STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676170	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Dominic Village Rehabilitation and Nursing Cent	2409 E Holcombe Blvd Houston, TX 77021

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to Centers for Medicare and Medicaid Services a complete and accurate direct care staffing information, including information for agency and contract staff, based on 1 of 4 quarters for payroll and other verifiable and auditable data in a uniform format according to specification established by Centers for Medicare and Medicaid Services. The facility failed to submit to Centers for Medicare and Medicaid Services the Payroll Base Journal data for the second quarter of 2026. The failure could put Residents at risk for inadequate staffing and not having their needs meets. Findings include: Record review of Centers for Medicare and Medicaid Services-Payroll Base Journal Staffing Data Report CASPER Report 1705D-Fiscal Year Quarter 2 -2026 (January 1-March 31) reveals the facility failed to submit data for the second quarter of 2026. In an interview on 6/25/2026 at 9:16 a.m. with the Administrator, he stated he has been at the facility since 2018. He stated the Payroll Base Journal for the second quarter of 2026 was not submitted due to transition of human resource personnel. He stated human resources was responsible for submitting Payroll Base Journal. He states the risk to the resident if the Payroll Base Journal are not able to be verified that the facility may not have adequate care for the Residents. In an interview on 6/25/22026 at 9:21 a.m. with the Human Resource Director, she states she has been working at the facility for three weeks. She states she has no idea why the Payroll Base Journal was not submitted for the second quarter of 2026. She stated human resources are responsible for ensuring it was completed. She states the risk to the Residents was the facility may not have adequate staffing levels to meet the needs of the Resident. Record review of the facility policy titled, Payroll Base Journal-Staffing revised in August 2023 revealed, Policy Statement: It is the policy of the facility that the Human Resource Director or Designee submit the Payroll Base Journal according to Centers for Medicare and Medicaid Services schedule below:

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 13% based on 4 errors out of 30 opportunities, which involved 3 of 4 residents (Resident #1, Resident #51, and Resident #75) and 1 of 1 staff (MA A) observed during medication administration reviewed for medication errors. The facility failed to ensure:1. Resident #1's Aspercreme lidocaine patch 4% was applied to the correct area of the body as ordered2. Resident #1 received the enteric coated extended release aspirin instead of chewable aspirin3. Resident #51 did not receive Vitamin D 25 mcg without a physician's order4. Resident #75 received the correct dosage of Cetirizine HCl Theses failures could place residents at risk of not receiving therapeutic dosages and/or effects of medications. Findings included:Resident #1Observation and interview on 6/24/26 at 8:47 a.m. revealed MA A administered chewable aspirin 81 mg tablet to Resident #1 orally and applied lidocaine patch 4% to Resident #1's right knee. MA A asked Resident #1 where she wanted the lidocaine patch and Resident #1 said she wanted the lidocaine patch on her right knee. Record review of Resident #1's Order Summary Report dated 6/24/26 revealed physician orders for aspirin EC oral tablet delayed release 81 mg with instructions to give 1 tablet my mouth one time a day, Aspercreme Lidocaine External Patch 4% (Lidocaine) with instructions to apply to across chest topically one time a day for pain and remove per schedule and Aspercreme Lidocaine External Patch 4% (Lidocaine) with instructions to apply to between shoulder blades topically one time a day for pain and remove per schedule. Record review of Resident #1's June 2026 MAR revealed administration on 6/24/26 at 9 a.m. both lidocaine administrations had a notation of 2 which per the MAR chart code meant Drug Refused. MAR revealed administration of aspirin EC oral tablet delayed release 81 mg with instructions to give 1 tablet by mouth one time a day on 6/24/26 at 9 a.m. Record review of Resident #1's progress notes revealed progress notes dated 6/24/26 at 11:21 a.m. of Note Text: Aspercreme Lidocaine External Patch 4% Apply to between shoulder blades topically one time a day for PAIN and remove per schedule want on right knee nurse notified. Record review of Resident #1's progress notes revealed progress notes dated 6/24/26 at 11:22 a.m. of Note Text: Aspercreme Lidocaine External Patch 4% Apply to across chest topically one time a day for PAIN and remove per schedule resident want on right knee charge nurse notified. Resident #51Observation on 6/24/26 at 8:31 a.m. revealed MA A administered Vitamin D 25 mcg orally to Resident #51. Record review of Resident #51's Order Summary Report dated 6/24/26 did not reveal a physician's order for Vitamin D 25 mcg. Record review of Resident #51's June 2026 MAR did not reveal Vitamin D 25 mcg. Resident #75Observation on 6/24/26 at 8:47 a.m. revealed MA A administered cetirizine hydrochloride 10 mg to Resident #75. Record review of Resident #75's Order Summary Report dated 6/24/26 revealed physician's order for Cetirizine HCl oral tablet 10 mg with instructions to give 0.5 tablet by mouth one time a day. Record review of Resident #75's June 2026 MAR revealed administration of Cetirizine HCl oral tablet 10 mg with instructions to give 0.5 tablet by mouth one time a day on 6/24/26 at 9 a.m. During interview on 6/24/2026 at 10:31 a.m., MA A said Resident #51 was on a vitamin and that she had just gotten back to work recently and maybe they had changed the order, but the order was supposed to be for vitamin B12. MA A said that the order was for Resident #75's Cetirizine was for 1/2 tablet. MA A said the cetirizine tablet did not have a score line so she would not be able to score the medication to administer a half tablet and she would notify the nurse to notify the doctor. MA A said Resident #1's aspirin should not have been chewable. MA A said she let Resident #1's nurse know that she was in pain somewhere different each time regarding the lidocaine patch. MA A said Resident #1 wanted the lidocaine patch on her leg rather than the shoulder. MA A said the possible effect it could have on a resident if they were given the wrong medication was that hopefully they were not allergic and she would let the nurse know that it was a medication error. MA A said they did in-services twice a month and as needed that include information regarding hand washing, blood pressure parameters and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	isolation. During interview on 6/24/2026 at 10:42 a.m., LVN B said she would speak to the doctor today when they come to the facility regarding the Cetirizine for Resident #75 because the medication could not be cut in half as ordered. On 6/25/2026 at 10:40 a.m., the surveyor attempted to contact the Consultant Pharmacist and left a message with the surveyor's contact information but did not receive a return phone call. During interview on 6/25/2026 at 1:51 p.m., RN A said she was the nurse for Resident #1. RN A said that the lidocaine patch order for Resident #1 was for across her chest and to her shoulders. RN A said the MA A came and told her that she put the patch on Resident #1's leg. RN A said she told Resident #1 that she had an order for the lidocaine patch that was to her chest and shoulder and if she was having pain somewhere else to let her know and she would take care of it. RN A said she checked Resident #1 this morning and this afternoon after therapy and she was doing fine. RN A said she told the MA A to let her know if there was another location that Resident #1 wanted to have the lidocaine patch somewhere else than was ordered. During interview on 6/25/26 at 9:43 a.m., the DON said if a medication was not administered per the order was that it could have an adverse effect on the resident. The DON said medication monitoring for MAs was done through the monitoring of the MAR and random observations. The DON said the pharmacy consult did observations. The DON said there was education and in-servicing done by the facility and pharmacy. The DON said the pharmacist did necessary education if there was a need. During interview on 6/25/26 at 10:14 a.m., the ADON said regarding medication administration oversight for the MAs that it was the Infection Control and Education Coordinator's responsibility, but she did education from time to time if there was a situation that they needed to address immediately. The ADON said she did cart audits and MAR to cart audits to make sure the medications were on the medication cart.During interview on 6/25/26 at 11:36 a.m., the Infection Control Nurse and Education Coordinator said she did education for the MAs that included mandatory in-services[TT4.1][CD4.2]. The Infection Control Nurse and Education Coordinator said she did medication administration observations [TT5.1][CD5.2]with each MAs a couple of times a year. The Infection Control Nurse and Education Coordinator said during these observations she looked at the entire process. The Infection Control Nurse and Education Coordinator said that she checked that when the MAs pulled the medication card that it matched what was in the computer. Record review of the facility's policy Medication Administration revised August 2025 revealed it was the policy to administer medications to residents verified with physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #9) reviewed for adequate supervision.The facility failed to ensure Resident #9 had quarterly fall risk assessments completed. The failure could place residents at risk of possible injury and not having appropriate interventions in place. Findings included:Record review of Resident #9's face sheet dated 6/25/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a condition in which the brain's function is impaired due to underlying metabolic or systemic disturbances rather than structural brain damage), muscle wasting and atrophy (decrease in size), other lack of coordination, generalized muscle weakness, weakness, and unspecified abnormalities of gait (a person's manner of walking) and mobility.Record review of Resident #9's annual MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 9 that indicated moderate cognitive impairment. Section J (Health Conditions) revealed Resident #9 had not had any falls since admission/entry or reentry or the prior assessment whichever was most recent. Record review of Resident #9's care plan dated 6/25/26 revealed Resident #9 was care planned with a focus of being at risk for falls related to immobility and incontinence with intervention to follow the facility's fall protocol.Record review of Resident #9's assessments tab in the electronic medical record accessed by the surveyor of 6/25/26 at 12:51 p.m. revealed Resident #9's last quarterly Fall Risk Assessment was completed 11/10/2025. Review of Resident #9's Fall Risk Evaluation dated 11/10/2025 revealed Resident #9 had not had any falls in the past three months.During interview on 6/25/26 at 9:43 a.m., the DON said the last fall evaluation for Resident #9 that had been completed was dated 11/10/25. The DON said fall evaluations were typically completed on admission, after each fall and with the quarterly evaluation of the resident. The DON said if a fall risk assessment was not completed then it could lead to missing some intervention that could have been done. The DON said fall assessments were completed by the floor nurses and sometimes the manager depending on the circumstances. The DON said there was a falls meeting by the falls committee on Fridays where they went over the falls. The DON said the falls committee was the DON, ADON, Education Coordinator, activity coordinator and restorative. The DON said regarding the fall evaluation for Resident #9, that he was due for the second quarter and they were still in the second quarter so Resident #9 would have one completed. The DON said the quarter was for everybody and if it could align with their quarterly assessment, they make sure it was completed for things like falls. During interview on 6/25/26 at 10:14 a.m., the ADON said fall assessments were completed on admission, quarterly and at the time of a fall. The ADON said an effect if could have on the resident if a fall assessment was not completed when they should be was that they could miss an intervention that needed to be put in place for safety for the resident. The ADON said regarding Resident #9 he had a fall evaluation assessment dated [DATE] that was created 1/23/26. The ADON said evaluations should be completed within the quarter. During interview on 6/25/2026 at 1:49 p.m., Resident #9 denied having any falls since he had been at the facility. Resident #9 said he did not walk but used the wheelchair to move around which was observed in the room. Resident #9 said staff were available to assist him when needed to get into the wheelchair. During interview on 6/25/26 at 11:36 a.m., the Infection Control Nurse and Education Coordinator said she did education regarding fall assessments. The Infection Control Nurse and Education Coordinator said fall assessments should be completed each time there was a fall and was completed when the nurse completed the incident report. The Infection Control Nurse and Education Coordinator said fall assessments were completed upon admission and quarterly or four months later. The Infection Control Nurse and Education Coordinator said she did not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do audits or monitoring of fall assessments as the educational coordinator. Record review of the facility's policy Falls and Injuries written June 2025 revealed reassessment of fall risk shall be conducted at least quarterly and after any fall incident.

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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 failed to ensure resident's medical records included documentation that indicated the resident, or their responsible party, received education of the benefits, and potential side effects, of the influenza or pneumococcal immunization, receipt of the influenza or pneumococcal immunization, or residents did not receive the influenza or pneumococcal immunization due to medical contraindication, or refusal, for 2 of 5 residents reviewed for immunizations. (Resident #3 and Resident #65)The facility failed to document, in Resident #3's and Resident #65's medical records, having had received education, whether by self or with responsible party, of the benefits and potential side effects of the influenza immunization and receipt of the of the pneumococcal immunization or having had not received the pneumococcal immunization due to medical contraindication or refusal.This failure could place residents at risk of contracting a viral illness, influenza and pneumococcal, or being informed of the benefits/risk which could cause respiratory complications and potential adverse health outcomes.Findings included:Resident #3 Record review of Resident #3's face sheet dated 6/23/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including vascular dementia (a type of dementia caused by problems with blood flow to the brain, leading to cognitive decline).Record review of Resident #3's quarterly MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 10 that indicated moderate cognitive impairment. Section O (Special Treatments, Procedures, and Programs) revealed Resident #3 did not receive the influenza vaccine in this facility and was not in the facility during this year's influenza vaccination season. Section O did not reveal any information regarding Resident #2's pneumococcal vaccination. Record review of Resident #3's admission MDS dated [DATE] revealed Resident #3 did not receive the influenza vaccine in this facility and was not in the facility during this year's influenza vaccination season. Section O did not reveal any information regarding Resident #3's pneumococcal or COVID-19 vaccinations. Record review of Resident #3's care plan dated 6/25/26 did not reveal any information related to immunizations.Record review of Resident #3's electronic medical record, accessed 6/25/26 at 1:37 p.m. did not reveal any information under the immunization's tab. Resident #65Record review of Resident #65's face sheet dated 6/25/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cellulitis (bacterial infection of the skin and underlying tissues) of right lower limb. Record review of Resident #65's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 3 that indicated severe cognitive impairment. Section O (Special Treatments, Procedures, and Programs) revealed Resident #65 did not receive the influenza vaccine in this facility and was not in the facility during this year's influenza vaccination season. Section O revealed Resident #65's pneumonia and COVID-19 vaccinations were not up to date. Record review of Resident #65's care plan dated 6/25/26 did not reveal any information related to immunizations.Record review of Resident #65's electronic medical record, accessed 6/25/26 at 1:37 p.m. did not reveal any information under the immunization's tab. During interview on 6/25/2026 at 1:54 p.m., the ADON said they did not have consent forms for vaccines for Resident #65. The ADON said she had gone through the medical record, and it did not have the immunization vaccine information. The ADON said Resident #65 was combative and not agreeable at times. The ADON said they would call Resident #65's family to see about getting consent for the vaccines or ask if he had the vaccines. The ADON said Resident #65 had been at the facility for about three weeks. The ADON said they tried to get the vaccine information as soon as the resident came in the facility. The ADON said they offered the vaccines and if the resident declined, they had the resident sign the form that they did not want the vaccines. The ADON said if the resident had vaccine information from the hospital records, then they put the information in the immunizations tab in the electronic medical record. The ADON said hopefully we would have been able to get in touch with the family and if they do not want the resident to get the (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vaccines then we would get verbal information over the phone. The ADON said she was over the 400 hallway where Resident #65 resided as unit manager. The ADON said if immunization information was not documented the resident could potentially develop an infection. The ADON said it was her and the manager's responsibility to make sure immunizations were being monitored. During interview on 6/25/2026 at 2:10 PM, the DON said immunization history should be completed as soon as they receive the record and sometimes, they had to rely on the family for the residents that could not speak for themselves. The DON said they typically document immunization information on admission but some families you could not reach right away but as soon as they give the information they could proceed. The DON said some local hospitals did not put the vaccine information in the clinicals while others local hospitals did but not all the hospitals. The DON said that immunization data was not part of the admission screening or any other assessment. The DON said if a resident came in and the vaccine data was not available then that information should be documented in the nurse's note. The DON said the unit manager and the ADON monitored that the immunizations were input. The DON said the unit manager for Resident #3 was Unit Manager A. The DON said if vaccine information was not documented and the resident did not receive the vaccine then an effect could be if they do not receive the vaccine and they were exposed to the disease was then they could develop the disease.During interview on 6/25/2026 at 2:20 p.m., Unit Manager A said he was the unit manager for Station #2 where Resident #3 resided. Unit Manager A said it was the nurse on duty who admitted the resident to screen them for vaccinations. Unit Manager A said if the nurse did not have the vaccine information they could call the responsible party, call the discharging facility or ask the resident if able. Unit Manager A said he monitored that immunization information was being updated in the electronic medical record by going into the electronic medical record and having checked the immunizations tab. Unit Manager A said he was not aware that Resident #3 did not have immunization information documented. Unit Manager A said he did not have an answer to why immunization information was not documented for Resident #3, but he did refuse care often. Unit Manager A said if Resident #3 had refused immunizations, then that should have been documented.During interview on 6/25/26 at 2:31 p.m., the Infection Control Nurse and Education Coordinator said she assisted with the administration of the flu vaccines for the residents. The Infection Control Nurse and Education Coordinator said the admitting nurse was responsible for screening residents for immunizations and would offer the vaccine. The Infection Control Nurse and Education Coordinator said she was not involved with the monitoring of the immunization screenings of the residents. Record review of the facility's policy Control of Communicable Disease Influenza revised December 2024 revealed Upon admission to the facility, the admissions staff will present the resident or family member or responsible party with an informed consent to obtain permission to give the vaccine at the appropriate time of the season. (If it is known by the family, resident or responsible party that the vaccine has been given prior to admission, proof of vaccination is requested).Record review of the facility's policy Pneumonia vaccine revised December 2023 revealed Upon admission, the resident medical record is reviewed to determine their pneumococcal vaccination history.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 implement their policy to ensure the residents, or their responsible party, received education of the benefits and risks, or potential side effects of Covid-19 immunizations, receipt of Covid-19 immunizations, or the residents did not receive the Covid-19 immunizations, due to medical contraindication, or refusal, for 2 of 5 residents who were reviewed for immunizations. (Resident #3 and Resident #65) The facility failed to document, in Resident #3's and Resident #65's medical records, having had received education, whether by self or with their responsible party, of the benefits and risk, and potential side effects, of the Covid-19 immunization, receipt of the of the Covid-19 immunization, or having had not received the Covid-19 immunization due to medical contraindication or refusal.This failure could place residents at risk of not being informed of complications and potential adverse health outcomes.Findings included:Resident #3 Record review of Resident #3's face sheet dated 6/23/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including vascular dementia (a type of dementia caused by problems with blood flow to the brain, leading to cognitive decline).Record review of Resident #3's quarterly MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 10 that indicated moderate cognitive impairment. Section O (Special Treatments, Procedures, and Programs) did not reveal any information regarding COVID-19 vaccinations. Record review of Resident #3's admission MDS dated [DATE], section O (Special Treatments, Procedures, and Programs) did not reveal any information regarding Resident #3's pneumococcal or COVID-19 vaccinations. Record review of Resident #3's care plan dated 6/25/26 did not reveal any information related to immunizations.Record review of Resident #3's electronic medical record, accessed 6/25/26 at 1:37 p.m. did not reveal any information under the immunization's tab. Resident #65Record review of Resident #65's face sheet dated 6/25/26, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cellulitis (bacterial infection of the skin and underlying tissues) of right lower limb. Record review of Resident #65's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 3 that indicated severe cognitive impairment. Section O (Special Treatments, Procedures, and Programs) revealed Resident #65's pneumonia and COVID-19 vaccinations were not up to date. Record review of Resident #65's care plan dated 6/25/26 did not reveal any information related to immunizations.Record review of Resident #65's electronic medical record, accessed 6/25/26 at 1:37 p.m. did not reveal any information under the immunization's tab. During interview on 6/25/2026 at 1:54 p.m., the ADON said they did not have consent forms for vaccines for Resident #65. The ADON said she had gone through the medical record, and it did not have the immunization vaccine information. The ADON said Resident #65 was combative and not agreeable at times. The ADON said they would call Resident #65's family to see about getting consent for the vaccines or ask if he had the vaccines. The ADON said Resident #65 had been at the facility for about three weeks. The ADON said they tried to get the vaccine information as soon as the resident came in the facility. The ADON said they offered the vaccines and if the resident declined, they had the resident sign the form that they did not want the vaccines. The ADON said if the resident had vaccine information from the hospital records, then they put the information in the immunizations tab in the electronic medical record. The ADON said hopefully we would have been able to get in touch with the family and if they do not want the resident to get the vaccines then we would get verbal information over the phone. The ADON said she was over the 400 hallway where Resident #65 resided as unit manager. The ADON said if immunization information was not documented the resident could potentially develop an infection. The ADON said it was her and the manager's responsibility to make sure immunizations (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were being monitored. During interview on 6/25/2026 at 2:10 PM, the DON said immunization history should be completed as soon as they receive the record and sometimes, they had to rely on the family for the residents that could not speak for themselves. The DON said they typically document immunization information on admission but some families you could not reach right away but as soon as they give the information they could proceed. The DON said some local hospitals did not put the vaccine information in the clinicals while others local hospitals did but not all the hospitals. The DON said that immunization data was not part of the admission screening or any other assessment. The DON said if a resident came in and the vaccine data was not available then that information should be documented in the nurse's note. The DON said the unit manager and the ADON monitored that the immunizations were input. The DON said the unit manager for Resident #3 was Unit Manager A. The DON said if vaccine information was not documented and the resident did not receive the vaccine then an effect could be if they do not receive the vaccine and they were exposed to the disease was then they could develop the disease.During interview on 6/25/2026 at 2:20 p.m., Unit Manager A said he was the unit manager for Station #2 where Resident #3 resided. Unit Manager A said it was the nurse on duty who admitted the resident to screen them for vaccinations. Unit Manager A said if the nurse did not have the vaccine information they could call the responsible party, call the discharging facility or ask the resident if able. Unit Manager A said he monitored that immunization information was being updated in the electronic medical record by going into the electronic medical record and having checked the immunizations tab. Unit Manager A said he was not aware that Resident #3 did not have immunization information documented. Unit Manager A said he did not have an answer to why immunization information was not documented for Resident #3, but he did refuse care often. Unit Manager A said if Resident #3 had refused immunizations, then that should have been documented.During interview on 6/25/26 at 2:31 p.m., the Infection Control Nurse and Education Coordinator said she assisted with the administration of the flu vaccines for the residents. The Infection Control Nurse and Education Coordinator said the admitting nurse was responsible for screening residents for immunizations and would offer the vaccine. The Infection Control Nurse and Education Coordinator said she was not involved with the monitoring of the immunization screenings of the residents. Record review of the facility's undated Policy and Procedure COVID-19 revealed the facility was to ensure all residents were up to date with COVID-19 vaccinations, including booster doses as recommended and to provide education on the benefits and potential