R35 sat in a wheelchair in her bedroom. Certified Medication Aide (CMA) S administered the resident's medications. On 08/20/24 at 08:50 AM, Administrative Nurse D verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan for R35. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Policy and Procedure policy, dated 06/2024, documented the facility would identify in writing the services that the Hospice would be providing and address the resident's person-centered care plan. Along with the hospice provider, discuss the plan and obtain orders for preference in pain management, symptom control, treatment of acute illness, and choices regarding hospitalization . A member of the interdisciplinary team would be responsible for working with a hospice representative to collaborate and coordinate the hospice care plan, communicate with hospice representatives and other health care providers participating in the hospice care, ensure the hospice medical director and the attending physician or other practitioners collaborate and communicate to coordinate the hospice care. A nursing progress note stating hospice saw the resident and notes to follow should be documented in the progress notes. Hospice documents would include; the most recent hospice plan of care, hospice election form, physician certification for terminal illness, names and contacts of hospice personnel involved for each resident, instructions for the 24-hour on-call system, hospice medication and supplies specific to each resident, hospice physician and attending physician orders specific to each resident, and visit notes from all hospice disciplines, nurse, chaplain, social services and volunteers. The community retains the ultimate responsibility for the care plan. Coordinate the care plan with the hospice provider, community staff, and resident/family. The care plan may be in two portions, each maintaining its own, but changes should be discussed. The hospice provider retains the primary responsibility for the provision of care and services, the community must coordinate care and ensure the resident receives all necessary care and services. The facility failed to coordinate care between the facility and the hospice provider for R35, who received hospice services. This deficient practice placed her at risk for inappropriate end-of-life care. 37450 - R81's Electronic Medical Record (EMR) included diagnoses of schizoaffective disorders (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings of sadness), deaf nonspeaking, pneumonia, lack of coordination, pain, and drug-induced secondary Parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). R81's Annual Minimum Data Set (MDS), dated [DATE], documented R81 had intact cognition, hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and exhibited no behaviors. R81 was independent with bed mobility, walking in the room, locomotion on and off the unit, required limited assistance from one person for transfers, dressing, and personal hygiene, had no functional range of motion impairment, and used a wheelchair for mobility. The MDS further documented R81 was frequently incontinent of urine and bowel, had pain, and received as-needed (PRN) pain medication. R81 also received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and hypnotic (a class of medications used to induce sleep). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated [DATE], documented R81 had moderately impaired cognition, delusions, and rejected evaluation of care which occurred one to three days of the observation period. R81 had functional range of motion impairment upper and lower extremities of both sides and used a wheelchair for mobility. The MDS further documented R81 required substantial/maximal assistance with eating, toileting, upper and lower body dressing, and personal hygiene. R81 required partial/moderate assistance with sitting to standing, chair to bed, and toilet transfers. R81 received scheduled and PRN pain medications, antipsychotics, and antidepressants. The MDS lacked documentation that R81 had a condition or chronic disease that may result in a life expectancy of less than six months or hospice care (care that focuses on the care, comfort, and quality of life who are approaching end-of-life). R81's Care Plan, dated 07/07/24, documented R81 used medication to help manage some health problems that may cause adverse reactions and directed staff to notify the doctor if any adverse reactions occurred. The care plan lacked end-of-life or hospice care and services interventions. The Physician Order, dated 11/06/23, informed facility staff R81 admitted to hospice as of 10/25/23. The Progress Note dated 11/14/23 at 03:05 PM, documented hospice had been notified of the need for over-the-counter cream three times a day for 14 days of treatment. On 08/20/24 at 07:49 AM, observation revealed R81 in the dining room, dressed for the day. R81 sat in a high-backed wheelchair and was fed by staff. Staff communicated with the resident by using sign language. On 08/21/24 at 09:38 AM, Certified Medication Aide (CMA) R reported R81's hospice information is in a book at the nurse's station. CMA R stated hospice provided incontinent briefs and pads, a Certified Nurse Aide (CNA) twice a week for showers and a nurse comes when facility staff calls with concerns. On 08/20/24 at 08:32 AM, Administrative Nurse D verified R81's plan lacked hospice care and services provided. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Policy and Procedure policy, dated 06/2024, documented the facility would identify in writing the services that the Hospice would be providing and address the resident's person-centered care plan. Along with the hospice provider, discuss the plan and obtain orders for preference in pain management, symptom control, treatment of acute illness, and choices regarding hospitalization . A member of the interdisciplinary team would be responsible for working with a hospice representative to collaborate and coordinate the hospice care plan, communicate with hospice representatives and other health care providers participating in the hospice care, ensure the hospice medical director and the attending physician or other practitioners collaborate and communicate to coordinate the hospice care. A nursing progress note stating hospice saw the resident and notes to follow should be documented in the progress notes. Hospice documents would include; the most recent hospice plan of care, hospice election form, physician certification for terminal illness, names and contacts of hospice personnel involved for each resident, instructions for the 24-hour on-call system, hospice medication and supplies specific to each resident, hospice physician and attending physician orders specific to each resident, and visit notes from all hospice disciplines, nurse, chaplain, social services and volunteers. The community retains the ultimate responsibility for the care plan. Coordinate the care plan with the hospice provider, community staff, and resident/family. The care plan may be in two portions, each maintaining its own, but changes should be discussed. The hospice provider retains the primary responsibility for the provision of care and services, the community must coordinate care and ensure the resident receives all necessary care and services. The facility failed to coordinate care between the facility and the hospice provider for R81, who received hospice services. This deficient practice placed him at risk for inappropriate end-of-life care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 94 residents. The sample included 19 residents with six residents reviewed for immunizations to include pneumococcal (type of bacterial infection) vaccinations. Based on record review and interview the facility failed to assess Resident (R)85, R16, R57, and R42 for eligibility to receive further pneumococcal immunizations (helps protect against serious illnesses like pneumonia- inflammation of the lungs) and failed to follow the latest guidance from the Centers for Disease Control and Prevention (CDC) when they failed to offer, obtain an informed declination or a physician documented contraindication for the PCV20 pneumococcal vaccination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from the pneumococcal disease. Findings included: - A review of the facility's current residents' Electronic Medical Records (EMR) revealed numerous residents lacked pneumococcal vaccinations or documented refusal of the vaccination. The following residents were over [AGE] years of age: R85 had no pneumococcal vaccinations or refusals documented. R85's EMR recorded a Physician Order, dated 06/15/23, that directed staff to provide pneumococcal vaccine as per facility protocol. R16 had no pneumococcal vaccinations or refusals documented. R16's EMR recorded a Physician Order, dated 02/19/24, that directed staff to provide pneumococcal vaccine as per facility protocol. R57 had no pneumococcal vaccinations or refusals documented. R57's EMR recorded a Physician Order, dated 08/14/24, that directed staff to provide pneumococcal vaccine as per facility protocol. R42 had no pneumococcal vaccinations or refusals documented. R42's EMR recorded a Physician Order, dated 04/24/24 that directed staff to provide pneumococcal vaccine as per facility protocol. On 08/20/24 at 08:50 AM, Administrative Nurse D stated she was unaware of the CDC guidelines for the PCV20 vaccine and did not know about vaccine requirements, who would be eligible, or if any of the residents would be. On 08/21/24 at 950 AM, Administrative Nurse E stated the facility used the PPSV23 pneumococcal vaccinations and verified they had not assessed if any residents were eligible for further pneumococcal vaccinations. The facility's Pneumococcal Vaccine policy, dated 09/2023, stated residents would be offered the pneumococcal vaccine to aid in preventing pneumococcal infections. Prior to or upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine and when indicated would be offered the vaccination unless medically contraindicated or the resident was already vaccinated. Assessment of pneumococcal vaccination status would be conducted within five working days of the resident's admission. Administration of the pneumococcal vaccination would be made in accordance with current CDC recommendations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to assess residents for eligibility for the PCV20 vaccination, offer the vaccination, or obtain an informed declination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from the pneumococcal disease.