STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215174	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ginger Cove	4000 River Crescent Drive Annapolis, MD 21401

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40927 Based on observation and interview it was determined that the facility failed to ensure residents had a homelike environment. This was evident for 3 (#21, #34, and #39) of 16 residents reviewed during the initial pool process. The findings include: An observation of Resident #21's room on 5/28/24 at 12:29 PM revealed the walls on the right side of the hallway had 7 or more black marks varying from light to dark and measuring from 3-12 inches in length. In the bathroom the shower stall had grip strips that were partially peeled up. An observation of Resident #34's room on 5/28/24 at 12:06 PM revealed on the left side of the hallway there were multiple black marks varying from light to dark and measured between 47 inches to 3 inches in length and between the second and third picture hanging in the hallway there were 2 circular black marks measuring about 2 1/2 inches. There were black marks on the right side of the hallway between the closet door and the corner wall. The door to the bathroom had two holes the size of a nail head on the right side. Inside the bathroom was a shower stall that had grip strips that were peeling or torn off. An observation of Resident #39's room on 5/29/24 at 11:35 AM revealed the wall to the left of the doorway multiple black marks varying in shades of black that extended about 3 feet up the wall and over to the resident's dresser. The wall to the right of the entrance and adjacent to the closet door had black marks and on the corner of the wall the metal corner piece was exposed. The closet doors had multiple black marks on them. The bathroom had a shower stall, and the grip strips were peeling off. One tile in front of the toilet had a 2 x 2 area that the coating was peeled off, a second and third tile had an area the size of a dime that was peeled off. An interview with Director of Maintenance and the Chief Engineer on 6/4/24 at 12:00 PM revealed they have a computer-based system for staff to put in work orders when they notice anything that needed fixed. They reported that they make weekly rounds to check the resident's rooms. Also, when a resident was discharged the rooms were painted and new carpet installed. However, these areas had not been fixed. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of the interview a tour of Resident #34's and Resident #39's room was conducted, and the areas of concern were reviewed with them. Resident #21's room was not available for a tour at that time, so the concerns were reviewed with the staff verbally.

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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. 34484 Based on medical record review and interview it was determined that the facility failed to have a process in place to ensure that residents and resident representatives received a notice of transfer in writing. (Resident #40 and #246). This was evident in 2 of 3 residents reviewed for hospitalization during the survey. The findings include: 1. Review of Resident #40's medical record on 5/29/24 revealed the Resident was transferred to the hospital on 1/9/24. Further review of Resident #40's medical record revealed the Resident had 2 physician certifications of incapacity. Review of the facility's hospital transfer documents on 5/29/24 revealed no written notification to the Resident's representative of the transfer to the hospital on 1/9/24. On 6/3/24 at 11:05 AM, Interview with the Director of Nursing (DON) confirmed the facility staff failed to provide written notification to Resident #40's Representative of transfer to the hospital on 1/9/24. 40927 2. An attempt to review the electronic medical record (EMR) on 5/31/24 at 10:30 AM revealed Resident #246 could not be viewed by the surveyor. A review of Resident #246's closed medical record on 6/4/24 at 7:45 AM revealed a progress note printed from the EMR that was dated 5/20/24. The note read that the resident was transferred to the local acute care hospital for emergent treatment. The resident was nonresponsive at the time of transfer and family were made aware of the transfer via a phone call. Further review failed to reveal a written notice of transfer was given to the resident and the resident's representative. An interview with Licensed Practical Nurse (LPN) #18 on 6/4/24 at 7:59 AM revealed that a transfer form was completed when a resident was sent to the hospital and copy was given to the emergency medical services (EMS) staff and not to the resident. She was not aware of it being sent to the resident representative as they were verbally made aware either in person or over the phone. An interview with LPN #19 on 6/4/24 at 8:18 AM revealed that the transfer form was completed when a resident was sent to the hospital and a copy was given to EMS staff. She was not aware that it was given to the resident unless the resident was alert and oriented with capacity to make health care decisions. She reported she was not aware that the transfer form was sent to the resident's representative, but that they will call them when a resident was transferred to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 11:09 AM the concerns were discussed with the Director of Nursing (DON) and she confirmed that the notice of transfer was not provided to Resident #246 or to their representative as soon as possible after a hospital transfer.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 34484 Based on record review and staff interview it was determined that the facility failed to have a process in place to ensure that residents and resident representatives received the bed hold policy in writing within 24 hours after being sent to the hospital (Resident #40 and #246). This was evident for 2 of 3 resident records reviewed for hospitalization during an annual survey. The findings include: Bed hold notice includes providing written information to the resident; and bed charges, including the duration, during which the resident is permitted to return and resume residence in the nursing facility. 1. Review of Resident #40's medical record on 5/29/24 revealed the Resident was transferred to the hospital on 1/9/24. Further review of Resident #40's medical record revealed the Resident had 2 physician certifications of incapacity. Review of the facility's hospital transfer documents on 5/29/24 revealed no evidence that the Resident or representative received a bedhold notice on 1/9/24. Interview with the Director of Nursing on 6/3/24 at 11:05 AM confirmed the facility staff failed to provide bedhold notice to Resident #40's representative on 1/9/24. 40927 2. An attempt to review the electronic medical record (EMR) for Resident #246 on 5/31/24 at 10:30 AM revealed the resident was not showing up in the system. During a closed record review for Resident #246's on 6/4/24 at 7:45 AM a copy of a progress note printed from the EMR was reviewed. The note read that Resident # 246 was transferred to the local acute care hospital for emergent treatment in 5/20/24. The resident was nonresponsive at the time of transfer and family were aware of the transfer via a phone call. Further review failed to reveal a notice of transfer for the resident and the resident representative. An interview with Licensed Practical Nurse (LPN) #18 on 6/4/24 at 7:59 AM revealed that a copy of the bed hold policy was given to the emergency medical services (EMS) staff when a resident was sent to the hospital and not to the resident. She reported that the resident or resident representative signs a bed hold policy at the time of admission. Furthermore, she reported that she will make a copy of the signed form and change the date on it. She was not aware that it was given to the resident or resident representative each time the resident was sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN #19 on 6/4/24 at 8:18 AM revealed that a copy of the bed hold policy was given to EMS staff at the time a resident was transferred to the hospital. She was not aware that it was given to the resident unless the resident was alert and oriented with capacity to make health care decisions. She was unaware of whether the bed hold policy was sent to the resident's representative at the time of each transfer because it was signed on admission and a copy was in the chart. On 6/4/24 at 11:09 AM the concerns were discussed with the Director of Nursing (DON) and she confirmed that the bed hold policy was not provided to the resident or the resident representative within 24 hours after a hospital transfer.

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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** 34484 Based on record review and interview it was determined that the facility failed to have a process in place to ensure that a baseline care plan was provided to the resident and resident representative within 48 hours of admission to the facility (Resident #40 and #42). This was evident for 2 of 4 residents reviewed for baseline care plans during an annual survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1. Review of Resident #40's medical record on 5/29/24 revealed the Resident was admitted to the facility on [DATE] from the hospital and the facility staff developed a baseline care plan on 1/5/24. Further review of Resident #40's medical record revealed the Resident had 2 physician certifications of incapacity. Review of the baseline care plan developed on 1/5/24 by facility staff revealed it was not signed by the Resident's representative. Further review of the Resident's medical record revealed the Resident was discharged from the facility on 1/9/24 and returned to the facility on [DATE]. The facility staff completed a baseline care plan on 1/15/24 and 1/16/24. Review of the baseline care plan revealed it was not completed with the Resident and their representative. It was not signed and given to the Resident's representative until 1/29/24, 2 weeks after completion. The medical record review failed to reveal evidence that the facility offered the Resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility. Interview with the Director of Nursing on 5/31/24 at 1:00 PM confirmed the facility staff failed to provide a summary of the baseline care plan to Resident #40 and their representative within 48 hours of the resident's admission to the facility. 40927 2. During an interview with Resident #42's family on 5/28/24 at 2:15 PM it was reported that they were informed of the resident's plan of care until 6 days after admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical record review for Resident #42 on 5/30/24 at 11:18 AM revealed a base line care plan. Review of the baseline care plan revealed that dietary, nursing, and rehab staff had signed a review of the care plan was conducted on 5/3/24, however it was blank where they could check if the resident or resident agent had participated in the review. Further down the page it noted that 4 days after admission the resident's agent had signed the care plan and Unit Manager (UM) Staff #17 signed she provided a copy. An interview with UM Staff #17 on 5/30/24 at 1:05 PM revealed that Resident #42 had been admitted to the facility on a weekend and was not able to review the baseline with the family until Tuesday. She reported she works Monday - Friday. She reported that she was aware of the required 48-hour timeframe but was not meeting that timeframe with every new admission. On 5/30/24 at 2:11 PM the concerns were discussed with the Director of Nursing (DON). She reported that they have weekend supervisors who could ensure that baseline care plans are reviewed with the 48-hour requirement.

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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. 31982 Based on medical record review and interview with the resident and staff it was determined the facility staff failed to ensure residents' plans of care included individual resident care needs and interventions to assist each resident in reaching their highest practicable level of wellbeing. This was evident for 1 (#10) of 1 resident reviewed for Dialysis. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. In an interview on 5/29/24 at 10:36 AM, Resident #10 revealed he/she received dialysis 3 times per week. When asked if he/she was on a specialized diet he/she indicated yes but did not know what it involved. Resident #10 also stated he/she was on a fluid restriction but didn't know what the restriction was. Review of Resident #10's medical record on 6/3/24 at 9:37 AM revealed physicians' orders which included but were not limited to a diet order for: Regular diet, regular texture, thin liquids, renal precautions. No citrus fruit or juices; no bananas, no tomatoes, milk/dairy limited to 1 cup per day, Potatoes limited to 1 serving at lunch and/or supper. Avoid dark sodas, chocolate. Protein served at all meals. Another physician order for 1.5 L(liter) fluid restriction - 350 ml(milliliters) four times a day allows for 350 ml with all meals and before bedtime. Allow for an extra 100 ml of fluids to be consumed in food with high water content. Please document ml consumed. Another order for: Offer ice chips if resident gets thirsty, every shift. Resident #10's Nutritional Plan of Care revealed that the facility staff failed to include Resident #10's specific fluid and dietary restrictions related to his/her dialysis and renal needs as ordered by the physician, including the provision of ice chips. The record review also revealed physician orders for weights 3 times per week before dialysis, application of Lidocaine-Prilocaine 2.5%-2.5%, a numbing cream, 1 application topical 3 times per week. Apply to the access site 1 hour prior to dialysis; and another physician's order for no tub baths. A Renal Care Plan was developed with the problem: Dialysis: (Resident #10) receives hemodialysis and has potential for complications. The Resident's goal was identified as: he/she would not experience complications from hemodialysis requiring hospitalization for medical intervention. The interventions for staff to implement to assist the resident in reaching his/her goals were: Arrange for meals around dialysis session (with instructions). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide water soluble medications after dialysis to avoid being dialyzed out of system. Check with physician about holding antihypertensive medications and check with physician about removing nitroglycerin patch if applicable. If blood work is ordered, coordinate with Dialysis nurse about who is to draw the blood to prevent unnecessary needlesticks and loss of blood. Send IV (intravenous) medications with the client to dialysis sessions for the dialysis nurse to administer so that fluid removal rates are adjusted to prevent fluid overload. When client returns from dialysis, assess access site for bleeding and make sure BP (blood pressure) is stable before client resumes activity. The plan did not identify specific complications related to hemodialysis the staff should monitor for. The plan did not identify Resident #10's individual care and precautions staff should implement related to Resident #10's dialysis access site. It did not identify that blood pressures blood samples should not be obtained from the arm with the access site or that Resident #10 should not take tub baths. The plan did not identify assessments of the access site including frequency, patency, infection or complications other than bleeding and who should be notified and when. The plan did not reflect the resident's other care needs including application of numbing cream and weight assessments 3 times per week, prior to dialysis. During an interview on 6/4/24 at 11:00 AM Resident #10's Plan of Care was reviewed with the Director of Nursing. She was made aware that standard and individualized care interventions related to renal/dialysis and dietary restrictions were not included in Resident #10's Plan of Care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on medical record review and interview with staff it was determined the facility staff 1) failed to measure resident centered objectives in order to determine the effectiveness of the residents care plan interventions; (Resident #10) and 2) failed to ensure resident's care plan reviews were completed by an interdisciplinary team which included the attending physician, a registered nurse and nurse aide involved in the resident's care, a member of food and nutrition services staff and the resident/representative; (Resident #10) and 3) failed to hold quarterly care plan meetings to include the interdisciplinary team, resident and resident's representative for residents. (Resident #40). This was evident for 2 out of 5 residents reviewed for care planning during an annual survey. The findings include: Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Care planning drives the type of care and services that a resident receives and must include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goal(s). The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. 1) Review of Resident #10's medical record on 6/3/24 at 9:37 AM revealed Plans of Care which included but were not limited to: Impaired mobility, Urinary incontinence, Alteration in mood related to Anxiety, Multiple fall history related to decreased safety awareness and unsteady gait, Dental care, Risk for skin breakdown due to incontinence and needs help for bed mobility and constant reminders for positioning and fragile skin, Pain, Potential for complications due to Anemia, At risk for complications from blood thinning medication, Cardiovascular related to Atrial Fibrillation, Potential for complications from Diabetes, Potential for complications due to gastrointestinal distress, Renal - receives hemodialysis and has potential for complications, Potential for complications from Hypothyroidism, Has Systemic Lupus Erythematosus and has potential for complications, Podiatry care, Potential for adverse drug effects and drug interactions related to use of 9 or more medications, Potential for cardiac alteration secondary to diagnosis of Hypertension, At risk for impaired skin integrity due to fragile skin, Hyperlipidemia (high cholesterol), Remains at risk for COVID-19 related to advanced age greater than 74, and other comorbidities HTN (hypertension), DM (Diabetes), ESRD (End Stage Renal Disease) as evidenced by global pandemic COVID-19 of geriatric patients. Risk for infection while in healthcare. In an interview on 6/3/24 at approximately 1:00 PM Staff #4 the Assistant Director of Nursing (ADON) who is also the MDS (Minimum Data Set) coordinator was asked where to find the treatment team's evaluation notes for Resident #10's plans of care. She showed the surveyor a tab located in the Care Plan section of Resident #10's Electronic Medical Record (EMR). She confirmed that care plan evaluations were not documented anywhere else in the medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the resident's medical record on 6/3/24 at 1:05 PM revealed the most recent evaluation notes for Resident #10's care plans were dated 5/27/24. The evaluation notes for the plans of care identified above reflected the conclusion: Goals and approaches reviewed and continue to be appropriate. Continue with current approaches x 90 days. The notes did not reflect how the treatment team came to the conclusion that the approaches continued to be appropriate. There was no evidence that resident specific objectives were measured and evaluated to determine the resident's progress. 2) In an interview on 5/29/24 at 10:36 AM, Resident #10 revealed he/she received dialysis 3 times per week. When asked if he/she was on a specialized diet he/she indicated yes but did not know what it involved. Resident #10 also stated he/she was on a fluid restriction but didn't know what the restriction was. A review of Resident #10's medical record on 6/3/24 at 1:05 PM revealed that there were no evaluations of the effectiveness of Resident #10's Nutrition Care Plan interventions or if any revisions were made to assist the resident in better meeting his/her goals. On 6/4/24 at 9:36 AM the surveyor requested copies of documentation including but not limited to Resident #10's Care Plans with evaluations and a Care Plan meeting attendance sheet from his/her most recent care plan meeting. Review of the copies on 6/4/24 at 11:00 AM failed to reveal an evaluation of Resident #10's Nutrition Care Plan. No Care Plan meeting attendance record was provided. A Social Work progress note dated 5/23/24 at 8:36 AM by Staff #6 a Social Worker stated, Careplan meeting held today with IDT (Interdisciplinary Team). R/T (resident)/family invited but declined to attend. The progress note did not identify the members of the IDT that attended the meeting. A copy of an email correspondence between the Social Worker and the resident's representative was included with the copies of documents requested. The email was dated 5/15/24 at 8:17 AM from the Social Worker which stated, Just confirming that we are cancelling our meeting for this afternoon? Resident #10's representative responded on 5/15/24 at 11:19 AM: Yes, we are cancelling since we probably wont be back. Lets reschedule, just sure when yet. No documentation was found in Resident #10's record to indicate that facility staff attempted to reschedule Resident #10's Care Plan meeting as requested by the resident's representative in the email. An interview was conducted with Staff #6 the Social Worker on 6/4/24 at 11:18 AM. She confirmed that the resident's representative was not able to attend the meeting scheduled for 5/15/24 and requested that it be rescheduled, as indicated in the email. When asked if the meeting was rescheduled, she stated, the (representative) did not call back to reschedule. She then confirmed that the facility did not reach out to the representative to reschedule, and they did not have the meeting on 5/15/24 but instead held Resident #10's Care Plan meeting on 5/23/24. She confirmed that she did not reach out to the resident's representative regarding the meeting on 5/23/24 (which was the resident's scheduled dialysis day) yet documented that the resident and representative declined to attend. She stated, I see what you mean. She also confirmed that her note, written at 8:36 AM on 5/23/24, indicated the meeting was held that day. When asked what time the meeting was held, she stated I'm not sure. She was asked to provide the meeting attendance sheet and stated, there is none. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 11:00 AM, the Director of Nursing was made aware that there was no evidence that the required interdisciplinary team members met to review Resident #10's Plan of Care, or that a review was conducted of Resident #10's Nutrition Plan of Care. She indicated that no additional documentation was found. 34484 3) The facility staff failed to have a quarterly care plan meeting for Resident #40. Review of Resident #40's medical record on 5/29/24 revealed the Resident was admitted to the facility on [DATE] and the facility staff completed a quarterly MDS assessment on 4/22/24. During interview with the Resident's Representative on 5/29/24 at 9:00 AM, the Representative stated the facility staff has not had a care plan meeting since January 2024. Further review of Resident #40's medical record revealed no care plan meeting since 1/22/24. Interview with the Director of Nursing on 5/31/24 at 1:00 PM confirmed the facility staff failed to hold a quarterly care plan meeting for Resident #40 in April 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215174	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ginger Cove	4000 River Crescent Drive Annapolis, MD 21401

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 40927 Based on record review and staff interview it was determined that the facility failed to ensure that a discharge summary was complete and accurate. This was evident for 1 (#42) of 3 closed records reviewed. The findings include: A medical record review for Resident #42 on 5/30/24 at 11:18 AM revealed a history and physical visit conducted by the attending physician on the day of the resident's admission. The physician noted that the resident had progressing weakness, reoccurring falls, Parkinson's disease, and worsening dementia. The plan for treatment was noted as physical and occupational therapy, continue the same mediations, and repeat labs. The physician noted that the resident's potential for rehab was fair, and the resident had a poor prognosis. A review of the discharge summary revealed that the physician documented the resident had completed their course of treatment and was being discharged back to independent living with family. The physician failed to include the medications that the resident was on and which one that should be continued after discharged . An interview with the Social Worker (SW) #6 on 5/30/24 at 1:50 PM that the resident's family initiated the discharge. During an interview with the Director of Nursing (DON) on 5/30/24 at 2:15 PM she confirmed that Resident #42's discharge was initiated by family. She stated that there were safety concerns for the resident residing in independent living. The resident had been falling frequently while at home which was the reason s/he had been sent to the hospital before their admission to the facility. The facility felt the resident was better suited for long term care. An interview with the attending physician on 6/4/24 at 8:56 AM revealed that he was aware that the discharge summary includes a narrative of significant events during the resident's stay however, he failed to accurately document that the resident's discharge was initiated by family and that 24-hour supervision had been recommended due to the likelihood of the resident continuing to have falls. Lastly, he was aware that the resident's medications should be listed and which medications he wanted the resident to continue after discharge. However, he stated that if the facility form allows for this information, he will document it, but if a resident was on multiple medications he may not.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37296 Based on observations, a review of daily staffing records, and staff interviews it was determined the facility failed to post the total number and actual hours worked by categories of Registered nurses, Licensed practical nurses, and Certified nursing aides per shift and in an accurate, clear and readable format. The findings include. Observations on 6/4/24 at 10:30 AM, did not reveal the Federal requirements related to the posting of staff. The total number of and actual hours worked by categories of Registered nurses, Licensed practical nurses, and Certified nursing aides per shift was not observed in any part of the facility Nursing Units. On 6/4/24 at 11 AM, an interview was conducted with the Director of Nursing and a review of the current posting confirmed that the Staffing record failed to document the total number of hours worked by categories.

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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 - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and staff interview it was determined that the facility failed to develop and implement policies and procedures to ensure all residents were offered and/or receive the appropriate pneumococcal vaccinations as per the national standards. This was evident for 2 (#21 and #34) of 5 residents reviewed for pneumococcal vaccinations. The findings include: The Centers for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP) releases an Adult Immunization Schedule which assist healthcare workers in determining the vaccinations that are recommended for their residents. CDC released a Morbidity and Mortality Weekly Report (MMWR) on January 28, 2022, with further guidance for determining which pneumococcal vaccination is recommended based on previous vaccinations. Pneumococcal vaccinations are available in a formulation of pneumococcal conjugate vaccine (PVC) followed by the number of strands of pneumonia it protects against and a 23 - valent pneumococcal polysaccharide vaccine (PPSV). On 6/4/24 at 11:30 AM a review of the facility's policy titled, Pneumococcal Vaccination revealed no date of implementation or a date it was last reviewed. The policy stated that staff were to review the preadmission history and physical form to determine if the resident had been previously vaccinated. Secondly, they were to offer the vaccination to all residents over [AGE] years of age who had no record of a previous vaccination. The policy provided no guidance to the staff as to how to determine which vaccine was recommended for each resident based on their history of immunizations, medical conditions, and age. The policy was misleading in the fact that if should be offered to residents over the age of 65 as this does not follow the national standards. 1) A medical record review of the hard chart for Resident #21 on 5/30/24 at 7:53 AM revealed the resident was admitted in 2023 and had no evidence of a pneumococcal vaccination in the medical record. A medical record review of the electronic medical record (EMR) for Resident #21 on 5/30/24 at 8:10 AM revealed no record of a pneumococcal vaccination being offered or administered. An interview with the Infection Preventionist (IP) on 6/3/24 at 1:37 PM revealed that the Assistant Director of Nursing (ADON) reviewed resident's vaccination history upon admission and informed her as to which vaccinations were needed. A subsequent interview with the IP on 6/4/24 at 9:13 AM revealed she had a printout of a clinical summary for Resident #21 as of 1/22. The form was highlighted where PPSV23 was noted. However, further review revealed that the resident had been due for this vaccine in 1989 and not administered on this date. Once the IP read it again, she confirmed that the resident had not been given a pneumococcal vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A medical record review for Resident #34 on 5/31/24 at 8:11 AM revealed the resident was admitted to the facility in 2022 and there was no evidence that the facility had obtained the residents vaccine history nor provided a pneumococcal vaccination. On 6/4/24 at 9:13 AM during an interview with the IP she provided a copy of a printout of a clinical summary for Resident #34 as of 1/15/22, which documented the resident had a PPSV23 vaccination in 1997. When asked if the resident should have been given additional pneumococcal vaccinations the IP stated she did not know. According to the national standards in 2022 the resident should have been offered a pneumococcal conjugate vaccine to compete the series, however this was not done. The ADON was interviewed on 6/4/24 at 9:53 AM, she reported that the clinical summaries provided to the surveyor were from a system called EPIC which was used in other sections of the facility, but not in the long-term care section. She reported that the resident's vaccine information was documented in the EMR under the immunization tab. When the surveyor reviewed Resident #21 and #34 with the ADON it was confirmed the surveyor was unable to view this information. The ADON provided printed copies of the vaccination information entered for Resident #21 and #34, however, it confirmed that the pneumococcal vaccination history and not been added for Resident #34 and neither had been offered pneumococcal vaccine. She reported that when she checks the resident's vaccination records upon admission, she confirms that a pneumococcal vaccine was given and how many years ago it was given. Reviewed with the ADON that this does not follow the national standards.