STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366127	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Health and Rehab Center	6831 North Chestnut Street Ravenna, OH 44266

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview, the facility failed to ensure Resident #94's discharge summary was signed, verifying receipt of discharge instructions. This affected one resident (Resident #94) of three reviewed for discharge process.Review of the closed medical record for Resident #94 revealed an admission date of 09/20/25 and a discharge date of 10/04/25. Diagnoses included foreign body in respiratory track, dysphagia, hypertension and anxiety.Review of the discharge Minimum Data Set 3.0 dated 10/04/26 revealed he was cognitively intact and required set-up to moderate assistance with activities of daily living.Review of the Discharge summary dated [DATE] revealed no evidence the resident or family member signed the discharge summary acknowledging wound care instructions as the form indicated a signature should be obtained.Interview on 04/01/26 at 10:13 A.M. with Registered Nurse (RN) #317 verified she did not obtain a signature on Resident #94's discharge summary.Interview on 04/01/26 at 1:39 P.M. with Divisional Director of Clinical Education revealed the facility audited discharge summaries after reviewing complaint involving Resident #94. She stated they discovered nurses were not obtaining signatures from residents or responsible parties on discharge summaries.This deficiency represents non-compliance investigated under Complaint Number 2667505.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #8's care plan was revised to indicate an accurate right buttock wound classification and failed to ensure Resident #50's care plan included individualized interventions to address her diagnosis of gastroesophageal reflux disease This affected one resident (Resident #8) out of three residents reviewed for pressure ulcers and one resident (Resident #50) out of four residents reviewed for medication administration. The facility census was 79.Findings include: 1.A review of Resident #8's clinical record revealed an admission date of 06/18/22 with diagnoses including congestive heart failure, atrial fibrillation (heart arrhythmia), atherosclerotic heart disease, anemia, high blood pressure and cholesterol, chronic kidney disease, polyneuropathy, diabetes mellitus, osteoarthritis, gout, restless leg syndrome, benign enlarged prostate and cognitive communication deficit.A review of Resident #8's plan of care initiated on 05/12/25 and edited on 01/09/26 indicated an alteration in skin integrity related to a surgical wound on the right buttocks. A review of Resident #8's wound assessment dated [DATE] indicated the right buttock wound was a pressure ulcer measuring 2.5 centimeters (cm) long by 2.5 cm wide with no depth measured. The right buttock wound was a stage III pressure ulcer which was originally identified on 05/08/25 and was surgically repaired and the classification was changed to a surgical wound but was still a pressure ulcer.An observation of Resident #8's wound treatment completed by Licensed Practical Nurse (LPN) #304 revealed Resident #8 had a pressure ulcer located on the sacrum and right buttock area. The right buttock area was approximately the size of a quarter and approximately one centimeter (cm) deep with red wound bed and no yellow slough or necrosis. Resident #8's surrounding skin was scarred and very red.An interview with Resident #8 on 03/31/26 at 4:28 P.M. revealed he had chronic pressure ulcers located on his buttock and sacral areas which had healed and re-opened several times over the past several years. Resident #8 stated he used a wheelchair and was unable to ambulate and staff assisted him with turning and repositioning to offload the wound areas. Resident #8 stated he had surgical repair of the right buttock pressure ulcer wound in the past but the pressure ulcer did not fully heal.An interview with Wound Registered Nurse (WRN) #309 on 04/01/26 at 8:19 A.M. verified the documentation on Resident #8's care plan had incorrect right buttock wound classification. WRN #309 stated the wound should be classified as a pressure ulcer instead of a surgical wound. WRN #309 agreed Resident #8's plan of care needed revised to indicate a pressure ulcer instead of a surgical wound.2. A review of Resident #50's clinical record revealed an admission date of 03/22/25 with diagnoses including chronic kidney disease, atherosclerotic heart disease, cerebral vascular disease with cerebral infarction (stroke), gastroesophageal reflux disease (GERD), diabetes mellitus, high blood pressure and cholesterol, and hypothyroidism.During medication administration on 03/31/26 at 8:10 A.M. Resident #50's son approached Licensed Practical Nurse #322 and informed her Resident #50 had vomited her medications into a napkin. LPN #322 stated she would check on Resident #50.A review of Resident #50's clinical record revealed no care plan was developed to address Resident #50's diagnosis of GERD. A care plan was initiated to address an increased risk for nutrition/hydration risk related to GERD and other diagnoses, but no specific interventions were initiated to address her reflux/vomiting of medications and risk for aspiration.An interview with LPN #337 on 04/01/26 at 7:17 A.M. revealed she had assessed Resident #50 after she completed the morning medication administration on 03/31/26 and found no negative findings. LPN #322 stated she informed Certified Nurse Practitioner (CNP) #392 that Resident #50 had vomited her medications but had not documented the notification in Resident #50's clinical record. LPN #322 verified there was no documentation in Resident #50's clinical record of the vomiting incident. LPN #337 stated Resident #50 often had reflux and would often have trouble swallowing food and medications due to her swallowing issues. LPN #322 stated (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNP #392 was present on the nursing unit at the time she was notified of Resident #50's vomiting her medication episode. LPN #322 stated CNP #392 had assessed Resident #50 but also verified there was no documentation that CNP #392 had assessed Resident #50 after the incident in Resident #50's clinical record.An interview with CNP #392 on 04/02/26 at 10:51 A.M. verified she was notified by LPN #337 that Resident #50 had vomited her undissolved medications in a napkin on 03/31/26. CNP #392 stated this was a common recurrence for Resident #50. CNP #392 stated she had assessed Resident #50 after the incident and found no negative outcome and no signs of aspiration. CNP #337 agreed she had not documented the incident in Resident #50's clinical record at the time she was notified or after she had assessed Resident #50.An interview with Regional Director of Clinical Service (RDCS) on 04/06/25 at 11:45 A.M. verified the above findings and agreed Resident #50's care plan did not had a care plan initiated to address her care needs regarding the diagnosis of GERD and individualized interventions were implemented to address Resident #50's risk of aspiration and reflux/vomiting her undissolved medications.This deficiency represents non-compliance investigated under Complaint Number 2688522.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide showers according to resident preferences. This affected two residents (Resident #9 and Resident #35) out of four residents sampled for activities of daily living. Findings include:1.Review of Resident #9's medical record revealed an admission date of 09/26/2023 with diagnoses that included stroke, type 2 diabetes mellitus, heart disease, heart failure, contracture (a shortening or stiffening of muscles, tendons, or skin that limits joint movement) of right hand, contracture of the thigh, contracture of the lower leg, and functional quadriplegia (inability to move the limbs and body from the neck down). Review of Resident #9's Activities Observation dated 12/09/25 revealed it was very important to choose between a tub bath, shower, bed bath, or sponge bath.Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed it was very important to choose between a tub bath, shower, bed bath, or sponge bath. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #9 was cognitively impaired, did not reject care, was dependent on staff for all activities of daily living, and was incontinent of bowel and bladder.Review of the care plan revealed Resident #9 had a self-care deficit due to a stroke with a goal to have needs met by staff dated 03/22/26 with interventions that included bathing assistance of two and hygiene assistance of two. Review of the physician orders revealed an order dated 02/11/26 for Resident #9 to receive a shower two times a week on Wednesday and Saturday.Review of the electronic medical record (EMR) shower sign off from 01/03/26 to 02/01/26 revealed Resident #9 received a shower on 01/04/26, 01/15/26, 01/22/26, 01/24/26, 01/28/26, 01/29/26, 01/30/26 and 01/31/26.Review of the EMR shower sign off from 02/01/26 to 02/28/26 revealed Resident #9 received a shower on 02/11/26, 02/14/26, 02/18/25, 02/21/25, 02/25/26 and 02/28/26. Review of the EMR shower sign off from 03/01/26 to 03/31/26 revealed Resident #9 was showered on 03/04/26, 03/07/26, 03/11/26, 03/14/26, 03/18/26, 03/21/26, 03/25/26, and 03/28/26.Review of the paper showers sheets from 01/15/26 to 03/29/26 revealed Resident #9 received a bed bath on 01/15/26, a bed bath 01/24/26, a bed bath on 01/29/26, a bed bath on 01/31/26, a bed bath on 02/05/26, a bed bath on 02/07/26, a bed bath on 02/14/26, a bed bath on 02/18/26, on 02/22/26 the method of bathing wasn't documented, a bed bath on 02/25/26, a bed bath on 03/04/26, a bed bath on 03/07/26, a bed bath on 03/14/26, a bed bath on 03/18/26, a bed bath on 03/21/26, and a bed bath on 03/29/26. An interview on 04/02/26 at 12:56 P.M. with Licensed Practical Nurse (LPN) #335 revealed showers are documented on paper sheets and the nurse reviews the shower sheet once completed. An interview on 04/02/26 at 1:18 P.M. with Certified Nursing Assistant (CNA) #353 revealed showers are documented on paper shower sheets and the nurse on the floor had to sign them afterwards.An interview on 04/02/26 at 4:05 P.M. with the Director of Nursing (DON) verified the above findings of the resident's preference to receive showers with multiple bed baths given instead.2. Resident #35 was admitted to the facility on [DATE] with re-entry on 02/17/26 with diagnoses that included orthopedic aftercare following surgical amputation, osteomyelitis (a bone infection) of the left tibia and fibula, stroke, acquired absence of left leg below the knee, chronic kidney disease, need for assistance with personal care, and acute respiratory failure.Review of the admission Observation dated 01/12/26 at 7:09 P.M. revealed Resident #35 preferred a shower and preferred bathing three times a week. Review of the care plan revealed Resident #35 had a self-care deficit related to weakness and debility with a goal to improve their level of function dated 01/22/26. Interventions included to provide assistance with activities of daily living and to report deterioration to the physician.Review of the five-day MDS 3.0 assessment dated [DATE] revealed Resident #35 was moderately cognitively impaired, did not reject care, required maximal assistance with activities of daily living, was occasionally incontinent of bladder, and was frequently incontinent of bowel. Review of the physician orders revealed an order dated 01/28/26 for showers twice a week on Wednesday and Saturday which was discontinued on 02/025/26 and an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for showers twice a week on Tuesday and Friday dated 02/18/26. Review of the EMR shower sign off from 01/28/26 to 01/31/26 revealed Resident #35 received a shower on 01/28/26 and 01/31/26.Review of the EMR shower sign off from 02/01/26 to 02/28/26 revealed Resident #35 received a shower on 02/04/26, the resident was then hospitalized from [DATE] until 02/17/26, and then received showers on 02/20/26, 02/24/26, and 02/27/26. Review of the EMR shower sign off from 03/01/26 to 03/31/26 revealed Resident #35 received a shower on 03/03/26, 03/06/26, 03/10/26, 03/13/26, 03/17/26, 03/20/26, 03/24/26, and 03/27/26. Review of the paper showers sheets from 01/21/26 to 03/27/26 revealed Resident #35 received a bed bath on 01/21/26, a bed bath on 01/24/26, refused bathing on 01/28/26, the method of bathing wasn't documented on 02/20/26, the method of bathing wasn't documented on 02/22/26, the method of bathing wasn't documented on 02/24/26, on 02/27/26 received a shower, on 03/03/26 received a shower, the method of bathing wasn't documented on 03/06/26, the method of bathing wasn't documented on 03/10/26, on 03/17/26 received a shower, the method of bathing wasn't documented on 03/20/26, the method of bathing wasn't documented on 03/24/26, and received a shower on 03/27/26. An interview on 03/30/36 at 9:01 A.M. with Resident #35 revealed he doesn't always get showers on his scheduled shower days.An interview on 04/02/26 at 12:56 P.M. with Licensed Practical Nurse (LPN) #335 revealed showers are documented on paper sheets and the nurse reviews the shower sheet once completed. An interview on 04/02/26 at 1:18 P.M. with Certified Nursing Assistant (CNA) #353 revealed showers are documented on paper shower sheets and the nurse on the floor had to sign them afterwards.An interview on 04/02/26 at 4:05 P.M. with the Director of Nursing (DON) verified the above findings of the resident not being bathed three times a week as scheduled.This deficiency represents non-compliance investigated under Complaint Number 2667505.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to follow their legionella water management plan and practice appropriate hand hygiene during medication administration and wound care. This affected two residents (Residents #8 and #100) observed for infection control and had the potential to affect all 79 residents in the facility. Findings include:1. Review of the facility's water management plan (WMP), dated 04/12/19 identified the ice machine as a risk factor. Control measures were listed as cleaning and disinfecting the ice machine based on equipment manufacturer's instructions. Change filter and clean if installed. Make sure to schedule and document all cleanings. Corrective actions were listed as if cleaning schedule was missed, remove unit from service and clean according to manufacturer's instructions If a legionella-positive sample was found outside of control limits, more frequent samples may be required as part of the review of the system operation in order to establish the source of the contamination and determine when the system was back within control limits as specified in the WMP. Review of facility legionella documentation revealed an analytical report containing results from facility water samples taken on 03/10/25. The first floor ice machine had two colony-forming units (CFU)/milliLiter (mL) of legionella detected. Further review of the analytical report defined the theoretical detection unit for legionella as one CFU/mL. No other areas of the facility were identified to have legionella detected from the provided samples. Review of a legionella flush-out form dated 03/25/25 listed the dedicated area(s) of the first floor ice machine and the beauty shop and contained spaces for seven days (filled out 03/26/25 through 04/03/25) and checkboxes for five steps. The instructions read: 1) for the next seven days, flush all available water outlets in the site for 10 minutes per day on hot and another 10 minutes per day on cold. 2. In addition, adjust shower head temperature knob to provide warm water in order to ensure that both hot and cold water and being flushed and run for five minutes. 3. Remove sink aerators, clean and disinfect upon initiating flush out. 4. On the hot water side, test and document any hot water storage tanks, a sink closest to the hot water storage tank and a sink farthest away from the hot water storage tank for temperature (verify below 120 degrees Fahrenheit), free chlorine and total chlorine. 5. Document all flushing activities and testing results and place them into your site Water Management Plan binder. 6. Retest the same outlets within seven days of the final day of flushing. 7. If subsequent legionella water testing comes back as detected, repeat steps one through five and contact corporate for guidance. The sheet was signed off by Environmental Services Director (ESD) #305. No additional testing information or follow-up since 04/03/25 was noted in the facility's legionella documentation. Interview on 04/06/26 at 10:43 A.M. with the Director of Nursing (DON) and Divisional Director of Clinical Education (DDCE)/Registered Nurse (RN) #379 revealed ice machines were out of service after the positive legionella results in March 2025 as the facility was renovating their dining rooms. DDCE/RN #379 confirmed the only area in the facility with a positive legionella result was the first floor ice machine and stated follow-up testing was completed in August 2025. DDCE/RN #379 stated the beauty shop was added to the flush-out protocol as it was an area that had tested positive for legionella in the past. Both the DON and DDCE/RN #379 confirmed there had been no cases of Legionnaire's disease in the facility corresponding with the infection control logs reviewed from January 2025 through March 2026. Follow-up interview on 04/06/26 at 1:11 P.M. with DDCE/RN #379 verified the facility could not locate any evidence of re-testing after the positive legionella result and subsequent flush-out procedure. DDCE/RN #379 shared the facility had not completed their 2026 legionella testing as of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	time of the interview as the company had not yet sent them the specimen cups for testing. Interview on 04/06/26 at 1:18 P.M. with ESD #306 revealed she did not recall the positive legionella result from March 2025 and did not recall any further corrective actions taken by the facility after the seven days of flush-out protocol ending 04/03/25. ESD #306 stated the ice machines were disconnected, drained and covered and not in service during the dining room renovations that went on until August or September 2025. ESD #306 verified she could not recall completing any re-testing in the facility after the positive legionella result in March 2025. Review of the facility policy, Legionella Assessment and Prevention Program, revised 01/10/25 revealed if positive results from water testing are received, abatement to mitigate will take place according to source and species. The facility will document the steps taken to mitigate the source and then re-test to ensure the water is free of bacterial growth. [NAME] Healthcare Group policy requires testing to be performed annually at four water sources in the building. These sources should include one resident room sink faucet, one resident showerhead, ice machine and one kitchen sink faucet. These areas should be the furthest location(s) from the water source. Samples should be collected by someone on the assessment team according to the instructions on the test kit. These samples are then mailed to a qualified water testing form. 2. A review of Resident #8's clinical record revealed an admission date of 06/18/22 with diagnoses including congestive heart failure, atrial fibrillation (heart arrhythmia), atherosclerotic heart disease, anemia, high blood pressure and cholesterol, chronic kidney disease, polyneuropathy, diabetes mellitus, osteoarthritis, gout, restless leg syndrome, benign enlarged prostate and cognitive communication deficit. A review of Resident #8's dated 02/16/26 physician orders indicated to cleanse the sacrum and right gluteus pressure ulcer area with Dakin's solution, dry, apply pink polymem to wound bed and cover with foam dressing once a day. An observation of Licensed Practical Nurse (LPN) #304 on 03/31/26 at 4:52 P.M. perform Resident #8's wound treatment revealed a failure to perform hand hygiene to prevent cross contamination of germs. LPN #304 gathered the supplies needed and sanitized the over-the-bed table and placed the supplies on the over-the-bed table. LPN #304 performed hand hygiene and donned a pair of gloves and removed the soiled wound treatment from Resident #8's sacrum and right buttock area. The wound dressing was saturated with serosanguinous fluid and LPN #304 discarded the soiled dressing in the waste receptacle. LPN #304 removed her soiled gloves and performed hand hygiene and donned another set of gloves. LPN #304 proceeded to perform the wound treatment task following infection control standards. Upon completion of the wound treatment LPN #304 removed her soiled gloves and did not perform hand hygiene. LPN #304 then proceeded to touch various items in Resident #8's room including the bed remote, adjusting the bed and Resident #8's bed linens and other surfaces in Resident #8's room. An interview with LPN #304 on 03/31/26 at 5:19 P.M. verified she had not performed hand hygiene after she removed her gloves upon completing the wound treatment task and proceeded to touch various items in Resident #8's room. A review of the facility policy titled Clean Dressing Change Policy effective 03/10/24 indicated the procedure included for the staff to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Perform hand hygiene.2. Introduce self to patient/resident.3. Confirm patient/resident ID. 4. Explain procedure to patient/resident, offer bathroom, analgesia.5. Ensure privacy. 6. Set up clean field using a barrier, towel, chux etc. 7. Position patient to visualize area to be dressed.8. Perform hand hygiene.9. [NAME] clean gloves. 10. Check any dressing present, remove and wrap in gloves as you take gloves off, discard in trash bag. 11. Assess wound (if you need to touch the area perform hand hygiene and don new clean gloves).12. Perform hand hygiene.13. Prepare supplies on field including any cleansing solution.14. [NAME] clean gloves.15. Cleanse with ordered solution or normal saline soaked gauze pads. 16. Remove gloves and discard.17. Perform hand hygiene and don clean gloves.18. Apply new dressing[s] as ordered.19. Assist patient/resident back to comfortable position.20. Remove and discard gloves.21. Perform hand hygiene.22. Document procedure and update findings.23. Notify provider if necessary. 3. A review of Resident #100's clinical record revealed an admission date of 03/25/26 with diagnoses including fractured right humerous, Parkinson's disease, mood and psychotic disturbance, atrial fibrillation (heart arrhythmia), hypothyroidism, high blood pressure and cholesterol, lymphedema, gastroesophageal reflux disease, and cognitive communication deficit. A review of Resident #100's physician order dated 03/01/26 to 03/31/26 indicated to administer the following medications orally between 7:30 A.M. 11:30 A.M.: -Allopurinol 300 milligrams (mg) -Citalopram 10 mg -Ferrous sulfate 325 mg -Metoprolol extended release 25 mg -Mirabegron extended release 25 mg -Spironolactone 25 mg -Eliquis 5 mg -Omeprazole 25 mg and to administer Xidra eye drops, one drop each eye between 7:30 A.M. and 11:30 A.M. An observation on 03/31/25 at 8:07 A.M. of LPN #322 administer medications to Resident #100 revealed a failure to perform hand hygiene. LPN #322 approached the medication cart and used hand sanitizer and started to dispense the above listed medications. LPN #322 found one medication (Omeprazole 20 mg tablet) was not in the medication cart and she would need to obtain the medication from the central supply room. LPN #322 locked the medication cart and pushed the button for the elevator. LPN #322 moved the housekeeping cart out of her way when entering the elevator and ushed the buttons in the elevator. LPN exited the elevator and walked to the central supply room and obtained the Omeprazole medication. LPN then used the elevator to travel back to the medication cart and continued to dispense Resident #100's medications in a medication cup without performing hand hygiene before resuming the task. LPN #322 the proceeded to administer Resident #100's oral medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with LPN #322 on 03/31/26 at 8:21 A.M. confirmed should have performed hand hygiene prior to resuming dispensing and administering Resident #100's medications. A review of the facility policy titled Hand Hygiene Policy effective 09/01/11 indicated hand hygiene was the most important component for preventing the spread of infection. The procedure indicated to perform hand hygiene for the following clinical indications.: -Immediately before touching a resident. -Before performing an aseptic task. -Before moving from a soiled body site to a clean body site. -After touching a resident or resident's immediate environment. -After contact with blood, body fluids, or contaminated surfaces. -Immediately after glove removal.

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Woodlands Health and Rehab Center	6831 North Chestnut Street Ravenna, OH 44266

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, hospital/emergency department documentation, facility policy review, and staff interviews, the facility failed to ensure staff verified Resident #2's documented allergy (to the COVID-19 vaccine) prior to administering the vaccine. The facility also failed to provide timely clinical assessment and medical intervention after the vaccine was administered. This affected one resident (Resident #2) of five residents reviewed for vaccinations.On 11/07/25 at 12:10 P.M., staff administered a COVID 19 vaccination to Resident #2 despite the vaccine being listed as an allergy in the resident's medical record. No immediate assessment or monitoring was completed following administration of the contraindicated vaccine. The resident did not receive a clinical assessment until 11/07/25 at 10:50 P.M., when she was noted to be in respiratory distress with abnormal and unstable vital signs, including: heart rate of 140 beats per minute (normal 60-100), pulse oximetry of 84% on two liters per minute of oxygen (normal 95-100%), respiratory rate of 25 breaths per minute (normal 12-20), and a blood pressure unable to be obtained. Due to the delayed recognition and response to the adverse reaction, Resident #2 required transfer to the emergency department on 11/07/25 and was subsequently admitted for diagnoses including altered mental status, encephalopathy, and acute hypoxic respiratory failure. The resident was treated for anaphylaxis and hospitalized until 11/11/25. Findings include:Review of Resident #2's medical record revealed an admission date of 12/15/11 and a re-entry date of 11/11/25. Resident #2's diagnoses included end stage renal disease, dependence on renal dialysis, type 2 diabetes, heart disease, chronic obstructive pulmonary disease (lung disease), heart failure, reduced mobility, and need for assistance with personal care. Review of Resident #2's allergy list revealed she was allergic to the Pfizer mRNA, BNT 162b2, LNP-S, COVID-19 vaccine with reactions of altered mental status and anaphylaxis dated 04/12/24 and Moderna mRNA-1273, LNP-S, COVID-19 vaccine with reactions of altered mental status dated 04/12/24.Review of the guardianship papers dated 05/06/25 revealed a (court-appointed) guardian was appointed for Resident #2 due to being assessed as incompetent to make her own decisions. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact, did not reject care, was dependent on staff for toileting hygiene, required maximal assistance for bathing, required maximal assistance for personal hygiene, required moderate assistance for transferring, required dialysis, and had a legal guardian.Review of the dialysis communication form dated 11/07/25 at 11:00 A.M. revealed Resident #2's final vital signs from the dialysis center prior to returning to the facility included a pulse of 79 beats per minute (bpm), respirations of 17 breaths per minute, and a blood pressure of 130/53 millimeters of mercury (mm/hg).Review of the physician orders revealed an order (dated 11/07/25) for a single dose of Mnexspike 2025-2026 COVID vaccine syringe ten micrograms (mcg) per 2 tenths of a milliliter (ml) intramuscular.Review of the COVID-19 vaccine administration report revealed consent was obtained from the guardian, education was provided to the guardian, the guardian was educated by a Registered Nurse (RN), and Resident #2 received the Moderna mNEXSPIKE COVID-19 vaccine on 11/07/25 at 12:10 P.M. in the left deltoid (shoulder muscle), prior to the RN assessing/screening whether the vaccine was contraindicated due to allergies.Review of the progress notes from 11/07/25 to 11/11/25 in the electronic medical record (EMR) revealed the absence of documentation that an assessment had been performed on Resident #2 after she was administered the COVID vaccine nor was it was identified she received a vaccine that was listed as an allergy. Record review revealed no evidence of physician notification of the incident at the time of the vaccine administration. Review of the evaluation screen in the EMR from 11/07/25 to 11/11/25 revealed the absence of documentation Resident #2 was assessed after it was identified she received a vaccine (continued on next page)

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