STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366316	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Acres Senior Living at Clifton	476 Riddle Road Cincinnati, OH 45220

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on review of the medical record and staff interview, the facility failed to complete a baseline care plan within 48 hours after admission. This affected one (#14) of 15 residents reviewed for baseline care plans. The facility census was 51. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypoxia, pneumonia, dementia, and malignant neoplasm of prostate. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of seven. The resident was assessed to require supervision with eating and transfers, and required partial assistance with toileting, bathing, and dressing. Review of the baseline care plan dated 05/30/24 revealed it was not completed for Resident #14. Interview on 06/24/24 at 9:55 A.M. with MDS Nurse #22 verified Resident #14's baseline care plan had not been completed.

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

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 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** 44412 Based on observation, medical record review, staff and resident interview, the facility failed to ensure residents were provided with timely and adequate personal hygiene. This affected three (#6, #14, and #23) of four residents reviewed for activities of daily living (ADLs). The facility census was 51. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD) stage four, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10. The resident was assessed to require supervision with eating, substantial assistance with toileting, bathing, and dressing, and partial assistance with transfers. Review of the care plan dated 03/28/24 revealed Resident #6 had an ADLs self-care performance deficit related to impaired balance. Interventions included physical and occupational therapy and treatment per physician orders, staff to provide maximal assistance with personal hygiene, staff to explain all care to be rendered and cue Resident #6 to do the same if able, and staff encouragement to participate to the fullest extent possible with each interaction. Observations of Resident #6 throughout the annual survey at random times revealed Resident #6 had facial hair noted on her chin. Interview and observation on 06/25/24 at 1:45 P.M. with Resident #6 revealed she usually shaved her facial hair while at home but did not bring a razor with her to the facility. Resident #6 verified that staff had not asked her to shave the hair on her chin and she would like it to be shaved. Resident #6 had noticeable hair on her chin during the interview. Interview on 06/25/24 at 1:48 P.M. with State tested Nurse Aide (STNA) #102 stated shaving should be completed for residents on shower days, and verified Resident #6 had facial hair noted on her chin. 2. Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypoxia, pneumonia, dementia, and malignant neoplasm of prostate. Review of the admission MDS assessment dated [DATE] revealed Resident #14 had severe cognitive impairment as evidenced by BIMS score of seven. The resident was assessed to require supervision with eating and transfers, and partial assistance with toileting, bathing, and dressing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 05/30/24 revealed Resident #14 had an ADLs self-care performance deficit related to acute respiratory failure with hypoxia. Interventions included podiatry care as needed, staff encouragement to participate to the fullest extent possible with each interaction, staff to praise all efforts at self-care, staff to encourage to use call light for assistance, and staff to explain all care and cue participation. Observations throughout the annual survey at random times revealed Resident #14's fingernails extended approximately a quarter of an inch to half an inch beyond his fingertips and were yellow in color with jagged edges. Further observation revealed the underside of Resident #14's fingernails were coated in a dark brown substance. Interview and observation on 06/25/24 at 1:43 P.M. with Resident #14 revealed his fingernails were long with a built up substance under them. Resident #14 stated he had not been asked by staff to cut them and wanted them cut. Interview on 06/25/24 at 1:51 P.M. with STNA #102 verified residents' fingernails should be trimmed and maintained as needed. STNA #102 verified Resident #14's fingernails were long, jagged, and needed cut. 3. Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, CKD, depression, and atrial fibrillation. Review of the admission MDS assessment dated [DATE] revealed Resident #23 had severe cognitive impairment. The resident was assessed to require supervision with eating, substantial assistance with toileting, bathing, and dressing, and dependent with transfers. Review of the care plan dated 03/26/24 revealed Resident #23 had an ADLs self-care performance deficit related to metabolic encephalopathy and hemiplegia to the right side. Interventions included physical therapy (PT) and occupational therapy (OT) evaluation and treatment per orders, staff to explain all care and cue to do the same, staff to assist with hygiene and bed mobility, and staff to directly supervise all meals. Observations throughout the annual survey at random times revealed Resident #23's fingernails extended approximately a quarter of an inch to a half an inch beyond his fingertips. Interview and observation on 06/25/24 at 12:23 P.M. with Resident #23 revealed he wanted his fingernails trimmed and had not been asked by staff for them to be trimmed. Observation of Resident #23 during the interview revealed his fingernails remained untrimmed. Interview on 06/25/24 at 1:52 P.M. with STNA #102 verified Resident #23's fingernails were long and should be cut. STNA #102 reported nail trimming should be offered during hygiene.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, staff interview, and review of a facility policy, the facility failed to appropriately assess pressure ulcers as required. This affected one (#51) of one resident reviewed for pressure ulcers. The facility census was 51. Findings include: Review of the medical record for Resident #51 revealed an admission of 04/01/24. Diagnoses included dementia, atrial fibrillation, type two diabetes mellitus, protein-calorie malnutrition, and malignant neoplasm of prostate. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. The resident was assessed to require supervision with eating, and was dependent with toileting, bathing, dressing, and transfers. Review of the care plan dated 05/15/24 revealed Resident #51 had a stage four pressure ulcer (full thickness skin and tissue loss) of the coccyx/sacrum related to impaired mobility, refusal of care, refusal to get out of bed, and impaired nutrition. Interventions included to administer medications as ordered, staff to administer treatments as ordered and monitor for effectiveness, staff to apply protective skin barrier sprays/ointments as ordered by physician, staff to assess, record, and monitor wound healing with wound care, and staff to encourage and assist with turning and repositioning every two hours. Review of a physician order dated 06/07/24 revealed Resident #51 was ordered for staff to cleanse the area to the sacrum with soap and water, apply betadine fluffed gauze followed by Calmoseptine buttered abdominal pad every morning and at bedtime for wound care with instructions to assess for pain prior to the dressing change. Review of a physician order dated 06/07/24 revealed Resident #51 was ordered weekly skin assessments every Monday evening for monitoring. Review of the weekly skin assessments revealed Resident #51 did not have a weekly skin assessment completed on 05/06/24, 06/14/24, and 06/21/24. Interview on 06/25/24 at 12:00 P.M. with Director of Nursing (DON) verified Resident #51's weekly skin assessments were not completed as ordered. Review of the facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revealed the nursing staff would assess and document an individual's significant risk factors for developing pressure sores. The staff would review and modify the care plan as appropriate, especially when wounds were not healing as anticipated or new wounds developed despite existing interventions. The physician would authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressing, and application of topical agents if indicated for type of skin alteration.

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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** 44412 Based on medical record review, staff interview, and review of a facility policy, the facility failed to ensure resident fall risks were assessed after falls to determine risk factors to the resident. This affected two (#23 and #27) of four residents reviewed for falls. The facility census was 51. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic kidney disease, depression, and atrial fibrillation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had severe cognitive impairment. The resident was assessed to require supervision with eating, and substantial assistance with toileting, bathing, and dressing, and dependent with transfers. Review of the care plan dated 03/26/24 revealed Resident #23 was at risk for falls related to deconditioning and gait/balance problems. Interventions included Dycem (non-slip device) to wheelchair to reduce risk for sliding out of the seat, staff to keep frequently used items within reach, staff to monitor positioning when up in wheelchair, staff to apply nonskid socks to be worn in bed, and staff will ensure the room was free of clutter and spills. Review of the medical record for Resident #14 revealed a fall risk assessment had not been completed after a fall on 04/03/24, 04/11/24, 04/20/24, and 05/10/24 to identify potential risk factors which contributed to the falls. Interview on 06/25/24 at 10:49 A.M. with MDS Nurse #22 verified she was only completing a fall risk assessment on residents when they were due for the admission or quarterly MDS assessments. Interview on 06/26/24 at 1:28 P.M. with the Director of Nursing (DON) verified Resident #23 had not had a fall risk assessment completed after multiple falls. 2. Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, heart disease, dementia, anxiety, malnutrition, and chronic constipation. Review of the MDS assessment dated [DATE] revealed Resident #27 had severely impaired cognition and required partial assistance to walk, was dependent on staff for transfers, and required partial assistance for eating. Further review of the the assessment revealed the resident had a history of falls prior to admission within the previous two to six months. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's fall investigations revealed the resident fell on [DATE] in the lounge area, fell on [DATE] which required evaluation in the hospital, fell in the bathroom on 06/19/24, and fell from a reclining chair on 06/21/24 and 06/23/24. Further review of Resident #27's medical record revealed no fall risk assessments were completed following the resident's falls on 06/03/24, 06/09/24, 06/19/24, 06/21/24, or 06/23/24 to identify potential risk factors which contributed to the falls. Interview on 06/26/24 at 1:30 P.M. with the Director of Nursing (DON) verified there had been no fall risk assessments completed with Resident #27's falls on 06/03/24, 06/09/24, 06/19/24, 06/21/24, and 06/23/24. The DON stated fall risk assessments should be completed at admission, after each fall, quarterly, and if there was a significant change in clinical status. Review of an undated facility policy titled, Falls, revealed the facility will identify and evaluate the resident's specific fall risks to reduce the risk of falls. 44083

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on medical record review and staff interview, the facility failed to ensure nutritional assessments were completed and interventions were put into place timely for residents with significant weight loss and at risk for nutritional deficits. This affected two (#18 and #51) of four residents reviewed for nutrition. The facility census was 51. Findings include: 1. Review of Resident #18's medical record revealed the resident was readmitted to the facility on [DATE]. Diagnoses include malnutrition, heart failure, atrial fibrillation, congestive heart failure , peripheral neuropathy, anemia, thrombophilia, leukemia, and depression. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition and required supervision for meal assistance. The resident received a no added salt diet and a supplement three times a day. Review of physician orders revealed weekly weights were ordered by the physician on 11/17/23. Review of the plan of care revealed Resident #18 was a nutritional risk due to being resistive to eating, refusing to eat, expressing weight loss behaviors, and congestive heart failure. Interventions included received a no added salt diet, provide nutritional supplements, and weight monitoring as ordered by the physician. Reviewed of the weight log revealed Resident #18 weighed 164 pounds on readmission on 11/10/23. On 06/06/24, Resident #18 weighed 150 pounds. Review of a nutritional assessment dated [DATE] was completed by Registered Dietitian (RD) #106. The assessment revealed Resident #18 had a history of 15 percent (%) weight loss over the previous two months prior to admission, and a current weight of 165 pounds. The weight loss was assessed to be related to a diagnoses of depression and a recommendation was made for a no added salt diet due to congestive heart failure and edema. Further review of Resident #18's medical record between 11/13/23 through 06/25/24 revealed no further nutritional assessments or progress notes were completed. Interview on 06/25/24 at 1:22 P.M. with RD #106 verified she had not completed a nutritional assessment for Resident #18 since 11/23/23. RD #106 verified she should have completed a nutritional assessment every three months and after a significant change for Resident #18. RD #106 verified Resident #18 had a history of gradual weight loss and changes due to edema, leukemia diagnosis, and eating behaviors including low food intake. RD #106 stated she did not know Resident #18 had physician orders for weekly weight monitoring and verified she had not completed weekly weight monitoring and documentation. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #51 revealed an admission of 04/01/24. Diagnoses included dementia, atrial fibrillation, type two diabetes mellitus, protein-calorie malnutrition, and malignant neoplasm of prostate. Review of the significant change MDS assessment dated [DATE] revealed Resident #51 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. The resident was assessed to require supervision with eating, and was dependent with toileting, bathing, dressing, and transfers. Review of the care plan dated 04/02/24 revealed Resident #51 had a potential nutritional problem due to anorexia related to dementia, resistive to eating, and protein-calorie malnutrition. Interventions included to administer medications to stimulate appetite per physician order, administer vitamin and mineral supplements per orders, provide and serve diet as ordered and monitor intake and record every meal, registered dietician to evaluate and make diet change recommendations as needed, and provide and serve supplements as ordered. Review of the medical record for Resident #51 revealed the resident had a 6.97% weight loss over one month when the resident was noted as weighing 160.8 pounds on 04/12/24 and 149.6 pounds on 05/14/24. Review of Resident #51's physician orders revealed no interventions were implemented to address Resident #51's weight loss until 06/07/24. Interview on 06/25/24 at 2:02 P.M. with RD #106 revealed she was not made aware of Resident #51's weight loss and verified proper interventions were not put in place to address timely the resident's weight loss. 44412

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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** 44412 Based on observation, medical record review, and staff interview, the facility failed to perform adequate hand hygiene and provide care in a manner to prevent potential contamination during wound and urinary catheter care. Additionally, the facility failed to ensure residents were placed on enhanced barrier precautions as required for residents with wounds and/or indwelling medical devices. This affected one (#51) resident of six residents reviewed for infection control measures. The facility census was 51. Findings include: Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included dementia, atrial fibrillation, type two diabetes mellitus, protein-calorie malnutrition, and malignant neoplasm of prostate. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. The resident was assessed to require supervision with eating, and was dependent with toileting, bathing, dressing, and transfers. Review of the care plan dated 05/01/24 revealed Resident #51 had an indwelling urinary catheter related to obstructive uropathy and malignant neoplasm of the prostate. Interventions included to administer medications per physician orders, change drainage bag weekly and as needed, provide catheter care every shift with soap and water, check tubing for kinks each shift and with care, and monitor and document for pain and discomfort due to catheter. Review of the care plan dated 05/15/24 revealed Resident #51 had a stage four pressure ulcer (full-thickness skin and tissue loss) of the coccyx/sacrum related to impaired mobility, refusal of care, refusal to get out of bed, and impaired nutrition. Interventions included to administer medications as ordered, administer treatments as ordered and monitor for effectiveness, apply protective skin barrier sprays/ointments as ordered by physician, to assess, record, and monitor wound healing with wound care, and staff to encourage and assist with turning and repositioning every two hours. Review of a physician order dated 06/07/24 revealed Resident #51 was ordered for staff to cleanse the area to the sacrum with soap and water, apply betadine fluffed gauze followed by a Calmoseptine buttered abdominal pad every morning and at bedtime for wound care. Further review included instructions to assess for pain prior to the dressing change. Review of a physician order dated 06/07/24 revealed Resident #51 was ordered to have staff provide urinary catheter (Foley) care with soap and water every shift. Observation on 06/25/24 at 11:06 A.M. of wound care to Resident #51's coccyx completed by Licensed Practical Nurse (LPN) #56 revealed LPN #56 washed her hands and put on gloves prior to the dressing change. After removing the soiled dressing, LPN #56 removed her gloves but did not perform hand hygiene. LPN #56 put on a new pair of gloves and cleansed the wound bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/25/24 at 11:18 A.M. of catheter care to Resident #51's urinary catheter performed by State tested Nurse Aide (STNA) #39 revealed STNA #39 assisted LPN #56 with wound care prior to completing catheter care. STNA #39 did not remove gloves or perform hand hygiene before starting catheter care. During catheter care, STNA #39 cleaned the catheter tubing cleaning down and back to the urethra causing potential contamination. Observation during wound and catheter care on 06/25/24 between 11:06 A.M. and 11:18 A.M. revealed Resident #51 had no signs posted to indicated the resident was on enhanced barrier precautions. Interview on 06/25/24 at 11:28 A.M. with LPN #56 verified she did not perform hand hygiene when she removed her gloves after removing the old, soiled dressing from Resident #51's coccyx. Interview on 06/25/24 at 11:30 A.M. with STNA #39 verified she did not remove gloves or perform hand hygiene after assisting LPN #56 with wound care and beginning on Resident #51, and verified she failed to cleanse Resident #51's catheter tubing away from the urethra. Interview on 06/26/24 at 11:48 A.M. with the Director of Nursing (DON) verified Resident #51 should be in enhanced barrier precautions. The DON reported the facility did not currently have a policy for enhanced barrier precautions.

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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** 44412 Based on medical record review, staff interview, and policy review, the facility failed to ensure resident pneumococcal vaccinations were up to date. This affected five (#15, #17, #18, #19, and #37) of five residents reviewed for pneumococcal vaccinations. The facility census was 51. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included acute kidney failure, major depressive disorder, acute respiratory failure with hypoxia, and metabolic encephalopathy. Review of the medical record for Resident #15 revealed Pneumococcal vaccine Prevnar 13 was given on 07/21/15. Resident #15 should have received Prevnar 20 (PCV20) or Pneumovax 23 (PPSV23) one year after PCV13; however, there was no documentation either was given. 2. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic kidney disease stage three, and chronic obstructive pulmonary disease (COPD). Review of the medical record for Resident #17 revealed the resident refused a pneumococcal vaccine on 08/24/17. Resident #17 was not offered the pneumococcal vaccine since the refusal in 2017. 3. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included congestive heart failure (CHF), atrial fibrillation, chronic lymphocytic leukemia, and dementia. Review of the medical record for Resident #18 revealed Pneumococcal vaccine Prevnar 13 was given on 06/01/08. Resident #18 should have received Prevnar 20 (PCV20) or Pneumovax 23 (PPSV23) one year after PCV13; however, there was no documentation either was given. 4. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included CHF, type two diabetes mellitus, and bipolar disorder. Review of the medical record for Resident #19 revealed Pneumococcal vaccine Prevnar 13 was given on 10/10/21. Resident #19 should have received Prevnar 20 (PCV20) or Pneumovax 23 (PPSV23) one year after PCV13; however, there was no documentation either was given. 5. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, chronic kidney disease stage three, and CHF. Review of the medical record for Resident #37 revealed Pneumococcal vaccine Prevnar 13 was given on 03/18/16. Resident #37 should have received Prevnar 20 (PCV20) or Pneumovax 23 (PPSV23) one year after PCV13; however, there was no documentation either was given (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/26/24 at 1:25 P.M. with the Director of Nursing (DON) verified Resident #15, Resident #17, Resident #18, Resident #19, and Resident #37 were not up to date for the pneumococcal vaccine. Review of the facility policy titled, Pneumococcal Vaccine, revealed the facility would offer residents and staff immunizations against pneumococcal disease in accordance with current Centers for Disease Control and Prevention (CDC) guidelines and recommendations. Each resident would be assessed for pneumococcal immunization upon admission.