STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375365	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pointe Rehabilitation and Care Center	5725 South Ross Oklahoma City, OK 73119

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 46653 Based on record review and interview, the facility failed to act upon grievances presented during residents council meetings or provide rationale as to why concerns could not be provided from the facility. The DON identified 177 residents resided in the facility. Findings: A facility's policy titled Grievance/Missing Property, revised 04/26/23, read in part, Purpose: To provide an opportunity for Residents, Resident Representatives, and/or Families to present concerns or Grievances to the proper authorities at the Facility and to receive responses to the issue(s) raised. On 04/28/25 at 11:37 a.m., resident council minutes were reviewed and no rationale was provided for the past 6 months from the facility staff. On 04/28/25 at 1:11 p.m., the administrator stated no issues or concerns in resident's council meetings had not been addressed in the past 6 month (November 2024, December 2024, January 2025, Feburary 2025, March 2025 and, April 2025.) On 04/28/25 at 1:12 p.m., the administrator stated resident council had requested lawn furniture since November 2024. Resident council had also expressed concerns with food temperatures and missing items in laundry rooms. On 04/28/25 at 1:13 p.m. the administrator stated they were not doing resident council grievances as they should.

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 35389 Based on record review and interview, the facility failed to ensure residents had access to their personal funds during non banking hours for 2 (#27 and #39) of 3 sampled residents reviewed for personal funds. The BOM identified 103 residents in the facility trust account. Findings: An undated resident trust fund policy and procedure, read in part, The resident or their legal guardian are the only ones who can designate what the monies are spent on and have the right to request their Resident Trust Fund Ledger at anytime .Residents shall be able to make withdrawals from their account at any time. 1. Resident #27's fund management service agreement, dated 03/09/23, read in part, I may make deposits to and withdrawals from my resident fund account at the facility. A quarterly resident assessment, dated 03/12/25, showed Resident #27's cognition was intact (BIMS 15). On 04/22/25 at 11:47 a.m., Resident #27 reported they had not been able to get their own money from their personal funds to give to their family member. They stated they had filed a grievance. 2. Resident #39's fund management service agreement, dated 02/21/21, read in part, I may make deposits to and withdrawals from my resident fund account at the facility. A quarterly resident assessment, dated 03/26/25, showed Resident #39's cognition was severely impaired (BIMS 04). On 04/22/25 at 12:59 p.m., family member #1 voiced concerns with whether or not Resident #39 was receiving their money. On 04/24/25 at 1:55 p.m., the BOM stated there was a box kept at the front receptionist desk that held personal funds for the residents to access when needed. They stated each day residents could request funds. They stated the receptionist would fill out the appropriate form and give the resident's up to $50 at a time. They stated if it was over the $50 amount, they would print out a receipt and have the resident sign it so it could get scanned in. The BOM stated the receptionist was only there during working hours. The BOM stated after that, the box was placed in a safe. On 04/24/25 at 1:11 p.m., the BOM stated the facilty had a receptionist on the weekend from 8:00 a.m. to 5:00 p.m. They stated the facility did not have a process in place for residents to access their funds during non banking hours. On 04/24/25 at 1:42 p.m., the BOM stated residents had access to their funds seven days a week during the hours of 8:00 a.m. to 5:00 p.m.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 35389 Based on record review and interview, the facility failed to ensure residents received quarterly statements for 2 (#27 and #39) of 3 sampled residents reviewed for personal funds. The BOM identified 103 residents in the facility trust account. Findings: An undated resident trust fund policy and procedure, read in part, An internal audit of the resident trust will be completed on a quarterly basis by the corporate office. The resident/legal guardian reserves the right to be informed of internal Resident Trust audits and the results of those audits. A resident trust statements signature page, dated 01/01/25 through 03/31/25, showed a blank for the signature for Resident #27 and Resident #39. 1. Resident #27's fund management service agreement, dated 03/09/23, read in part, I will receive a statement of any account I have at least uarterly [sic]. A quarterly resident assessment, dated 03/12/25, showed Resident #27's cognition was intact (BIMS 15). On 04/22/25 at 11:47 a.m., Resident #27 reported they had not been able to get their own money from their personal funds to give to their family member. They stated they had filed a grievance. 2. Resident #39's fund management service agreement, dated 02/12/21, read in part, I will receive a statement of any account I have at least uarterly [sic]. A quarterly resident assessment, dated 03/26/25, showed Resident #39's cognition was severely impaired (BIMS 04). On 04/22/25 at 12:59 p.m., family member #1 voiced concerns with whether or not Resident #39 was receiving their money. On 04/24/25 at 1:07 p.m., the BOM stated they were new to the position and now they were completing the resident trust statement list for quarterly statements. They stated they would have the residents sign they received the statement. They stated for residents who were unable to sign, they would place an m next to their name and the facility would mail the statement to the appropriate party. The BOM stated they were working on getting them in the mail yesterday and today. They stated the deadline was by the end of April for the quarter. On 04/25/25 at 7:20 a.m., the BOM stated they did not have quarterly statements for the resident trust accounts. They stated the previous employee had left and the BOM would have been responsible for the quarterly statements and they were not provided.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure residents were educated and offered the opportunity to create an advance directive for 5 (#46, 55, 77, 94, and #175) of 35 sampled residents reviewed for advance directives. The DON identified 177 residents who resided in the facility. Findings: 1. Resident #46 was admitted to the facility on [DATE]. A review of Resident #46's electronic health records showed no advance directive information had been provided. 2. Resident #55 was admitted to the facility on [DATE]. A review of Resident #55's electronic health records showed no advance directive information had been provided. 3. Resident #77 was admitted to the facility on [DATE]. A review of Resident #77's electronic heath record showed no advanced directive information had been provided. 4. Resident #94 was admitted to the facility on [DATE]. A review of Resident #99's electronic heath record showed no advanced directive information had been provided. 5. Resident #175 was admitted to the facility on [DATE]. A review of Resident #175's electronic heath record showed no advanced directive information had been provided. On 04/23/25 at 9:19 a.m., the DON stated the advance directive acknowledgement form was not completed on many residents because prior to March, they were just asking them about advance directives and putting the DNR in the chart if they had one.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30267 Based on record review and interview, the facility failed to perform a background check for 1 (contract laborer #1) of 1 contracted employee. The DON identified 176 residents resided in the facility. Findings: The employee file for contracted laborer #1 did not have proof a background check was performed. On 04/25/25 at 9:11 a.m., the HR specialist stated they did not know contract laborer #1 provided services in the facility until recently. The HR specialist stated the contracted laborer never returned the contract agreement they were to sign or provided information for their background check. The HR specialist did not know when the contracted laborer started working in the facility. The HR specialist stated they should know when the contracted laborer started but they did not get out of the office much and there was a general lack of communication among the administrative staff.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46653 Based on record review and interview, the facility failed to report an allegation of abuse for 1 (#79) of 4 sampled residents to the Oklahoma State Department Health for alleged abuse within 2 hours after the allegation was made. The DON identified 177 residents resided in the facilty. Findings: A facility's policy titled Abuse Prevention, dated 10/21/22, read in part, In addition, the facility will follow Section 1150B of the Social Security /Act's time limits for reporting a reasonable suspicion of crime (immediately but no later than 2 hours if abuse or seriously bodily injury . Resident #79's diagnoses which included major depressive disorder, seizures, suicidal ideations, and bipolar disorder. A incident report, dated 04/22/25 at 5:00 a.m., showed Resident complains of being slaps[sic] them on their buttocks every time incontinent care is done by a 10-6 staff member. A transaction report, dated 04/22/25, showed Incident report dated 04/22/25 at 5:00 a.m. for Resident #79 was faxed to the Oklahoma State Department of Health on 04/22/25 at 2:37 p.m. On 04/28/25 at 4:17 p.m., the DON stated the incident report for Resident #79 was not reported within the 2 hour timeframe.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure resident assessments were coded to reflect the status for 3 (#105, 126, and #175) of 35 sampled residents reviewed for resident assessments. The DON identified 177 residents resided in the facility. Findings: 1. Resident #105's care plan, dated 4/24/25, showed the resident had diagnoses which included dementia, heart failure and chronic obstructive pulmonary disorder. A progress note, dated 04/12/25, showed a nurse confirmed there was a new open wound on Resident #105's left buttock that was not there the week before. A quarterly MDS assessment, dated 04/15/25, showed Resident #105 had no wounds. On 04/28/25 at 1:25 p.m., MDS #2 stated they would expect the MDS to catch the wound and put it somewhere, once staff determined what kind of wound it was. On 04/28/25 at 2:55 p.m., the DON stated it was expected the MDS assessments be accurate. 2. Resident #175's care plan, dated 4/24/25, showed the resident had diagnoses which included severe intellectual disabilities and metabolic acidemia noted at birth. A progress note, dated 3/17/25 at 10:27 a.m., showed the nurse found no [NAME] tube (a low profile gastrostomy tube used for delivering nutrition). The note showed the physician sent Resident #175 to ER for replacement. A progress note, dated 3/17/25 at 4:27 p.m., showed Resident #175 returned from the ER with no peg tube in place and no new orders. A quarterly assessment, dated 04/09/25, showed peg tube as present even though it was not. On 04/23/25 at 9:07 a.m., LPN #2 stated Resident #175 was not on a feeding tube because they pulled it out on 3/17/25. LPN #2 stated Resident #175 ate well and their family stated they were the happiest they have ever been. On 04/24/25 at 12:27 p.m., MDS #1 stated Resident #175 does not have a peg tube. The quarterly assessment was coded inaccurately. 3. Resident #126's care plan, dated 04/16/2025, showed the resident had diagnoses which included unspecified dementia and abnormalities of gait and mobility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A fall incident report, dated 03/05/25, showed the resident was found face down on the floor. The report showed the resident was assessed and assisted back in bed. A fall incident report, dated 03/21/25, showed the resident was observed laying on the fall mat on their left side. The report showed the resident was assisted into their wheelchair. Resident #126's quarterly resident assessment, dated 03/26/25, showed the resident had no falls since admission/entry or reentry or the prior assessment. On 04/24/25 at 2:14 p.m., MDS #2 stated the 03/26/25 quarterly resident assessment showed the resident had no falls. On 04/24/25 at 2:15 p.m., MDS #2 stated the assessment should have captured the fall on 03/05/25 and 03/21/25. 48344

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35389 Based on observation, record review and interview, the facility failed to ensure physician ordered abdominal girth measurement amounts were completed for 1 (#21) of 1 sampled resident reviewed for non pressure skin conditions. The DON identified one residents with orders to measure abdominal girth resided in the facility. Findings: On 04/25/25 at 9:38 a.m., LPN #3 was observed measuring Resident #21's abdominal girth. They placed the measuring tape across the mid section of the abdomen and stated it measured 53 inches. A physician order policy, last reviewed 09/28/22, read in part, Physician Orders that are missing required components, are illegible or unclear must be clarified prior to implementation. A quarterly resident assessment, dated 02/12/25, showed Resident #21's cognition was intact (BIMS 15). A physician order, dated 02/25/25, showed daily girth/abdomen measurement one time a day for increased girth/abdomen. A nurse progress note, dated 03/02/25, showed the resident's girth measurement was 48.2 inches. A nurse progress note, dated 03/16/25, showed the resident's girth measurement was 43 inches. There was no measurement amount documented between the 03/02/25 and the 03/16/25 measurement. A nurse progress note, dated 03/24/25, showed the resident's girth measurement was 47.5 inches. There was no measurement amount documented between the 03/16/25 and the 03/24/25 measurement. A nurse progress note, dated 03/26/25, showed the resident's girth measurement was 48 inches. A nurse progress note, dated 03/31/25, showed the resident's girth measurement was 47.5 inches. There was no measurement amount documented between the 03/26/25 and the 03/31/25 measurement. The March 2025 TAR showed staff initials and a checkmark for completion daily for the daily girth/abdomen measurement order. There were no values of the measurement located on the TAR. A nurse progress note, dated 04/01/25, showed the resident's girth measurement was 47.4 inches. A nurse progress note, dated 04/07/25, showed the resident's girth measurement was 49 inches. There was no measurement amount documented between the 04/01/25 and the 04/07/25 measurement. A nurse progress note, dated 04/08/25, showed the resident's girth measurement was 49 inches. (continued on next page)

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	375365	A. Building B. Wing	04/28/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note, dated 04/14/25, showed the resident's girth measurement was 48 inches. There was no measurement amount documented between the 04/08/25 and the 04/14/25 measurement. A nurse progress note, dated 04/15/25, showed the resident's girth measurement was 49 inches. This was the most recent measurement amount documented. The April 2025 TAR showed staff initials and a checkmark for completion daily for the daily girth/abdomen measurement order. There were no values of the measurement located on the TAR. An order summary report, dated 04/25/25, showed Resident #21's diagnoses included abscess of the liver and stage three chronic kidney disease. On 04/23/25 at 11:13 a.m., Resident #21 stated staff were measuring their abdomen in the morning and weighed them to make sure it doesn't swell up. They stated they had a softball size mass in their liver that was removed, and they were monitoring them to ensure there were no more concerns with their liver. On 04/25/25 at 9:28 a.m., LPN #3 stated the staff did not have an option to put the amount of the abdominal girth measurement on the TAR. On 04/25/25 at 9:29 a.m., LPN #3 stated they did not have a value to compare the measurement to. They stated the value they were wanting them to compare was the daily weights. LPN #3 stated that was what they gathered from the report. LPN #3 stated they took a tape measure from the manager's office to measure Resident #21's abdomen. They stated they measured from the highest mid area of the abdomen. On 04/25/25 at 9:43 a.m., LPN #3 stated today the resident was 53 inches. They stated they wanted it to be between 53 and 60. They stated if it went above that, they would notify the physician. On 04/25/25 at 10:25 a.m., the DON stated unit manager #2 had reported they were monitoring Resident #21's abdominal girth due to everything that was going on with their wound and gallstones. They stated the unit manager would notify the physician if it got bigger, but I see there are no parameters. On 04/25/25 at 10:26 a.m., the DON stated the order should say when to notify the physician. On 04/25/25 at 10:27 a.m., the DON stated in order to generate a field to document the measurement value on the TAR, staff had to physically add it. They stated it did not automatically come up and staff would have to add supplementary documentation. The DON stated they just added it. They stated staff could also document in a progress note. On 04/25/25 at 10:28 a.m., the DON stated staff would not know if there was an increase in the resident's girth size if they were not documenting a value each day.

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	375365	A. Building B. Wing	04/28/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 46653 Based on record review and interview, the facility failed to ensure labs were obtained as ordered for: a. 1 (#24) of 1 sampled resident reviewed for dialysis; and b. 1 (#92) of 5 sampled residents reviewed for unnecessary medications. The DON identified 177 residents resided in the facility and three residents received dialysis services. Findings: 1. In the electronic health record, Resident #24's diagnosis sheet, dated 04/24/05, showed diagnoses which included renal dialysis and atrial fibrillation. Resident #24's Physician Order, read in part, revised 02/07/24 A1C Now AND EVERY 3 MONTHS (FEBRUARY, MAY, AUGUST, NOVEMBER). (A lab test that measures the average level of sugar in your blood over the past 2-3 months.) Labs services for Resident #24 was due for the month of Feburary 2025 and was not found. On 04/23/25 at 2:37 p.m., the DON stated the last A1C they had for Resident #24 was November 2024. On 04/24/25 at 11:21 a.m., LPN #4 stated they did not know how Resident #24's labs got missed. On 04/24/25 at 2:27 p.m., the director of nurses stated she did not think they had a policy. 2. Resident #92's physician's order, dated 01/24/25, showed Keppra level monthly for a total of three months starting on the 27th and ending on the 27th every month for seizures, and Keppra medications. A laboratory report for Keppra level, dated 01/28/25, showed a collection date of 01/27/25. There was no documentation the Keppra level was obtained for 02/2025 and 03/2025. Resident #92's order summary report, dated 04/2025, showed the resident had a diagnosis of seizures. On 04/28/25 at 1:37 p.m., the ADON stated the Keppra level was not obtained for 02/2025 and 03/2025. 48344

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 46653 Based on record review and interview, the facility failed to: a. notify the physician of missing labs for 1 (#24) of 1 residents reviewed for dialysis. b. develop a lab policy. The DON identified 177 residents resided in the facility. Findings: Resident #24's diagnosis sheet, dated 04/24/25, showed a diagnosis of renal dialysis. Resident #24's Physician Order, read in part, revised 02/07/24 A1C Now AND EVERY 3 MONTHS (FEBRUARY, MAY, AUGUST, NOVEMBER). (A lab test that measures the average level of sugar in your blood over the past 2-3 months.) Labs services for Resident #24 was due for the month of Feburary 2025 and was not found. On 04/23/25 at 2:37 p.m., the DON stated the last A1C they had for Resident #24 was November 2024. On 04/24/25 at 11:21 a.m., LPN #4 stated they did not know how Resident #24's labs got missed. On 04/24/25 at 2:23 p.m., the director of nurses stated we just notified the physician today. On 04/24/25 at 2:27 p.m., the director of nurses stated they did not think they had a policy for laboratory services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46653 Based on observation and interview, the facility failed to provide in between meal snacks for 1 (Hall 3) of 1 halls reported during resident council meeting. The administrator reported 174 residents were provided meals from the kitchen. Findings: A policy titled Meals and Snacks, dated 11/27/23, read in part, Meal service shall be provided to residents on a regularly scheduled basis according to facility established times. Nutritional Services shall be delivered to the nursing units by nutritional services personal. Nursing shall be responsible for distributing snacks to the residents. On 04/28/25 at 2:37 p.m., it was observed on hallway 3, no snacks were offered or distributed to residents. On 04/28/25 at 2:38 p.m., Resident #24 was visiting on hallway 3 and stated they did not get a 2:00 p.m. snack. On 04/28/25 at 2:46 p.m., Resident #79 stated they did not get a snack. On 04/28/25 at 3:16 p.m., the DON stated the snacks were not getting offered or distributed to the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375365	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Pointe Rehabilitation and Care Center	5725 South Ross Oklahoma City, OK 73119

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30267 Based on observation and interview, the facility failed to serve the noon day meal in a manner that minimized the risk of infection/cross contamination for 174 or 174 residents who ate meals prepared from the kitchen. The adminstrator identified 174 residents who ate meals from the facility kitchen. On 04/22/25 at 12:15 p.m., cook #1 was observed to plate food from the steam table to be served to residents. With gloved hands, the cook touched the counter, shelving, and utensils other kitchen staff had touched as well. [NAME] #1 was observed to use their gloved hands to hold plated food in position by placing their gloved fingers on the plate and pushing the food together to one side of the plate. The cook then used their gloved hands to place a roll on the residents' plates. On 04/22/25 at 12:25 p.m., the dietary manager stated the kitchen staff were to use serving utensils and tongs to plate food and not their gloved hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375365	A. Building B. Wing	04/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to ensure pneumococcal vaccines were offered to residents for 3 (#105, 123, and #133) of five sampled residents reviewed for vaccines. The DON identified 177 residents resided in the facility. Findings: The pneumococcal vaccine policy, last reviewed 04/28/22, read in part, The opportunity to receive the Pneumococcal Vaccine will be extended to all Residents. The Facility will provide pertinent information regarding the Risks/Benefits of receiving the Vaccine .Residents will be offered the Pneumococcal Vaccine upon Admission. 1. An admission record, dated 04/24/25, showed Resident #105 admitted to the facility on [DATE]. There was no documentation Resident #105 had been offered a pneumococcal vaccine. 2. An admission record, dated 04/24/25, showed Resident #123 admitted to the facility on [DATE]. There was no documentation Residents #123 had been offered a pneumococcal vaccine. 3. An admission record, dated 04/24/25, showed Resident #133 admitted to the facility on [DATE]. There was no documentation Residents #133 had been offered a pneumococcal vaccine. On 04/24/25 at 11:11 a.m., the IP stated they sent out letters to families of resident's who could not answer for themselves if they wanted to receive a vaccine. They stated for residents who could, they would ask them if they wanted to receive a vaccine. On 04/24/25 at 11:13 a.m., the IP stated immunizations were documented in the resident's clinical record. They stated it documented whether the resident or family agreed or declined the vaccine. On 04/24/25 at 11:14 a.m., the IP stated Resident #105 received a pneumonia vaccine on 11/02/98 and would be due for another pneumonia vaccine. On 04/24/25 at 11:33 a.m., the IP stated Resident #123 received the influenza vaccine at the hospital but not the pneumonia vaccine. On 04/24/25 at 11:37 a.m., the IP stated Resident #133 had not received a pneumonia vaccine.