STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00449191 and IN00452427. Complaint IN00449191 - No deficiencies related to the allegations are cited. Complaint IN00452427 - No deficiencies related to the allegations are cited. Survey dates: February 10, 11, 12, 13, 14, and 17, 2025. Facility number: 000468 Provider number: 155378 AIM number: 100290270 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 1 Medicaid: 77 Other: 6 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 19, 2025.	F 0000	Preparation and/or execution of this plan of correction in general, does not constitute an admission of an agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 3/03/2025. We are requesting a desk review.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Lazar	Administrator	02/28/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Based on interview and record review, the facility failed to ensure residents and/or their representatives were invited to participate in care plan meetings for 4 of 4 residents reviewed for care plan conferences. (Residents 36, 64, 75 and 58) Findings include: 1. The clinical record for Resident 36 was reviewed on 2/14/25 at 2:55 p.m. The diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes, and muscle weakness. A review of Resident 36's medical record indicated the facility had not held a care plan meeting for the resident since 11/3/23. During an interview, on 2/13/25 at 2:43 p.m., the Social Service Director indicated care plan meetings should be held quarterly. Care plan meetings had not been held for Resident 36 in 2024. 2. The clinical record for Resident 64 was reviewed on 2/13/25 at 2:28 p.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, and schizoaffective disorder. A review of Resident 64's medical record indicated the facility had not held a care plan meeting for the resident since 10/30/23. During an interview, on 2/13/25 at 2:43 p.m., the Social Service Director indicated care plan meetings should be held quarterly. Care plan meetings had not been held for Resident 64 in 2024. 3. The clinical record for Resident 75 was reviewed	F 0657	1 What corrective action will be accomplished for those residents found to have been affected by the deficient practices: a Resident 36, 58, 64, and 75 were affected. Residents were assessed with no concerns and care plan conferences completed. 2 How other residents having the potential to be affected by the same alleged deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by the alleged deficient practice. b Facility wide audit was completed to ensure all residents had a care plan meeting per guidelines. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As a measure of ongoing compliance SSD was re-educated on facility's care plan policy. b CEO and/or designee will audit 5 residents weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure the care plan meeting have been completed. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing	03/03/2025

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	on 2/14/25 at 10:19 a.m. The diagnoses included, but were not limited to, anxiety, schizoaffective disorder, and myocardial infarction (heart attack). A review of Resident 75's medical record indicated the facility had not held a care plan meeting for the resident since 4/8/24. During an interview, on 2/13/25 at 2:43 p.m., the Social Service Director indicated care plan meetings should be held quarterly. Resident 75 was invited and attended a care plan meeting on 4/8/24. Another care plan meeting was scheduled for July 2024 but did not happen.4. The clinical record for Resident 58 was reviewed on 2/12/25 at 11:42 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), heart failure, and pain. A review of Resident 58's medical record indicated the facility had not held a care plan meeting for the resident since 7/29/24. During an interview, on 2/12/25 at 11: 46 a.m., the Social Services Director indicated she was not able to find documentation for a care plan meeting held after 7/29/24 and the care plan meetings were to be held quarterly. A current facility policy, titled "Comprehensive Care Plans," dated as last reviewed on 1/31/25 and received from the Corporate Support Nurse on 2/17/25 at 11:28 a.m., indicated "...The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs...." A current facility policy, titled "Resident Rights,"		compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	

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	dated as last revised on 1/31/25 and received from the Corporate Support Nurse on 2/17/25 at 11:28 a.m., indicated "...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to...Participate in decisions and care planning...." 3.1-35(d)(2)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review, the facility failed to ensure a resident who resided on the locked memory care unit was provided cognitively stimulating activities according to the plan of care for 1 of 4 residents reviewed for activities. (Resident 20) Findings include: During an observation, on 2/10/25 at 10:19 a.m., Resident 20 was awake and lying in her bed. Her TV was off, and she was not doing any activities. During an observation, on 2/10/25 at 2:41 p.m., Resident 20 was resting in her bed with her eyes closed. During an observation, on 2/11/25 at 9:18 a.m., Resident 20 was in her room with her TV off while activities were occurring in the lounge. During an observation, on 2/11/25 at 9:52 a.m., there were activities occurring in the lounge. Activity staff member 3 started to ask residents if they wanted to play bingo. She came down Resident 20's hallway, knocked on doors, and asked residents if they wanted to play bingo. She looked in Resident 20's room and then went to the	F 0679	1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a Resident 20 was affected. Resident was assessed with no concerns, and Activity Assessment updated. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents on the dementia unit have the potential to be affected by alleged deficient practice. b Facility wide audit was completed to ensure all residents have accurate and updated Activity Assessments. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As a measure of ongoing	03/03/2025

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	next room without offering to take the resident to bingo. During an observation, on 2/11/25 at 9:53 a.m., Activity staff member 3 came back down the hallway after asking other residents if they wanted to play bingo and peaked inside Resident 20's room. She did not ask the resident if she wanted to play bingo. During an observation, on 2/12/25 at 8:49 a.m., activities were occurring in the lounge. Resident 20 was resting in her bed with the lights off. During an observation, on 2/12/25 at 10:25 a.m., Resident 20 was in her room with the TV off and was not doing any activities. During an observation, on 2/13/25 at 10:36 a.m., Resident 20 was awake in her room with the lights on. The TV was off, and she was not doing any activities. There were activities occurring in the lounge. During an observation, on 2/14/25 at 9:15 a.m., Resident 20 was asleep in her room while activities were occurring in the dining room. The clinical record for Resident 20 was reviewed on 2/12/25 at 8:51 a.m. The diagnoses included, but were not limited to Alzheimer's disease, dementia, and major depressive disorder. A current care plan, with an edit date of 1/7/25, indicated Resident 20 was involved in group activities such as music entertainment, socials, and activities in her room. She would often refuse to participate but enjoyed watching other people participate in activities. Her prior occupation was a nursing home worker and to offer her activities		compliance, the Activity Director was re-educated was re-educated on the facility's Activity Documentation Policy. b CEO and/or designee will audit 5 residents weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure the Activity Assessment/Care Plan reflect residents interests. 4 How the corrective action will be monitored to ensue the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	

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	towards cleaning. Interventions included, but were not limited to, invite, encourage, remind and escort resident to activity programs consistent with the resident's interests daily for socialization. A quarterly life enrichment review, dated 10/20/23, indicated Resident 20 enjoyed crafts and painting. She typically participated in group activities. Resident 20 preferred to spend time in the common areas. A quarterly life enrichment review, dated 9/26/24, was in progress and not completed. During an interview, on 2/14/25 at 11:21 a.m., Activity staff member 5 indicated the resident was not really a morning person. She liked to watch TV in her room in the mornings and to read magazines and color. She could not find the remote to the TV in the resident's room this morning and was not sure where it was. She was not sure what activities were available in the resident's room. During an interview and observation, on 2/14/25 at 11:27 a.m., Qualified Medication Aide (QMA) 4 searched for Resident 20's TV remote. She could not find the TV remote and indicated the resident did like to watch TV in her room. There were no magazines or coloring books in the resident's room. A current facility policy, titled "Activity Program," dated as last reviewed on 1/31/25 and received from the Clinical Support Nurse on 2/17/25 at 11:28 a.m., indicated "...Group Activities will be scheduled on the Activity calendar and will be offered at times convenient and reflect the Residents' schedules, preferences, and rights...Individual Activities will be offered to provide adequate opportunities to residents who			

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	prefer not to engage in a large or small group setting, but do not require a one-to-one delivery method...." 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review, the facility failed to ensure a dressing for a non-pressure wound was maintained in a sanitary manner and to ensure bed sheets were changed/cleaned after being soiled from the wound and failed to ensure the physician was notified of blood glucose readings outside of the physician's ordered parameters for 2 of 2 residents reviewed for quality of care. (Resident 139 and 50) Findings include: 1. During a random observation, on 2/10/25 at 11:29 a.m., Resident 139 was observed in the therapy room. She had a wound dressing on her right lower leg from the ankle to below the knee. The dressing was noted to have brown and red drainage soaked through. The dressing was dated 2/9/25. The resident indicated her dressing was changed daily. During an observation, on 2/12/25 at 10:53 a.m., Resident 139 was observed resting in bed, wearing a pressure reduction boot and a dressing on her right lower leg. The dressing was dated 2/11/25 and had a large brownish color drainage which had soaked through the dressing and onto the resident's bedsheets leaving three soiled areas on the sheet which were brown in color. During an interview, on 2/12/25 at 10:53 a.m., LPN	F 0684	1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a Resident 139 and 50 were affected. Residents were assessed with no adverse effects. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by alleged deficient practice. b Facility wide audit was completed to ensure all residents with diagnosis of diabetes to ensure that are call parameters were correct. A facility wide audit was completed to ensure that any resident with soiled or dislodged dressings were changed per PRN order. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As a measure of ongoing	03/03/2025

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	1 indicated she was going to change the dressing. She had administered pain medication to the resident and was waiting for the effectiveness of the medication. LPN 1 indicated the CNA was to change the sheets. During an observation, on 2/13/25 at 11:22 a.m., two staff were observed in enhanced barrier precautions assisting the resident to her wheelchair. The resident's dressing on the lower right leg had drainage consistent with the color of blood which had soaked through the dressing. The resident indicated her dressing had not been changed yet. Two towels were also noted to be on the bed at about the same area where the resident's leg would have laid while in bed. Upon lifting the towels, the sheet was found to have a blood stain. During an interview, on 2/13/25 at 11:28 a.m., LPN 1 indicated she was waiting to change the dressing until the resident could have pain medication again which would be at 1:40 p.m. During an interview, on 2/13/25 at 11:41 a.m., the Corporate Support Nurse indicated the dressing needed to be changed now. The Director of Nursing indicated the resident did have an as needed dressing change ordered for soilage of the dressing. The Director of Nursing indicated Resident 139 had not been educated on the potential risks of infection or other risks which could arise from not keeping the wound dressing clean and dry. During an interview, on 2/13/25 at 11:53 a.m., the Director of Nursing indicated the resident had gone to lunch and the dressing would be changed after she finished her meal.		compliance all nursing staff will be educated on following physician order and facility skin policy. b DON and/or designee will audit 5 residents weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure call parameters are in placed and residents with soiled or dislodged dressings are changed per PRN order. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	

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	On 2/14/25 at 10:19 a.m., the wound dressing change to the lower right leg was observed. The wound was noted to span around the lower extremity and from the ankle and up the shin area. It was noted to be red with serosanguineous drainage (blood and serum fluid) with yellow coloration from the ordered dressing used. The dressing change was completed, and the appropriate date was placed on the dressing. The clinical record for Resident 139 was reviewed on 2/17/25 at 9:45 a.m. The diagnoses included, but were not limited to, cellulitis of the right lower limb, type 2 diabetes without complication and necrotizing fasciitis (a rare but life-threatening bacterial infection which rapidly destroys the soft tissues and fascia (connective tissue) beneath the skin). A physician's order, initiated on 1/18/25, indicated for staff to clean the right lower venous stasis wound with normal saline, pat dry, apply Xeroform, cover with abdominal dressings, wrap with kerlix and secure with an ACE wrap daily and as needed for spoilage or displacement. Special instructions on the order indicated for staff to change the wound dressing once a day between 6:00 a.m. to 2:00 p.m. The order was discontinued on 2/13/25. A physician's order, initiated on 1/18/25, indicated for staff to clean the right lower venous stasis wound with normal saline, pat dry, apply Xeroform, cover with abdominal dressings, wrap with kerlix and secure with an ACE wrap daily and as needed for spoilage or displacement. Special instructions on the order indicated for staff to change the wound dressing as needed. A physician's order, initiated on 1/22/25, indicated			

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	to give hydrocodone-acetaminophen (a narcotic pain reliever) every six (6) hours as needed for pain. The Medication/Treatment Administration Record (MAR/TAR) indicated the resident received the narcotic pain-relieving medication on 2/10/25 at 8:29 a.m., on 2/12/25 at 10:26 a.m., on 2/13/25 at 7:38 a.m., and on 2/14/25 at 9:11 a.m.2. The clinical record for Resident 50 was reviewed on 2/14/25 at 11:51 a.m. The diagnoses included, but were not limited to, type 2 diabetes, type 2 diabetes with ketoacidosis (a complication of diabetes), and acute kidney failure. A care plan, dated 8/7/24, indicated Resident 50 had diabetes. Interventions included, but were not limited to, to administer medications according to the physician's order. A physician's order indicated to notify the physician if Resident 50's blood glucose reading was less than 150. The Medication Administration Record (MAR) indicated Resident 50's blood glucose reading was below 150, 14 times in January 2025 and 14 times in February 2025. There was no documentation in Resident 50's medical record to indicate the physician was notified of the blood glucose readings below 150 according to the physician's order. During an interview, on 2/14/25 at 1:32 p.m., LPN 2 indicated when a blood sugar was below the parameter set by the physician, the blood sugar and notification to the physician would be documented in the progress notes.			

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	During an interview, on 2/14/25 at 1:38 p.m., the Director of Nursing (DON) indicated the facility used a messaging system to communicate with physicians. The call orders the facility used were to call the physician if the blood sugar was under 60 or 70. The order was placed into Resident 50's record incorrectly. If the order instructed staff to notify the physician when a blood sugar reading was below 150, then staff should have been notifying the physician. During an interview, on 2/14/25 at 1:48 p.m., the Administrator indicated when an order was placed into the chart, the parameter would need to be set to match the physician's order. When Resident 50's order was placed, the parameter was not set correctly. A current facility policy, titled "Review of Physician Orders," dated as last revised 1/31/25 and received from the Corporate Support Nurse on 2/17/25 at 11:28 a.m., indicated "...Licensed staff implement the physician's orders as applicable...." A current facility policy, titled "Resident Rights," dated as last revised on 1/31/25 and received from the Corporate Support Nurse on 2/17/25 at 11:28 a.m., indicated "...All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life...." A current facility policy, titled "Skin Integrity," dated as last revised 1/31/25 and received from the Corporate Support Nurse on 2/17/25 at 11:28 a.m., indicated "...The facility will ensure...A resident with impaired skin integrity receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent avoidable			

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	skin integrity issues from developing...." 3.1-37(a)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on interview and record review, the facility failed to ensure a consent for an Influenza vaccination was obtained prior to administration and to ensure Influenza and Pneumococcal vaccines were offered for 3 of 5 residents reviewed for immunizations. (Resident 53, 139 and 11) Findings include: The immunization records for Residents 53, 139, and 11 were reviewed, on 2/14/25 at 9:02 a.m., and indicated the following: a. There was no documentation to indicate Resident 53 was offered the Influenza or Pneumococcal vaccination in 2024 or 2025. b. There was no documentation to indicate Resident 139 was offered the Influenza or Pneumococcal vaccination in 2024 or 2025. c. Resident 11 was administered the Influenza vaccination, on 10/9/24, without a documented signed consent and there was no documentation to indicate a Pneumococcal vaccination was offered. During an interview, on 2/14/25 at 10:52 a.m., the Administrator indicated vaccine status and obtaining consents was part of the admission process into the facility. There was a fault in the follow-through with ensuring each resident	F 0883	1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices. a Residents 53, 139, and 11 were affected. Residents were assessed with no concerns and immunizations consents completed. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by alleged deficient practice. b Facility wide audit was completed to ensure all residents had immunizations consents in place per facility guidelines. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As measure of ongoing compliance Market Liaison, Nurse Managers, and Nursing Staff were re-educated on the facility's vaccine policy. b DON and/or designee will	03/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE AT PARKWOOD	1001 N GRANT ST LEBANON, IN 46052

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	signed or declined the vaccination consent forms and the administration of the vaccinations. During an interview, on 2/17/25 at 1:14 p.m., the Administrator indicated the facility had no further information to provide. A current facility policy, titled "Vaccination of Resident," dated as last revised on 1/31/25 and received by the Clinical Support Nurse on 2/12/25 at 10:20 a.m., indicated "...All residents will be offered vaccines that aid in preventing infections disease unless the vaccine is medically contraindicated, or the resident has already been vaccinated...Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations...All new residents shall be assessed evaluated for current vaccinations status upon admission...." A current facility policy, titled "Vaccines and Immunizations," dated as last revised on 11/14/24 and received by the Clinical Support Nurse on 2/17/25 at 11:28 a.m., indicated "...Minimize the risk of residents acquiring, transmitting, or experiencing complications from communicable diseases through immunizations by following the CDC Guidance...." 3.1-18(b)(5)		audit 5 residents weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure residents have immunization consents and vaccines given as appropriate. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on interview and record review, the facility failed to ensure COVID-19 vaccinations were offered to residents for 3 of 5 residents reviewed for immunizations. (Resident 53, 139 and 23)	F 0887	1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practices.	03/03/2025

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	Findings include: The immunization records for Residents 53, 139, and 23 were reviewed, on 2/14/25 at 9:02 a.m., and indicated the following: a. Resident 53 had received the COVID-19 vaccination in 2021 and 2022. There was no documentation to indicate Resident 53 was offered the COVID-19 vaccination after 2022. b. Resident 139 had received the COVID-19 vaccination in 2021. There was no documentation to indicate Resident 139 was offered the COVID-19 vaccination after 2021. c. Resident 23 had declined the COVID-19 vaccination in 2024 on admission. There was no documentation to indicate Resident 23 was offered the COVID-19 vaccination after admission. During an interview, on 2/14/25 at 10:52 a.m., the Administrator indicated vaccine status and obtaining consents was part of the admission process into the facility. There was a fault in the follow-through with ensuring each resident signed or declined the vaccination consent forms and the administration of the vaccinations. During an interview, on 2/17/25 at 1:14 p.m., the Administrator indicated the facility had no further information to provide. A current facility policy, titled "Vaccination of Resident," dated as last revised on 1/31/25 and received by the Clinical Support Nurse on 2/12/25 at 10:20 a.m., indicated "...All residents will be offered vaccines that aid in preventing infections disease unless the vaccine is medically contraindicated, or the resident has already been		a Residents 53, 139, and 23 were affected. Residents were assessed with no concerns, and immunizations consents completed. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by alleged deficient practice. b Facility wide audit was completed to ensure all residents had immunizations consents in place per facility guidelines. 3 What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: a As measure of ongoing compliance Market Liaison, Nurse Managers, and Nursing Staff were re-educated on the facility's vaccine policy. b DON and/or designee will audit 5 residents weekly times 4 weeks, twice monthly times 2 months, then monthly times 3 months to ensure residents have immunization consents and vaccines given as appropriate. 4 How the corrective action will be monitored to ensure the alleged deficient practice will not recur, what quality assurance program will be put into place: a As a measure of ongoing	

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	vaccinated...Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations...All new residents shall be assessed evaluated for current vaccinations status upon admission...." A current facility policy, titled "Vaccines and Immunizations," dated as last revised on 11/14/24 and received by the Clinical Support Nurse on 2/17/25 at 11:28 a.m., indicated "...Minimize the risk of residents acquiring, transmitting, or experiencing complications from communicable diseases through immunizations by following the CDC Guidance...." 3.1-18(b)(5)		compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.	