STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215142	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesapeake Shores Nursing Center	21412 Great Mills Road Lexington Park, MD 20653

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews, record review, and observations, it was determined that the facility 1) failed to ensure resident rights to eat in a location of their choice, and 2) failed to follow the resident's preference in care providers. This was found to be evident for breakfast and dinner services and had the potential to affect all residents, and evident in 1 (Resident #28) out of 2 resident reviewed for choices. The findings include: 1) During an interview on 01/05/2026 at 10:22 AM, Resident #49 stated that the only time residents can eat in the dining room is during lunch and has been told they don't have enough staff for residents to eat in the dining room during breakfast and dinner. On 01/06/2026 at 10:36 AM, the facility's schedule of mealtimes was reviewed. Lunch in the dining room was listed to begin at 12:00 PM. There was no dining room serving time listed for breakfast or dinner. On 01/06/2026 at 11:11 AM, Resident #48 was interviewed and stated that they eat in their room for breakfast and dinner. Resident #48 stated residents only eat in the dining room during lunch but would like to eat in the dining room for dinner if that was an option. Resident #48 stated that only lunch in the dining room has been going on for some time. On 01/06/2026 at 12:01 PM, lunch service in the dining room was observed. 14 residents were eating in the dining room being assisted by 4 staff members. The staff members included 1 registered nurse, 1 speech therapist, 1 staffing coordinator, and 1 unknown staff member. On 01/06/2026 at 12:35 PM, the staffing coordinator (Staff #5) was interviewed and stated that there was a rotating schedule for lunch service assistance Monday through Friday, but no weekends. Staff #5 stated there was no dinner service in the dining room because a lot of the day staff who are available to attend and assist the residents have left for the day. On 01/07/2026 at 10:19 AM, concerns about the lack of breakfast and dinner services in the dining room were addressed with the Nursing Home Administrator (NHA). The NHA stated that the facility has plenty of clinical staff but does not have enough kitchen staff to allow residents to eat in the dining room for breakfast and dinner. The NHA stated that residents were allowed to eat in the rehabilitation area if they desire during breakfast and dinner. 2) On 1/8/2026 at 10:29 AM, an interview was conducted with Resident #28. Resident #28 stated that on one occasion a night shift Geriatric Nursing Assistant (GNA #27) came into Resident #28's room (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unannounced. Resident #28 expressed to the Director of Nursing (DON) that they did not want GNA #27 to care for him/her anymore. According to the resident, GNA #27 continued to care for him/her despite making the DON aware of his/her preferences. On 1/8/2026 at 11:16 AM, an interview was conducted with the DON. When asked if the DON recalled when Resident #28 made a request to not have GNA #27 care for them after they came into their room unannounced, the DON stated that they do recall and ensured the GNA did not work with Resident #28. When asked what happens when a resident requests not to have a certain staff member or a change in nurse, the DON stated that they let the staffing coordinator know so that they do not schedule the Staff member with the resident. This surveyor requested evidence that GNA #27 did not work with the resident after the request. On 1/8/2026 at 11:50 AM, an interview with the DON and review of the staffing schedule was conducted. The DON stated that after their review of the staff schedule for December of 2025, GNA #27 did work with Resident #28 after the request was made. The DON stated that GNA #27 picked up an extra shift and worked with the Resident on 12/27/25 when they should not have. The DON stated that they were made aware of this on 12/29/25 and the facility administration made him a Do Not Return the same day. When asked how other staff members in the facility were made aware of the resident preferences, the DON stated that they currently did not have a system in place to make resident preferences known.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on interviews, observations, and record review, it was determined that the facility failed to provide a functional and comfortable environment to residents. This was found to be evident in 2 of 2 facility courtyard awnings.The findings include:During an interview on 01/05/2026 at 11:05 AM, Resident #49 stated to this writer that the awning in the outside courtyard where residents go to smoke was ripped and was told by staff that there were no plans to repair the awning.A observation was made by this writer of the outside courtyard on 01/05/2026 at 12:26 PM from inside the dining room. The awning located outside next to the dining room was observed to have a large tear.On 01/06/2026 at 1:00 PM, surveyors went outside and observed the courtyard. The awning located next to the dining room exit and entrance in the outside courtyard had a long tear of several feet and and dozens of smaller holes. The awning located across the courtyard next to the rehabilitation gym entrance and exit was completely removed.On 01/06/2026 at 1:04 PM, an interview was conducted with Residents #29, #55, #65, and #41 during their smoke break in the outside courtyard. Resident #41 stated it had been a while since there was an awning next to the rehabilitation gym entrance and exit. Resident #29 also stated that there had not been an awning in that location for several years. Resident #65 stated that the awning next to the dining room entrance and exit had been in disrepair since they had been at the facility which was 3 years. The residents interviewed stated they must huddle in little areas underneath the awning by the dining room when it rains so they don't get wet. Resident #65 stated they had heard rumors about the awnings being replaced for years.On 01/07/2026 at 10:11 AM, the facility's Maintenance Director (MD) was interviewed by this writer. They stated they were aware that the awning was in bad condition and has replaced with tarps previously, but they don't last very long. The MD stated that they were not aware of the current status of replacing the awnings.On 01/07/2026 at 10:19 AM, the courtyard was toured with the Nursing Home Administrator (NHA) and surveyor addressed concern of the current condition of the awnings. The NHA stated that the facility has been looking to replace them but cannot find a vendor. The NHA stated they would provide emails of the vendor search.On 1/7/2026 at 2:08 PM, this writer reviewed an email provided by the NHA. The email showed correspondence between facility ownership and Apex Global Solutions on 05/08/2025 about vendors for awning (ownership) and suggesting to buy locally (Apex Global Solutions). No additional information about awning procurement was provided by the facility.

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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** Based on medical record review and staff interviews, it was determined that facility staff failed to accurately code the resident's status on the Minimum Data Set (MDS) assessment. This failure was evident for 1 resident (Resident #4) out of 8 residents reviewed for MDS assessments during the facility's recertification survey.The findings include:The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement. Care Area Assessments (CAAs) are a crucial part of the Minimum Data Set (MDS) process in skilled nursing facilities, serving as prompts for detailed reviews of specific resident issues like delirium, nutrition, falls, or mood, forming the basis for personalized care plans by an interdisciplinary team (IDT) to address needs, set goals, and enhance resident well-being. These assessments trigger deeper evaluations beyond basic MDS data, ensuring comprehensive, individualized care plans for residents. PRN, from the Latin **pro re nata, means as needed or as the situation arises, commonly used in healthcare for medications (taken only when symptoms occur) or for flexible, on-call staffing for nurses and other professionals who work shifts as required, rather than on a fixed schedule. Transdermally means through the skin, referring to the administration of medicine that is absorbed via the skin and into the bloodstream, often using patches (like nicotine or hormone patches) or ointments, to provide a controlled, sustained dose without needing oral ingestion or injections. On 01/06/2026 at 10:58 AM, during review of Resident #4's most current MDS and Care Area Assessments (CAAs) dated 10/17/2025, the surveyor noted the following: Section J showed that the resident received scheduled pain medications and indicated No for receipt, offer, or refusal of PRN pain medication during the last five days of the assessment. On 01/06/2026 at 11:13 AM, review of Resident #4's physician orders for pain management revealed the following active orders: Tylenol Oral Tablet 325 mg (Acetaminophen), give 2 tablets by mouth three times daily for Other Chronic Pain. Fentanyl Transdermal Patch 72 Hour 50 mcg/hr, apply one patch transdermally every three days for Other Chronic Pain. Hydromorphone HCl Oral Tablet 2 MG (Hydromorphone HCl) *Controlled Drug*, Give 1 tablet by mouth every 4 hours as needed for Pain - Severe 6-10 related to Other Chronic Pain. On 01/06/2026 at 11:49 AM, review of the resident's Licensed Nurse Medication Administration Record (LNMAR) for October 2025 showed that Resident #4 received PRN pain medication on 10/01, 10/03, 10/04, 10/06, 10/08, 10/11, 10/12, 10/14, 10/15, 10/16, 10/20, 10/21, and 10/22, which included dates within the five-day look-back period of the MDS assessment dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/06/2026 at 12:18 PM, during an interview with the MDS Nurse (Staff #12), she stated that Section J of the MDS was coded based on the resident's status during the last five days of the assessment period. She stated that Section J, item related to PRN pain medication, indicates whether the resident received, was offered, or declined PRN pain medication during that time frame. When asked how the determination was made, she stated the LNMAR was reviewed. Upon a dual review of the LNMAR and the MDS, Staff #12 confirmed that PRN Hydromorphone had been administered during the five-day look-back period and acknowledged that the MDS was incorrectly coded by another staff member. She stated it should have been coded Yes instead of No. When informed that the inaccurate coding was a concern, she acknowledged the concern and stated she would re-educate staff to prevent recurrence during the resident's next scheduled MDS assessment on 01/13/2026. A copy of the MDS Section J dated 10/17/2025 was requested and provided. On 01/06/2026 at 12:33 PM, the Director of Nursing (DON) was informed of the concern regarding inaccurate MDS coding, and she acknowledged it as a concern.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, it was determined that the facility staff failed to maintain professional standards of practice related to signing off resident care services. This was evident for 1 (Resident #1) of 2 residents reviewed for wounds. The findings include:On 01/05/2026 at 11:32 AM, review of Resident #1's medical record revealed a progress note titled, HP skin and wound note, dated 12/29/25 which indicated the resident had multiple wounds. The progress note noted recommendation of, turning/repositioning precautions per protocol.At the same time further record review revealed another progress note titled, HP skin and wound note, dated 01/08/26 which indicated the resident had multiple wounds. The progress note noted recommendation of, turning/repositioning precautions per protocol. On 01/07/2026 at 8:08 AM, review of the most recent Minimum Data Set, dated [DATE] revealed that the resident needed substantial to maximal assistance (of staff) to roll left and right. The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans and monitor quality of care.On 01/07/2026 at 8:27 AM, an observation of the resident revealed they were on their left side.On 01/07/2026 at 10:21 AM, an observation of the resident revealed they were on their left side.On 01/07/2026 at 12:46 PM, an observation of the resident revealed they were on their left side.On 01/07/2026 at 1:37 PM, review of documentation titled, Documentation Survey Report v2- MONITOR Turn and Reposition, revealed that GNA (Staff #29) documented Y (YES) on the document for dayshift on 1/7/26.At the same time, review of documentation titled, Documentation Survey Report v2- GG Roll Left and Right, revealed GNA (Staff #29) documented that the resident was dependent (needed staff help entirely to turn onto left and right side) for the day shift on 1/7/26.On 01/07/2026 at 2:40 PM, an observation of the resident revealed they were on their left side.On 01/08/2026 at 8:01 AM, an observation of the resident revealed they were on their left side.On 01/08/2026 at 10:03 AM, an observation of the resident revealed they were on their left side.On 01/08/2026 at 10:04 AM, an interview with Wound Nurse (Staff #25) regarding what turning/repositioning precautions per protocol meant revealed that it meant that it was encouraged that staff turn the resident left to right every two hours.On 01/08/2026 at 11:56 AM, an observation of the resident revealed they were on their left side.On 01/08/2026 at 2:01 PM, an observation of the resident revealed they were on their left side.On 01/08/2026 at 2:19 PM, review of documentation titled, Documentation Survey Report v2- MONITOR Turn and Reposition, revealed that GNA (Staff #30) documented Y (YES) on the document for dayshift on 1/8/26.At the same time, review of documentation titled, Documentation Survey Report v2- GG Roll Left and Right, revealed GNA (Staff #30) documented that the resident needed substantial to maximal assistance (needed staff help to do more than half the effort to help the resident turn onto left and right side) for the day shift on 1/8/26.On 01/08/2026 at 2:41 PM, an interview with the Director of Nursing revealed that when the GNAs signed off Y on the document titled, Documentation Survey Report v2- MONITOR Turn and Reposition, it meant the resident was turned throughout the shift. At the same time, the surveyor reviewed the concern with the Director of Nursing, she indicated that the resident often refuses care, but that staff should not be documenting that the resident had been turned and repositioned throughout the shift if they were not.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on resident interview, record review, and staff interview, it was determined that the facility failed to arrange vision appointments for a resident. This was evident for 1 (Resident #41) out of 1 resident reviewed for vision. The findings include:Based on resident interview, record review, and staff interview, it was determined that the facility failed to arrange vision appointments for a resident. This was evident for 1 (Resident #41) out of 1 resident reviewed for vision. The findings include: On 1/5/2026 at 9:01 AM, an interview with Resident #41 was conducted. The resident stated that they were supposed to receive new glasses around 3 months ago and they have not received them yet. On 1/6/2026 at 10:51 AM, a review of Resident #41's vision consult notes was conducted. A note from 9/02/2025 the ophthalmologist referred Resident #41 to a Retinologist within 2 weeks for retinal injections evaluation. On the Retinologist note from 9/12/25 the resident received an intravitreal injection of Avastin and was recommended for follow up in 1 month. A progress note from the Director of Nursing (DON) 10/16/2025 stated, Resident and RP notified of having to re-schedule today's retina appointment. Awaiting call back from Retina office. On 1/6/2026 at 11:33 AM, an interview with DON was conducted. This surveyor reviewed the Retina Center note from 9/12/2025 with DON. When asked DON if the follow up appointment was scheduled, The DON stated that the original follow up appointment from 10/16/2025 had to be rescheduled but was not arranged by the facility. The DON stated that the facility would ensure that the appointment is scheduled today (1/6/2026).

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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. Based on observation, medical record review, and staff interviews, it was determined that the facility staff failed to ensure residents received respiratory care consistent with professional standards of practice by failing to ensure respiratory/oxygen equipment was properly labeled and dated. This deficient practice was evident for 2 (Residents #48 and #3) out of 4 residents reviewed for respiratory/oxygen therapy during the facility's recertification survey.The findings include:Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from the health care provider. Oxygen tubing is a medical-grade hose that connects an oxygen source (like a concentrator or tank) to an oxygen delivery device, such as a nasal cannula or mask. It is designed to be lightweight, flexible, and kink-resistant to ensure a steady and uninterrupted flow of oxygen for therapy. Liters per minute (LPM) is the standard measurement for supplemental oxygen flow, indicating how much oxygen is delivered over time. On 01/05/2026 at 8:34 AM, during the initial tour of the facility, the surveyor observed Resident #48 in bed receiving oxygen at 3 liters per minute (LPM) via nasal cannula. The oxygen tubing in use was observed to have no date or label. On 01/05/2026 at 10:35 AM, the surveyor conducted a dual observation with Licensed Practical Nurse (LPN) #10, who confirmed the oxygen tubing was not dated or labeled as required and stated the issue would be corrected. On 01/06/2026 at 7:46 AM, during a follow-up visit with residents receiving oxygen therapy, the surveyor observed Resident #3 in bed receiving oxygen therapy. The oxygen tubing in use was observed to have no date or label. On 01/06/2026 at 7:51 AM, during an interview with the Unit Manager on A-Wing (Staff #8), the surveyor asked about the expectation for labeling and dating oxygen equipment. Staff #8 stated that oxygen tubing and humidifiers should be dated and labeled. During a dual observation, Staff #8 confirmed the oxygen tubing for Resident #3 was not dated or labeled and stated nursing staff should have dated and labeled the equipment after it was changed. On 01/06/2026 at 7:55 AM, during a follow-up observation of Resident #48, the surveyor observed the nasal cannula connected to the oxygen tubing remained not dated or labeled. On 01/06/2026 at 7:57 AM, the surveyor conducted a dual observation with LPN #11, who confirmed the oxygen tubing connected to the nasal cannula was not dated or labeled. When asked about expectation, LPN #11 stated the equipment should have been dated and labeled after it was changed. On 01/06/2026 at 8:07 AM, the Director of Nursing (DON) was informed of the concerns regarding the failure to date and label oxygen tubing. The DON acknowledged the concern and stated the oxygen tubing should have been dated and labeled after it was changed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it was determined that the facility failed to maintain accurate resident records. This was evident for 1 (Resident #2) out of 27 residents in the recertification survey. The findings include:Based on record review and staff interview, it was determined that the facility failed to maintain accurate resident records. This was evident for 1 (Resident #2) out of 27 residents in the recertification survey. The findings include: On 1/5/2026 at 11:09 AM, a review of Resident #2's progress notes was conducted. During the initial pool record review of Resident #2's chart, a Skin and Wound note from 11/25/25 indicated that the resident had 1 chronic abdominal wound and 2 bilateral lower extremity wounds. On 1/6/2026 at 9:53 AM, further review of the Skin and Wound note from 11/25/25 revealed that the resident's name on the note in Resident #2's chart was another resident's name. On 1/6/2026 at 10:09 AM, an interview with the Director of Nursing (DON) was conducted. The survey team made the DON aware of concern of incorrect name in wound note. DON acknowledged the incorrect name and stated that the resident did not have any wounds. Confirmed with the DON that the Wound Practitioner (Staff #28) entered the incorrect resident's wound note into Resident #2's chart.

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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. Based on observation and staff interviews, it was determined that the facility failed to maintain appropriate infection prevention and control practices. This failure was identified during observations of Activities of Daily Living (ADL) care provided to 2 of 5 sampled residents (Residents #6 and #54) who were on Enhanced Barrier Precautions (EBP) during the facility's recertification survey.The findings include:Activities of Daily Living (ADL) care involves assisting individuals with fundamental self-care tasks essential for health and independence, such as eating, bathing, dressing, toileting, grooming, and mobility, often assessed in elderly, disabled, or recovering persons to determine their need for support. Enhanced Barrier Precautions (EBP) are infection control measures, primarily for nursing homes, requiring healthcare workers to wear gloves and gowns during high-contact resident care activities (like bathing, dressing) to prevent spreading multidrug-resistant organisms (MDROs) to hands and clothing, even if blood/body fluid exposure isn't expected, extending standard precautions for residents with multidrug-resistant organisms (MDROs) or at high risk (wounds, devices). Personal Protective Equipment (PPE) refers to specialized gear like gloves, gowns, masks, and goggles that create a barrier to protect healthcare workers from infectious materials (blood, body fluids, germs) and prevent them from spreading infections to patients or others. On 01/05/2026 at 9:23 AM, during the initial tour of the facility, the surveyor was present in Resident #6's room. The resident, who had an EBP signage on his/her door, requested assistance to use the bathroom. A staff member passing by was notified. The surveyor observed that two Geriatric Nursing Assistants (GNA #15 and GNA #16) entered the room and provided care without performing hand hygiene prior to entry and without donning a gown, as required under EBP. On 01/05/2026 at 9:27 AM, during an interview, GNA #15 was asked about expectations for appropriate PPE use while providing resident's hygiene care. She stated that she was expected to sanitize her hands and wear gloves. When asked about why she did not use PPE as required in context of the gown, she stated she was unaware that a gown was required during toileting or personal care and believed the gown requirement posted on the resident's door applied only to wound care. On 01/05/2026 at 10:17 AM, during an interview, GNA #16 was asked about expectations for appropriate PPE use during hygiene for residents. She stated that EBP protocol required hand hygiene, gloves, and a gown. When asked why she did not use the required PPE while providing care for Resident #6, she stated she was unaware the resident was on EBP because she usually cared for other residents and acknowledged she should have checked the door signage prior to providing care. 01/07/2026 2:33 PM, surveyor informed the Nursing Home Administrator (NHA) the concern about using inappropriate precaution and she acknowledged the concern. On 01/07/2026 at 2:42 PM, surveyors heard an overhead page requesting nurses to meet with the Director of Nursing (DON) on the B-Wing of the facility. Surveyors observed the DON provides verbal education to nursing staff regarding PPE requirements for residents on EBP. When asked how she identified noncompliance, the DON stated that she had been informed that staff members were not following the PPE protocol and she had also observed staff failing to use PPE appropriately, she added that the verbal education was to reinforce adherence to PPE protocol. The surveyor informed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON that surveyor had also observed staff not donning PPE appropriately and had informed the NHA about it. On 01/08/2025 at 10:10 AM, during a follow-up walk through the units, the surveyor observed agency staff GNA #26 transfer Resident #54 who also had an EBP post on his/her door from bed to wheelchair while wearing gloves only and no gown. On 01/08/2026 at 10:16 PM, the surveyor reviewed the electronic health records for Residents #6 and #54 and it revealed that both residents had an order for Enhance Barrier Precautions (EBP). On 01/08/2025 at 10:47 AM, during an interview, the Infection Preventionist (IP) was asked about staff expectations regarding PPE use. She stated staff were expected to follow EBP protocols and further indicated the staff member involved was agency staff. When asked if agency staff received facility-specific training prior to working a shift at the facility, she stated no, explaining that agency staff were expected to rely on training provided by their agency. On 01/08/2025 at 10:49 AM, the surveyor, accompanied by the Director of Nursing (DON) and the IP, observed the resident receive a shower while staff wore gloves only and no gown. On 01/08/2025 at 10:50 AM, during an interview, agency GNA #26 was asked about expectations for PPE use when providing ADL care to residents on EBP. She stated the expectation was for her to wear gloves and a gown for the procedure. She further stated she had not previously worked with the resident and reported the resident told her that he/she was not on EBP, which she cited as the reason for not wearing the required PPE.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215142	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesapeake Shores Nursing Center	21412 Great Mills Road Lexington Park, MD 20653

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 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. Based on record review and staff interviews, it was determined that the facility failed to ensure residents were educated on the benefits and risks of Influenza vaccine following a refusal. This was evident for 1 resident (Resident #41) out of 5 residents reviewed for immunizations during the facility's recertification survey.The findings include:Based on record review and staff interviews, it was determined that the facility failed to ensure residents were educated on the benefits and risks of Influenza vaccine following a refusal. This was evident for 1 resident (Resident #41) out of 5 residents reviewed for immunizations during the facility's recertification survey. The findings include: A BIMS score is derived from the Brief Interview for Mental Status, a brief screening tool for assessing cognitive function in long-term care settings. A score between 0 and 15, where higher scores indicate better cognitive ability, helps facilities track cognitive changes. Scores are categorized: 0–7 is severe impairment, 8–12 is moderate impairment, and 13–15 is cognitively intact. The assessment evaluates temporal orientation and short-term recall. On 01/07/2026 at 1:03 PM, the surveyor reviewed the immunization records for 5 residents randomly selected and identified that Resident #41's immunization record lacked documentation that education regarding the risks and benefits of the influenza vaccine was provided following the resident's refusal of the vaccine. Review of the record showed that Resident #41 had a BIMS score of 13, indicating Resident #41 was cognitively intact. On 01/07/2026 at 1:34 PM, during an interview with the Infection Preventionist (IP), she stated that immunizations were offered to new residents upon admission and that during influenza season, consents were obtained from both new and existing residents. When asked about the facility's expectation regarding education following declination of vaccination, she stated that residents or their representatives were required to receive education on the risks and benefits of the vaccine regardless of whether they consent or decline, and that such education should be documented in the resident's electronic health record. When asked to provide documentation of education given to Resident #41 after declining the influenza vaccine, she stated it would be in the electronic health record and left to retrieve it. On 01/07/2026 at 1:42 PM, the IP returned and confirmed that there was no evidence that education regarding the risks and benefits of the influenza vaccine had been provided to Resident #41 following the refusal. She further stated that the facility should have provided the education and documented it in the resident's health record. On 01/07/2026 at 1:55 PM, the Director of Nursing (DON) was informed of the concern regarding the lack of education provided to residents following refusal of the influenza vaccine. The DON acknowledged this as a concern.