STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465188	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pointe Meadows Health and Rehabilitation	2750 North Digital Drive Lehi, UT 84043

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that services provided by the facility, as outlined by the comprehensive care plan, met professional standards of quality. Specifically, for 2 out of 49 sampled residents, medications were left unattended at a resident's bedside and a resident's tube feed was not labeled with the date and time. Resident identifiers: 5 and 128. Findings include:1. Resident 128 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and cognitive communication deficit. On 8/4/25 at 9:03 AM, an interview was conducted with resident 128. The medication Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated was observed on resident 128’s bedside table. When resident 128 was asked how often she took the medication, resident 128 stated that she thought she took the medication twice a day. When resident 128 was asked if the staff allowed her to keep the medication at bedside, resident 128 stated “no” the staff would usually take the medication away after use but sometimes they would forget the medication. Resident 128’s medical record was reviewed on 8/5/25. A physician's order dated 7/28/25, documented Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT [micrograms per actuation] (FluticasoneSalmeterol) 1 puff inhale orally two times a day for COPD [chronic obstructive pulmonary disease.]” It was documented on the August 2025 Medication Administration Record that the medication had been administered on the morning of 8/4/25. On 8/6/25 at 7:53 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that if a resident was self administering medication there had to be a physician’s order to leave the medications at bedside. LPN 1 stated medications like ear drops, eye drops, and albuterol inhalers were examples of medications she would consider leaving at the bedside or medications that the resident took often. LPN 1 stated there was one resident on the other side of the building that administered their own medications. On 8/6/25 at 8:14 AM, an interview was conducted with LPN 6. LPN 6 stated that medication should not be left at the residents bedside unless there was a physician’s order to do so. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/25 at 12:10 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that generally staff should not leave medications at the residents bedside unless the resident had it care planned and a self administration assessment had been completed. 2. Resident 5 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included nontraumatic intracranial hemorrhage, aphasia, quadriplegia, and hydrocephalus. On 8/4/25 at 8:22 AM, an observation was made of resident 5. Resident 5 was observed to have a feeding tube. The tube feed bag was observed to be unlabeled and undated. Resident 5’s medical record was reviewed on 8/4/25 through 8/7/25. A review of resident 5’s physician orders revealed, “Enteral feed order every shift CONTINUOUS FEEDING OF: [NAME] Farms 1.4 50cc/hr [cubic centimeter/hour] + [plus] FWF [free water flush] 75 cc/hr from 15:00 [3:00 PM] to 11:00 am daily. …” On 8/5/25 at 2:10 PM an interview was conducted with LPN 2. LPN 2 stated that resident 5 had a continuous tube feed. LPN 2 stated that resident 5 was disconnected from the tube feed from 11:00 AM to 3:00 PM daily. On 8/6/25 at 9:47 AM, an interview was conducted with LPN 3. LPN 3 stated that all tube feeds should be labeled with the date, time the tube feed was started, and initialed by the nurse. On 8/7/25 at 8:24 AM, an interview was conducted with the DON. The DON stated that for tube feeds every 24 hours a new bottle or bag and tubing should be replaced. The DON stated that there should be a date and time labeled on the tube feed bottle or bag.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the resident received treatment and care in accordance with professional standards of practice. Specifically, for 1 out of 49 sampled residents, a resident reported constipation with no bowel movement for five days and no effective treatment was provided. Resident identifier: 119.Findings included: Resident 119 was admitted to the facility on [DATE] with diagnoses which included, psoas muscle abscess, cognitive communication deficit, and neuromuscular dysfunction of bladder.Resident 119's medical record was reviewed on 8/4/25 through 8/7/25.On 8/4/25 at 9:07 AM, an interview was conducted with resident 119. Resident 119 stated that he had been really constipated and had not had a bowel movement for a while. Resident 119 stated that his stomach hurt. An observation was made of resident 119's abdomen and it appeared distended.A review of resident 119's physician orders revealed:a. Bisacodyl Rectal Suppository 10 milligram (mg). Insert one suppository rectally every 24 hours as needed for no results from Senna Plus-Bowel Care. Notify Provider if no results. Start date: 7/28/25.b. Lactulose Oral Solution 10 gram (gm)/15 milliliters (ml). Give 15 ml by mouth one time a day for constipation. Hold for loose stools. Start date 7/29/25.c. MiraLax Oral Powder 17 gm/scoop. Give 17 gm by mouth every 24 hours as needed for bowel care. Mix in six toeight8 ounces of liquid. Start date 7/28/25.d. Naloxegol Oxalate Oral Tablet 25 mg. Give one tablet by mouth in the morning for opioid-induced constipation. Hold for loose stools. Start date: 7/29/25.e. Senna-Plus Oral Tablet 8.6-50 mg. Give one tablet by mouth every 12 hours as needed for Miralax ineffective - Bowel Care. Start date 7/28/25.A review of resident 119's bowel log revealed bowel movements on 7/30/25 at 2:01 PM and 7/30/25 at 9:05 PM.A review of resident 119's Medication Administration Record revealed:a. Lactulose was not given to resident 119 on 7/31/25, as the medication was pending delivery from the pharmacy. It should be noted that resident 119 refused the medication on 7/29/25.b. Naloxegol was not given to the resident on 8/3/25 and 8/4/25, as the medication was on order. c. Bisacodyl Rectal Suppository had not been given to resident 119.d. MiraLax had been given to resident 119 on 7/31/25, 8/3/25, and 8/4/25.e. Senna had been given to resident 119 on 8/4/25. A review of resident 119's progress notes revealed:a. On 7/29/25 at 3:35 PM, a Nurse Practitioner / Physician Assistant progress note documented, . his last BM [bowel movement] was a couple of days ago and he does feel like he is getting constipated.b. On 7/31/25 at 9:26 AM, an electronic Medication Administration Record (eMAR) medication administration note documented, Lactulose Oral Solution 10 GM/15ML Give 15 ml by mouth one time a day for constipation. Hold for loose stools. pending delivery from pharmacy.c. On 7/31/25 at 4:54 PM, an eMAR medication administration note documented, MiraLax Oral Powder 17 GM/SCOOP Give 17 gram by mouth every 24 hours as needed for Bowel Care *Mix in 6 to 8 ounces of liquid PRN [as needed] Administration was: Unknown pt [patient] able to sit on commode and pass gas, which did relieve some discomfort, but no BM as of yetafter [sic] miralax given.d. On 8/3/25 at 8:35 AM, an eMAR medication administration note documented, Naloxegol Oxalate Oral Tablet 25 MG Give 1 tablet by mouth in the morning for opioid-induced constipation. Hold for loose stools. drug on order., miralax given. e. On 8/4/25 at 8:47 AM, an eMAR medication administration note documented, Naloxegol Oxalate Oral Tablet 25 MG Give 1 tablet by mouth in the morning for opioid-induced constipation. Hold for loose stools. drug on order.f. On 8/4/25 at 10:31 AM, an eMAR medication administration note documented, MiraLax Oral Powder 17GM/SCOOP Give 17 gram by mouth every 24 hours as needed for Bowel Care Mix in 6 to 8 ounces of liquid per patient request.g. On 8/4/25 at 2:47 PM, an eMAR medication administration note documented, MiraLax Oral Powder 17GM/SCOOP.PRN Administration was: Ineffective not effective.h. On 8/4/25 at 2:47 PM, an eMAR medication administration note documented, Senna Plus Oral Tablet 8.6-50 MG Give 1 tablet by mouth every 12 hours as needed for Miralax ineffective - Bowel Care per patient request.A review of resident 119's care plan did not reveal any focus, goals, or interventions regarding constipation.On 8/6/25 at 8:17 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that residents were checked every two hours to see if they had a bowel movement. CNA 1 stated that they informed nurses if a resident complained of constipation. CNA 1 stated that CNAs documented in the resident's chart when residents had bowel movements. CNA 1 stated that CNAs do not monitor how often residents had bowel movements as that was something nurses did.On 8/6/25 at 8:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that nurses monitored resident's bowel movements by what CNAs document in the chart. LPN 1 stated that residents should not go more than three

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with accepted professional principles, and the drugs were stored under proper temperature controls. Specifically, for 2 out of 49 sampled residents, the medication cart contained an opened insulin vial that had expired and there were three unopened insulin auto injector pens that were stored in the medication cart instead of the refrigerator. Resident identifiers: 29 and 111.Findings included:On [DATE] at 7:53 AM, an observation was conducted of the E hall medication cart with Licensed Practical Nurse (LPN) 1. A vial of insulin lispro that belonged to resident 29 was labeled with an open date of [DATE]. LPN 1 verified the open date on the vial and stated that resident 29's insulin came from a different facility with resident 29. LPN 1 stated as long as the insulin was not open the insulin was good by the expiration date on the bottle. LPN 1 stated that once the insulin was opened it was good for 30 days. LPN 1 stated that there were still a few days left before resident 29's insulin vial needed to be discarded. Three insulin auto injector pens were observed in the medication cart unopened. LPN 1 stated that the insulin auto injector pens had not been opened as of yet. The Humalog kwikpen that belonged to resident 111 was in a bag labeled refrigerate. LPN 1 stated resident 111 had an insulin pump and resident 111's blood glucose was checked every four hours. LPN 1 stated that resident 111 was a type 1 diabetic and the insulin pump would malfunction. There were two lispro insulin kwikpens that belonged to resident 29 unopened and stored in the medication cart. LPN 1 stated the unopened insulin was stored in the medication cart and the extras would be stored in the medication fridge. On [DATE] at 8:14 AM, an interview was conducted with LPN 6. LPN 6 stated that insulin was good for 28 days once it was opened. LPN 6 stated that she dated everything when it was opened.On [DATE] at 10:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that insulin should be dated with an open date and was good for 28 days. The DON stated if the insulin was not open and in use it should be stored in the refrigerator.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not file in the resident's clinical record the laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, for 2 out of 49 sampled resident's, laboratory results were not located in the medical record. Resident identifiers: 3 and 10. Findings included:1. Resident 3 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia, Crohn's disease, and hemiplegia affecting the left nondominant side.Review of resident 3's medical record was completed on 8/4/25 through 8/7/25.On 5/19/25, a completed Physician's Order documented a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP), one time only for follow up labs. It should be noted that no laboratory results could be located in the medical record.On 7/5/25 at 9:44 AM, a Nursing progress note revealed the provider gave orders for immediately (STAT) CBC and CMP related to the patient complaining of burning with urination.On 7/5/25, a completed Physician's Order documented a STAT CBC and CMP one time only.It should be noted that no laboratory results could be located in the medical record.On 7/16/25 at 2:44 PM, a Nursing progress note revealed new orders per the physician's assistant, Clostridioides difficile (C-diff) sample due to diarrhea greater than five days.On 7/16/25, a completed Physician's Order documented C-diff one time only for diarrhea.It should be noted that no laboratory results could be located in the medical record.2. Resident 10 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, diabetes mellitus with kidney complication, and chronic kidney disease.Review of resident 10's medical record was completed on 8/4/25 through 8/7/25. On 7/6/25, an active physician's order for Glycated Hemoglobin (HgbA1C) to be drawn every six months on the 7th for diabetes.It should be noted that no laboratory results could be located in the medical record.On 8/7/25 at 9:39 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated that if a STAT lab was requested, the results were usually faxed to the facility then reviewed by the medical provider. For routine labs, those results were located on the online portal, medical records would then upload the results to the resident's medical record.On 8/7/25 at 11:20 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated they were having issues with the online lab portal that was providing their lab results. The facility had reached out and recently made changes to their online portal. The ADON stated that she had been tracking ordered labs and lab results with a spreadsheet and binder, so she was aware of which labs need to be attached to the resident's medical record. The ADON stated that Medical Records oversaw that lab results were attached to the resident's medical record, that was done by going to the online portal, downloading the lab results, and uploading them to the resident's medical record.On 8/7/25 at 11:20 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the lab results for resident 3 and resident 10 were not in their medical record, they were found on the website the facility used to retrieve results and were downloaded when requested to view results. The DON stated that STAT labs were located on a different online portal than the routine lab results. The DON stated that she was the one that accepted the labs to be reviewed by the provider, and this was done within 24 hours, sooner if there was an urgency regarding the results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 4 out of 49 sampled residents, Enhanced Barrier Precautions (EBP) were not implemented for a resident with a peripherally inserted central catheter (PICC) line and the glucose monitor was not disinfected between resident usage. Resident identifiers: 6, 29, 119, and 121.Findings included:1. On 8/6/25 at 7:25 AM, Licensed Practical Nurse (LPN) 1 was observed to return to the medication cart after obtaining resident 29’s blood sugar. LPN 1 was observed to gather supplies for the next resident. LPN 1 did not clean or disinfect the glucose monitor. On 8/6/25 at 7:26 AM, LPN 1 was observed to donn gloves, collect an alcohol wipe, lancet, glucose monitor, and enter resident 121’s room. LPN 1 was observed to obtain resident 121’s blood sugar, doffed the gloves, and used the alcohol based hand rub (ABHR) in the hallway. LPN 1 went back to the medication cart and gathered supplies for the next resident. LPN 1 did not clean or disinfect the glucose monitor. On 8/6/25 at 7:29 AM, LPN 1 was observed to donn gloves, collect an alcohol wipe, lancet, glucose monitor, and enter resident 6’s room. LPN 1 was observed to obtain resident 6’s blood sugar, doffed the gloved, and used the ABHR in the hallway. LPN 1 went back to the medication cart and was observed to wipe down the glucose monitor with an alcohol wipe and immediately put the glucose monitor in its case and in the medication cart. On 8/6/25 at 7:33 AM, an interview was conducted with LPN 1. LPN 1 stated that she cleaned the glucose monitor every time she did a resident blood sugar. LPN 1 stated she wiped down the glucose monitor with the alcohol wipe before she left the resident room. LPN 1 stated she would wipe the glucose monitor down again with an alcohol wipe when she was finished with all of the resident blood sugars and would put the glucose monitor away. LPN 1 stated the glucose monitor brand was a One Care Pro. The medication cart on the E hall was observed with purple top wipes. On 8/6/25 at 10:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the glucose meter should be cleaned in between resident usage preferably with a bleach wipe. The DON stated there were purple or blue top wipes, germicidal disposable wipes, on the medication carts. On 8/6/25 at 1:08 PM, an interview was conducted with LPN 3. LPN 3 stated that she would use the purple top wipes on the glucose monitor between residents. LPN 3 stated she would wipe down the glucose monitor and would wait the two minute dry time. LPN 3 stated she would check the crevices of the glucose monitor to make sure there was no blood. The medication cart on the F hall was observed with purple top wipes. On 8/6/25 at 1:46 PM, an interview was conducted with LPN 7. LPN 7 stated that she would clean the glucose monitor between residents with the saniwipes and she would let the glucose monitor dry before using it again. The medication cart on the A hall was observed with blue top wipes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Infection Control Policy and Procedure for Glucometer, Cleaning and Disinfection of was reviewed. “POLICY: It is the policy of this facility to follow recommendation from the CDC [Centers for Disease Control and Prevention]. The CDC states that HBV [hepatitis B Virus] can survive for at least one week in dried blood on environmental surfaces or on contaminated instruments. The following recommendations provide the guidance for cleaning and decontamination of glucometers that may be contaminated with blood and body fluids. PROCEDURES: 1. Clean glucometer surface when visible blood or bloody fluids are present by wiping with a cloth dampened with soap and water to remove any visible organic material. 2. If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer’s directions using a cloth/wipe with either an EPA [Environmental Protection Agency]-registered detergent/germicide with a tuberculocidal or HBV/HIV [human immunodeficiency virus] label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration. Additional Information: • Directions for glucometer disinfection vary between manufacturers and models within brands. • Many manufacturers do not recommend the use of quaternary ammonium compounds because of the corroding effects on metal parts. This includes products that combine bleach with detergents or disinfectants. • All manufacturers caution that having the cloth too saturated could allow liquid to get inside the glucometer and cause damage. Screens and ports currently are not sealed on these devices. Therefore, using a bleach-only disinfecting wipe is less likely to cause Damage. …” The policy was issued and revised on 12/2009. Resident 119 was admitted to the facility on [DATE] with diagnoses which included, psoas muscle abscess, cognitive communication deficit, and neuromuscular dysfunction of bladder. 2. On 8/4/25 at 8:50 AM, an observation was made of resident 119’s room. There was no EBP signage or Personal Protective Equipment (PPE) on the resident’s door or inside the resident’s room. On 8/4/25 at 8:55 AM, an observation was made of LPN 5 access resident 119’s PICC line without wearing a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/25 at 8:59 AM, an interview was conducted with resident 119. Resident 119 stated that he had been receiving intravenous (IV) antibiotics while at the facility. Resident 119’s medical record was reviewed on 8/4/25 through 8/7/25. A review of resident 119’s physician orders revealed that on 7/28/25 at 10:31 PM, Enhanced Barrier Precautions were ordered. A review of resident 119’s care plan dated 7/29/25, revealed a focus of “[Resident 119] has infection of Psoas Muscle: 7/29/25: IV Cefepime and Daptomycin until 09/02/2025.” Interventions included, “Use Enhanced Barrier Precautions.” On 8/5/25 at 2:10 PM, an interview was conducted with LPN 2. LPN 2 stated that residents that have tube feeds, urinary catheters, and central or midlines all required the use of EBP. On 8/5/25 at 2:28 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that residents should have EBP precautions if they have PICC lines, catheters, or for a resident that may get an infection easily. CNA 2 stated that she wore PPE if she was bathing a resident or performing any personal hygiene on a resident with EBP. CNA 2 stated that she knew which residents were on EBP because there was a sign on the door stating that the resident required EBP. CNA 2 stated that if there was no sign then the resident did not require any precautions or special PPE. On 8/7/25 at 8:28 AM, an interview was conducted with the DON. The DON stated that residents who have dialysis and urinary catheters should have EBP. The DON stated that any direct care with these residents required a gown and gloves. The DON stated that residents that have EBP have a sign on their door and bin full of gowns and gloves outside the room. The DON stated that there was a collaboration between nursing staff and the Infection Preventionist about who puts the precaution signs up on resident’s doors. The DON stated that if a resident had a PICC line then they would require EBP.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident was offered the pneumococcal vaccine. In addition, the resident's medical record did not include documentation that indicated the resident either received, refused, or the vaccine was medically contraindicated. Specifically, for 1 out of 5 sampled residents, a resident did not have documentation in the medical record stating either the pneumococcal immunization was offered, received, or refused. Resident identifier: 93.Findings included:Resident 93 was admitted to the facility on [DATE] with diagnoses which included chronic diastolic heart failure, emphysema, and unspecified dementia. Review of resident 93's medical record was completed on 8/4/25 through 8/7/25.A form titled admission Immunization Record and Consent Form was reviewed. Under Pneumococcal Vaccine: lists four different options; I have been screened and found to be eligible to receive the Pneumococcal vaccine, I have received verbal and written patient education concerning the risks vs benefits of receiving this, I understand the risks and benefits and desire to RECEIVE the pneumococcal vaccine, I understand the risks and benefits and wish to REFUSE the pneumococcal vaccine, or I have already received two (2) pneumococcal immunizations. It was noted there were no marked options for pneumococcal vaccine. No documentation was located indicating that resident 93 had a history of previously receiving the pneumococcal vaccine or had been offered the pneumococcal vaccine.The Center of Disease Control (CDC) recommends adults 50 years or older to be administered the pneumococcal vaccine, if they have never received one or whose previous vaccination history is unknown.On 8/7/25 at 9:39 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated when a resident was admitted to the facility the admitting nurse would briefly go over vaccines and ask if any were needed. LPN 4 stated the vaccines which were offered were Coronavirus disease 2019 (COVID 19), influenza, and pneumococcal. LPN 4 stated that the immunization history was per resident's recall or listed in the admitting paperwork. If a resident was wanting any of the offered vaccines, the nurse was able to administer those vaccines. LPN 4 stated he would document resident's vaccine refusals in the medical record.On 8/7/25 at 10:41 AM, an interview was conducted with LPN 1. LPN 1 stated the facility had a sheet that listed three vaccines; COVID-19, influenza, and pneumococcal. When a resident was admitted to the facility the nurse would review and offer the three vaccines. LPN 1 stated that if it was not flu season at the time of admission the influenza vaccine would not be offered at that time. The nurse would ask the resident about the resident's pneumococcal vaccine status to see if they have had any. LPN 1 stated the sheet was then forwarded to the Infection Preventionist (IP). The IP would then follow up and provide education with the resident regarding any refusals or pneumococcal vaccine status. LPN 1 stated that when a resident wanted or needed the pneumococcal vaccine, an order would be placed to the pharmacy and once it arrived it would then be administered to the resident.On 8/7/25 at 11:05 AM, an interview was conducted with the IP. The IP stated that she tracks a new resident's immunization status with a vaccine question form that was filled out by the admitting nurse. The IP stated that she would review, follow-up, and track the resident, regarding the vaccines that were due and offered pneumococcal and COVID-19. Every year during the flu season, influenza vaccines were offered to all the residents. The IP stated that all residents should be offered the vaccines and this needed to be documented in the resident's chart if the vaccine was administered or refused.On 8/7/25 at 11:43 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that vaccines should be offered to all residents upon admission to the facility. If a resident was requesting or in need of the pneumococcal vaccine, they would check the CDC guidelines to confirm if the resident was able to receive it. It should be documented in the resident's medical record if any vaccine was administered or refused. For the pneumococcal vaccine it should be documented in the resident's record regarding the CDC guidelines, if the resident was unable to receive one. https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html