STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Crest Health Center	2824 North 66th Avenue Omaha, NE 68104

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04 (F)(i)(5) Based on record review and interview, the facility staff failed to notify the physician of a missed dialysis appointment for 1 of 1 residents (Resident 54). The facility identified a census of 150. Findings are: Record review of Resident 54's Census Sheet revealed an admitted [DATE] to the facility and had the diagnoses of Renal Dialysis Record review of Resident 54's Minimum Data Set (MDS, a federally mandated assessment tool used for care-planning) dated 5/8/2024 revealed Resident 54 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) with a score of 15. According to the MDS [NAME] a score of 13 to 15 indicates a person is cognitively intact. Resident 54 required set up/clean up assist with eating, substantial/maximum assist with bed mobility and toileting, and was dependent for transfers and had the diagnosis of renal insufficiency, renal failure, End Stage Renal Disease (ESRD). Record review of Resident 54's Care Plan revealed a Focus dated 6/11/2021 Resident 54 needs dialysis and on Hemodialysis as evidenced by End Stage renal failure. Record review of Resident 54's Progress Notes dated 7/8/2024 revealed Resident 54 did not get Hemodialysis and that staff would reschedule the treatment. On 7/08/2024 at 9:05 AM an interview was conducted with Resident 54. During the interview Resident 54 reported their appointment had been cancel due to canceled as the dialysis center did not have enough staff and was rescheduled. A interview on 7/10/2024 at 2:12 PM was conducted with the Director of Nursing (DON). During the interview the DON confirmed Resident 54 had missed a dialysis appointment and that Resident 54 practitioner had not been notified and should have been. Record review of the policy Change of Condition dated 4/2023: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policy Statement -It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative according to their authority and reported to the attending physician or delegate (hereafter designated as the physicians). The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by staff. -Objective of the notification of change policy The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment, and preferences to address the changes. -Purpose The facility shall promptly notify the resident and/or the resident representative and his or her physician or delegate of changes in the resident condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident right to make choices about treatment and care preferences. -Procedure: 1. The nurse will immediately notify the resident, resident's physician, and the resident representative for the following: a. An accident involving the resident, which results in injury and has the potential for requiring physician intervention, b. A significant change in the resident physical, mental, or psychosocial status is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complications. c. A need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment. d. A decision to transfer or discharge the resident from the facility. 2. The nurse will notify the resident, resident physician, and the resident representative of non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. 3. Document the notification and record any new orders in the resident medical record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Educate the resident and/or representative about the proposed plan to treat, manage, or monitor the resident change in condition. 5. Educated the resident and/or resident representative about the risks and benefits of the proposed treatment change and provide an opportunity for the resident to make an informed choice of the treatment or alternative that they prefer. Communicate the resident's preference to the provider if it differs from the provider's proposed plan. 6. Update the resident's care plan, transcribe, and implement the provider's orders. 7. Communicate the changes to the staff on the oncoming shift.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12.006.02(H) Based on record review and interview, the facility failed to complete a thorough written investigation and report an allegation of staff to resident abuse within the required timeframe to the Department of Health and Human Services [DHHS] for 1 (Residents 143) of 3 facility self-report investigations reviewed. The facility census was 150. Findings are: Record review of 2 facility policies entitled Abuse Investigations and Abuse Reporting dated August 2006 revealed the following information: Abuse Investigations: 1. When the incident or suspected incident of resident abuse, neglect, or injury of unknown source is reported, the administrator will appoint a staff member to investigate the incident. 2. The person conducting the investigation will, as a minimum: a. An interview with the person reporting the incident. b. Interviews with any witnesses to the incident. c. An interview with the resident. d. An interview with the attending physician when deemed appropriate and a review of the residents' medical record. e. Am interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident. f. Interviews with the residents roommate, family members, visitors g. Interviews with other residents to which the accused employee provides care or services. h. A review of all circumstances surrounding the incident. 12. The results of the investigation will be kept with the abuse file in the SS [social services] office and remain confidential. 13. A copy of the completed Resident abuse investigation report form will be provided to the administrator within 5 working days of the reported incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14. Upon completion of the investigation or sooner if necessary, the abuse investigation committee will convene to review all necessary information concerning all allegations of abuse. 16. The results of all investigations and report shall be faxed or emailed to the State survey and certification agency (Nebraska DHHS) within 5 days of the notification of the allegations. Abuse reporting: # 9. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to the facility management regardless of the time lapse since the incident occurred. # 14. In accordance with the Elder Justice Act, the facility administrator or designee will immediately notify, but not later than 2 hours after the allegation is made if the events that caused the allegation involved result in serious bodily injury or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, the following persons or agencies of such incident as applicable: a. The state licensing / certification agency responsible for surveying the facility. b. The state / local Ombudsman c. The resident's representative d. Adult Protective Services e. Law Enforcement f. The residents attending physician g. The facility Medical Director #16: The Administrator / designee will provide the Department of Health and Human Services - Health Facility Investigations a written report of the findings of the investigation within 5 business days of the occurrence of the incident. Record review of Resident 143's significant change Minimum Data Set (MDS, a clinical assessment of the resident used to develop a comprehensive plan of care) dated 6/11/24 revealed an admitted [DATE] with diagnoses that included adult failure to thrive, Diabetes Mellitus, Alzheimer's disease and Parkinson's. The MDS identified that Resident 143 had a BIMS (Brief interview Mental Status, a brief screener that aids in detecting cognitive impairment) score of 10 (indicated moderate cognitive impairment), lower extremity impairment with walker and wheelchair use, substantial to maximum assist with lower body dressing, putting on/taking off footwear and sitting to lying on the bed. Record review of an Adult Protective Services [APS] report dated 1/12/24 revealed that facility staff had called in an allegation of staff to resident abuse against Resident 143 on 1/12/24 at 4:20 PM. The APS report revealed that the facility reporter stated that Resident 143 had reported to staff a week ago that a male caregiver had gotten upset and slammed [gender] feet on the bed. The event was reported to have happened on 1/5/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/08/24 at 09:50 AM with Resident 143 revealed that Resident 143 had no memory of any negative instances that involved staff. Resident 143 was unable to remember any incident in which staff had slammed [gender] legs onto the bed. Record review of all facility reportable incidents since January 1st 2024 revealed that no incidents that involved Resident 143 had been reported to APS or DHHS. Record review of Resident 143's Electronic Medical Record Progress Notes since January 1st 2024 revealed no written record of any incidents with staff or reports to the facility Social Worker [SW] of alleged abuse. Interview on 07/08/24 at 02:21 PM with the facility Administrator confirmed that no written investigation had been completed or a 5-day report sent into DHHS within 5 working days. Interview on 07/10/24 at 10:43 AM with SW A confirmed that Resident 143 had been interviewed by SW A on 1/12/24 about the allegation and APS was called to report the allegation of staff to resident abuse. SW A confirmed that a written investigation had not been completed and an investigation report had not been sent into DHHS within 5 working days.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 Licensure Reference Number NAC 12-006.09 (B) Based on record review and interview, the facility failed to accurately identify Special Treatments in Section O-Special Treatments, Procedures, and Programs on the Minimum Data Set (MDS, a federally mandated assessment tool used for care-planning) for 2 (Residents 54 and 122) of 30 reviewed. The facility staff identified a census of 150. Findings are: A. Record review of Resident 54 Census Sheet revealed an admitted [DATE] to the facility with the diagnoses of Dependence on Renal Dialysis. Record review of Resident 54's MDS dated [DATE] revealed the Resident 54 had renal insufficiency, renal failure, End Stage Renal Disease (ESRD) marked on the MDS. Section O, Question J 1 Dialysis revealed the MDS was not coded for Dialysis treatment. A interview on 07/10/24 at 2:38 PM was conducted with the MDS Coordinator. During the interview the MDS Coordinator confirmed the MDS dated [DATE] should have had Section O-Question J 1 marked for Dialysis While a Resident and was not. B. Record review of Resident 122's Census Sheet revealed a readmitted [DATE] to the facility. The Census Sheet also revealed that on 4/15/24 Resident 122 started on Hospice Services. Record review of Resident 122's Order Summary revealed an order for Hospice dated 4/15/2024. Record review of Resident 122's MDS dated [DATE] revealed Under Section O-Special Treatments, Procedures, and Programs question K 1 Hospice Care was not marked. A interview on 07/10/24 at 2:38 PM, with MDS Coordinator confirmed the MDS dated [DATE] should have had Section O-Question K 1 marked for Hospice While a Resident.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Based on record review and interview, the facility failed to ensure a new PASRR (Pre-Admission Screening and Resident Review, a screening to determine the presence of a mental illness or intellectual disability) referral had been completed after a diagnosis of a mental disorder was identified for 1 (Resident 57) out of 3 reviewed for PASRR screens. The facility census was 150. Findings are: Record review of a facility policy entitled Admissions and PASRR update policy dated 5/25/23 revealed the following information: 4. PASRR process: - a. Screening: The discharging hospital or nursing home staff or designated PASRR coordinator shall conduct an initial screening of all individuals seeking admission to determine if there is a reasonable suspicion of serious mental illness, intellectual or developmental disabilities, or both. Screening may involve a review of medical records, assessments, and interviews with the individual or their authorized representative. Re-screens or status updates of residents may be necessary due to changes in condition, new diagnoses, or other situational circumstances that warrant re-evaluation by the screening agency. Record Review of Resident 57's PASRR Level 1 screen with a determination date of 4/18/17 revealed the following information: The level 1 screen conducted for this individual determined that there was no evidence to suggest the presence or known conditions of mental illness, intellectual disability, or a condition related to intellectual disability, As such, no further level 1 screening is required unless the individual is later suspected or found to have a mental illness or intellectual disability condition. Record review of Resident 57's annual MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 5/4/24 revealed that Resident 57 was admitted on [DATE]. Section A1500 for PASRR revealed that Resident 57 was not considered by the State level PASRR process to have a serious mental illness or intellectual disability or a related condition. The MDS identified that Resident 57 had a BIMS (Brief interview for mental status, a screener to determine level of cognitive impairment] score of 3 which indicated severe cognitive impairment. The MDS identified diagnoses that included non-Alzheimer's dementia, traumatic brain injury, anxiety, depression, Post Traumatic Stress Disorder, and major depressive disorder. Record review of Resident 57's Diagnoses List revealed that Resident 57 received the following new psychiatric diagnoses on the following dates: - 9/28/20: adjustment disorder with depressed mood - 8/4/21: generalized anxiety disorder (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/1/22: vascular dementia, moderate, with other behavioral disturbance - 11/4/22: Post Traumatic Stress Disorder - 1/13/23: major depressive disorder Record review of Resident 57's Electronic Medical Record revealed that a referral for a new PASRR had not been completed since 4/18/17. Interview on 07/10/24 at 05:52 AM with the facility Administrator confirmed that Resident 57 had received several new psychiatric diagnoses since admission on 4/26/17 and that a referral for a new PASRR screening had not been made to determine whether further evaluation through a level 2 screen was required.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Based on record review and interview, the facility failed to accurately complete a Level I PASARR screen (PASARR, a federally mandated screening process to ensure Nursing Home residents will mental illness and/or developmental disabilities receive the care and services they need in the most appropriate setting) for 1 (Resident 23) of 2 sampled residents. The facility census was 150. Findings are: Record Review of PASARR screen dated 05/04/2018 revealed Resident 23 was assessed as having no diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual Disability or Related Condition (ID/RC). Record Review of Facility's Diagnosis Report for Resident 23 revealed the following admission diagnoses which would have triggered a Level II screen: -Vascular Dementia, mild, with mood disturbance -Moderate intellectual disabilities -Major Depressive Disorder, recurrent, moderate -Generalized Anxiety Disorder -Unspecified Psychosis not due to a substance or known physiological condition Record Review of Resident's 23 medical record revealed no other completed PASARR screens since 05/04/2018. Record review of Medication Administration Record for 07/01/2024 thru 07/31/2024 revealed the following medical conditions: -Mild Cognitive Impairment of uncertain or unknown etiology, Moderate Intellectual Disability, Unspecified Psychosis not due to a substance or known physiological condition, Major Depressive Disorder-recurrent and moderate, Generalized Anxiety Disorder, Vascular Dementia- mild with mood disturbance. Interview on 07/10/24 at 8:17 AM with Administrator confirmed the PASARR completed on 05/04/18 for Resident 23 was not accurate and if the initial PASARR was completed correctly that a Level II PASARR would have triggered for further review. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Admissions and PASRR update Policy with Dated Implemented: 03/05/2022 and Date Reviewed/Revised: 05/25/2023 revealed Policy statement: This policy outlines the Pre-Admission Screening and Resident Review (PASRR) process for determining the appropriateness of admission to a nursing home. The PASRR process is designed to identify individuals with a serious mental illness ([NAME]), intellectual or developmental disabilities (IDD) or both, and ensure they received the necessary specialized services and appropriate placement in accordance with federal regulations and state guidelines.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49164 Licensure Reference Number 175 NAC 12.006.09(H)(i)(3) Based on observation, interview, and record review the facility failed to provide position changes and incontinence care for 1 (Resident 33) of 4 residents. The facility census was 150. Findings are: Record Review of Resident 33's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 05-27-2024 revealed Resident 33 had the diagnosis of Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), Lewy body Dementia (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood.), Schizophrenia (Schizophrenia is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and Depression. The MDS also indicated Resident 33 was not able complete a Brief Interview of Mental Status (BIMS, an assessment that aids in detecting cognitive impairment), was incontinent of bowel and bladder and was dependent on facility staff for eating, oral hygiene, bathing, dressing, toileting, bed mobility and transfers. Record Review of Resident 33's Care Plan (CP) printed on 07-09-2024 revealed facility staff were to assist Resident 33 with position changes and skin care every 2 hours and to check incontinence brief every 3 hours. A continuous observation on 07-10-2024 from 8:15 AM to 12:15 PM of Resident 33 revealed no provision of assistance with position changes or incontinence care. An observation on 07-10-2024 at 2:30 PM of Nurse Aid (NA) D and NA E assisting Resident 33 into bed and providing incontinent care revealed Resident 33's incontinent brief was wet. An interview on 07-10-2024 at 2:38 PM with NA D and E confirmed that Resident 33 was not repositioned or provided with incontinence care from 8:15 AM until 2:30 PM. An interview conducted on 07-10-2024 at 2:45 PM with Licensed Practical Nurse (LPN) D confirmed Resident 33's normal routine is to be checked for incontinence between breakfast and lunch and was to be transferred to bed after lunch and checked for incontinence care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.09(I)(i)(1) Based on observations, record review and interviews, the facility failed to implement assessed interventions to prevent skin injuries for Resident 105 and falls for Resident 63. A total of 4 residents were reviewed for accident prevention. The facility census was 150. Findings are: A. Record review of Resident 105's annual Minimum Data Set (MDS) (a federally mandated comprehensive assessment tool used for care planning) dated 4/7/24 identified an admitted [DATE]. The MDS Identified that Resident 105 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 5 which indicated severe cognitive impairment. The MDS identified that Resident 105 exhibited inattention and disorganized thinking, physical and verbal behavioral symptoms, and rejection of care 1-3 days per week, required wheelchair use for ambulation, required substantial to maximum assistance with transfers from the bed to the wheelchair and had no alterations in skin condition. Diagnoses included depression, vascular dementia, and age-related osteoporosis. Record review of Resident 105's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 4/24/24 identified the following concerns for Resident 105: Problem: Potential for alteration in skin integrity related to frequent reopening of an area to the left shin, potential for shear and friction occurring during bed mobility and transfers, her skin is thin and fragile, history of skin tears, she is on Xarelto [a blood thinner medication that increases risk of bruising] which has to potential for bruising and bruises easily. Braden assessment [a skin risk assessment to determine level of risk for skin concerns] score of 17. [This was an indication of high risk for skin concerns.] Interventions included: - Rooke [a soft protective boot that surrounds the leg and foot to protect the skin] boot to LLE while up and with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility investigation that involved Resident 105 dated 2/8/24 revealed that on 2/3/24 Resident 105 received an injury / skin tear to the lateral left side of the leg while being transferred from the wheelchair to the bed. The resident was immediately assessed, the wound cleaned, and the resident was sent to the hospital for further treatment. The resident returned to the facility with staples to the lateral left leg. The facility investigation revealed that Resident 105 had a similar incident in August 2022 with the leg area being at risk and split and reopened at that time with sutures required. The facility investigation revealed that Resident 105's family were aware of the risk to the left leg and that it had been an ongoing issue since 2020 when the resident had a hematoma [Bruise] that wouldn't resolve. The family stated that was why the area was discolored and had opened many times in the past. The facility identified interventions after the incident 2/3/24 as follows: - Due to the fragility of [Resident 105's] skin on the left leg, a [NAME] boot will be placed and [Resident 105] will be given a new wheelchair. [Resident 105] will also be assessed by therapy to see if [gender] can propel herself in a wheelchair. - Order was received for therapy for wheelchair mobility. Record review of Resident 105's Physician Orders revealed the following dated orders: 2/5/24: Rooke Boot to left lower extremity [LLE] while up and with transfers. 2/7/24: OT [Occupational Therapy] to evaluate for wheelchair. Interview on 07/10/24 at 11:50 AM with Social Worker [SW] J revealed that an order was received for a referral for therapy for the wheelchair but that this order was never communicated to OT and never got done. Observations of Resident 105 on the following dates and times revealed the following; - 07/08/24 12:52 AM: Resident seated in a wheelchair in the main dining room, no Rooke boot present on the left leg. - 07/8/24 1:00 PM: Rooke boot laying on the floor in Resident 105's room at the foot of the bed. - 07/09/24 11:45 AM; Resident not in room. Rooke boot laying on the floor. - 07/09/24 11:55 AM: Resident in lobby area in wheelchair. No Rooke boot in place on the left leg. - 07/9/24 2:00 PM: seated in wheelchair in the therapy gym participating in an activity. No [NAME] boot on left leg. - 07/9/24 2:06 PM: Rooke boot on the floor in room - 07/10/24 8:06 AM: Resident seated in the dining room waiting for breakfast. No Rooke boot on the left leg. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 07/10/24 10:13 AM: Resident seated in activity area by nurses' station. No Rooke boot in place on left leg. - 07/10/24 10:20 AM: Rooke boot on the floor in room. - 07/10/24 12:00 PM: Observation with the facility Administrator: Observed Resident 105 not in room. Observed Rooke boot laying on the floor at the foot of the bed in the same position as all previous observations. Interview on 07/10/24 at 12:05 PM with the facility Administrator confirmed that the Rooke boot was laying on the floor at the foot of the bed and should be on Resident 105 when up and also for transfers to protect the left leg. Observation on 07/11/24 between 7:10 AM and 7:25 AM with Restorative Aide [RA] H and NA I revealed an observation of transfer from the bed to the wheelchair for Resident 105. The resident was seated on the edge of the bed with a walker in front of the resident. A Rooke boot was present on the left leg. NA I removed the Rooke boot and placed a shoe on the resident. RA H placed a gait belt on the resident, positioned the walker and assisted the resident to stand and pivot transfer to the wheelchair. NA I then placed the Rooke boot back onto the residents left leg. Interview on 07/11/24 at 07:26 AM with RA H confirmed that the Rooke boot was taken off during the transfer because the staff felt there was a potential for the resident to slip if the boot was in place during the transfer. 49164 the facility failed to implement assessed interventions for accidents with injury for resident 105 and 63. B. Record Review of Resident 63's MDS dated [DATE] revealed a BIMS score of 9 indicating moderate cognitive impairment. The MDS revealed Resident 63 had diagnosis of Parkinson's Disease, Lewy Body Dementia, Stroke, anxiety, and depression. The MDS also indicated Resident 63 required partial assistance from staff for bed mobility, personal and oral hygiene, and upper body dressing and required maximal assistance with toilet hygiene, showering, lower body dressing and transfers. Record Review of Resident 63's care plan dated 06-02-2023 revealed Resident 63 was at high risk for falls with a fall assessment score of 9 and the interventions the facility had put into place were: -03-01-2024 FALL: per resident report she was reaching for an item and slid out of the wheelchair. A piece of Dycem (a non-slip material that keeps objects from sliding) will be applied to the chair to prevent reoccurrence. -03-05-2024 FALL: Blue tape applied to the wall to indicate appropriate bed height and non-skid strips applied to the floor for increase grip. -06-06-2024 FALL: [NAME] will be assisted with morning cares and assisted to the main lounge by 630 am to prevent future occurrences. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03-15-2023 FALL: will offer toileting at 6:30 AM -06-14-2023 FALL: will place a sign on her wall for visual cues to remind her to use the call light for assistance A continuous observation on 07-11-2024 from 6:15 AM to 7:40 AM revealed Resident 63 was not assisted by staff until 7:20 AM when Nurse Aid (NA) L entered the room and assisted Resident 63 to the bathroom. This observation also revealed the absence of Dycem in the wheelchair, the absence of blue tape on the wall to indicate the appropriate bed height, and the absence of signage to remind resident to call for help. NA L took Resident 63 to the main lounge at 7:40 AM. During the continuous observation on 07-11-2024 from 6:15 AM to 7:40 AM, an interview was conducted with NA L which revealed NA L did not know to check for Dycem in Resident 63's wheelchair, and confirmed the absence of Dycem in the wheelchair, blue tape on the wall, and signage in the room to remind Resident 63 to use the call light. Record review of the facility Fall Policy and Procedure dated 01-29-2021 revealed under Evaluation Procedure: -A fall risk assessment will be done within the first 14 days of admission, readmission, annually and with a significant change to identify potential risk factors and fall history. -The completed fall risk assessment will be presented to the interdisciplinary care plan team to evaluate the information and to place the resident in low, moderate, or high-risk categories. -Once a resident has been identified as High Risk, the interdisciplinary care plan team will implement the 'Falling Star' program with increased interventions and an escalating plan of care and treatment that is designed to reduce risk of injury from any potential falls. -the Clinical Manager or designee and the interdisciplinary team will include fall risk in the care plan and include all interventions being used. An interview conducted with Licensed Practical Nurse (LPN) G, Clinical Manager on 07-11-2024 at 8:40 AM confirmed Resident 63 was not assisted and out of room in main lobby area by 6:30 AM, the Dycem was not in place in wheelchair, the blue tape was not on the wall near the bed, and signage was not posted to use call light.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Licensure Reference Number 175 NAC12-006.12E1 Based on observation, interviews, and record review, the facility failed to secure one medication for 1 (Resident 55) of 4 sampled residents and failed to secure a medication cart on the first floor. The facility identified a total of 102 residents resided on the first floor and identified 8 residents who were self-mobile and had poor safety awareness. The facility census was 150. Findings are: A. Record review of clinical census in resident's electronic medical record revealed Resident 55 admitted to the facility on [DATE] with diagnoses including: Chronic Obstructive Pulmonary Disease (a common lung disease causing restricted airflow and breathing problems), Congestive Heart Failure (a serious condition when the heart doesn't pump blood as well as it should), Chronic Kidney Disease (means a gradual loss of kidney function over time), Morbid (severe) Obesity due to excess calories (a complex chronic disease in which a person has a body mass index (BMI) of 40 or higher), Diabetes Mellitus with Diabetic Neuropathy (is nerve damage that can occur in people with diabetes), Altered Mental Status (is a symptom when there is a change in mental function that stems from an illness, disorder or injury affecting the brain), Schizoaffective Disorder (a serious mental illness that affects how a person thinks, feels and behaves), Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) , and Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A record review of the MDS (Minimum Data Set (MDS is a federally mandated standardize tool used to assess a resident's capabilities and to help determine a resident's care) dated March 12, 2024 for Resident 55 revealed a BIMS (Brief Interview for Mental Status is a screening tool used to identify the cognitive condition of a resident) score of 12, which indicates moderate cognitive impairment. An observation on 07/09/2024 at 11:16 AM revealed a white bottle sitting in the windowsill in Resident 55's room next to a nebulizer mask and tubing. The white bottle had a visibly worn prescription label of Miconazole 2% powder with Resident 55's name on it. One half of the container is empty and Date on the label is illegible. A record review on 07/09/2024 of Physician Orders for Resident 55 revealed no order for Miconazole Powder. An interview with the Director of Nursing (DON) on 07/09/2024 at 11:30 AM when shown the Miconazole Powder in the windowsill in Resident 55's room, confirmed that medications should not be kept unsecured in resident rooms. DON then removed the Miconazole Powder from Resident 55's room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. An observation of medication storage and medication carts with DON on 07/11/2024 between 7:00 AM and 7:20 AM revealed one medication cart, identified by staff as [NAME] East Treatment Cart, located in [NAME] Hallway near room [ROOM NUMBER] was unlocked. An interview with DON confirmed that all Medication and Treatment Carts should be locked when unattended. DON then locked the [NAME] East Treatment Cart. A record review of facility's Medication Storage policy dated 08/15/2023 revealed the Standard was: The facility must secure all medications in a locked storage area under proper temperature controls, and to limit access to authorized personnel consistent with state or federal requirement and professional standards of practice. #4 b revealed Medication Carts are locked when not in use or when unattended by authorized nursing personnel.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Licensure Reference Number 175 NAC 12-006.14 Based on observation, record review and interview, the facility failed to ensure 1 (Resident 55) of 1 sampled residents received follow up dental services. The facility census was 150. Findings are: An interview with Resident 55 was conducted on 07/08/2024 at 9:54 AM. During the interview, Resident 55 reported that they had no teeth, was seen and fitted for dentures in April (2024) and that they were still waiting for their dentures. A record review on 07/09/2024 of a Doctor Referral Form for Resident 55, dated 05/20/2024 revealed Resident 55 was seen by the dentist with the following notation tried in teeth in wax. Patient approved. Next Visit-Deliver Dentures. A review of Resident 55's medical record revealed there was not any evidence that the facility had any contact with the dentist from 05/21/2024 through 07/08/2024. An interview with facility's Social Worker (SW) on 07/09/2024 at 2:22 PM confirmed that the facility was unaware that Resident 55 hadn't received their dentures and that after calling the dentist, the dentures for Resident 55 would be delivered to the facility on [DATE]. Record review of facility policy labeled Dentures Policy and Procedure dated 2005 Med-Pass, Inc (Revised April 2007) revealed the following: Preface: This facility promotes and supports a resident centered approach to care. The purpose of this policy is to ensure that the facility has integrated a system for proper resident assessment and care with dentures and assisting the resident in obtaining necessary repair or replacement of damaged or lost dentures timely to meet the quality of care of the resident. In addition, the facility with outline the process and circumstances for responsibility for financial replacement of dentures. Policy: It is the policy of the facility to provide ongoing assessment an care of the resident with dentures. In the event that the resident's dentures are damaged or lost, the facility will refer the resident for dental services timely, within 3 days for an appointment, The resident will not be charges for the repair or replacement of dentures in the event that the loss or damage of dentures was incurred by facility staff.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50106 Licensure Reference Number 175 NAC 12-006.09B Based on observations, record review, and interviews, the facility failed to maintain the nutritive value of pureed food. This had the potential to affect 18 residents. The facility identified a census of 150. Findings are: Observation on 7/9/24 at 9:10 AM revealed [NAME] B scooped with a slotted spoon an indeterminate amount of cooked green beans into the blender. [NAME] B measured 2 teaspoons of salt and put it in the blender with the green bean. [NAME] B added 2 scoops of liquid butter to the blender and added boiling water of indeterminate amount. After this mixture was blended, [NAME] B added 4 ounces of thickener. Observation on 7/9/24 at 9:30 AM [NAME] B placed an indeterminate amount of cooked ground beef into the blender. [NAME] B added 2 scoops of country gravy and 2 cups of boiling water into the blender. After this mixture was blended, [NAME] B added 4 ounces of thickener. A interview was conducted on 7/10/24 at 8:40 AM with [NAME] B. During the interview [NAME] B reported having already pureed the meat for lunch. [NAME] B stated (gender) mixed 3 cooked turkey breasts with gravy (indeterminate amount) and 2 cups of boiling water. Observation of [NAME] C on 7/11/24 at 6:36 AM revealed [NAME] C added 10 cooked cheese omelets, 3 cups of boiling water, and 5 scoops of thickener and blended the mixture. [NAME] C then added an additional 2 scoops of thickener to the blended food. A interview on 07/11/24 at 7:19 AM, the Dietician confirmed the use boiling water in preparation of the pureed foods would not be appropriate. After tasting the pureed eggs prepared this AM the dietician stated the taste was not good. The Dietician confirmed 18 residents receive a pureed diet. Record review of recipe (undated) for pureed green and wax beans, turkey breast, and egg cheese omelets revealed the following: Green and Wax Beans The International Dysphagia Diet Standardization Initiative (IDDSI) is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and for all cultures. IDDSI Level 4: Pureed: measure desired number of servings into a food processor. Blend until smooth. Use the fork Drip Test or the Spoon Tilt Test to confirm texture is within IDDSI Level 4 specifications. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note: For any of the above modified texture diets: Add small amounts of gravy, sauce, vegetable juice, cooking water, fruit juice, milk, or half and half to meet desired consistency. Drain and discard any excess liquid that has separated from the solid food pieces. Add commercial thickener if product needs thickening. Based on type and amount of liquid/ thickener added in texture modification process, nutrition information may vary. Turkey Roast (3 Breast) IDDSI Level 4: Pureed: measure desired number of servings into a food processor. Blend until smooth. Use the fork Drip Test or the Spoon Tilt Test to confirm texture is within IDDSI Level 4 specifications. Note: For any of the above modified texture diets: Add small amounts of gravy, sauce, vegetable juice, cooking water, fruit juice, milk, or half and half to meet desired consistency. Drain and discard any excess liquid that has separated from the solid food pieces. Add commercial thickener if product needs thickening. Based on type and amount of liquid/ thickener added in texture modification process, nutrition information may vary. Egg Cheese Omelet IDDSI Level 4: Pureed: measure desired number of servings into a food processor. Blend until smooth. Use the fork Drip Test or the Spoon Tilt Test to confirm texture is within IDDSI Level 4 specifications. Note: For any of the above modified texture diets: Add small amounts of gravy, sauce, vegetable juice, cooking water, fruit juice, milk, or half and half to meet desired consistency. Drain and discard any excess liquid that has separated from the solid food pieces. Add commercial thickener if product needs thickening. Based on type and amount of liquid/ thickener added in texture modification process, nutrition information may vary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 LICENSURE REFERENCE NUMBER 178 NAC 1-005.06(D) Based on observation, record review and interview, the facility staff failed to perform hand hygiene and gloving to prevent cross contamination in 2 residents (Resident 122 and Resident 33) of a sample size of 30. The facility identified a census of 150. Findings are: A. Record review of Resident 122's Census Sheet revealed the resident was readmitted to the facility on [DATE]. Record review of Resident 122's Minimum Data Set (MDS, a federally mandated assessment tool used for care-planning) dated 4/21/2024 revealed a Brief Interview of Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) with a score of 6. A score of 6 indicated the resident was severely cognitively impaired. Resident required substantial/maximal assist with eating and was dependent for toileting, bed mobility, and transfers. Record review of Resident 122's Care plan revealed an intervention dated 3/5/2024 for catheter cares every shift. Care plan entry dated 5/3/2024 revealed a focus of Enhanced Barrier Precautions for Foley Catheter Care. Interventions for Enhanced Barrier Precautions included: -Green star on the wall front of the door near the room to alert staff of enhanced barrier precautions. -Ensure all staff members are proficient in hand hygiene practices, including handwashing with soap and water or using alcohol-based hand sanitizers. -Regularly assess the catheter site for signs of infection, such as redness, swelling, or discharge. -Encourage the resident to maintain good perineal hygiene. Provide assistance with hygiene as needed. -Ensure the resident bedding and clothing are kept clean and changed regularly to minimize the risk of contamination. -Use barrier precautions, such as disposable gowns when providing cares. -Monitor the resident's fluid intake and output to ensure adequate hydration and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary drainage. -Communicate any changes in the resident condition or catheter-related issues to the healthcare team promptly. Observation on 7/10/24 at 7:34 AM with the facility Director of Nursing (DON) of Nursing Assistant (NA)-M preparing to complete catheter care on Resident 122. NA-M completed hand hygiene with hand sanitizer then gowned and gloved. NA-M removed a positioning pillows from around the resident unhooked the tabs on the brief and pushed the dirty brief between Resident 122's legs NA-M wiped the catheter tubing from the penis away from the resident twice, using a clean peri-wipe each time. NA-M removed gloves and completed hand hygiene with hand sanitizer. The DON left the room to get the charge nurse,Licensed Practical Nurse (LPN)-N. LPN-N completed hand hygiene with hand sanitizer and then applied a gown and gloves and assisted NA-M with Resident 122's personal care. NA-M and LPN-N assisted the resident to roll to right side and LPN-N began doing peri-care at the anal area revealing each wipe LPN-N made removed bowel movement. After Resident 122's anal area was clean, LPN-N went to the hand sanitizer dispenser, put hand sanitizer on (gender) gloves, rubbed gloved hands together and then went to the bed to finish with Resident 122's cares. LPN-N with the same soiled gloves assisted NA-M with placed a clean brief on Resident 122 and touched Resident 122's blanket. Interview on 7/10/24 at 8:10 AM, LPN-N confirmed (gender) put hand sanitizer over (gender) gloved hands, rubbed hands together and continued to assist with peri-care and touched linen on the bed for Resident 122. Record review of Infection Control Guidelines for All Nursing Procedures revealed the purpose was to provide guidelines for general infection control while caring for residents. Preparation: 1. Prior to having direct-care responsibilities for resident, staff must have appropriate in-service training on general infection and exposure control issues, including: a. The facility protocols for isolation (standard and transmission-based precautions; b. The location of all personal protective gear; c. The location of medical waste disposal containers; d. The facility exposure control plan; and e. The facility protocol for occupational exposures to bloodborne pathogens. 2. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: a. Types of Healthcare-Associated Infections b. Methods of preventing their spread; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. How to recognize and report signs and symptoms of infection; and d. Prevention of the transmission of multi-drug resistant organisms. General Guidelines 1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. 2. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. 3. Employees must wash their hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents. b. When hands are visibly dirty or soiled with blood or other body fluids; c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; d. After removing gloves; e. After handling items potentially contaminated with blood, body fluids, or secretions; f. Before eating and after using a restroom; and g. When there is likely exposure to spores such as C. Difficile or Bacillus anthracis). 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents; b. Before donning sterile gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications; e. Before handling clean or soiled dressing, gauze pads, etcetera. f. Before moving from a contaminated body site to a clean body site during resident care; g. After contact with a resident's intact skin (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. After handling used dressings, contaminated equipment, etcetera; i. After contact with objects (for example medical equipment) in the immediate vicinity of the resident; and j. After removing gloves. 5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials. 6. In addition to these general guidelines, refer to procedures for any specific infection control precautions that may be warranted. 49164 B. Record Review of Resident 33's MDS dated [DATE] revealed Resident 33 had the diagnosis of Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), Lewy body Dementia (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood.), Schizophrenia (Schizophrenia is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and Depression. The MDS also indicated Resident 33 was not able complete a Brief Interview of Mental Status (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) was incontinent of bowel and bladder and was dependent on facility staff for eating, oral hygiene, bathing, dressing, toileting, bed mobility and transfers. An observation on 07-10-2024 at 8:15 AM of Nurse Aid (NA) E providing care to Resident 33 revealed NA E placed 3 washcloths in the bottom of the sink and turned the water on. After the washcloths were wet, NA E rung each one out and set them on the counter next to the sink., NA E brought the washcloths to the bedside and placed them in a clear plastic bag that was lying open on Resident 33's bed. NA E used the washcloths to provide perineal care (means washing the genitals and anal area) and to wash Resident 33's face. Record review of the facility policy Urinary Incontinence-Peri Care revealed a policy statement: It is the policy at Maple Crest to cleanse the perineal and rectal area of residents to prevent skin rash, skin breakdown, infection and odors. Under the Section Option 1: equipment needed gloves, wash basin, trash bag, soap and water, washcloth and towels, barrier ointment as designated. An observation on 07-10-2024 at 2:30 PM of NA E providing care for Resident 33 revealed NA E placed washcloths in the sink and ran water on them. After wringing out the washcloths, NA E placed the washcloths in a clear plastic bag on the bed. The washcloths were then used to perform perineal care for Resident 33. An interview on 07-10-2024 with NA E at 2:38 PM confirmed the washcloths were placed in the bottom of the sink, and the bottom of the sink could be contaminated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Crest Health Center	2824 North 66th Avenue Omaha, NE 68104

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) D on 07-10-2024 at 2:45 AM confirmed that by placing washcloths in the bottom of the sink could cause cross contamination.

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 - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 LICENSURE REFERENCE NUMBER 175 NAC 12-006.07(C) Based on record review and interview; the facility staff failed to identify and offer the Pneumococcal immunization to 4 (Resident 122, 138, 130, and 80) of 5 sampled residents. The facility staff identified a census of 150. Findings are: A. Record review of Facility Policy dated 8/2016 Pneumococcal Vaccine: Policy Statement: All residents will be offered Pneumococcal vaccines to aid in preventing pneumonia/Pneumococcal infections. Policy Interpretation and Implementation 1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Assessment of Pneumococcal vaccination status will be conducted within 5 days of the resident admission if not conducted prior to admission. 3. Before receiving a Pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the Pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. 4. Pneumococcal vaccines will be administered to the resident (unless medically contraindicated, already given, or refused) per our facility's physician-approved Pneumococcal vaccination protocol. 5. Resident/representatives have the right to refuse the vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of Pneumococcal vaccination. 6. For resident who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. 7. Administration of the Pneumococcal vaccines or revaccination's will be made accordance with current Centers for Disease Control Prevention recommendations at the time of the vaccination. B. Record review of Centers for Disease Control Prevention current Pneumococcal vaccination recommendations are as follows for adults [AGE] years or older: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Routine vaccination Administer Pneumococcal vaccine 15 (PCV15) or Pneumococcal Vaccine 20 (PCV20) for all adults [AGE] years or older. -Who have never received any Pneumococcal conjugate vaccine. -Whose previous vaccination history is unknown. Pneumococcal Vaccine 15 (PCV15): Additional vaccination needed. If Pneumococcal Vaccine 15 (PCV15) is used, administer a dose of Pneumococcal Polysaccharide 23 (PPSV23) one year later, if needed. PCV20: Additional vaccination not recommended. If PCV20 is used, a dose of PPSV23 isn't indicated. Recommendation for shared clinical decision-making: Based on shared clinical decision-making, adults [AGE] years or older have the option to get PCV20 if they have received both -PCV13 (but not PCV15 or PCV20) at any age and -PPSV23 at or after the age of [AGE] years old C. Record review of Resident 122 Diagnosis Sheet revealed Resident 122 was [AGE] years of age. Resident 122's diagnosis include: encounter for palliative care, congestive heart failure, hypertension, aortic valve stenosis, vascular dementia, and history of myocardial infarction (heart attack). Record review of Resident 122's immunization report dated 7/8/24 revealed there was no evidence the facility staff had identified and offered the Pneumococcal immunization to the resident. D. Record review of Resident 138 Diagnosis sheet revealed the resident was [AGE] years old. Resident 138's diagnosis include: chronic respiratory failure, adult failure to thrive, severe protein and calorie malnutrition, and Type II diabetes. Record review of Resident 138's immunization report dated 7/8/24 revealed there was no evidence the facility staff had identified and offered the Pneumococcal immunization to the resident. E. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 80 Diagnosis sheet revealed the resident was [AGE] years old. Resident 80's diagnosis include: cerebral infarction (stroke), vascular dementia, hypertension, type II diabetes, heart disease, and hypertension. Record review of Resident 80's immunization report dated 7/8/24 revealed there was no evidence the facility staff had identified and offered the Pneumococcal immunization to the resident. F. Record review of Resident 130 Diagnosis sheet revealed the resident was [AGE] years old. Resident 130's diagnosis include: Parkinson's disease, respiratory failure, neurocognitive disorder with Lewy body, dementia, severe protein-calorie malnutrition, hypothyroidism, osteoporosis, and anemia. Record review of Resident 130's immunization report dated 7/8/24 revealed there was no evidence the facility staff had identified and offered any additional Pneumococcal immunization to the resident. Resident 130 had received a PPSV23 on 12/3/2021. G. Interview on 7/11/24 at 2:15 PM, the Assistant Director of Nursing/Infection Preventionist Nurse confirmed there was no evidence the facility had offered or identified the need for the Pneumococcal vaccine for Resident 122, 138, and 80 and no additional Pneumococcal vaccine had been offered to Resident 130.