STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to allow family visitation for one of one resident (Resident (R) 38). This failure violated R38's right as a resident of the facility and had the potential to violate the rights of 83 residents that lived in the facility. Findings include: Review of R38's admission Record located in the electronic medical record (EMR) under the Profile tab revealed R38 was admitted to the facility on [DATE]. Review of R38's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/22/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated the resident was severely cognitively impaired. During observation of the facility entrance on 05/21/25 at 12:40 PM, a sign was posted that read, ATTENTION! ATTENTION! VISITING HOURS: 7 AM - 7 PM, NO RE-ENTRY AFTER 7 PM. CALL [Phone number] FOR AUTHORIZED RE-ENTRY. During an interview on 05/21/25 at 12:33 PM, the Receptionist stated the facility had a visitor's policy of 7:00 AM to 7:00 PM with no re-entry to the facility after 7:00 PM without authorized entry. She stated she usually left the building between 4:30 PM - 5:00 PM. During an interview on 05/21/25 at 12:45 PM, the Administrator stated the facility had a visitor's sign posted at the front door of the facility restricting visitors to 7:00 AM to 7:00 PM unless authorized to re- enter the building. During an observation on 05/21/25 at 3:30 PM, the phone number listed on the posted sign for visiting hours located by the front door entrance was called. The phone number was answered by the facility receptionist. (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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 11:30 AM, Family (F) 4 stated during a recent visit with R38, she requested some food items from a nearby grocery store. F4 stated he left the facility to go to the grocery store and when he returned at 7:10 PM, he was denied re-entry by a staff member (name unknown). He stated the staff member said she would deliver the food items to R38 but could not allow him to come inside as instructed by the Administrator. F4 also stated he worked during the week and got off work too late to visit R38, because the posting at the front door to the facility stated he must have authorization to enter the facility after 7:00 PM. He stated he called the phone number listed on the posted sign multiple times, but no one answered the phone. He stated he also called to speak to R38 during business hours and was transferred to the charge nurse for R38. He stated most of the time, a nurse would not answer his calls but if a charge nurse answered, he was told the batteries for the portable phones were not charged and they could not take the phone to her room. During an observation on 05/22/25 at 7:10 PM, 7:30 PM, and 7:45 PM, the phone number listed on the posted sign for visiting hours located by the front door entrance was called. The phone number was not answered by a staff member or by an answering service and had no voice mail service. During an interview on 05/23/25 at 4:15 PM, the Director of Nursing (DON) stated visiting hours for the facility were from 7:00 AM to 7:00 PM as posted at the front door entrance. She also stated that visitors could call the listed phone number for authorized re-entry to the facility. She stated the phone number was answered by the nursing staff and that they have portable telephones that could be answered from anywhere in the facility and that were used by residents needing to receive phone calls from family members. She stated she never called the phone number to audit the phone was answered by the nursing staff during business hours or after business hours. During an interview on 05/23/25 at 4:30 PM, the Administrator stated the visiting hours posting located at the front door entrance indicated visiting hours to be 7:00 AM - 7:00 PM but she said family members could call the phone number listed at any time and be allowed entrance to the facility. She stated that she was not sure where the phone number was routed in the facility, but the nursing staff were responsible for answering the phone after business hours. The surveyor informed the administrator that the phone number was answered by the receptionist at 3:30 PM but was not answered on three subsequent calls after 7:00 PM. The Administrator was asked if she ever audited the phone number to verify staff members answering the phone number after 7:00 PM. She replied she had never called the phone number after business hours and was not aware that the phone number was unanswered. She stated her expectation was for the phone to be answered by the nursing staff after hours but that sometimes they were too busy to answer the phone.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on review of the facility policy, observations and interviews, the facility failed to ensure residents' equipment was kept clean and blinds were in good working order for two of two residents (Residents (R) 47, and R72) reviewed for the environment of 21 sample residents. Specifically, R47's bedside fall mats were observed with a dry brown substance, and R72's window blinds were in disrepair. This failure had the potential to not support the residents' right to a safe, clean, comfortable, and homelike environment. Findings Include: Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated 12/08, revealed Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC [Centers for Disease Control and Prevention] recommendations for disinfection and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard. 1. During observations conducted on 05/21/25 at 10:29 AM, 05/22/25 at 9:09 AM, and 05/23/25 at 10:00 AM, R47's fall mats, located on the floor next to the resident's bed, had dried brown colored substance splattered on the mats. During an interview on 05/23/25 at 10:02 AM, Housekeeper (Hskp) 1 was asked who was responsible for ensuring the resident's bedside equipment was kept clean from spills. Hskp1 stated that the nurse aides were responsible for keeping the bedside equipment clean. During an interview on 05/23/25 at 10:03 AM, Certified Nursing Assistant (CNA) 1 was asked who was responsible for ensuring the resident's bedside equipment was kept clean from spills. CNA1 responded that they (CNAs) did it, or they could contact housekeeping to assist. During an interview on 05/23/25 at 10:09 AM, the Assistant Director of Nursing (ADON) confirmed R47's fall mats were soiled, and the expectation would be that the staff would clean any spills right away. During an interview on 05/23/25 at 12:19 PM, the Director of Nursing (DON)was questioned what her expectations were related to keeping resident's bedside equipment, such as the floor fall mats. The DON responded that housekeeping was responsible for cleaning the floor fall mats and would have expected that staff would do a check and cleaning throughout their shifts for soiled equipment. 2. During observations conducted on 05/21/25 at 10:46 AM, 05/22/25 at 1:30 PM, and 05/23/25 at 9:50 AM, the window blinds in R72's room appeared to be bent and not in good working order. During an observation and interview on 05/23/25 at 9:50 AM, the window in R72's room had been opened allowing the fully extended window blinds to flap in the wind. R72 was asked if he would like the window blind raised so it would stop flapping in the wind. R72 shook his head to indicate yes. CNA2 was asked to raise the window blinds in R72's room to stop the flapping of the blind. CNA2 tried to raise the window blinds but the bent slats of the blinds would not allow her to raise the blinds, and the center of the blinds appeared to fall from the middle of the blind support. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/25 at 4:30 PM, the Administrator stated she was not aware that the window blinds were not in good working order and that the maintenance department staff was responsible for making sure the window blinds in each resident room were in good working order. She stated she had not visually seen the window blinds and did not ensure the maintenance department staff consistently monitored the condition of the window blinds. She stated a staff member (name unknown) had reported the broken window blinds in R72's room and that it had been repaired on 05/23/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record reviews and interviews, the facility failed to report an allegation of resident-to-resident abuse for two of three residents (Resident (R) 28 and R35) reviewed for abuse out of 21 sampled residents. This had the potential to affect all residents who received care. Findings include: Review of the facility's undated policy titled, Abuse Prevention Policy and Procedure, revealed once a complaint or situation is identified involving alleged mistreatment, neglect, exploitation, or abuse, including injuries of unknown source and misappropriation of resident property the incident will be immediately reported. If the event that caused the allegation involves abuse or results in serious bodily injury, the report must be made within two hours to the Administrator, Director of Nursing, Physician and Medical Director, and SC-DHEC (South Carolina Department of Health and Environmental Control). Review of R28's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of R28's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R28 was cognitively intact. Review of R28's Nurse's Note, dated 11/23/24 at 10:54 PM located in the EMR under the "Notes" tab, written by Licensed Practical Nurse (LPN) 3 revealed, Resident was throwing punches with another resident. During an interview on 05/22/25 at 3:15 PM, R28 stated R35 accused him of taking his money so he hit him in his d*** face. He said the staff broke it up and separated them. He said when the staff asked him about what happened that he told the staff he hit the other resident. Review of R35's Face Sheet located in the EMR under the Profile tab revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included major depressive disorder. Review of R35's quarterly MDS with an ARD of 03/13/25 and located in the resident's EMR under the MDS tab revealed a BIMS score of 12 out of 15 which indicated R35 was moderately cognitively impaired. During an interview on 05/22/25 at 3:00 PM, R35 stated on 11/23/24, R28 wanted to borrow a dollar from him and then he rolled off. R35 stated then he wheeled forward and they hooked up. He said that meant they started fighting. He stated R28 hit him in the face, and then the staff stepped in and broke it up. He stated he was not afraid, and it hasn't happened again. Review of Facility Reportable Logs, from May 2024 to May 2025, revealed the incident that occurred on 11/23/24 was never reported to the state survey agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/25 at 2:14 PM, the Director of Nursing (DON) stated they did not suspect abuse and that was why it was not reported within two hours. She said she interviewed the residents the following day and neither told her that R28 hit R35. She confirmed she did not interview the resident within two hours, and did not report it.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record reviews and interviews, the facility failed to investigate an allegation of resident-to-resident abuse for two of three residents (Resident (R) 28 and R35) reviewed for abuse out of 21 sampled residents. This had the potential to affect all residents who received care. Findings include: Review of the facility's undated policy titled, Abuse Prevention Policy and Procedure revealed, once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, the following investigation and reporting procedures will be followed: I. The description of the alleged complaint is written on the investigation form. Any physical evidence and description of emotional state will be documented. 2. Information gathering - The following information will be gathered: Who did it? (who is the suspect); Who did they do it to? (who is the resident); What happened? (be specific about the event that occurred); When did it happen? (be as specific as you can with date and time it occurred); Where it happened? (the residents room, bathroom, dining room, etc.); Why? (or any extenuating circumstances that you might have information about. For example, the resident became very combative and was hitting at the aide and the aide hit back). 3. Interviews will be conducted of all pertinent parties. Written signed statements from any involved parties will be obtained and notarized, if possible. Statements will be gathered from the suspect, person making accusations, resident involved, reliable residents who may have witnessed the incident, and any other persons who may have some information. 4. Past performances and/or previous incidents of involved parties will be evaluated. 5. All investigative information will be kept on file in a secure location. All information gathered is confidential in nature. Review of R28's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of R28's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R28 was cognitively intact. Review of R28's Nurse's Note, dated 11/23/24 at 10:54 PM, located in the EMR under the Notes" tab, written by Licensed Practical Nurse (LPN) 3, revealed Resident was throwing punches with another resident. During an interview on 05/22/25 at 3:15 PM, R28 said R35 accused him of taking his money so he hit him in his d*** face. He said the staff broke it up and separated them. He said when the staff asked him about what happened that he told the staff he hit the other resident. Review of R35's Face Sheet located in the EMR under the Profile tab revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included major depressive disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R35's quarterly MDS with an ARD of 03/13/25 and located in the resident's EMR under the MDS tab revealed a BIMS score of 12 out of 15 which indicated R35 was moderately cognitively impaired. During an interview on 05/22/25 at 3:00 PM, R35 said on 11/23/24, R28 wanted to borrow a dollar from him and then he rolled off. R35 stated then he wheeled forward and they hooked up. He said that meant they started fighting. He stated R28 hit him in the face, and then the staff stepped in and broke it up. He stated he was not afraid, and it hasn't happened again. During an interview on 05/23/25 at 2:14 PM, the Director of Nursing (DON) stated they did not suspect abuse and that was why it was not investigated.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a written transfer notice that contained all required information was provided for two of five residents and/or their representatives (Resident (R) 11 and R39) reviewed for hospital transfer out of 21 sample residents. This failure had the potential to affect the residents and their Resident Representative (RP) by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired. Findings include: 1. Review of R11's admission Record located in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including intellectual disabilities. Review of R11's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 04/24/25, revealed he had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R11 was cognitively intact. Review of the R11's Evaluations tab, Documents tab, and Progress Notes tab of the EMR did not reveal evidence that a written notice of transfer was provided to R11 or their RP after a facility-initiated transfer to the hospital on [DATE]. 2. Review of R39's admission Record located in the Profile tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including major depressive disorder. Review of R39's quarterly MDS located under the MDS tab of the EMR and with an ARD of 02/06/25 revealed he had a BIMS score of 11 out of 15, which indicated R39 was moderately cognitively impaired. Review of the R39's Evaluations tab, Documents tab, and Progress Notes tab of the EMR did not reveal evidence that a written notice of transfer was provided to R39 or their RP after a facility-initiated transfer to the hospital on [DATE] and 07/27/24. During an interview on 05/22/25 at 2:19 PM, the Administrator stated the facility has not been sending out a transfer notice anytime a resident was discharged from the facility. She said she was unaware they were supposed to.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure there was an active physician ' s order for oxygen administration for one of one residents reviewed, (Resident (R) 12) reviewed for oxygen administration of 21 sample residents. This failure had the potential for residents to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen). Findings include: Review of R12's admission Record, located in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including intellectual disabilities. Review of R12's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/13/25, revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed. Review of R12's Care Plan located under the Care Plan tab of the EMR, dated 03/31/25, revealed the resident was on continuous oxygen therapy. Review of R12's Physician Orders located under the Orders tab in the EMR, dated 07/21/23, revealed no current order for oxygen. During observations on 05/21/25 at 4:35 PM, 05/22/25 at 3:15 PM, and 05/23/25 at 10:33 AM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at two LPM (liters per minute). During an observation and interview on 05/23/25 at 10:33 AM, Licensed Practical Nurse (LPN) 2 observed R12 in bed with nasal cannula on at two LPM. She stated R12's oxygen order was two liters continuously. She said she had not looked at the order in a while, but she was sure she had seen one. She stated staff should be looking at the order every time they were checking the resident's oxygen saturation and flow. During an interview on 05/23/25 at 12:06 PM, the Nurse Practitioner (NP) said R12's order for oxygen was discontinued and he should not be receiving continuous oxygen. She said she was unaware that staff were still administering. She said she would have expected staff to discontinue the order and stop administering it to R12. During an interview on 05/23/25 at 4:15 PM, the Director of Nursing (DON) said nursing staff should be looking at the physician orders each time they assessed the resident to ensure the correct liters and oxygen saturations. She stated she also expected staff to stop administering oxygen after an order to discontinue it.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure residents received alternative measures prior to the installation of side rails and that assessments were completed for the risk of entrapment for one of two residents (Resident (R) 12) reviewed for side rails out of 21 sample residents. The lack of alternate side rail measures and proper assessment could lead to potential restraint or side rail entrapment. Findings include: Review of R12's admission Record located in the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including intellectual disabilities. Review of R12's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/13/25, revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed. Review of R12's Care Plan, located under the Care Plan tab of the EMR and dated 03/31/24, revealed The resident was at risk for ADL [activities of daily living] decline. Interventions in place were bilateral siderail per family request. Review of R12's Physician Orders, located under the Orders tab in the EMR and dated 05/22/25, revealed, no order for siderail use. Review of R12's Siderail Assist Device, located under the Observations tab in the EMR and dated 05/20/25, revealed no evidence of alternates explored or an assessment of the risk for entrapment. During observations on 05/22/25 at 3:15 PM and 05/23/25 at 10:33 AM, the resident was lying in bed with head of bed upright, full side rails up on both sides. During an interview on 05/22/25 2:38 PM, the MDS Coordinator (MDSC) stated she completed R12's side rail assessment. She stated they were not exploring alternates prior to side rail use or assessing for risk of entrapment. She said the facility was unaware of these requirements. During an interview on 05/23/25 at 4:15 PM, the Director of Nursing (DON) said upon siderail use staff completed a side rail assessment and they got signed consent. The DON stated they were not exploring alternatives or assessing for entrapment.

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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 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. Based on observation and interviews, the facility failed to label and date all food stored in the walk-in cooler and ensure food was cooked at the proper temperature prior to service with the potential to affect 79 of 83 residents who consumed food prepared from the facility's kitchen. This failure had the potential to lead to food borne illnesses. Findings include: During initial observation of the kitchen and interview on 05/21/25 at 9:45 AM with the Dietary Manager (DM), the walk-in refrigerator revealed a container of leftover meat that he could not identify; not labeled or dated. A box of sausage links in the walk-in refrigerator was opened and sausage links wrapped in aluminum foil were not labeled or dated. The walk-in refrigerator also contained a half full pitcher with the appearance of orange juice/pulp that separated from the water content with no label or date. The DM said, oh we don't serve from a pitcher anyway, we use the juice dispenser. The walk-in cooler also contained an opened package of cheese, not labeled, or dated. The prepared cups of tea did not have lids that properly fit the cups, and the DM did not know what happened to the correct lids for the serving cups. During observation and interview on 05/23/25 at 12:10 PM, the Dietary Manager (DM) utilized a digital thermometer to check the food temperature of the meat patties being served. It was found to be at a temperature of 126 degrees Fahrenheit (F). He stated he had checked the temperature before serving the meat and determined it was not at the proper temperature, so he removed a portion of the meat patties and placed them back in the oven to increase the temperature. However, he continued to serve some of the meat patties at an unacceptable safe temperature for meat patties. A re-check of the meat patties temperature at 12:20 PM indicated the temperature was 155 degrees and appeared to be crisp and dry. During an interview on 05/23/25 at 1:00 PM, the DM stated that he was aware that re-heating the meat patties had caused them to be dry and tough and should have been prepared to the proper temperature initially, before serving the residents. The DM stated his expectation was for the temperature to be 165 degrees F with a holding temperature of 135 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure that residents were offered and received the pneumonia vaccinations for two of five residents (Resident (R) 45 and R57) reviewed for immunization of 21 sample residents. This places residents at an increased risk of complications related to pneumonia. Findings Include: Review of the facility's policy titled, Immunizations-Pneumococcal Vaccination (PPV), dated 06/19, revealed the facility will follow current recommended practice guidelines for the pneumococcal vaccination. Residents will be offered the pneumococcal vaccination as appropriate. 1. Review of R45's undated admission Record located in the electronic medical record (EMR) under the Profile tab, indicated that R45 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, diabetes, and chronic kidney disease. Review of R45's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score was four out of 15 which indicated the resident was severely cognitively impaired. Additionally, it was indicated under the Pneumococcal Vaccine section that the resident's Pneumococcal vaccination was not up to date, and the reason selected was it was not offered. Review of R45's Immunization Record located in the EMR under the Immunization tab, revealed R45 had not received or been offered the pneumococcal immunization. 2. Review of R57's undated admission Record located in the EMR under the Profile tab, indicates that R57 was admitted to the facility on [DATE], with diagnoses including cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side, and hypertension. Review of R57's quarterly MDS with an ARD date of 01/23/25, located in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. The MDS indicated that R57's pneumococcal vaccination was up to date, although there was no additional documentation provided. Review of R57's Immunization Record located in the EMR under the Immunization tab, revealed R57 had not received or been offered the pneumococcal immunization. During an interview conducted on 05/22/25 at 12:16 PM, the Director of Nursing (DON) confirmed that R45 and R57 had not received or been offered the pneumococcal vaccination. DON stated R45's resident representative was called on 05/21/25 at 4:29 PM to obtain consent on behalf of R45 to receive the pneumococcal vaccination. The DON stated, additionally R57 was offered and accepted the pneumococcal vaccination on 05/21/25 at 5:32 PM. DON added that R45 and R57 were offered the vaccinations, and they had gone back and forth on whether they wanted the vaccinations, but the DON had no evidence to corroborate this statement. DON stated she would expect the Infection Preventionist (IP) to offer the vaccinations to residents and/or resident representatives and to document any refusal of the vaccinations.