STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555132	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vista Nursing and Transitional Care LLC	6120 N. Vineland Ave North Hollywood, CA 91606

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure staff followed the facility's Infection Prevention Control Policy to prevent the spread of infection, when facility failed to ensure the facility's Water Management Program (WMP - a written, step-by-step plan for buildings to ensure their water system was safe, clean, and efficient) was implemented as written. This failure had the potential to result in a lack of a structured plan and allows dangerous pathogens to thrive in the water system, that can lead to disease outbreaks in the facility and cause residents to get sick. Findings: During a concurrent interview and record review on 5/20/2026 at 11:20 a.m. with the Infection Preventionist (IP) and Maintenance Supervisor (MS), the facility's document titled, Water Management Program 2026 Committee was reviewed. The IP stated that he (IP) and the MS are responsible for the water management plan for the facility. The Water Management Program 2026 Committee indicated the meeting was conducted on 1/2/2026. The IP stated the purpose of water management is to prevent having legionella (bacteria found in freshwater environments can multiply rapidly in man-made water systems, posing a serious health risk if inhaled as mist or vapor) in the facility. The IP stated that he (IP) is not responsible for the implementation of water management since he (IP) was not the one checking the temperatures. The IP stated the MS checked the water temperatures. The MS stated that he (MS) checks the hot temperature but not the cold temperature or the chlorine content for any of the water sources. The IP stated the legionella infection prevention plan meeting includes the Administrator (ADM), me (IP), and the MS. The IP stated the MS is supposed to oversee Legionella. The MS stated he (MS) only checks hot temperature, does not perform chlorine testing, and does not check cold water temperatures. The IP stated the ADM is aware of the water management plan. The IP and MS stated the plan provided doesn't talk about what to do in an emergency, if needed. During a review of the facility's policy and procedure (P&P) titled, Legionnaire's Disease, dated 6/2017, the P& P indicated the facility will determine risk areas by completing the Building Water System Process Flowchart, implement controls, and indicate where these controls are located by completing the Control Area Monitoring Flowchart. During routine inspections of control areas, the facility will attempt to reduce areas of concern with the specific plans that have been developed. Preventative maintenance plans have been developed for each control area. During a review of the facility's Environmental Assessment Form (EAF), undated, the EAF indicated the section for who is completing the assessment was blank or not completed. The EAF indicated the total rooms and number of buildings was not filled out. The EAF indicate the section where the buildings with supplemental disinfection was blank or not filled up. The EAF for Measured Water System Parameters indicated to measure and document the current physical and chemical characteristics of the potable water, as this can help determine whether conditions are likely to support Legionella growth-think sediment, temperature, water age, and disinfectant residual. STEP 1: Plan a sampling strategy that incorporates all central water heaters/boilers, storage tanks, and various points along each loop of the potable water system. For example. If the facility has one loop serving all occupant rooms, an occupant room near (proximal) the central hot water heater and another at the farthest point (distal) of the loop should be sampled, at a minimum. STEP 2: For each sampling point (e.g., tap in an occupant room), turn on the hot water tap and allow the hot water tap to (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	run until is it as hot as it will get. Collect at least 50 milliliter (ml - a unit of measure for volume) and measure the temperature. Document the temperature and the time it took to reach the maximum temperature. Measure the disinfectant level and pH (measurement that indicates how acidic or basic a liquid is). Measure free chlorine if the disinfectant is chlorine. Measure total chlorine if another disinfectant is used. Repeat for the cold water after letting the tap run for 30 seconds.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic (ATB - a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic use protocols and a system to monitor antibiotic use for two of four sampled residents (Resident 46 and 66) when the facility failed to: 1. Ensure Resident 46's Ciprofloxacin HCl (a type of antibiotic) Oral Tablet 500 milligrams (mg - a unit of weight) for urinary tract infection (UTI - an infection in the bladder/urinary tract) had monitoring for its adverse effects (an unwanted, harmful, or unpleasant physical or mental reaction caused by a medical treatment, such as a medication or surgery).ˆ 2. Ensure there was monitoring for adverse side effects for Resident 66's cephalexin (a widely used prescription antibiotic designed to treat common bacterial infections of the skin, ears, bones, and the urinary or respiratory tracts) use. These deficient practices placed Resident 46 and 66 at risk for unmonitored development of adverse side effects which may result to delay in providing care the resident needs and result in multidrug resistant organisms (MDRO - are types of bacteria or germs that have developed the ability to withstand multiple, common antibiotics that used to kill them) resistance to antibiotics. Findings: 1. During a review of Resident 46's admission Record (AR), the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including UTI, neuromuscular dysfunction of bladder (a breakdown in communication between the brain, spinal cord, and bladder muscles), and punctured wound of abdominal wall. During a review of Resident 46's History and Physical (H&P), dated 4/11/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate impaired cognition (an intermediate stage of brain decline between normal aging and dementia). The MDS indicated the resident was on high-risk drug class antibiotic. During a review of Resident 46's Order Summary Report (OSR), dated 5/11/2026, the OSR indicated an order for Ciprofloxacin HCl Oral Tablet 500 mg (Ciprofloxacin HCl). Give one (1) tablet by mouth every 12 hours for UTI for seven (7) Days. During a review of Resident 46's Care Plan (CP) Report titled, Resident is on antibiotic therapy related to urinary tract infection and at risk for adverse reaction., initiated on 5/11/2026, the CP indicated an intervention to observed for any side effect or any adverse reactions of antibiotic therapy and call MD once noted. During a concurrent interview and record review on 5/20/2026 at 3:41 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 46's OSR, Progress Notes, and CP were reviewed. The MDSC stated there was an order for Ciprofloxacin HCl Oral Tablet 500 mg (Ciprofloxacin HCl). Give 1 tablet by mouth every 12 hours for UTI for 7 days on the resident's chart however, he (MDSC) cannot find the monitoring for adverse effects on the use of this significant medication. The MDSC stated there was a care plan to monitor for its adverse effects but there was no documentation to support that it was being done. The MDSC stated it was important to monitor for antibiotic Ciprofloxacin adverse effects to ensure its safe use. The MDSC stated monitoring for the adverse effects of the drug (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevents residents from suffering from harmful effects of the drug for the attending physician to promptly intervene. During an interview on 5/21/2026 at 1:52 p.m. with the Director of Nursing (DON), the DON stated Resident 46's use of Ciprofloxacin should have monitoring for its adverse effects to prevent residents from its harmful effects and the physician can intervene and change the course of antibiotic treatment and prevent antibiotic resistance. 2. During a review of Resident 66's AR, the AR indicated the facility admitted the resident on 2/20/2026 with diagnoses including visual loss both eyes, lack of coordination, and protein-calorie malnutrition (a condition when the body does not get enough nutrition and the body begins to break down its own muscles, fat, and tissues leading to weight loss). During a review of Resident 66's H&P, dated 2/20/2026, the H&P did not indicate Resident 66's capacity to understand and make decisions but had cognitive impairment. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make her needs known. The MDS further indicated Resident 66 had impairment of both upper and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 66 received antibiotics. During a review of Resident 66's telephone order, dated 5/6/2026, the telephone order indicated the following physician's order: Cephalexin oral tablet 7500 milligrams (mg – a unit of measurement) give 1 tablet by mouth every six (6) hours for 7 administrations until finished. During a review of Resident 66's care plans (CP) on antibiotic therapy, initiated on 5/6/2026, the CP indicated to administer medication as ordered, monitor the resident's vital signs and notify the physician for abnormal results, and observe for any side effect or any and call the physician once noted as a few of the interventions implemented to keep Resident 66 free of any signs and symptoms of adverse side effects from antibiotic. During a review of Resident 35's progress notes in the electronic health record (EHR) from 5/6/2026 to 5/11/2026, the progress notes did not indicate any monitoring for adverse side effects for the use of cephalexin on the following days and shifts: - 5/6/2026: 11 p.m. to 7 a.m. shift - 5/7/2026: 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. - 5/8/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. - 5/9/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. - 5/10/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/11/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. During an interview on 5/19/2026 at 11:30 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if residents are on antibiotic therapy, licensed nurses (LNs) are supposed to monitor the residents for adverse side effects every shift for the duration of the therapy and documented in the progress notes as the residents could have adverse reactions. LVN 2 stated it was important that the residents are not monitored every shift for adverse reactions as it could result in a delay in notifying the physician and result to a delay in resident care. During a concurrent interview and record review on 5/20/2026 at 9:58 a.m. with the MDSC, Resident 66, physician's order, CP, and progress notes were reviewed. The MDSC stated that Resident 66 had an order for cephalexin every 6 hours for 7 administrations until finished dated 5/6/2026. The CP indicated to monitor Resident 66's vital signs and observe for adverse side effects every shift and notify the physician, and that the progress notes did not indicate that Resident 66 was monitored for any adverse side effects on 5/6/2026: 11 p.m. to 7 a.m. shift; 5/7/2026: 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.; 5/8/2026 to 5/11/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. The MDSC stated if residents are on antibiotic therapy, the licensed nurses (LNs) are supposed to monitor the residents for adverse side effects every shift for the duration of the therapy plus another 3 days and document in the progress notes as the residents could develop adverse reactions. The MDSC stated that if the residents are not monitored every shift for adverse reactions and develop adverse side effects, it could result in a delay in notifying the physician which could result to the resident not receiving the care needed. The MDSC stated that the LNs should have monitored Resident 66 every shift for adverse side effect for the use of cephalexin as it is considered a high-risk medication and placed Resident 66 at risk for developing adverse side effects that the LNs did not know and could result in a delay in notifying the physician and delay in providing the care Resident 66 needed. During an interview on 5/21/2026 at 2:10 p.m. with the DON, the DON stated that the LNs are supposed to monitor the residents every shift for any adverse side effects with the use of antibiotic such as nausea, vomiting, diarrhea, or allergic reactions for the duration of the antibiotic and document in the progress notes. The DON stated that cephalexin is a significant medication and that monitoring for adverse side effects every shift was important so that the staff can detect immediately and notify the physician so the necessary treatment can be provided to the resident. The DON stated that the LNs should have monitored Resident 66 for development of any adverse side effects every shift and document in the progress notes. The DON stated that if Resident 66 was not monitored every shift, Resident 66 could develop adverse side effects without the staff being aware which could lead to a delay in notifying the physician and providing the necessary care for Resident 66. During a review of the facility's recent policy and procedure (P&P) titled, Antibiotic Stewardship, last reviewed on 4/23/2026, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Policy Interpretation and Implementation 3. Training and education will include emphasis on the relationship between antibiotic use and: a. gastrointestinal (related to the stomach and intestines) disorders; b. opportunistic infections; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. medication interactions; and d. the evolution of drug-resistant pathogens.^ During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 4/23/2026, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) regarding the resident's condition and response to care. The P&P further indicated: - The following information is to be documented in the resident's medical record: a. Objective observations b. Medications administered c. Treatments or services performed d. Changes in the resident's condition e. Events, incidents or accidents involving the resident f. Progress toward or changes in the care plan goals and objectives. - Documentation of procedures and treatments will include care-specific details, including: a. The date and time the treatment/procedure was provided. b. The name and title of the individual(s) who provided the care. c. The assessment date and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician, or other staff, if indicated.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure the influenza (also known as the flu, a highly contagious viral infection that attacks the respiratory system) Vaccination Record consent was signed by the Licensed Vocational Nurse (LVN) and the witness signature was obtained for four of four sampled residents (Resident 15,51,50 and 28). 2. Ensure one of four sampled residents (Resident 28) had documented evidence that the pneumonia (an infection in one or both lungs that causes lungs to become inflamed and fill with fluid or pus) vaccine was offered and administered when the consent was signed 9/2025 for Resident 28. These failures had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to pneumonia and influenza. Findings: 1a. During review of Resident 15's admission Record, the admission record indicated Resident 15 was initially admitted to the facility on [DATE], with diagnoses including type II diabetes (DM - a chronic condition that affects the way the body processes blood sugar) with foot ulcer (an open sore, wound, or crater that develops on the skin of your foot), immunodeficiency (weakened or absent immune system, making the body highly susceptible to frequent, severe, or unusual infections), and atherosclerotic heart disease (a condition where fatty deposits build up and harden inside your arteries, restricting oxygen-rich blood flow to your organs and limbs). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 15's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 15 required maximal assistance from staffs for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 15's Flu Vaccination Record Consent, dated 2/24/2026, the Flu Vaccination Record Consent indicated a missing signature from the licensed nurse who obtained and verified the consent. 1b. During review of Resident 51's admission Record, the admission record indicated Resident 51 was initially admitted to facility on 1/23/2026 with a diagnoses including DM with foot ulcer, cellulitis (potentially serious bacterial skin infection) of the left lower limb, and paraplegia (a medical condition characterized by partial or complete paralysis of the lower half of the body). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 15's cognitive skills for daily decisions were intact with normal thinking and memory function. The MDS indicated Resident 51 requires partial moderate assistance from staff for ADLs. During a review of Resident 51's Flu Vaccination Record Sheet, dated 1/28/2026, the Flu Vaccination Record Consent indicated a missing signature from the licensed nurse who obtained and verified the consent. 1c. During review of Resident 50's admission Record, the admission Record indicated Resident 50 was initially admitted to facility on 10/10/2025, with diagnoses including leukemia (a group of cancers that affect the blood and bone marrow) and DM . During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 50 required moderate assistance from staffs for ADLs. During a review of Resident 50's Flu Vaccination Record Sheet, dated 10/23/2025, the Flue Vaccination Record Sheet did not indicate a licensed nurse signature who obtained and witnessed for the signature. 1d. During review of Resident 28's admission Record, the admission record indicated Resident 28 was initially admitted to facility on 8/29/2025 with diagnoses including displaced fracture of fourth cervical vertebra (the fourth bone from the top of your neck is broken and has moved out of its normal alignment) and fracture of nasal bones (a crack or break in one or both of the paired nasal bones). During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 28 required maximal assistance from staffs for ADLs. During an interview on 5/20/2026 at 8:42 a.m. with the Infection Preventionist (IP), the IP stated residents that are newly admitted will be offered the influenza and pneumonia vaccine within the first five days of admission. During concurrent (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review and interview on 5/20/2026 at 8:42 a.m. with the IP, Resident 15's Informed Consent for Pneumococcal Polysaccharide Vaccine and Immunization Record, dated 2/24/2026, was reviewed. Resident 15's Informed Consent for Pneumococcal Polysaccharide Vaccine indicated the vaccine was administered six days after the consent was signed. The IP stated vaccines should be administered as soon as possible after the consent was signed by the resident to make sure any signs and symptoms that will show up after the vaccine is administered will be related to the vaccine. The IP reviewed Resident 15, 51, and 50's Flu Vaccination Record Consent and stated Resident 15, 51, and 50's consents were missing the licensed nurse's signature for who obtained the consent. The IP stated it is important for forms to be completed and signed by whoever obtained the consent to make sure that the vaccines were explained. 2. During a concurrent interview and record review on 5/20/2026 at 10:28 a.m. with the IP, the IP stated Resident 28 refused the flu vaccine in 9/2025. The IP stated he (IP) does not recall if the pneumococcal vaccine was offered since it is not in Resident 28's medical record. The IP stated consents and vaccine records are missing for Resident 28. The IP stated it is important for forms to be completed, signed, and filed in the medical records. During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, dated 1/2026, the P&P indicated all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. During a review of the facility's P&P titled, Pneumococcal Vaccine, dated 1/2026, the P&P indicated all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Provide documented evidence of all employees screening, education, offering, and current Corona virus disease, COVID-19 (highly contagious respiratory illness caused by the SARS-CoV-2 virus) vaccination (medications used to prevent diseases usually given by injection) status. 2. Ensure COVID-19 vaccine screening was done for two of three sampled residents (Resident 50 and 51). These failures had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to COVID-19. Findings: 1. During a concurrent interview and record review on 5/20/26 at 8:42 a.m. with the Infection Preventionist (IP), the Staff roster vaccination list was reviewed. The Staff roster vaccination list indicated the sections for the Administrator, Dietary Aide 1, and Head [NAME] were blank. The IP stated he (IP) does not have the Administrator, Dietary Aide 1, and the Head Cook's records. During a review of the facility's policy and procedure (P&P) titled, Corona virus Disease (COVID-19)-Vaccination of Staff, dated October 2022, the P&P indicated staff are required to be fully vaccinated for COVID-19 unless exempted by law. 2a. During review of Resident 51's admission Record, the admission record indicated Resident 51 was initially admitted to facility on 1/23/2026, with diagnoses including type two diabetes (DM - a chronic condition that affects the way the body processes blood sugar) with foot ulcer (an open sore, wound, or crater that develops on the skin of your foot) and cellulitis (potentially serious bacterial skin infection) of the left lower limb, and paraplegia (a medical condition characterized by partial or complete paralysis of the lower half of the body).^^ During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool), dated 4/21/2026, the MDS indicated that Resident 15's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact with normal thinking and memory function. The MDS indicated Resident 51 requires partial moderate assistance from staff for activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 5/20/2026 at 8:42 a.m. with the IP, Resident 51's COVID-19 Vaccine Consent Form, dated 1/28/2026, was reviewed. The COVID-19 Vaccine Consent Form indicated a missing screening section for vaccine eligibility. The IP stated Resident 51's COVID-19 vaccine form was not filled out. The IP stated screening is important to prevent unnecessary double dosing of vaccines. 2b. During review of Resident 50's admission Record, the admission record indicated Resident 50 was initially admitted to facility on 10/10/2025, with diagnoses including leukemia (a group of cancers that affect the blood and bone marrow), DM and keratitis (inflammation of the eye). During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 50 required moderate assistance from staff for ADLs. During a concurrent interview and record review on 5/20/2026 at 8:42 a.m. with the IP, Resident 50's COVID-19 Vaccine Consent Form, dated 10/23/2025, was reviewed and indicated a missing screening section for vaccine eligibility. The IP stated Resident 50's COVID-19 vaccine form was not filled out. During a review of the facility's P&P titled, Coronavirus Disease (COVID-19)-Vaccination of Residents, dated 6/2022, the P&P indicated residents are screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine.