STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205109	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Health Care and Rehab	16 Beal Street MacHias, ME 04654

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 - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33242 Based on record review and interviews, the facility failed to notify the resident and/or resident representative in writing for the reason of a transfer/discharge from the facility, for 2 of 3 facility initiated hospital transfers for Resident #44 (R44). In addition, the facility failed to notify the Ombudsman of the transfer/discharges from the facility. Finding: On 6/11/24, R44's clinical record was reviewed and indicated that R44 was transferred to the hospital on 3/25/24 and 3/28/24. The clinical record indicated that nursing notified the resident representative verbally and lacked evidence of the written transfer/discharge notices being provided to the resident/resident representative. On 6/11/24 at 11:58 a.m., during an interview with a surveyor, the Licensed Social Worker stated she did not send written notices of transfer/discharge notices to the resident representative and that she had not been notifying the Ombudsman of transfer/discharges; she has been working at the facility for 6 months. On 6/11/24 at 12:02 p.m., during an interview with a surveyor, the Administrator stated that she was unaware that written notices must be provided to the resident representatives.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to ensure that the Annual Minimum Data Set (MDS) 3.0 was coded accurately to indicate that a resident had a state Level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 sampled residents reviewed for PASRR (Resident #11 [R11]). Finding: On 6/10/24, R11's clinical record was reviewed. On 4/20/23, R11's PASSR was completed and indicated that R11 qualified for Level II services. Review of R11's Annual MDS, dated [DATE], Section: A1500 was coded to indicate that R11 did not have a Level II PASRR. On 6/12/24 at 8:29 a.m., during an interview with a surveyor, the Licensed Social Worker (LSW) stated that R11 did have a Level II PASRR and that the MDS was coded inaccurately. The surveyor confirmed this finding during this interview.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 33242 Based on record review and interview, the facility failed to obtain recommendations from the Preadmission Screening and Resident Review (PASRR) level II determination-Maine Summary of Findings for 1 of 1 sampled resident (Resident #11 [R11]). Finding: On 06/10/24, R11's clinical record was reviewed and included a PASRR level II determination explanation, dated 4/20/23 that indicated R11 met the State of Maine's definition for serious mental illness due to a diagnosis of bipolar disorder. R11's PASRR indicated that the nursing facility was required to provide: ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. On 6/12/24 at 11:22 a.m., during an interview with a surveyor, the Licensed Social Worker (LSW) stated that she did not realize that R11's PASRR recommended psychiatric services for medication management and that there was provider available to provide these services. She stated that the Social Worker was responsible to obtain these services and could not find documentation that indicated that these services had been offered or refused.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on interviews and record reviews, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 3 residents that were reviewed for new admissions (Resident #195 [R195]). Finding: R195 was admitted to the facility on [DATE]. R195's diagnosis list included Chronic obstructive pulmonary disease and admission orders included use of oxygen and nebulizer treatments. The baseline care plan lacked evidence for the use/care of these respiratory treatments. On 6/11/24 at 1:18 p.m., during an interview with the Director of Nursing, a surveyor confirmed this finding.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540 Based on record reviews and interviews, the facility failed to implement a care plan approach in the area of nutrition for 1 of 2 residents reviewed for nutrition (Resident #31 [R31] and failed to develop a care plan for respiratory care for 1 of 2 residents reviewed for oxygen (R195). Findings: 1. On 6/11/24 at 9:15 a.m., during an interview with R31, he/she stated that he/she needed help with meals. R31stated that sometimes after their meals he/she still feels hungry and does not get more food to eat. On 6/11/24 at 10:43 a.m., during record review for R31 his/her record has documentation that shows he/she has had an 8-pound weight loss in a 5-month time span. R31's care plan for nutrition was initiated on 4/23/24 to address swallowing precautions, with an approach that he/she needed dietary staff to provide him/her with pureed meals with large portions with enough calories. Review of R31's diet order slip used by the dietary staff, does not include the large portions for meals. On 6/11/24 at 2:20 p.m., during an interview with the Director of Nursing and the Administrator a surveyor confirmed the above finding. 33242 2. On 6/10/24 at 2:29 p.m., a surveyor observed R195 wearing oxygen via nasal cannula and observed a nebulizer treatment setup in the room on a nightstand. R195's clinical record indicated that the resident was admitted to the facility on [DATE] and the admission orders included use of oxygen and nebulizer treatments. R195's admission minimum data set (MDS) 3.0 care area assessment (CAA) was completed and signed on 6/3/24, making the care plan due to be completed within 7 days thereafter, or 6/10/24. On 6/11/24 at 2:00 p.m., R195's comprehensive care plan was reviewed with the Director of Nursing and the surveyor confirmed that the care plan lacked evidence of a care area and interventions related to R195's respiratory treatments which included the use of oxygen and nebulizer treatments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33242 Based on record review and interview, the facility failed to update a care plan for services outlined on the Preadmission Screening and Resident Review (PASRR) level II determination-Maine Summary of Findings, dated 4/20/23, for 1 of 1 sampled resident (Resident #11 [R11]). Finding: On 06/10/24, R11's clinical record was reviewed and included a PASRR level II determination explanation, dated 4/20/23 that indicated R11 met the State of Maine's definition for serious mental illness due to a diagnosis of bipolar disorder. R11's PASRR indicated that the nursing facility was required to provide: ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. On 6/12/24 at 11:22 a.m., during an interview with a surveyor, the Licensed Social Worker reviewed R11's care plan which did include a care area Mental Wellbeing and mentioned PASRR Level II but she was unable to find an intervention about psychiatrist medication management. The surveyor confirmed this finding during this interview.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 33242 Based on observations, interviews, and record review, the facility failed to follow physician orders and care plan for 1 of 4 residents reviewed for weight loss (Resident #40 [R40]). Finding: On 6/10/24, R40's clinical record was reviewed and indicated that on 2/06/24, the resident weighed was 137. 4 pounds (lbs) and on 4/30/2024, the resident weighed 126.4 pounds, which was an 8.01 percent loss. R40's physician orders for diet, dated 4/10/24, included carnation instant breakfast (CIB) mixed with thrive supplement, to be provided with breakfast, lunch, and supper, and a physician order, dated 3/6/24, for adaptive equipment-Kennedy cup (light weight, easy to grip with handle, spill proof cup). R40's nutrition care plan, dated 5/8/24, indicated that the staff were to provide all drinks in Kennedy cups and the that a thrive shake was to be provided 3 times a day. On 6/10/24 at 12:40 p.m., a surveyor observed R40 in the dining room, and noticed that there was an empty round cup with a straw poked thru the plastic wrap over the top of the cup on the table by R40, but there was no Kennedy cup. On 6/11/24 at 9:07 a.m., two surveyors observed R40 done eating breakfast, with a large plastic cup with no handles, with some beverage left in the cup. During an interview with two surveyors, the cook, who was in the room because he had plated the breakfast meal from the steam table, was unsure what a Kennedy cup was. The cook had R40's meal slip that identified the adaptive equipment as a Kennedy cup was to be used for R40. On 6/11/24 at 12:40 p.m., during an interview with a surveyor, Certified Nursing Assistant (CNA)1 and CNA2 stated they were unaware that R40 needed a Kennedy cup for beverages. CNA2 stated that R40 did not get her CIB shake at lunch time because the plastic wrap with writing fell into the cup (provided from the kitchen in what was not a Kennedy cup). On 6/11/24 at 12:52 p.m., during an interview with a surveyor, the Dietary Manager stated that the CNA was responsible for transferring the beverages over to the Kennedy cups. The surveyor explained that R40 did not get her shake today because the plastic wrap with writing fell into the beverage and that Kennedy cups were not being used.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33242 Based on observations, record reviews and interviews, the facility failed to provide respiratory care consistent with professional standards of practice by failing to follow physician orders for oxygen administration, failing to date and label oxygen tubing/nebulizer set ups, and/or failing to ensure that respiratory equipment was clean, for 2 of 2 sampled residents (Resident #195 [R195] and R2). Findings: 1. On 6/10/24 at 2:29 p.m,. a surveyor observed R195 wearing oxygen via nasal cannula with the concentrator set at 1.5 liters per minute (LPM). The surveyor also observed a nebulizer treatment setup with neither the oxygen or nebulizer setup dated to indicate when the tubing/setup was last changed and the concentrator filter located on the back of the machine was dusty. On 6/11/24 at 7:55 a.m., a surveyor observed R195 wearing oxygen via nasal cannula with the concentrator set at 1.5 LPM and the concentrator filter was still dusty. A review of R195's clinical record included physician orders included the following: -5/21/24 - apply oxygen at 2 LPM for shortness of breath and/or oxygen saturations of less than 90% and Albuterol Sulfate nebulization solution as needed. The surveyor was unable to find treatments that directed staff to document when the tubing/nebulizer setup was changed and the equipment to be cleaned on the treatment record. On 6/11/24 at 1:18 p.m. the Director of Nursing (DON) and surveyor observed R195 wearing oxygen with the concentrator set at 1.5 LPM, and not the physician ordered 2 LPM. R195 also stated that he/she had to ask for the oxygen tubing to be changed recently because he/she wasn't getting any air out of it. R195 stated that the nebulizer setup was changed this morning. The surveyor also confirmed that the concentrator filter was dirty with the DON at this time. After this observation, the DON stated that she was adding a treatment for R195 to change the tubing setups and clean the filter weekly. 35904 2. On 6/10/24 at 2:27 p.m., a surveyor observed R2 wearing oxygen via nasal cannula and the concentrator filter was dusty. A picture of the dusty filter was taken at this time. On 6/11/24 at 10:21 a.m., a surveyor observed R2 wearing oxygen via nasal cannula and the concentrator filter was dusty. R2's treatment administration (TAR) was reviewed and there are orders for cleaning of the concentrator filters 1 x wk, Tuesday PM (one time per week on Tuesday evenings). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at approximately 10:00 a.m. during an interview with the Administrator, a surveyor showed the picture of the dusty concentrator, and confirmed that R2's concentrator filter was dusty. The TAR was signed that the concentrator filter was cleaned on 6/4/24 as directed; however, the amount of dust on the filter was not consistent with being cleaned 6 days prior to 6/10/24's observation.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 4 newly admitted residents reviewed (Residents #40 [R40]). Finding: On 6/12/24, R40's clinical record was reviewed and indicated R40 was admitted to the facility on [DATE]. The Physician signed the admission orders on 2/5/24 and these were in effect for 30 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 3/16/24, but weren't signed until 3/19/24, 3 days late; these orders were in effect for 30 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 4/28/24, but were signed on 5/1/24, 3 days late. On 6/12/24 at 7:51 a.m., a surveyor confirmed with the Administrator that the Physician Orders were signed late.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540 Based on clinical record reviews and interviews, the facility failed to ensure the attending physician made required visits, at least every 30 or every 60 days (depending on date of admission) and wrote a progress note for 5 of 11 sampled residents (Resident #25 [R25,] R31, R11, R40, R44). Findings: 1. Documentation in R25's clinical record, under the progress notes section, indicates that R25 had a Physician visit on 2/23/24. His/her next Physician visit would have been due on 5/3/24 (this includes a 10-day grace period). Documentation in R25's clinical record indicates that the next Physician visit was completed on 5/31/24 making it 28 days overdue and beyond the 10-day grace period. 2. Documentation in R31 clinical record, under the progress notes section, indicates that R31 had a Physician visit on 2/6/24. His/her next Physician visit would have been due on 5/15/24 (this includes a 10-day grace period). Documentation in R31's clinical record indicates that the next Physician visit was completed on 5/23/24 making it 8 days overdue and beyond the 10-day grace period. On 6/12/24 at 1:00 p.m., during an interview with the RN, ICP/Unit Manager and the Administrator, a surveyor confirmed that the above residents R31 and R25's physician visits were not completed timely. 33242 3. On 6/11/24, Resident #11's clinical record was reviewed and included Physician progress notes for a visit completed on 11/8/23. The next 60-day Physician visit was due by 1/17/24 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 2/28/24, 42 days beyond the grace period. The next 60-day Physician visit was due by 5/8/24 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 5/24/24, 16 days beyond the grace period. On 6/12/24 at 12:59 p.m., during an interview with RN, ICP/Unit Manager and the Administrator, a surveyor confirmed this finding. The RN ICP/Unit Manager stated she thought they were due every 90 days. 4. On 6/11/24, R40's clinical record was reviewed and indicated that R40 was admitted to the facility on [DATE]. R40's first 30 day Physician visit was completed on 2/8/24 with the next 30 day Physician visit due on 4/18/24 (including a 10-day grace period) but was not completed until 5/24/24, 36 days beyond the grace period. On 6/12/24 at 7:51 a.m., during an interview with the Administrator, a surveyor confirmed this finding. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 6/11/24, R44's clinical record was reviewed with the Director of Nursing and Administrator and included Physician progress notes for a visit completed on 5/19/23. The next 60-day Physician visit was due by 7/28/23 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 9/11/23, 42 days beyond the grace period. The next 60-day Physician visit was due by 11/20/23 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 12/14/23, 16 days beyond the grace period. The next 60-day Physician visit was due by 2/22/24 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 3/13/24, 18 days beyond the grace period. On 6/11/24 at 1:02 p.m., during an interview with the Administrator and Director of Nursing, a surveyor confirmed these findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33242 Based on observations and interviews, the facility failed to remove fresh food items and out dated meat timely from the walk in cooler for 1 of 1 initial tours (6/10/24). In addition, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code and failed to ensure that equipment/cabinets were kept clean on 2 of 3 survey days (6/10/24 and 6/11/24). Findings: 1. On 6/10/24 at 11:30 a.m., an initial tour of the kitchen was completed with the Dietary Manager and a surveyor. The following were observed: - In the walk in cooler Cooked Turkey bacon in plastic bag, dated 5/11/24, and 12 heads of celery that had some brown, slimy stalks. The Dietary Manager stated that the bacon was good for 5 days. All items were removed from the stock available for use at the time of observation. A metal cabinet with doors, where dishes were stored, had dirty shelves. A photo was taken of the ice machine air gap for review as equipment needed to be moved in order to properly view. The air gap did not appear to be in compliance in the photo. 2. On 6/11/24 at 8:17 a.m., during an interview with the Maintenance Director, a surveyor reviewed the photo of what appeared to be an improper air gap on the ice machine. On 6/11/24 at 1:50 p.m., two surveyors returned to the kitchen as the Maintenance Director had moved the equipment out of the way so a surveyor could properly observe the ice machine air gap. During this observation, a surveyor confirmed with the Maintenance Director that the air gap was not in compliance and was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). During this visit to the kitchen, two surveyors also observed dust on the back of the juice machine and on the front of the ice maker with the Dietary Manager.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49635 Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the annual Long Term Care Recertification Survey, dated 6/12/24, was effective. The Federal citations F712, and F812 were cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 8/13/24. Findings: 1. During the annual Long Term Care survey, dated 6/12/24, a deficiency was cited at F712 for the facilities failure to ensure the attending physician made required visits, at least every 30 or every 60 days (depending on date of admission), and wrote a progress note. The facility's POC, dated 6/21/24, stated, Residents #40, #31, #11, #44, and #25's attending physician progress notes have been reviewed, updated, and signed off on per their individual plans of care accordingly. Administrator has provided education to each facility physician individually and reviewed Maine State rules and regulations regarding timeliness and frequency of physician documentation. All residents have the potential to be affected by this practice. To ensure compliance going forward the facility [NAME] Clerk and/or Designee will fax physician documentation, complete in-person runs to physician offices, and conduct follow-up phone calls to physician offices. The facility will also implement regular medical chart audits to ensure completion of documentation. Physician progress notes documentation will be reviewed and reported for compliance during monthly Quality Assurance and Performance Improvement (QAPI) meetings for a full quarter. The Administrator and/or Designee will ultimately be responsible for the process going forward, with the POC completion date of 7/1/24. During the re-visit on 8/13/24, record review revealed the facility failed to ensure the attending physician made required visits, at least every 30 or every 60 days (depending on date of admission), and wrote a progress note. It was determined the same tag F712 would be recited. On 8/13/24 at 3:15 p.m., the above concerns were discussed with the Administrator and Director of Nursing. 2. During the annual Long Term Care survey, dated 6/12/24, a deficiency was cited at F812 for the facilities failure remove fresh food items and outdated meat timely and ensure plumbing fixtures were properly installed to prevent backflow. The facility's POC, dated 6/21/24, stated, All non-servable food items were removed immediately. Metal cabinets, juice machine, and ice machine were also cleaned and sanitized accordingly during survey. The Maintenance Director fixed the ice machine air gap during survey as well. All residents have the potential to be affected by this practice. To ensure compliance going forward weekly sanitization audits of kitchen equipment as well as air gap compliance will be conducted for completeness. If deficient practice is identified throughout the audit process, corrective action will be taken immediately and education will be provided to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Health Care and Rehab	16 Beal Street MacHias, ME 04654

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate staff members accordingly. Kitchen equipment sanitization as well as air gap compliance will be reviewed and reported during monthly Quality Assurance and Performance Improvement (QAPI) meetings for a full quarter. The Dietary Supervisor and/or Designee will ultimately be responsible for the process going forward with the POC completion date of 7/1/24. During the re-visit on 8/13/24, observations of the kitchen and food storage revealed ongoing concerns regarding removal of food items timely. It was determined the same tag F812 would be recited. On 8/13/24 at 3:15 p.m., the above concerns were discussed with the Administrator and Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Marshall Health Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 16 Beal Street MacHias, ME 04654	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record reviews and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 5 of 6 residents reviewed for immunizations (Resident #5 [R] , R18, R2, R39, and R244). Findings: 1. R5 was admitted to the facility on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. 2. R18 was admitted to the facility on [DATE]. The CDC recommendation was to administer one dose of Prevnar 20 which had not been done. 3. R2 was admitted to the facility on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. 4. R39 was admitted to the facility on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. 5. R244 was admitted to the facility on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. R244'a pneumococcal vaccination status was reviewed for pneumococcal vaccines that did not include a Prevnar 20 vaccination. On 6/12/24 at 9:45 a.m. in an interview with the Unit Manager-Infection Preventionist and the Director of Nursing, a surveyor confirmed they are not following CDC recommendations and were unaware of the CDC recommendation to review, offer, and administer the Prevnar 20 vaccination.