

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/08/2024
NAME OF PROVIDER OR SUPPLIER  Resorts at Chester River Manor Corp		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Morgnec Road Chestertown, MD 21620	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49304</p> <p>Based on observation and interview with facility staff, it was determined that the facility failed to maintain the dignity and privacy of a resident as evidenced by the resident's nephrostomy bags left uncovered while outside of their room. This was evident for 1 (Resident # 193) of 86 residents that were observed during the survey.</p> <p>The findings include:</p> <p>A nephrostomy is a small tube inserted through the skin directly into the kidney to allow urine to drain from the kidney into a collecting bag outside the body. It is surgically placed by a healthcare provider if a person's urine cannot leave their body due to kidney stones, kidney infection, trauma, or other reasons.</p> <p>During an observation that took place on 3/5/24 at 10:40 AM, Resident #193 was in the Terrace Lounge during a social coffee time with both nephrostomy bags uncovered, leaving the resident's urine visible to view through the clear bags.</p> <p>On 3/5/24 at 10:41 AM, in an interview conducted with Licensed Practical Nurse (LPN #29), she stated that when a resident comes out of their room, their nephrostomy bags should be covered. The nurse took the resident back to their room to cover the bags.</p> <p>On 3/6/24 at 9:56 AM, in an interview with the Administrator, he was made aware that Resident #193 was in the Terrace Lounge with both of their nephrostomy bags uncovered. He confirmed the nephrostomy bags should have been covered.</p> <p>The Director of Nursing (DON), Regional DON, and Administrator were made aware of the above finding on 3/8/24 at 1:30 PM.</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</b></p> <p>Based on observation and interviews it was determined the facility staff failed to ensure that residents' call bells were in reach to request assistance. This deficient practice was evident in 2 of 8 (Resident #32 and Resident #58) residents assessed for call bell accommodations during the survey.</p> <p>The findings include:</p> <p>On 03/04/24, at 9:14 am during observation rounds the surveyor entered room [ROOM NUMBER]. Resident #32 was sitting on the side of the bed. The surveyor noticed that the call bell was draped over the bedside table and was not in the resident's reach. The surveyor greeted Resident #58 and noticed that the call bell was on the floor near the left side of the bed.</p> <p>On 03/04/24 at 9:19 am Social Worker#7 confirmed the surveyor's findings.</p> <p>On 03/06/24 at 12:49 pm during an interview with Director of Nursing #2 who verbalized the managers make rounds twice in the morning and twice in the evening before leaving. It was expected for the call bell to be always assessable to the residents. The Geriatric Nursing Assistants are expected to check on the residents periodically throughout the day.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>30440</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to ensure that scheduled pain medications for a resident were not misappropriated. This was found to be evident during a medication drug storage review and narcotic review and reconciliation for 1 of 3 medication carts reviewed during the survey.</p> <p>Findings include:</p> <p>During a review of a medication cart on the Osprey Unit with nurse (#27), a Licensed Practical Nurse (LPN) on 3/7/24 at 2:30 PM, the following concerns were identified while reviewing the narcotic drawer:</p> <p>The nurse counted the medication blister pack of Tramadol Tablet 50 mg for Resident # 5. There were 7 pills observed inside of the blister pack. At that time the surveyor and the nurse reviewed the controlled drug receipt record/disposition form. There was an entry on 3/7/24 at 0900 indicating that 1 tablet was given and 6 tablets were left with, a signature entry by the nurse.</p> <p>On the same date at 2:55 PM an interview was conducted with Resident # 5 who was sitting up in bed in their room, was asked if s/he was having any pain and the resident stated, no.</p> <p>At 3:10 PM on the same date, the survey team requested and received a medication administration audit report for Resident # 5 and Resident # 10. The audit report is a report that shows the time that a medication is documented as being administered when staff documents it in the computer. Review of the audit report for Resident # 5 revealed the resident was scheduled for tramadol 50 mg tablet on 3/7/24 at 0800 AM and the administration time was documented at 08:39 AM by the nurse.</p> <p>An interview was conducted with the nurse (# 27) on 3/7/24 at 4:00 PM with the Director of Nursing (DON) present. The nurse stated to the survey team that she worked at the facility for approximately six years. The surveyor asked the nurse to explain the discrepancy of the tramadol 50 mg blister pack with 7 pills in the pack, the controlled drug receipt record for tramadol that was signed at 0900 as 1 tablet given with a remainder of 6 pills, and the audit report for 3/7/24 for Resident # 5 with Tramadol as administered by her at 8:39 AM. The nurse explained that she thought she gave the medication. She further explained that for controlled medications, she must open the locked narcotic drawer with a key to retrieve the medication and then return to sign the controlled drug receipt record after administration. She went on to say that Resident # 10 was given the afternoon dose of pregabalin but she failed to sign the controlled drug receipt record. The DON stated that it is the facility's policy to complete a medication error form and that one was completed by the nurse for the omission of Resident # 5's scheduled 0900 AM tramadol 50 mg dose. The DON stated that staff will be re-educated by themselves and the Assistant Director of Nursing (ADN).</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a subsequent meeting with the DON at approximately 5:20 PM, she provided the survey team with a copy of the medication error form, a completed pain assessment and a progress note indicating the resident #5 received the medication. The DON stated that although the resident denied complaints of pain, the physician was notified and ordered that the medication be given as the resident receives it once daily. The facility provided the survey team with a copy of staff education that was done on 3/7/24.</p> <p>All concerns were discussed at the time of exit on 3/8/24 at 1:30 PM.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42782</p> <p>Based on medical record review and interviews it was determined that the facility staff failed to generate a person-centered care plan for a resident who required assistance with dental care. This deficient practice was evident in 1(Resident #35) of 5 resident records reviewed for person centered care plans during the survey.</p> <p>The findings include:</p> <p>On 03/05/24 at 10:22 am during an interview with Resident #35 he/she verbalized needing to see the dentist.</p> <p>On 03/06/24 at 11:58 am the surveyor received copies of Resident #35's dental visits; the last dental visit was 05/25/23. Continued review revealed a 12/19/22 dental summary recommendation to assist the resident with teeth brushing. The surveyor reviewed the resident's care plans which revealed assisting the resident with tooth brushing was not included in the ADL care plan.</p> <p>On 03/06/24 at 3:26 pm during an interview Director of Nursing (DON) #2 verbalized the Minimum Data Set Coordinator(MDS) initiates the baseline care plan. Each team does their own care plans. Whatever triggers out has a care plan. Anything acute that happens the unit manager, Assistant Director of Nursing, or MDS Coordinator updates the care plan. DON #2 was made aware teeth brushing was not included on Resident #35's ADL care plan.</p> <p>On 03/07/24 at 11:24 am during an interview with Geriatric Nursing Assistant (GNA) #8 who verbalized Resident #35 brushes his/her own teeth. Sometimes the resident is afraid to brush their teeth because he/she says their teeth hurt and the nurse knows and they have been working with the resident for about a year.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>42782</p> <p>Based on medical record review and interview it was determined that the facility staff failed to have quarterly care plan meetings. This deficient practiced was evidenced in 1 (#73) of 3 resident records reviewed for care plan meetings during the survey.</p> <p>The findings include:</p> <p>On 03/05/24 at 12:32 pm a review of Resident #73's electronic medical record (EMR) revealed the last care plan meeting was held 09/02/23.</p> <p>On 03/05/24 3:05 pm during an interview with Social Worker #7 revealed care plan meetings are held quarterly and as needed. Social worker #7 receives a list monthly of residents whose care plans meeting are due. They usually have the meetings on Tuesday. An invite is sent the week beforehand to the responsible party (RP) and resident. They set-up a time either on the phone or in person. Therapy, Activities, Social Services and the resident's Responsible party usually attends the meetings and Nursing will come if available. Afterwards they sign the attendance form. Social worker #7 advised she is working on getting all the care plan meetings done.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>49304</p> <p>Based on a review of the medication administration audit record (MAAR) and interview with facility staff, it was determined the facility staff failed to document after administering medications to residents. This was evident for 1 (Residents #32) of 6 residents reviewed for timely medication administration.</p> <p>The findings include:</p> <p>The surveyor reviewed the MAARs for Resident #32 on 3/7/24 at 2:07 PM for the period of 3/1/24 to 3/6/24. The MAAR is a document that shows the time that a medication is documented as being administered when staff documents it in the computer. Upon review of the MAAR, Resident #32's medications were documented as administered late.</p> <p>The surveyor interviewed Licensed Practical Nurse (LPN #23) on 3/6/24 at 3:50 PM, who was identified as documenting medication administration late. During the interview, when asked about medication administration for Resident #32 on 3/4/24, they had omeprazole scheduled for 8:00 AM and the documented administration time in the MAAR was 3/4/24 at 11:44 AM. LPN #23 stated the resident did get their medication on time, it is usually just a documentation error, meaning she did not put it in [document the medication] at the time she gave it, but she did give it. LPN #23 stated that medications should be signed off when the medication is given.</p> <p>Review of the facility's policy titled, Policy 5.3 General Guidelines for Medication Administration, on 3/6/24 at 3:22 PM revealed #14 of the facility policy which stated, Return to the medication cart and document medication administration with initials on the medication administration record (MAR) immediately after administering medication to each resident.</p> <p>On 3/6/24 at 4:00 PM, in an interview with the Director of Nursing (DON), she stated the standard of practice is to document the medication after it is administered.</p> <p>The DON, Regional DON, and Administrator were made aware of all concerns at the time of survey exit on 3/8/24 at 1:30 PM.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>30440</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to: 1.) ensure that a resident (#5) received a scheduled dose of medication as ordered by the physician; 2.) ensure medications were signed off on the controlled drug receipt/disposition form after being administered to a resident (#10). This was evident during a medication drug storage review and narcotic review and reconciliation for 1 of 3 medication carts; and 3) administer scheduled medications to residents at the physician ordered time (Resident #32, Resident #23, Resident #42). This was evident for 3 (Residents #32, #23, #42) of 6 residents reviewed during a medication administration observation</p> <p>Findings include:</p> <p>1. During a review of a medication cart on the Osprey Unit with nurse (#27), a Licensed Practical Nurse (LPN) on 3/7/24 at 2:30 PM, the following concerns were identified while reviewing the narcotic drawer:</p> <p>a. The nurse counted the medication blister pack of Tramadol Tablet 50 mg for Resident # 5. There were 7 pills observed inside of the blister pack. At that time the surveyor and the nurse reviewed the controlled drug receipt record/disposition form. There was an entry on 3/7/24 at 0900 indicating that 1 tablet was given and 6 tablets were left with, a signature entry by the nurse.</p> <p>b. The nurse counted the medication blister pack of Pregabalin Capsule 100 mg for Resident # 10. There were 29 pills observed inside the blister pack. At that time the surveyor and the nurse reviewed the controlled drug receipt record/disposition form. There was an entry on 3/7/24 at 0800 indicating that 1 tablet was given and 30 tablets were left with a signature entry by the nurse.</p> <p>On the same date at 2:55 PM an interview was conducted with Resident # 5 who was sitting up in bed in their room, and the resident was asked if s/he was having any pain and the resident stated, no.</p> <p>At 3:10 PM on the same date, the survey team requested and received a medication administration audit report for Resident # 5 and Resident # 10. The audit report is a report that shows the time that a medication is documented as being administered when staff documents it in the computer. Review of the audit report for Resident # 5 revealed the resident was scheduled for tramadol 50 mg tablet on 3/7/24 at 0800 AM and the administration time was documented at 08:39 AM by the nurse. Further review of the audit report for Resident # 10 revealed the resident was scheduled for Pregabalin 100 mg tablet at 1400 PM and the administration time was documented as administered at 13:39 PM by nurse.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the nurse (# 27) on 3/7/24 at 4:00 PM with the Director of Nursing (DON) present. The nurse stated to the survey team that she worked at the facility for approximately six years. The surveyor asked the nurse to explain the discrepancy of the tramadol 50 mg blister pack with 7 pills in the pack, the controlled drug receipt record for tramadol that was signed at 0900 AM as 1 tablet given with a remainder of 6 pills, and the audit report for 3/7/24 for Resident # 5 with tramadol as administered by her at 8:39 AM. The nurse explained that she thought she gave the medication. She further explained that for controlled medications, she must open the locked narcotic drawer with a key to retrieve the medication and then return to sign the controlled drug receipt record after administration. She went on to say that Resident # 10 was given the afternoon dose of pregabalin but she failed to sign the controlled drug receipt record. The DON stated that it is the facility's policy to complete a medication error form and that one was completed by the nurse for the omission of Resident # 5's scheduled 0900 AM tramadol 50 mg dose. The DON stated that staff will be re-educated by themselves and the Assistant Director of Nursing (ADN).</p> <p>During a subsequent meeting with the DON at approximately 5:20 PM, she provided the survey team with a copy of the medication error form, a completed pain assessment and a progress note indicating the Resident #5 received the medication. The DON stated that although the resident denied complaints of pain, the physician was notified and ordered that the medication be given as the resident receives it once daily. The facility provided the survey team with a copy of staff education that was done on 3/7/24.</p> <p>All concerns were discussed at the time of exit on 3/8/24 at 1:30 PM.</p> <p>49304</p> <p>2. Omeprazole is used to treat certain conditions where there is too much acid in the stomach. Your stomach contents are only supposed to travel one way, down. When acid from your stomach flows up into your esophagus (the tube that runs from your stomach up through your chest to your throat) and throat, it is called acid reflux. If you have chronic acid reflux, that is a condition known as gastroesophageal reflux disease (GERD). Stomach acid irritates and inflames the tissues inside your esophagus and throat. Omeprazole works by inhibiting (or preventing) the production of acid in the stomach. It should be taken before a meal and preferably in the morning. Food can delay how quickly omeprazole is absorbed by the body and can delay the inhibitory effects that help to ease acid reflux symptoms.</p> <p>During a medication administration observation that took place on 3/6/24 at 10:38 AM, the surveyor observed Licensed Practical Nurse (LPN #23) administer medications to Resident #32. The medications included one capsule of Omeprazole 20mg (milligrams) and one puff of Fluticasone-Salmeterol 250-50 mcg/act (micrograms/actuation).</p> <p>Review of the medical record on 3/6/24 at 11:31 AM for Resident #32 revealed that Resident #32's Omeprazole was scheduled to be administered at 8:00 AM; it was observed being administered at 10:38 AM.</p> <p>3. On 3/6/24 at 10:43 AM, LPN #23 was observed administering medications to Resident #23. During the administration, LPN #23 was observed giving one tablet of Seroquel 50mg to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor reviewed Resident #23's medical record on 3/6/24 at 12:18 PM. The review revealed that Resident #23's Seroquel was scheduled to be administered at 8:00 AM; it was observed being administered at 10:43 AM.</p> <p>4. On 3/6/24 at 10:48 AM, LPN #23 was observed dispensing Resident #42's medications, Seroquel 50mg and Celexa 10mg, into a medication cup, putting both tablets into a pill crusher located on top of the medication cart, crushing the tablets together, and pouring the crushed medications into a different medication cup filled with pudding. During this process, LPN #23 stated she crushes both medications together and mixes them with pudding because if she does not, Resident #42 will spit them out. The crushed medications mixed with the pudding were then administered to Resident #42 with a spoon.</p> <p>The surveyor reviewed Resident #42's medical record on 3/6/24 at 1:54 PM. The review revealed that Resident #42's Seroquel was scheduled to be administered at 8:00 AM; it was observed being administered at 10:43 AM.</p> <p>The DON, Regional DON, and Administrator were made aware of all concerns at the time of survey exit on 3/8/24 at 1:30 PM.</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>21859</p> <p>Based on medical record review and staff interviews, it was determined the physician failed to evaluate a resident with a change in condition in a timely manner. This was evident for 1 of 6 sampled residents (Resident #24) during the survey.</p> <p>The findings include:</p> <p>During observation rounds on Quail Unit on 3/4/24 at 9am, Resident #24 stated, s/he had a terrible a sore throat. S/he stated, I told the nurse.</p> <p>During a follow up visit on 3/5/24 at 10am the resident stated, My throat is still sore, and I want to see the doctor. This surveyor observed the Nurse Practitioner (NP) (staff # 21) sitting at the desk on Quail Unit at 10:15am on 3/5/24. This surveyor informed staff #21 of the resident complaint. She stated, I will add the resident to my list of residents to see.</p> <p>On 3/6/24 at 10:30am during an interview with the Unit Manager (staff #14) she was asked why the resident complaint of sore throat was not addressed on 3/4/24. She stated that Resident #24 did not tell the nurse that s/he had a sore throat.</p> <p>On 3/5/24 at 1pm during an interview with the NP staff #21 stated she was in the facility on Monday 3/4/24 and saw the resident because the nurse told her the resident had a sore throat. She stated she went to the resident room; however, the resident was receiving am care by the GNA (Geriatric Nursing Assistant). She stated she told the resident that she would return later; however, she became busy and did not get to see the resident on Monday 3/4/24.</p> <p>Review of the medical record on 3/5/24 at 1:30pm revealed the resident had been seen by staff #21 NP on 3/5/24 and medication ordered were written.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>49304</p> <p>Based on medication administration observation, medical record review and staff interview, it was determined that the facility staff failed to ensure a medication error rate of less than 5% during the medication observation facility task. This was evident for 5 of 27 medications administered during the observation which resulted in an error rate of 18.52%.</p> <p>The findings include:</p> <p>1. During a medication administration observation that took place on 3/6/24 at 10:38 AM, the surveyor observed Licensed Practical Nurses (LPN #23) administer medications to Resident #32. The medications included one capsule of Omeprazole 20mg (milligrams) and one puff of Fluticasone-Salmeterol 250-50 mcg/act (micrograms/actuation). LPN #23 failed to provide instructions to Resident #32 regarding rinsing the mouth after administration, and Resident #32 did not rinse his/her mouth after receiving the dose.</p> <p>Review of the medical record on 3/6/24 at 11:31 AM for Resident #32 revealed a physician order dated 1/30/23 for Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated, Give 1 puff by mouth two times a day for shortness of breath (sob) rinse mouth after administering. Further review revealed that Resident #32's Omeprazole was scheduled to be administered at 8:00 AM; it was observed being administered at 10:38 AM.</p> <p>2. On 3/6/24 at 10:43 AM, LPN #23 was observed administering medications to Resident #23. During the administration, LPN #23 was observed giving one tablet of Seroquel 50mg to the resident.</p> <p>The surveyor reviewed Resident #23's medical record on 3/6/24 at 12:18 PM. The review revealed that Resident #23's Seroquel was scheduled to be administered at 8:00 AM; it was observed being administered at 10:43 AM.</p> <p>3. On 3/6/24 at 10:48 AM, LPN #23 was observed dispensing Resident #42's medications, Seroquel 50mg and Celexa 10mg, into a medication cup, putting both tablets into a pill crusher located on top of the medication cart, crushing the tablets together, and pouring the crushed medications into a different medication cup filled with pudding. During this process, LPN #23 stated she crushes both medications together and mixes them with pudding because if she does not, Resident #42 will spit them out. The crushed medications mixed with the pudding were then administered to Resident #42 with a spoon.</p> <p>The surveyor reviewed Resident #42's medical record on 3/6/24 at 1:54 PM. The review revealed that Resident #42's Seroquel was scheduled to be administered at 8:00 AM; it was observed being administered at 10:43 AM. Furthermore, Seroquel is a medication that appears on the Do Not Crush List.</p> <p>Review of the facility's policy titled, Policy 5.3 General Guidelines for Medication Administration, on 3/6/24 at 3:22 PM revealed Number 1 in the Notes section which stated, Refer to Do Not Crush List prior to crushing any medication for assurance that it can be pulverized and Number 2 that stated, Refer to medication reference test for administration of any medication when added to or mixed with any substance to facilitate administration, (e.g. applesauce, juice, milk, etc).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Resorts at Chester River Manor Corp		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Morgnec Road Chestertown, MD 21620	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 3/6/24 at 2:17 PM, she was made aware that LPN #23 administered Resident #32's Omeprazole late. She stated, I did an in-service way back when and told them [the staff] they have to give the medications on time.</p> <p>4. During a second medication administration observation that took place on 3/7/24 AM at 9:05 AM, the surveyor observed LPN #24 administer medications to Resident # 191. While preparing the medications which included Folic Acid 1mg, Magnesium 400mg, Potassium 10mg, and Thiamine 100mg LPN #24 dropped the Potassium Chloride 10 mEq (Milliequivalent) tablet onto the top of the medication cart. He then picked up the tablet with an ungloved hand and placed it into the medication cup.</p> <p>In an interview at the medication cart with LPN #24 and the DON on 3/7/24 at 9:25 AM, the DON was asked by the surveyor what is the expectation for nurses regarding touching a medication with any part of their finger or hand, she stated no matter how much you've sanitized or cleaned your hands, you [nurse] cannot touch a medication with any part of your fingers or hand or take it off the top of the medication cart without gloves. She stated to LPN #24, this is your in-service. I'll get you to sign later and have the Assistant Director of Nursing (ADON) observe you.</p> <p>Review of the facility's policy titled, Policy 5.3 General Guidelines for Medication Administration, on 3/6/24 at 3:22 PM revealed Number 5, A), b. which stated, Never touch any of the medications with fingers.</p> <p>The DON and Administrator were made aware of all concerns at the time of survey exit on 3/8/24 at 1:30 PM.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42782</p> <p>Based on the medical record review and staff interview it was determined the facility failed to keep complete and accurate medical records. This deficient practice was evident in 7 of 20 (#37, #42, #58, #5, #10, #77, #24) resident during the survey.</p> <p>The findings include:</p> <p>1. During observation rounds on 03/05/24 at 11:21 am Resident #37 made the surveyor aware his/her wheelchair was too large and the wheelchair cushion was too small.</p> <p>On 03/06/24 at 9:51 am during an interview with Director of Rehabilitation #18, he/she verbalized the rehab staff measures the wheelchair to make sure it's a proper fit. When asked if the facility provided the resident with a wheelchair, he/she verbalized needing to check and follow-up.</p> <p>On 03/06/24 at 1:06 pm the surveyor received documentation from Rehab Director #18 which was an occupational therapy evaluation for Resident #37. Rehab Director #18 verbalized the resident's wheelchair and cushion were appropriate for Resident #37 when discharged from rehab services. Upon review of the documentation the surveyor noticed the form did not indicate the resident's wheelchair or cushion were evaluated. Rehab Director #18 verbalized giving the surveyor the wrong form.</p> <p>On 03/07/24 at 11:44 am during an interview with Director of Rehab #18, he/she verbalized after doing an investigation, the therapist did not feel seating and positioning was warranted at that time. Resident #37's wheelchair came from a fleet of wheelchairs. The resident will be evaluated to see if the wheelchair is appropriate. The process is the therapist assesses the resident and makes sure the wheelchair fits and they work on mobility. Director of Rehab #18 was unable to provide documentation the resident's wheelchair was assessed to be appropriate for Resident #37.</p> <p>2. On 03/05/24 at 10:42 am while reviewing Resident #42's medical record the surveyor noticed Section A of the resident's PASSAR was completed but there was not a signature indicating who completed Section A.</p> <p>On 03/05/24 at 3:52 pm during an interview with Social Worker #7 he/she verbalized Section A of Resident #42's assessment should have been signed. Social Worker #7 revealed they started going through the resident's files to update them but did not have the opportunity to review every file thus far and the files of the residents who were admitted since Social Worker #7 started working at the facility were up to date.</p> <p>3. On 03/05/24 at 12:15 pm the surveyor received a copy of Resident #58's transportation request form which was stamped with the date 12/13/23. Review of the transportation request revealed the form was not signed or dated by the staff.</p> <p>On 03/05.24 at 1:27 pm Director of Nursing #2 was made aware the transportation request form was not signed or dated by the staff who completed the form. Director of Nursing #2 made the surveyor aware the person who completed the form must have forgotten to sign and date the form.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>30440</p> <p>4. During a review of a medication cart on the Osprey Unit with nurse (#27), a Licensed Practical Nurse (LPN) on 3/7/24 at 2:30 PM, the following concerns were identified while reviewing the narcotic drawer:</p> <p>The nurse counted the medication blister pack of Tramadol Tablet 50 mg for Resident # 5. There were 7 pills observed inside of the blister pack. At that time the surveyor and the nurse reviewed the controlled drug receipt record/disposition form. There was an entry on 3/7/24 at 0900 indicating that 1 tablet was given and 6 tablets were left with a signature entry by the nurse.</p> <p>5. The nurse counted the medication blister pack of Pregabalin Capsule 100 mg for Resident # 10. There were 29 pills observed inside the blister pack. At that time the surveyor and the nurse reviewed the controlled drug receipt record/disposition form. There was an entry on 3/7/24 at 0800 indicating that 1 tablet was given and 30 tablets were left with a signature entry by the nurse.</p> <p>An interview was conducted with the nurse (# 27) on 3/7/24 at 4:00 PM with the Director of Nursing (DON) present. The nurse stated to the survey team that she worked at the facility for approximately six years. The surveyor asked the nurse to explain the discrepancy of the tramadol 50 mg blister pack with 7 pills in the pack, the controlled drug receipt record for tramadol that was signed at 0900 as 1 tablet given with a remainder of 6 pills, and the audit report for 3/7/24 for Resident # 5 with tramadol as administered by her at 8:39 AM. The nurse explained she thought she gave the medication and that medications are to be signed off after administration to the resident. She confirmed the Tramadol 50 mg was signed off on the controlled drug receipt form as being administered for Resident #5 but was not given. The nurse went on to say that she failed to sign the controlled drug receipt form after administering Pregabalin 100 mg capsule to Resident # 10 at 13:39. The DON stated that re-education will be provided to staff.</p> <p>All concerns were discussed with the Administration team on 3/8/24 at 1:30 PM at the time of exit.</p> <p>48167</p> <p>6. A Subjective, Objective, Assessment and Plan (SOAP) note is a method of structured documentation that healthcare providers use to document that resident/patient visits were completed.</p> <p>Review of resident #77's medical record on 03/06/2024 at 12:05 PM revealed that on 01/31/2024 a visit was completed with resident (#77) by nurse practitioner (#15) and an electronic SOAP note was used to document this resident encounter. The electronic SOAP note stated that resident (#77) was on no known medications and resident (#77) but was on medications at the time of the visit.</p> <p>During an interview on 03/06/24 at 02:58 PM nurse practitioner (#21) was made aware that the electronic SOAP note stated that resident (#77) was on no known medications and resident (#77) but was on medications at the time of the visit. The nurse practitioner (#21) stated that the electronic system does not allow for resident's medications to be listed and needs to be corrected. The Director of Nursing was present during the interview with nurse practitioner (#21).</p> <p>21859</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Seroquel is an Antipsychotic medication. It can treat schizophrenia, bipolar disorder, and depression.</p> <p>Review of the Resident #24's medical record on 3/6/24 at 10am revealed the resident was admitted to the facility in February of 2024 with diagnosis that included dementia with moderate agitation. A care plan was initiated on 2/24/24 for cognitive impairment. According to the care plan the resident was receiving Seroquel for mood/behavioral.</p> <p>Continued review of the medical record revealed a MAR (Medication Administration Record) for February and March of 2024, that indicated the diagnosis for Seroquel was depression.</p> <p>During an interview with the DON (Director of Nursing) on 3/6/24 at 1pm, she stated the diagnosis for the Seroquel was entered incorrectly on the MAR. The medication is being administered for psychosis with behavioral disturbances.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49304</p> <p>Based on medication administration observation and staff interview, it was determined that the facility staff failed to adhere to infection control practices and guidelines to prevent and control transmission of infectious agents during medication administration. This was evident for 2 of 27 medications administered during the medication administration observation.</p> <p>The findings include:</p> <p>1. During a medication administration observation that took place on 3/6/24 at 10:48 AM, Licensed Practical Nurse (LPN #23) was observed dispensing Resident #42's medications, Seroquel 50mg and Celexa 10mg, into a medication cup, putting both tablets into a pill crusher located on top of the medication cart, crushing the tablets together, and pouring the crushed medications into a different medication cup filled with pudding. During this process, LPN #23 stated she crushes both medications together and mixes them with pudding because if she does not, Resident #42 will spit them out. The surveyor did not observe the nurse clean the tablet crusher after its use nor for the remainder of the medication administration observation.</p> <p>Review of the facility's policy titled, Policy 5.3 General Guidelines for Medication Administration, on 3/6/24 at 3:22 PM revealed Number 5 in the Notes section which stated, Tablet Crusher should be cleaned after each use per facility policy.</p> <p>2. During a second medication administration observation that took place on 3/7/24 at 9:05 AM, the surveyor observed LPN #24 administer medications to Resident # 191. While preparing the medications which included Folic Acid 1mg, Magnesium 400mg, Potassium 10mg, and Thiamine 100mg, LPN #24 dropped the Potassium Chloride 10 mEq (Milliequivalent) tablet onto the top of the medication cart. He then picked up the tablet with an ungloved hand and placed it into the medication cup.</p> <p>In an interview at the medication cart with LPN #24 and the DON on 3/7/24 at 9:25 AM, the DON was asked by the surveyor what was the expectation for nurses regarding touching a medication with any part of their finger or hand, she stated no matter how much you've sanitized or cleaned your hands, you [LPN #24] cannot touch a medication with any part of your fingers or hand or take it off the top of the medication cart without gloves. She stated to LPN #24, this is your in-service. I'll get you to sign later and have the Assistant Director of Nursing (ADON) observe you.</p> <p>Review of the facility's policy titled, Policy 5.3 General Guidelines for Medication Administration, on 3/6/24 at 3:22 PM revealed Number 5, A), b. which stated, Never touch any of the medications with fingers.</p> <p>The DON, Regional DON, and Administrator were made aware of all concerns at the time of survey exit on 3/8/24 at 1:30 PM.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</b></p> <p>Based on medical record review and interviews it was determined that the facility staff failed to offer and administer the pneumococcal vaccine to a resident. This deficient practice was evidenced in 1 (#40) in 5 resident records reviewed for immunizations during the survey.</p> <p>The findings include:</p> <p>According to the Center for Disease Control website, there are certain risk conditions that warrant an individual to receive the pneumonia vaccine for adults ages of 19 - [AGE] years of age. These conditions are but not limited to alcoholism or cigarette smoking, chronic liver disease, Diabetes Mellitus, chronic heart disease (including CHF &amp; cardiomyopathies), decreased immune function from disease or drugs, and chronic lung disease, including COPD, emphysema, and asthma.</p> <p>On 03/07/24 at 4:50 pm the surveyor reviewed the facility's immunization report which revealed Resident #40 received the Pneumococcal Conjugate 13 vaccine on 06/26/12. The surveyor reviewed the resident's electronic medical record (EMR) which revealed the resident did not receive another pneumococcal vaccine after [AGE] years.</p> <p>On 03/07/24 at 5:30 pm The surveyor received and reviewed the facility's policy for resident immunizations which included pneumococcal vaccine. The policy indicated the pneumonia vaccine would be offered to all residents and a consent/declination form would be completed and maintained in the medical record. If a resident declines the vaccine, they would be offered the vaccine again later. Resident #40 did not have a consent or declination form in the paper medical record or EMR for the pneumococcal vaccine.</p> <p>On 03/08/24 at 7:45 am a review of Resident #40's diagnoses revealed the resident had a history of Diabetes Mellitus, alcohol abuse, and Viral Chronic Hepatitis C which makes him/her a candidate to receive the pneumococcal vaccine according to the CDC guidelines.</p> <p>On 03/08/24 at 10:21 am during an interview with Assistant Director of Nursing/Infection Preventionist #10 who verbalized when a resident is admitted their immunizations are reviewed. If the resident does not have an immunization they are offered the vaccine. If the resident declines a declination form is completed and added the EMR in Point Click Care (PCC) and she does a report to keep track of who needs a vaccine.</p> <p>On 03/08/24 at 12:04 pm during an interview with Assistant Director of Nursing/Infection Preventionist #10 when the surveyor asked why Resident #40 did not receive the pneumococcal vaccine, he/she verbalized Resident #40 did not receive the vaccine because he/she is not 65 or over and the facility follows the CDC guidelines. The surveyor asked if the resident was offered the vaccine and declined, Assistant Director of Nursing/Infection Preventionist #10 responded, no.</p>		