STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225315	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands, The	335 Nichols Road Fitchburg, MA 01420

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect the Resident's status for one Resident (#162) out of three applicable residents. Specifically, the MDS failed to accurately reflect that Resident #162 was discharged home. Findings include: Resident #162 was admitted to the facility in April 2024, with diagnoses that included traumatic arthropathy (a degenerative joint condition that can occur after an injury to the joint) of the left hip. Review of Resident #162's Nurses Progress Note dated 5/10/24, indicated that the Resident had been discharged home on the same day (5/10/24). Review of Resident #162's Discharge Summary assessment dated [DATE], indicated that the Resident had been discharged home. Review of Resident #162's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was discharged to a short-term hospital. During an interview on 7/23/24 at 3:16 P.M., the MDS Nurse said that the MDS had been inaccurately coded and should have marked the Resident as discharged home.

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

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

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F 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. 50138 Based on interview, record and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for one Resident (#29) out of a total sample size of 31 residents. Specifically, the facility staff failed to develop and implement timely a comprehensive person-centered care plan specific to required care and services for Resident #29 when the Resident was discharged from and then readmitted to the facility. Findings include: Review of facility's policy titled Comprehensive Care Plans and Revisions dated 8/22/23, indicated the following: -It was the facility's policy to ensure the timeliness of each resident's person-centered, comprehensive care plan .and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his/her care. -Comprehensive care plans must be developed within 7 days after completion of the comprehensive assessment. Resident #29 was readmitted to the facility in June 2024, with diagnoses including Diabetes (disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood), Asthma (a condition where the airways become inflamed and narrow making it difficult to breathe) and Congestive Heart Failure (CHF- caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs). Review of Resident #29's clinical record indicated the following: -The Resident had a previous admission to the facility in May 2024 to June 2024. -The most recent comprehensive assessment had been completed on 5/13/2024. -The Resident was readmitted to the facility in June 2024 (within 24 hours). -No evidence the facility staff had developed and implemented a comprehensive person-centered care plan after Resident #29 was readmitted to the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/24 at 4:52 P.M., MDS Nurse #1 said Resident #29's care plan had been deleted from the medical record when the Resident was discharged from the facility on 6/13/24. MDS Nurse #1 said Resident #29 was only discharged overnight and returned to the facility the day after discharge, therefore Resident #29 was classified as an interrupted stay. MDS Nurse #1 said Resident #29's comprehensive person-centered care plan should have been created on the date the Resident was readmitted to the facility. During an interview on 7/23/24 at 7:20 A.M., MDS Nurse #1 said Resident #29 did not have a comprehensive person-centered care plan in place from 6/14/24 through 7/21/24. MDS Nurse #1 said the comprehensive person-centered care plan should have been in place to ensure proper delivery of care and services to meet Resident #29's needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on interview, policy and record review, the facility failed to provide services according to professional standards of practice relative to medication administration for two Residents (#51 and #13) out of a total sample of 31 residents. Specifically, the facility staff failed to: 1. Administer Pantoprazole Sodium (prescription medication used to treat heartburn [burning, stabbing, or squeezing sensation in the chest, nausea] and conditions caused by too much acid in the stomach) to Resident #51 when the Pantoprazole Sodium was ordered by the Physician, was available to be administered, and the Physician was not notified of the missed doses of Pantoprazole Sodium, which increased the Resident's risk for discomfort. 2. Administer Lidocaine (topical [application to body surfaces such as skin or mucous membranes] medication used to treat symptoms of pain) External Patches to Resident #13 when the Lidocaine External Patches were ordered by the Physician, and were available to be administered, which increased the Resident's risk for experiencing pain. Findings include: Review of the facility's policy titled Administration of Medications dated 4/24/19, and revised 8/24/23, indicated the following: -The facility will ensure medications are administered . per Physician order to address residents' diagnoses and signs and symptoms. Review of the facility's policy titled Medication Shortages/Unavailable Medications, dated 12/1/07 and revised 1/1/22, indicated the following: -If a medication shortage is identified at the time of medication administration, facility staff should immediately take action to notify the Pharmacy. -The facility Nurse should document the missed dose and the explanation for such missed dose on the Medication Administration Record (MAR) . and in the Nurse's notes . -Such documentation shall include: a description of the circumstances of the medication shortage, a description of the Pharmacy's response upon notification, and actions taken. 1. Resident #51 was admitted to the facility in August 2021, with a diagnosis of gastroesophageal reflux disease (GERD: condition in which stomach acid repeatedly flows back up into the tube [esophagus] connecting the mouth and stomach resulting in irritation of the esophagus and heartburn) and Dementia (loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's clinical record indicated the following active Physician's order, initiated 4/11/24 with no stop date: -Pantoprazole Sodium Oral Suspension, give 10 milliliters (ml) by mouth two times a day for heartburn/GERD, 2 milligrams (mg)/1 ml dosing for total of 20 mg per dose. Further review of the Physician's order indicated the Pantoprazole Sodium Oral Suspension was stored in the refrigerator. Review of a Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident's speech was unclear. -The Resident rarely/never made him/herself understood. -Staff assessment of the Resident's cognitive patterns indicated the Resident was severely cognitively impaired. Review of Resident #51's June 2024 MAR indicated the ordered dose of Pantoprazole Sodium Oral Suspension was not administered to the Resident for: -one of two ordered doses on 6/13/24. -two of two ordered doses on 6/16/24. -one of two ordered doses on 6/20/24. Further review of the Resident's June 2024 MAR indicated the doses were not administered due to other/see progress note. Review of Resident #51's June 2024 Progress Notes indicated on the Orders Administration Notes that the ordered Pantoprazole Sodium Oral Suspension was not administered on the following dates due to being unavailable: -once on 6/13/24 -twice on 6/16/24 -once on 6/20/24 Further review of the June 2024 Progress Notes indicated no evidence that the Pharmacy was contacted regarding the Resident's Pantoprazole Sodium Oral Suspension being unavailable and what action was taken. Review of Resident #51's Monthly Pharmacy Review dated 6/30/24, indicated a recommendation: -that education be provided to staff that the Resident's Pantoprazole Sodium Oral Suspension was stored in the refrigerator and had been documented as unavailable. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-to make sure the Prescriber was aware of missed doses. Review of Resident #51's July 2024 MAR indicated the ordered dose of Pantoprazole Sodium Oral Suspension was not administered to the Resident for: -two of two ordered doses on 7/4/24. -one of two ordered doses on 7/16/24. -one of two ordered doses on 7/17/24. Further review of the Resident's July 2024 MAR indicated the doses were not administered due to other/see progress note. Review of Resident #51's July 2024 Progress Notes indicated on the Orders Administration Notes that the ordered Pantoprazole Sodium Oral Suspension was not administered on the following dates due to being unavailable: -twice on 7/4/24 -once on 7/16/24 -once on 7/17/24 Further review of the July 2024 Progress Notes indicated no evidence the Pharmacy was contacted regarding the Resident's Pantoprazole Sodium Oral Suspension being unavailable and what action was taken. 2. Resident #13 was admitted to the facility in March 2024, with diagnoses including Osteoarthritis (common form of degenerative arthritis found in the joints that can cause inflammation and result in pain, stiffness, and loss of mobility) and Dementia. Review of Resident #13's Pain Care Plan, initiated 3/23/24, and revised 4/2/24, indicated Pain meds (medications) as ordered. Review of Resident #13's active Physician's order, initiated 3/24/24, with no stop date, indicated the following: -Lidocaine External Patch 4% (Lidocaine), Apply to knee topically one time a day for pain. Review of Resident #13's March 2024 through June 2024 MARs indicated that the ordered dose of Lidocaine was not administered to the Resident on the following dates (a total of 10 days): -3/31/24. -4/4/24, 4/5/24, 4/10/24, 4/19/24, and 4/21/24. -5/13/24 and 5/20/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/11/24 and 6/20/24. Review of Resident #13's Orders Administration Notes for March 2024 through June 2024, indicated the Resident's Lidocaine Patch was not administered on: -3/31/24, 4/4/24, and 4/10/24 - due to medication pending arrival. -4/5/24, 4/19/24 and 4/21/24 - with no description of why the medication was not administered. -5/13/24, 5/20/24, 6/11/24, and 6/20/24 - due to the medication being unavailable. Further review of the Resident's Orders Administration Notes indicated no information to what actions were taken relative to Lidocaine Patches being unavailable for administration to Resident #13. During an interview on 7/19/24 at 11:48 A.M., with Unit Manager (UM) #2 and the Physician, UM #2 said staff did not administer the doses of Pantoprazole Sodium Oral Suspension as ordered for Resident #51 on the dates indicated above. UM #2 said Pantoprazole Sodium had never been unavailable for Resident #51 since it had been ordered by the Physician, that the medication was stored in the refrigerator because it was in liquid form and required refrigeration. UM #2 said the Physician's order specified that the medication was stored in the refrigerator to alert Nurses at the facility that they needed to obtain the medication from the refrigerator to administer it to the Resident. UM #2 further said the Nurse should have obtained the Pantoprazole Sodium Oral Suspension from the refrigerator and administered it to the Resident as ordered. UM #2 also said Lidocaine Patches were ordered as house stock and were available on all Units and in the facility's Central Supply storage room, and if there were no Lidocaine Patches in the medication cart at the time of administration, the Nurse should have obtained the Lidocaine Patches either from the Medication Room or the Central Supply storage room. UM #2 said if medication was unavailable, the Nurse would be required to contact the Pharmacy, and if the medication was unable to be obtained from the Pharmacy, the Nurse would be required to notify the Physician of the missed dose(s) and obtain new orders. During an interview at the time, the Physician said he did not recall ever having been notified of any missed doses of Pantoprazole Sodium Oral Suspension for Resident #51. The Physician further said that he takes his own calls for residents whose care he supervised on the Unit, so staff at the facility were expected to contact him to make him aware of missed medications. The Physician further said he was not the Physician who supervised Resident #13's care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/19/24 at 1:30 P.M., Nurse #1 said Resident #51's Pantoprazole Sodium Oral Suspension was stored in the refrigerator in the Medication Room on the Unit. Nurse #1 also said Lidocaine Patches were not ordered for specific residents but were ordered as house stock and were stored in the Medication Rooms on the Units and in the Central Supply storage room. At the time, the surveyor and Nurse #1 observed the Unit's Medication Room refrigerator and storage cabinet. The surveyor observed that the refrigerator contained Resident #51's bottle of Pantoprazole Sodium Oral Suspension which was approximately two thirds full, and the storage cabinet contained several boxes of unopened Lidocaine Patches. Nurse #1 said she had never been aware of a time when Resident #51's ordered Pantoprazole Sodium Oral Suspension was unavailable for administration. Nurse #1 further said she was not aware of any time Lidocaine Patches were not available to administer to Resident #13. Nurse #1 also said that the Nursing Supervisor always had access to the facility's Central Supply storage room, so if house stock medications were not available on the Units, the Nursing Supervisor could obtain the house stock medications from the Central Supply storage room. On 7/19/24 at 4:45 P.M., the surveyor and the Director of Nursing (DON) observed the facility's Central Supply storage room where the surveyor observed several unopened boxes of Lidocaine Patches on a shelf. During an interview at the time, the DON said Nurses administering medications were expected to adhere to the facility's policies relative to medication administration and missed medication doses.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, record review and interview, the facility failed to provide care and services according to professional standards for one Resident (#143) out of a total sample of 31 Residents, who had an indwelling urinary catheter (Foley Catheter/Foley - a tube placed through the urethra into the bladder to drain urine) and had been identified as being at risk for developing a urinary tract infection (UTI- an infection of the urinary system caused by bacteria entering the body through the urethra). Specifically, 1) The facility staff failed to change the indwelling urinary catheter according to professional standards of practice thereby increasing the risk of urinary infections for the Resident. 2) The facility staff failed to administer an antibiotic (medication that fights infection) to Resident #143 prior to changing an indwelling urinary catheter as ordered. Findings Include: Review of the 2009 Centers for Disease Contol (CDC) Healthcare Infection Control Practice Committee Guidelines last updated 6/6/19, indicated the folowing: -Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. -Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Review of the facility policy titled Indwelling Urinary Catheter (Foley) Maintenance Guidelines and Critical Notes last reviewed 8/24/23, indicated the following: -Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. -Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. -Inappropriate or unnecessary use of an indwelling urinary catheter can result in catheter associated urinary tract infection. Resident #143 was admitted to the facility in April 2023, with a diagnosis of Obstructive and Reflex Uropathy (condition when urine cannot drain through the urinary tract due to obstructed urinary flow which can cause back-up of urine into the kidneys). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #143 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of a total score of 15. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 9:36 A.M., the surveyor observed a urinary drainage bag hanging from Resident #143's bed. Review of the Physician's active orders dated 7/22/24 indicated the following: -Foley change monthly, every day shift starting on the 10th and ending on the 10th every month, -Levaquin (antibiotic) 750 mg (milligrams) prior to Foley change, initiated 5/27/24 -Levaquin oral tablet 750 mg, give 750 mg by mouth one time a day starting on the 28th of the month for Foley change, give Levaquin 750 mg prior to Foley change monthly, initiated 4/27/24 Review of the Treatment administration Record (TAR) dated 5/1/24 - 5/31/24 indicated that Resident #143's Foley catheter was changed on 5/27/24. Review of the Medication Administration Record (MAR) dated 5/1/24 -5/31/24 indicated Resident #143 had been administered Levaquin 750 mg by mouth at 9:00 A.M. on 5/28/24 (1 day after the Foley catheter was changed). Review of the Treatment administration Record (TAR) dated 6/1/24 - 6/30/24 indicated that Resident #143's Foley catheter was changed on 6/10/24 (14 days after the Foley catheter was previously changed). Review of the Medication Administration Record (MAR) dated 6/1/24 - 6/30/24 indicated Resident #143 had been administered Levaquin 750 mg by mouth at 9:00 A.M. on 6/28/24 (18 days after the Foley catheter was changed). Review of the Treatment administration Record (TAR) dated 7/1/24 - 7/31/24 indicated that Resident #143's Foley catheter was changed on 7/10/24 (one month after the Foley catheter was previously changed). Review of the Medication Administration Record (MAR) dated 7/1/24 - 7/31/24 indicated that Resident #143 was scheduled to be administered Levaquin 750 mg by mouth at 9:00 A.M. on 7/28/24. Further review of the May 2024, June 2024 and July 2024 TAR and MAR records did not indicate that Resident #143 had been administered Levaquin 750 mg prior to changing the Foley catheter as ordered on the following dates: -5/27/24 -6/10/24 -7/10/24 Review of Resident 143's Physician and Nursing Progress Notes in the clinical record provided no evidence that the routine Foley catheter changes that were performed on 5/27/24, 6/10/24, and 7/10/24, were based on clinical indications such as infection, obstruction or a compromised closed drainage system. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/24 at 9:32 A.M., Unit Manager (UM) #1 said there was a Physician's order in place to change Resident #143's Foley catheter routinely on the 10th of every month and an order for Levaquin 750 mg to be administered prior to changing the Foley catheter. UM #1 said that the Levaquin administration was documented on the MAR and the Foley catheter change was documented on the TAR. UM #1 said she was unsure why Resident #143 required monthly Foley catheter changes and said the Levaquin was ordered to be given a few hours prior to each Foley catheter change to help prevent infections because Resident #143 had frequent UTI's. During a review at the time of Resident 143's May 2024, June 2024 and July 2024 MARs and TARs, UM #1 said that Resident #143 had not been administered Levaquin 750 mg as ordered prior to Foley catheter changes on 5/27/24, 6/10/24 and 7/10/24. UM #1 said the Resident should have been administered the Levaquin to prevent him/her from developing a UTI.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50563 Based on observation and interview, the facility failed to maintain safe and sanitary conditions for two nourishment kitchens (Fifth Floor and Third Floor [Garden Terrace]) out of four applicable nourishment kitchens to prevent contamination and the spread of food borne infections. Specifically, 1. The facility failed to maintain the toaster in the Fifth Floor nourishment kitchen in a safe and sanitary manner. 2. The facility failed to maintain clean and sanitary conditions for the ice machine in the Third Floor nourishment kitchen. Findings include: Review of the facility's policy titled Ice Machines, dated 7/16/21 and revised 6/3/24, indicated the following: -Ice machines should be maintained in a clean and sanitary state . -Countertop ice makers sit on top of a counter and may also dispense water via touch control. 1. On 7/23/24 at 8:38 A.M., the surveyor observed that the Fifth Floor nourishment kitchen toaster had a buildup of crumbs and a butter packet wrapper inside the toaster. On 7/23/24 at 2:06 P.M., the surveyor observed that the Fifth Floor nourishment kitchen toaster still remained with a buildup of crumbs and a butter packet wrapper inside the toaster. During an interview on 7/23/24 at 3:32 P.M., Corporate Nurse #1 said the staff did not have a policy specific to cleaning of the kitchenettes. During an interview on 7/23/24 at 4:13 P.M., the Housekeeping Supervisor said that housekeeping cleaned the unit nourishment kitchens daily. The Housekeeping Supervisor further said that housekeeping cleaning included cleaning the outside of the ice machines and removing crumbs and debris from the toasters. 42761 2. On 7/23/24 at 1:25 P.M., the surveyor observed the following in the Garden Terrace Unit nourishment kitchen: -A countertop water and ice dispenser on top of the counter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The grate over the water and ice dispenser's drain pan had areas that were coated with dried white debris and rust. -The bottom of the drain pan contained areas of brown, black and white debris. -The outer edges of the touchless dispenser indicator (area on the front of the water and ice dispenser used to improve sanitation when retrieving ice or water) were surrounded by dried white debris. -There were two areas of white debris that extended from under the spout (where ice and water are dispensed), down the front of the ice and water dispenser. -Crusty, dried white buildup of debris was observed where the spout was attached to the water and ice dispenser. During an interview on 7/23/24 at 1:28 P.M., Certified Nurses Aide (CNA) #1 said staff on the Unit used the countertop water and ice dispenser every day to provide residents on the unit with ice and water. During an interview on 7/23/24 at 1:30 P.M., Unit Manager (UM) #2 said Housekeeping staff were responsible for cleaning the Unit nourishment kitchen, including the outer surfaces of the ice machine. During an interview on 7/23/24 at 1:35 P.M., the Housekeeping Supervisor said Housekeeping staff were responsible for cleaning the Unit nourishment kitchens. The Housekeeping Supervisor said there was no written cleaning schedule, list of items to be cleaned, or cleaning logs maintained for the Unit Nourishment Kitchens and that the Housekeeping staff knew what was supposed to be cleaned. The Housekeeping Supervisor said the Housekeeping staff were required to clean the outside areas of the countertop water and ice dispenser daily. The surveyor and the Housekeeping Supervisor observed the countertop water and ice dispenser in the Garden Terrace Unit nourishment kitchen at the time. The Housekeeping Supervisor said the front outer surfaces of the countertop water and ice dispenser had areas of dried debris that should have been cleaned. The Housekeeping Supervisor also said these areas of debris looked like they had been there for a while and that the countertop water and ice dispenser had not been cleaned thoroughly. The Housekeeping Supervisor further said it was important to ensure the countertop water and ice dispenser was clean to prevent bacterial growth, so that residents could safely consume water and ice from the dispenser.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225315	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands, The	335 Nichols Road Fitchburg, MA 01420

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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** 50563 Based on interview, record and policy review, the facility failed to offer Pneumococcal Vaccinations for one Resident (#51), out of five applicable Residents, out of a total sample of 31 residents, putting the Resident at risk for developing facility acquired Pneumonia. Specifically, the facility failed to ensure that Pneumococcal Vaccination was provided to Resident #51 after obtaining consent from the Resident's Representative. Findings include: Review of the CDC (Centers for Disease Control) website: Pneumococcal Vaccine for Adults greater than or equal to [AGE] years, https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-schedule-notes.html#note-pneumo indicated: -Adults aged >65 (greater than 65) years who have received both Pneumococcal Conjugate Vaccine 13 (PCV13) and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) according to previous Pneumococcal Vaccine recommendations but have not yet received a final dose of PPSV23 at age >[AGE] years are recommended to complete their Pneumococcal Vaccine series by receiving either a single dose of Pneumococcal Conjugate Vaccine 20 (PCV20) or PPSV23. >If PCV20 is selected, it can be administered at least 5 years after the last Pneumococcal Vaccine dose. >If PPSV23 is selected, it can be administered at an interval >1 year since the PCV13 dose and >5 years since the last PPSV23 dose. Review of the facility policy titled Influenza Vaccine and Pneumococcal Vaccine Policy for Residents dated 9/13/23, indicated but was not limited to: -Guidance to follow CDC recommendations for Pneumococcal Vaccination timing. -Education is provided to the resident and/or representative regarding benefits and side effects or risks and a consent form is signed. -If, based on the Nurse's assessment contraindications are not noted, the Pneumococcal Vaccine is administered per Physician standing orders. Resident #51 was admitted to the facility in August 2021, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease that causes restricted airflow from the lungs and difficulty breathing), Emphysema (a chronic lung condition where air is abnormally present in the lungs causing shortness of breath) and was over the age of 65. Review of Resident #51's Massachusetts Immunization Information System (MIIS) record indicated Unspecified Pneumococcal Vaccination on 10/1/10 and PCV13 vaccination on 4/26/19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Review of Resident #51's vaccination consents indicated Pneumococcal consent dated 8/19/21, requesting Pneumococcal Vaccination. Review of the Resident's July 2024 Physician's orders indicated an order dated 6/4/24, to give Pneumococcal Vaccine per CDC guidelines. Review of the Resident's clinical record did not indicate that the Resident had received any additional doses of Pneumococcal Vaccination. During an interview on 7/23/24 at 3:25 P.M., Corporate Nurse #1 said Resident #51 should have received the PCV20 vaccination. Corporate Nurse #1 further reviewed the clinical record and said she was unable to find evidence that the Resident had received the PCV20 vaccination.