

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366335	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Snf-the Villa at Marymount		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 Marymount Village Drive Garfield Heights, OH 44125	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51525 Based on record review, observation, interviews and review of facility policy, the facility failed to ensure staff treated residents with respect and dignity. This affected one resident (Resident #81) of four residents reviewed for dignity. The facility census was 110. Findings include: Record review revealed Resident #81 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other nontraumatic intracerebral hemorrhage, muscle weakness, adjustment disorder with mixed anxiety and depressed mood. Pertinent medication orders included (Remeron Oral Tablet (antidepressant) 15 milligrams (MG) once daily for depression. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13 of 15, indicating the resident was cognitively intact. Resident #81 was usually understood, usually understands. Resident #81 required set up with eating, supervision with oral care, was dependent with bathing and toileting, and required substantial assistance with hygiene and dressing. Observation of Resident #81 on 03/10/25 at 10:16 A.M. revealed the resident lying shirtless in his bed leaning to his right side. The surveyor observed a large brown stain to the left side of Resident's fitted bed sheet and observed his hospital gown balled up next to him with large brown stains. The resident stated Certified Nurse Aide (CNA) #402 threw his breakfast tray down and spilled coffee all over him and his bed. Observation on 03/10/25 at 10:37 A.M. revealed CNA #402 responded to Resident #81's call light; CNA #402 did not knock on entry to room. Resident #81 began angrily saying that she threw his tray on him. CNA #402 angrily and loudly said, Don't say I threw your tray down. I know exactly what I did. No sir! Interview with CNA #402 on 03/10/25 at 10:39 A.M. revealed she said she took his tray to the room, and it was on the floor when she returned. The surveyor confirmed the above findings and CNA #402 said she wasn't arguing with Resident #81 but we've had a lot of trouble with him. (continued on next page)		

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Dignity policy dated February 2021 revealed staff was expected to knock and request permission before entering residents' rooms and staff was to speak respectfully to residents at all times. This deficiency represents noncompliance investigated under Complaint Number OH00161932.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51525 Based on observations, interviews and record review, the facility failed to ensure residents received adequate timely assistance with eating and oral hygiene. This affected two residents (Resident #16 and Resident #223) of three residents investigated for activities of daily living (ADL) care. The facility census was 110. Findings include: Resident #16 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, and other specified disorders of bone density and structure. Review of Resident #16's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had mild or no cognitive impairment and required substantial/maximal assistance for hygiene care. Review of Resident #16's care plan dated 02/11/25 revealed the resident had an ADL self-care performance deficit due to impaired balance, had Multiple Sclerosis, and bilateral lower extremities weakness. Goals included the resident would improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, and ADL Score through the review date. Interventions included personal hygiene/oral care: the resident was dependent with personal hygiene and oral care. Interview with Resident #16 and his wife on 03/10/25 at 2:31 P.M. revealed his teeth were not being brushed routinely and he would like to have them brushed daily. Observation of resident's teeth revealed them to appear unclean. Interview with Resident #16 on 03/11/25 at 3:05 P.M. revealed the resident stated he had no oral care that morning or the previous day. Observation of resident's teeth revealed them to appear unclean. Interview with CNA #402 on 03/11/25 at 3:12 P.M. revealed CNA said Resident #16 was eating breakfast when she went in for A.M. care and she got busy with other residents, so she did not do A.M. oral care for him. She is to do the care on her shift. Observation of Resident #16 on 03/12/25 at 10:09 A.M. revealed him to be awake and alert in bed. He stated no oral care had been provided to him that morning. Observation of resident's teeth revealed them to appear unclean. Observation of Resident #16 on 03/12/25 at 2:24 P.M. revealed him sitting up in bed awake and alert. He stated he received no oral care that day. The surveyor observed a new unopened toothbrush on the tray table along with a partially used tube of toothpaste and a small bottle of partially used mouthwash. Resident #16 stated it bothered him that his teeth weren't being cleaned daily and would like to have them brushed every morning after breakfast. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA #402 on 03/12/25 at 3:01 P.M. who stated Resident #16 was dependent on staff for ADL care and stated she performed oral care for the resident this morning but hadn't been able to get into the computer so it wouldn't be documented anywhere. Review of the task sheet in Resident #16's medical record on 03/12/25 revealed completion of oral care had not been documented since 03/09/25 which was verified with CNA #402. 2. Resident #223 was admitted to the facility on [DATE]. Medical diagnosis included hemiplegia, fractured right humerus, hypertension, orthopedic follow up surgical amputation, type two diabetes, acute kidney failure, and dementia. Review of Minimum Data Set (MDS) 3.0 dated 02/28/25 in progress revealed cognitive status was pending, maximum assistance was needed to roll in bed, maximum assistance was needed to lie back in bed, maximum assistance was needed to sit up in bed and was dependent on staff for transfers out of bed. Resident #223 did not attempt to walk ten feet and was always incontinent. Review of Admission assessment dated [DATE] revealed Resident #223 was on a regular diet , oriented to person and place. Pain was in the upper arm and shoulders due to broken arm. Maximal assistance for eating and maximal assistance for oral hygiene. Review of Care Plan dated 03/03/25 Resident # 223 had an ADL self-care performance intervention including staff assist with set up and assist as needed with eating. Observation on 03/12/25 at 1:30 P.M. revealed Resident #223 was lying in bed flat with an unopened food tray across the room. Resident #223 stated she did not eat lunch. Resident #223 resided on the second floor. Interview on 03/12/25 at 1:43 P.M. with CNA #402 revealed Resident #223 needed assistance to eat. CNA #402 stated Resident #223 was not fed because other residents needed assistance. Interview on 03/12/25 at 3:38 P.M. with Dietary Manager # 347 revealed residents on the second floor lunch trays arrived between 12:15 P.M. and 12:30 P.M. daily. This deficiency represents noncompliance investigated under Complaint Number OH00161932.		

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F 0689 Level of Harm - 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** 37095 Based on record review, hospital record review, and interview, the facility failed to ensure Resident #16 was safely assisted with activities of daily living to prevent a fall with major injury. Actual harm occurred on 02/06/25 when Resident #16, who was comprehensively assessed and ordered to need two staff members to assist when giving personal care, received incontinence care by only one staff member, resulting in a fall, hospitalization, and fractured hip. This affected one resident (#16) of five residents reviewed for falls. The total census was 110. Findings include: Review of Resident #16's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, disorder of bone density, and obesity. A plan of care dated 10/11/24 revealed the resident required two people to be present when providing care. Record review revealed the resident had an active physician order dated 10/13/24 for two people to be present when providing care. Resident #16's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and dependent on staff for turns in bed. Review of the MDS instruction manual revealed residents were coded as dependent if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities. Resident #16's fall risk assessment dated [DATE] revealed the resident was at moderate risk for falls. Review of a progress note revealed on 02/06/25 at 2:30 P.M. the resident's wife alerted the nurse that the resident was on the floor. The resident was found on his knees facing the wall hunched over with a Certified Nursing Assistant (CNA) supporting him in a kneeling position. The CNA said the resident fell out of bed while turning to the left. The resident was assisted off the floor in a Hoyer sling. No distress was noted, and the resident did not want to go to the hospital. The certified nurse practitioner was notified and ordered x-rays. The resident was subsequently hospitalized [DATE] for a fracture to the right femur head and returned to the facility 02/08/25. Review of the incident report for Resident #16's fall on 02/06/25 revealed post-fall investigation identified a bruise to the resident's left lower leg, pain to the right groin and right upper leg, and a right femoral head fracture. The witness statement by CNA #900 stated that she entered (the resident's room) with the resident around 2:35 P.M. to give care. She had the resident on his side after getting cleaned and was placing the incontinence pad when he lost balance and fell. The resident did not hit his head. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the radiology results report for Resident #16 dated 02/06/25 revealed the resident had an acute fracture to the right femoral neck. Review of Resident #16's hospital notes dated 02/07/25 to 02/08/25 revealed he presented with acute pain in the right hip. An X-ray showed him to have a hip fracture. Orthopedic staff were consulted and signed off after the patient and family elected to pursue conservative measures. Interview with Resident #16 and his wife on 03/10/25 at 2:31 P.M. revealed the resident had multiple falls in the facility. During the most recent fall (on 02/06/25), only one staff was providing care and the resident fell off the bed when the staff member turned him. The resident/wife reported the resident was supposed to have two staff providing care when being repositioned. X-rays identified the resident had a broken hip and he was hospitalized. Resident #16 and his wife elected to not pursue surgery (for the fracture) and the resident returned to the facility the next day. During the interview, a concern was voiced that there had been multiple occasions when the resident was repositioned with only one staff member, which they stated created a safety hazard. Interview with Licensed Practical Nurse (LPN) #258 on 03/12/25 at 11:29 A.M. revealed Resident #16 had a fall in February (2025) which resulted in a hip fracture. The resident rolled out of bed during care and initially did not want to go to the hospital, however x-rays revealed a hip fracture and the resident was sent out. The LPN recalled the nurse aide providing the care was the only staff in the room at the time of the incident but indicated the resident's wife was also present in the room. LPN #258 stated she believed only one staff member was needed to turn the resident. Interview with Certified Nurse Aide (CNA) #900 on 03/12/25 at 1:32 P.M. revealed she was an agency aide who was providing care when Resident #16 fell on [DATE]. She said she received a paper report form which said Resident #16 only needed one person for assistance with care. She was providing incontinence care with no other staff in the room, and when she set him on his side, he rolled forward away from her off the bed. She stated she assisted lowering the resident to the ground. Resident #16's wife was in the roommate's section talking with the roommate during the event, and she stated after the incident she ran into the hall to get help. The above findings were confirmed with the Director of Nursing during an interview on 03/12/25 at 3:34 P.M. This deficiency represent noncompliance investigated under Complaint Number OH00161932.		

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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** 47570 Based on record review, and interview the facility failed to monitor and implement nutrition oral supplements as recommended by the registered dietitian and implement weekly weights as ordered by the physician. This affected one resident (Resident # 166) of three residents reviewed for nutrition. The facility census was 110. Findings include: Review of Resident's #166 medical record revealed an admitted [DATE] with diagnoses included pressure ulcer of sacral region stage four, type two diabetes, neuromuscular dysfunction of bladder, urinary tract infection, major depressive disorder, sepsis, anemia, protein calorie malnutrition, gastro-esophageal reflux, dementia, fracture of right lower leg, fracture of tibia. Review of Resident #166 Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed cognition was moderately impaired. Resident #166 had no rejection of care. Set up clean up assistance was needed for eating, and personal hygiene. Moderate assistance was needed to roll left and right in bed. Resident #166 was dependent on staff to sit on the side of the bed and maximum assistance was needed to lie back in bed. Resident #166 did not attempt to walk ten feet. No swallowing difficulties. No weight change on admission and Resident #166 was on a therapeutic diet. Review of Resident #166's plan of care dated 01/12/25 revealed she was at risk for altered nutrition related to inadequate oral intake, increased nutrient needs, pressure injuries, diabetes, sepsis, hypertension, infections and protein calorie malnutrition. Interventions included determining food preferences, monitoring weight, labs and skin status. Provide supplements as ordered. Administer medication as ordered. Monitor, record and report to medical doctor as needed signs and symptoms of malnutrition such as significant weight loss of five percent in one month, seven and one half percent in three months and greater than ten percent in six months, monitor intake and record meal every meal. Registered Dietitian (RD) to evaluate and make change recommendations as needed. Weigh as ordered. Review of Resident #166's admission weight dated 01/10/25 revealed a weight of 153.6 lbs. Review of weight record dated 01/30/25 revealed Resident #166 weighted 150.0 lbs. Review of Resident #166 physician order dated 02/18/25 revealed a consistent carbohydrate diet, regular texture and thin liquids. Review of Resident #166 physician order dated 02/18/25 revealed the dietitian may change, alter, or modify dietary orders. Review of weight record dated 02/25/25 revealed Resident #166 weighed 140.2 lbs. Resident #166 was reweighed on 02/25/25 that revealed a weight of 140.2 lbs. Resident #166 had a 6.3 percent (%) weight loss in one month. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician order start date 02/25/25 at 7:00 A.M. revealed an order for Resident #166 to have weekly weights in wheel chair no leg rests on chair Tuesday. Review of Dietitian Progress Note dated 02/26/25 at 7:58 P.M. revealed Resident #166 current body weight was 140.2 lbs. on 02/25/25 that triggered a 9.8 pound or 6.5 percent weight loss since 01/30/25. Resident #166 was on a controlled carbohydrate diet, regular texture, thin liquid. Meal intake varied from 25 to 100 percent. Resident #166 had a pressure ulcer to sacrum and altered skin to right lower leg. The dietitian recommended to start Ensure Plus 120 milliliters (ml) three times a day for added calories and protein support and would continue to monitor as needed. Review of Resident#166 medical record from 02/25/25 to 03/11/25 revealed no indication Resident 166 was reweighed or Ensure Plus 120 ml three times a day was implemented. Review of Medication Administration Record and Treatment Administration Record revealed Ensure Plus 120 ml three times a day was not ordered or documented. Interview on 03/11/15 at 4:43 P.M. with Licensed Practical Nurse (LPN) #999 stated there was no physician order for 120 ml Ensure Plus three times a day therefore no nutrition supplement was provided. LPN #999 also verified the weekly weights were not done since 02/25/25 because Resident #166 was a Hoyer lift. LPN #999 also stated if a weekly weight was obtained the weight would be documented in the electronic medical record under the weight vitals. Interview on 03/11/25 at 4:50 P.M. with Resident #166 revealed she was a poor historian and could not give a nutrition history or weight history. An interview on 03/12/25 at 10:06 A.M. with Registered Dietitian (RD) #902 stated the dietitian could write a nutrition supplement order and nursing would verify the order in the medical record. RD #902 verified 03/04/25 weekly weight was missed in the medical record and Ensure Plus 120 ml order was not placed therefore Resident #166 did not receive a nutrition supplement. Review of policy titled Weighing and Measuring the Resident, undated, revealed the following information should be recorded in the resident's medical record, the date and time the procedure was performed, the name of the individual who performed the procedure, and if the resident refused the procedure. This deficiency represents non-compliance investigated under Complaint Number OH00161681.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure Resident #216's antibiotic medication was discontinued timely following notification of a negative urine culture. This finding affected one (Resident #216) of six residents reviewed for medication administration. Findings include: Review of Resident #216's medical record revealed the resident was admitted on [DATE] with diagnoses including adult T-Cell lymphoma not having achieved remission, essential hypertension and hyperlipidemia. Review of Resident #216's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #216's physician orders revealed an order dated 02/24/25 to give Cephalexin capsule 500 milligrams (mg) one capsule by mouth three times a day for an infection until the sensitivity was available. Review of Resident #216's medication administration records (MARS) from 03/01/25 to 03/11/25 revealed the Cephalexin antibiotic was due at 6:00 A.M., 2:00 P.M. and 10:00 P.M. and the antibiotic was administered for all doses except the dose on 03/04/25 at 10:00 P.M. (blank). The resident received 11 additional doses from 03/08/25 to 03/11/25 following the negative urine culture identified in the Lab Results Report form dated 03/07/25. Review of Resident #216's Lab Results Report form dated 03/07/25 revealed the urine culture was negative for growth. Interview on 03/12/25 at 2:25 P.M. with Registered Nurse (RN) Unit Manager (UM) #257 confirmed the results of the culture were obtained on 03/07/25 but antibiotic was not stopped until 03/11/25. Interview on 03/13/25 at 9:30 A.M. with Nurse Practitioner (NP) #701 revealed Resident #216's urine culture was returned to the facility on [DATE] and she was not made aware of the results until 03/11/25 at which time the antibiotic was discontinued. NP #701 confirmed the resident received additional doses of the antibiotic after the negative urine culture was received by the facility.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation and interview the facility did not ensure food was served at a palatable temperature. This had the potential to affect 107 residents who received food from nutrition services. The facility census was 110. Findings include: Observation was conducted on 03/11/25 at 11:40 A.M. during meal service. The food temperatures were taken with a calibrated thermometer as follows: roasted chicken 185 degrees Fahrenheit (F), green beans 165 degrees F, twice baked potato 165 degrees F, and entree substitute was 185 degrees F. The test tray was placed on the [NAME] Unit hall cart at 12:40 P.M. where nurse staff passed the [NAME] Unit trays. At 12:56 P.M a test tray was taken from the [NAME] Unit food cart, after the last tray was passed. The Dietary Manager #347 proceeded to take the food temperatures with the facility digital thermometer confirming the temperatures. The test tray temperatures were as followed: roasted chicken 112 degrees F, green beans 107 degrees F, twice baked potato 121 degrees F, coffee was missing from the tray, apple juice 65 degrees F, and 2 percent one pint milk was 49.5 degrees F. The test tray food was tasted and revealed the chicken and green beans mildly warm and the twice baked potato had hard edges and crusted cheese on top was observed. Interviews on 03/10/25 during initial tour revealed Resident #163, #161, #68 and #40 stated the food did not taste good or was cold when delivered. Review of the 2019 Food Code - Chapter 3717-1-03 Reference Guide revealed cold temperature controlled (TCF) for safety cold food should be 41 degrees F or less and TCF hot food should be 130 degrees F or above. Review of facility policy titled Minimum Cooking, Holding and Reheating Temperatures, dated, January 2024, revealed all food must be cooked, held and reheated according to Food and Drug Administration guidelines to ensure food safety.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation, staff interview and facility policy review the facility failed to ensure the kitchen was clean and sanitary. This had the potential to affect all 107 residents receiving food from the kitchen as three residents (Resident #30, #102, and #167) received no food by mouth. The facility census was 110. Findings include: Observation during initial kitchen tour on [DATE] between 08:36 A.M. and 9:30 A.M. with Dietary Manager #347 revealed the following concerns: Hand drying paper towels were not available at the employee handwashing station. Cooler doors were not clean with food residue stuck on the door handles. The tray line cooler contained opened American cheese that was not dated, along with food debris throughout the cooler. An expired one half gallon on milk dated [DATE], expired lime juice dated [DATE], and no expiration date was on the gallon size mayonnaise container. The griddle had multiple food items charred on it. Food was charred on the stove top with food debris under the stove. The range broiler window was coated in grease and food was burnt to the bottom of the range broiler. The service ware drawer contained four spatulas with ripped and frayed edges. Dirt, grease and food debris were present in the service ware drawers by the cook station. At the time of the observation the Food Service Manager # 347 confirmed areas of concern. Review of policy titled, Marymount Sanitation Kitchen Sanitation, undated, revealed employees would recognize sanitation problems as evidenced by completion of Sanitation checklist.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42734 Based on record review and interview the facility failed to have quarterly Quality Assurance meetings. This had the potential to affect all residents. The census was 110. Findings Include: Review of the Quality Assurance (QA) meeting minutes revealed minutes starting in October 2024 to current date. Interview on 03/13/25 at 2:22 P.M. with the Administrator revealed he developed the QA program when he started at the facility in October 2024. He stated there were no prior meeting minutes for review.		

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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** 34297 Based on observation, record review and interview, the facility failed to ensure the glucometer blood glucose testing (BGT) machine was appropriately sanitized and disinfected to prevent the potential of cross contamination of blood borne pathogens. This finding affected two residents (Residents #80 and #166) of three residents (Residents #80, #166 and #209) who receive medications from the Hall One medication administration cart. Findings include: 1. Review of Resident #209's medical record revealed the resident was admitted on [DATE] with diagnoses including type two diabetes, difficulty in walking and muscle weakness. Review of Resident #209's physician orders revealed an order dated 02/16/25 for BGT before meals and at bedtime for hypo/hyerglycemia and diabetes. Review of Resident #209's medication administration records (MARS) from 03/01/25 to 03/10/25 revealed the BGT's were due at 6:00 A.M., 11:00 A.M., 4:00 P.M. and 9:00 P.M. The documentation confirmed Licensed Practical Nurse (LPN) #650 obtained a BGT at 11:00 A.M. with a result of 98 and no insulin was administered. Observation on 03/10/25 at 12:00 P.M. revealed LPN #650 went into Resident #209's room with the BGT machine, laid the machine on the bed, picked up the machine and obtained the resident's BGT with a result of 98. On 03/10/25 at 12:08 P.M., LPN #650 walked out of the room, laid the glucometer on the medication administration cart and cleaned the glucometer with a 70% alcohol prep pad. Interview on 03/10/25 at 12:05 P.M. with LPN #650 confirmed she disinfected the BGT machine with a 70% alcohol prep pad. 2. Review of Resident #166's medical record revealed the resident was readmitted on [DATE] with diagnoses including type two diabetes, neuromuscular dysfunction of the bladder and major depressive disorder. Review of Resident #166's physician orders revealed an order dated 02/19/25 for BGT before meals and at bedtime. Review of Resident #166's MARS from 03/01/25 to 03/10/25 revealed the BGT's were due at 6:00 A.M., 11:00 A.M., 4:00 P.M. and 9:00 P.M. The documentation confirmed LPN #650 obtained a BGT due at 11:00 A.M. with a result of 105 and no insulin was administered. (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 03/10/25 at 12:21 P.M. revealed LPN #650 obtained Resident #166's BGT with a result of 105. LPN #650 was observed to place the BGT machine in her left side scrub top pocket, walk out of the resident's room and walk into the women's bathroom outside in the hall. LPN #650 came out of the women's bathroom and the glucometer was still observed in the left side pocket. The nurse placed the BGT machine on the medication administration cart and the BGT machine was not sanitized and disinfected. 3. Review of Resident #80's medical record revealed the resident was admitted on [DATE] with diagnoses including diabetes type with with ketoacidosis without coma, repeated falls and muscle weakness. Review of Resident #80's physician orders revealed an order dated 03/05/25 for BGT before meals and at bedtime and an order dated 03/06/25 for contact isolation due to possible Clostridium Difficile (C. diff or a contagious bacterium that can cause diarrhea, abdominal pain and tenderness). Review of Resident #80's MARS from 03/01/25 to 03/10/25 revealed the BGT's were due at 6:00 A.M., 11:00 A.M., 4:00 P.M. and 9:00 P.M. The documentation confirmed LPN #650 obtained a BGT due at 11:00 A.M. of 120 and no insulin was administered. On 03/10/25 at 12:53 P.M. revealed LPN #650 had donned a yellow isolation gown and gloves, picked up the glucometer and walked into Resident #80's room to obtain a blood sugar with a result of 106. The nurse disposed of the yellow isolation gown and gloves, performed hand hygiene and walked out of Resident #80's room with the BGT machine in the nurse's right pant leg pocket. Interview on 03/10/25 at 12:56 P.M. with LPN #650 confirmed she had placed the BGT machine in her right leg pocket prior to leaving Resident #80's room and the resident was in contact isolation precautions for C. diff. The nurse confirmed she had not sanitized and disinfected the BGT machine because she did not know what to sanitize and disinfect the machine with to prevent the potential of cross contamination of blood borne pathogens. Review of the Obtaining a Fingerstick Glucose Level policy dated 10/2011 revealed to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Review of the undated Blood Glucose Monitoring and Equipment Cleaning Competency form revealed in step 24 to disinfect the BGT meter before and after each use, or when the monitor was visibly soiled by using a Super Sani-Cloth Germicidal Disposable Wipe to wipe down the meter using caution not to get liquid in the test strip and key code parts of the meter. Allow the meter to dry completely before using for the next resident. If a Super-Sani Cloth was not available, use a 1:10 sodium hypochlorite solution and a soft cloth. The deficiency represents non-compliance investigated under Complaint Number OH00163622.		

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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** 34297 Based on record review and interview, the facility failed to ensure residents and/or representatives were provided education regarding the benefits and potential side affects of the influenza and pneumococcal immunizations and the resident's records reflected the consent or refusal of the vaccines and the education provided. This finding affected four (Residents #80, #166, #215 and #217) of five residents reviewed for immunizations. Findings include: 1. Review of Resident #80's medical record revealed the resident was admitted on [DATE] with diagnoses including acute kidney failure, diabetes and muscle weakness. Review of Resident #80's immunization section of the medical record revealed the resident refused the influenza and pneumococcal vaccines. There was no evidence the resident received a Vaccine Conset Form with education regarding the vaccine. Interview on 03/11/25 at 3:08 P.M. with Registered Nurse (RN) Infection Preventionist (IP) #338 confirmed these findings and revealed she was new to the IP role as of 03/10/25 and was unaware residents were not provided the Vaccine Consent Form for the influenza and pneumococcal vaccines which confirmed education on the risks and benefits including the right to refuse the vaccines were provided to the residents and/or resident representatives. Review of the Influenza policy revised 03/2022 revealed prior to the vaccination, the resident or resident's legal representative or employee would be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. Review of the Pneumococcal Vaccine policy revised 03/2022 revealed before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education was documented in the resident's medical record. Review of the undated Vaccine Consent Form revealed a yes or no was listed because the Pneumococcal Vaccine. The form stated the resident authorized or did not authorize the pneumococcal vaccine on admission. The resident was 65 or older and had not received the vaccine in the past or had received the vaccine before age 65 and it had been five years since the first dose. The resident did not have allergies to any vaccine component, nor had the resident had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if it was not covered under the insurance provider. (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated Vaccine Consent Form revealed a yes or no was listed beside the Influenza (flu) Vaccine. The form stated the resident authorized the flu vaccine to be administered yearly during the time period of 10/01 through 03/31 for the length of the residence. The resident did not have any allergies to eggs or any other vaccine component, nor had the resident ever had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if not covered by the insurance provider. 2. Review of Resident #166's medical record revealed the resident was readmitted on [DATE] with diagnoses including diabetes, anemia and essential hypertension. Review of Resident #166's immunization section of the medical record did not list the influenza and pneumococcal vaccines. Review of Resident #166's medical record did not have evidence the resident and/or representative signed a Vaccine Consent form for the influenza and pneumococcal vaccines. Interview on 03/11/25 at 3:08 P.M. with RN IP #338 confirmed these findings and revealed she was new to the IP role as of 03/10/25 and was unaware residents were not provided the Vaccine Consent Form for the influenza and pneumococcal vaccines which confirmed education on the risks and benefits including the right to refuse the vaccines were provided to the residents and/or resident representatives. Review of the Influenza policy revised 03/2022 revealed prior to the vaccination, the resident or resident's legal representative or employee would be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. Review of the Pneumococcal Vaccine policy revised 03/2022 revealed before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education was documented in the resident's medical record. Review of the undated Vaccine Consent Form revealed a yes or no was listed because the Pneumococcal Vaccine. The form stated the resident authorized or did not authorize the pneumococcal vaccine on admission. The resident was 65 or older and had not received the vaccine in the past or had received the vaccine before age 65 and it had been five years since the first dose. The resident did not have allergies to any vaccine component, nor had the resident had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if it was not covered under the insurance provider. (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated Vaccine Consent Form revealed a yes or no was listed beside the Influenza (flu) Vaccine. The form stated the resident authorized the flu vaccine to be administered yearly during the time period of 10/01 through 03/31 for the length of the residence. The resident did not have any allergies to eggs or any other vaccine component, nor had the resident ever had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if not covered by the insurance provider. 3. Review of Resident #215's medical record revealed th resident was readmitted on [DATE] with osteomyelitis, unspecified dementia and diabetes. Review of Resident #215's immunization section of the medical record revealed the resident refused the influenza vaccine and received the pneumococcal vaccine on 11/13/19. There was no evidence the resident received a Vaccine Conset Form with education regarding the vaccine. Interview on 03/11/25 at 3:08 P.M. with RN IP #338 confirmed these findings and revealed she was new to the IP role as of 03/10/25 and was unaware residents were not provided the Vaccine Consent Form for the influenza and pneumococcal vaccines which confirmed education on the risks and benefits including the right to refuse the vaccines were provided to the residents and/or resident representatives. Review of the Influenza policy revised 03/2022 revealed prior to the vaccination, the resident or resident's legal representative or employee would be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. Review of the Pneumococcccal Vaccine policy revised 03/2022 revealed before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education was documented in the resident's medical record. Review of the undated Vaccine Consent Form revealed a yes or no was listed because the Pneumococcal Vaccine. The form stated the resident authorized or did not authorize the pneumococcal vaccine on admission. The resident was 65 or older and had not received the vaccine in the past or had received the vaccine before age 65 and it had been five years since the first dose. The resident did not have allergies to any vaccine component, nor had the resident had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if it was not covered under the insurance provider. Review of the undated Vaccine Consent Form revealed a yes or no was listed beside the Influenza (flu) Vaccine. The form stated the resident authorized the flu vaccine to be administered yearly during the time period of 10/01 through 03/31 for the length of the residence. The resident did not have any allergies to eggs or any other vaccine component, nor had the resident ever had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if not covered by the insurance provider. (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #217's medical record revealed the resident was readmitted on [DATE] with diagnoses including pneumonia, acute bronchospasm and hyperlipidemia. Review of Resident #12's immunization section of the medical record revealed the resident received the influenza vaccine on 11/11/24 (prior to admission) and refused the pneumococcal vaccine. There was no evidence the resident received a Vaccine Consent Form with education regarding the vaccine. Interview on 03/11/25 at 3:08 P.M. with RN IP#338 confirmed these findings and revealed she was new to the IP role as of 03/10/25 and was unaware residents were not provided the Vaccine Consent Form for the influenza and pneumococcal vaccines which confirmed education on the risks and benefits including the right to refuse the vaccines were provided to the residents and/or resident representatives. Review of the Influenza policy revised 03/2022 revealed prior to the vaccination, the resident or resident's legal representative or employee would be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. Review of the Pneumococcal Vaccine policy revised 03/2022 revealed before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education was documented in the resident's medical record. Review of the undated Vaccine Consent Form revealed a yes or no was listed because the Pneumococcal Vaccine. The form stated the resident authorized or did not authorize the pneumococcal vaccine on admission. The resident was 65 or older and had not received the vaccine in the past or had received the vaccine before age 65 and it had been five years since the first dose. The resident did not have allergies to any vaccine component, nor had the resident had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if it was not covered under the insurance provider. Review of the undated Vaccine Consent Form revealed a yes or no was listed beside the Influenza (flu) Vaccine. The form stated the resident authorized the flu vaccine to be administered yearly during the time period of 10/01 through 03/31 for the length of the residence. The resident did not have any allergies to eggs or any other vaccine component, nor had the resident ever had an adverse reaction in the past. The resident had been informed of the side effects and was aware of the right to refuse. The resident understands that he/she may be billed for the vaccination if not covered by the insurance provider.		