STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00409852. Complaint IN00409852 - No deficiencies related to the allegations are cited. Survey dates: June 12,13,14,15, and 16, 2023 Facility number: 000537 Provider number: 155409 AIM number: 100267270 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 12 Medicaid: 44 Other: 9 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 20, 2023.	F 0000	July 5, 2023 Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Recertification and Licensure Survey on June 16, 2023. Please accept this plan of correction as the provider's credible allegation of compliance with Federal Medicare and Medicaid requirements. We respectfully request a desk review.	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Fields	Administrator	07/08/2023

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	course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to ensure a resident's medications were reconciled before discharge for 1 of 3 residents reviewed for discharge. (Resident 29) Finding includes: On 6/25/23 at 9:51 a.m., Resident 29's closed clinical record was reviewed. Resident 29 discharged to home on 6/6/23. A Resident Discharge Summary, dated 6/6/23, indicated all Resident 29's medications were sent home with the resident. The discharge summary lacked the quantity of each medication, the	F 0661	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 29 no longer resides in this facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	07/22/2023

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	dosage of each medication, the instructions for each medication, and staff signatures. The discharge medication included, but were not limited to: - Midodrine (a medication used to treat high blood pressure) HCL 5 mg (milligrams), no instructions for frequency. - Atorvastatin calcium (a medication used to treat high cholesterol), no dosage or instructions for frequency. - Apixaban (a blood thinner), no dosage or instructions for frequency. - Multivitamin, no dosage or instructions for frequency. - Torsemide (a diuretic medication), no dosage or instructions for frequency. - Sennosides-docusate sodium (a stool softener) 8.6-50 mg, no instructions for frequency. - Miralax oral powder (a stool softener) 17 grams, no instruction for frequency. - Metoprolol succinate (a medication used to treat high blood pressure, chest pain, and heart failure) ER 25 mg, no instructions for frequency. - Aspirin (a non steroidal anti inflammatory medication), no dosage or instructions for frequency. During an interview on 6/14/23 at 2:00 p.m., the Director of Nursing (DON) indicated the medications were sent home with the resident. No documentation of the quantity of each medication or instructions for the medications were available. 3.1-36(b)		Residents who discharge have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The DON or designee will reeducate the nurses on the procedure for Documentation of Drug Disposition at the time of Discharge, specifically including inclusion of quantity and instructions for each medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON or qualified designee will audit discharge medication reconciliation weekly for 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	

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F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to provide 8 continuous hours of Registered Nursing (RN) services, seven days a week, for 12 of 31 days reviewed. Findings include: On 6/15/23 at 1:00 p.m., the Director of Nursing (DON) provided copies of the Daily Staffing Sheets for 5/13/23 through 6/12/23. On 6/16/23 at 8:15 a.m., the DON provided copies of the Report of Nursing Staff Directly Responsible for Resident Care for each day in the reviewed period of 5/13/23 through 6/12/23. A review of these reports included, but was not limited to the following data for each calendar day: facility census; number of hours worked for each of the three work shifts for the day, evening, and night shifts; the number of Registered Nurses who worked that shift; and number of hours	F 0727	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility is engaged in continual efforts to recruit and retain licensed nurses in order to comply with RN coverage dictated by CMS. These efforts are documented and available for review. No resident has been negatively impacted by this finding. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this deficient	07/22/2023

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	worked. A review of this period utilizing both sets of daily staffing reports indicated the following: On 5/13/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 70. On 5/17/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 69. On 5/20/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 70. On 5/21/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 69. On 5/22/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 71. On 5/24/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 68. On 5/27/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 66. On 5/31/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 67. On 6/3/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 67.		practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The facility will provide 8 continuous hours of Registered Nursing services 7 days per week. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** RN labor audits will be conducted by the DON/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved.	

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	On 6/4/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 67. On 6/7/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 63. On 6/10/23, the reports lacked documentation to indicate any RN coverage was provided. The facility census was 64. During an interview on 6/15/23 at 1:40 p.m., the DON indicated the facility was to have 8 consecutive hours of RN coverage every day as indicated by the Federal guidelines. On 6/16/23 at 8:15 a.m., the DON provided an undated copy of a policy titled Registered Nurse Services which indicated, "A facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week." 3.1-17(b)(3)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 6 of 7 kitchen observations. Staff hair was not covered while in the kitchen food preparation area and the steam table was in disrepair. (Dietary Aide 2, Dietary Aide 3, Cook 4, Dietary Manager, and Maintenance Director) Findings include: 1. During the initial kitchen tour with the Dietary Manager (DM), on 6/12/23 from 7:32 a.m. to 8:10 a.m., the following was observed: a. The DM was observed walking through out the kitchen area where the breakfast meal was being served. The DM was observed to have hair braids located on the right side of the head just above the ear and a 10-inch single braid hanging in the middle of the back. The hair braids were observed to not be covered. b. Dietary Aide 2 was observed walking through out the kitchen area where the breakfast meal was being served. Dietary Aide 2 was observed to have facial hair (beard and mustache) approximately one-fourth inch in length. Dietary	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident was found to be affected by this alleged deficient practice. Staff who work in and/or enter the kitchen will have all facial and head hair properly covered and secured per policy and regulation. The temperature control knob on the steam table was replaced. The steam table well has been repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No other residents were found to be affected by this alleged deficient practice.	07/22/2023

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	Aide 2's facial hair was observed to not be covered. c. Dietary Aide 3 was observed walking through out the kitchen area where the breakfast meal was being served. Dietary Aide 3 was observed to have facial hair (above and below the lips) approximately one-half inch in length. Dietary Aide 3's facial hair was observed to not be covered. d. Cook 4 was observed at the steam table where the breakfast meal was being served. Cook 4 was observed to have loose hairs above the ears and at the neckline approximately one-inch in length. Cook 4's hair was observed to not be covered. 2. During a follow up kitchen observation, on 6/12/23 from 11:55 a.m. to 12:30 p.m., the following was observed: a. Dietary Aide 2 was observed walking through out the kitchen area where the noon meal was being prepared and plated and was observed assisting with the food tray preparation. Dietary Aide 2 was observed to have facial hair (beard and mustache) approximately one-fourth inch in length. Dietary Aide 2's facial hair was observed to not be covered. b. Dietary Aide 3 was observed walking through out the kitchen area where the noon meal was being prepared and plated and was observed assisting with the food tray preparation. Dietary Aide 3 was observed to have facial hair (above and below the lips) approximately one-half inch in length. Dietary Aide 3's facial hair was observed to not be covered. c. Cook 4 was observed at the steam table where		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator or designee will reeducate all staff on the policy to ensure hair is entirely covered to prevent exposure to food while in the kitchen. Staff who are non-compliant with the policy will receive additional education and/or progressive discipline as appropriate. The Administrator or designee will educate maintenance and dietary staff on the requirement that all kitchen equipment including the steam table should be in good repair and operate properly to meet set standards. Maintenance Supervisor and Dietary Manager will inspect all kitchen equipment including the steam table monthly to ensure they all operate properly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**	

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	the noon meal was being temped and plated. Cook 4 was observed to have loose hairs above the ears and at the neckline approximately one-inch in length. Cook 4's hair was observed to not be covered. d. The Maintenance Director was observed working on the refrigerator unit located to the left of the stove/oven unit located approximately 4 feet from the steam table where the noon meal was being held. The Maintenance Director was observed to have facial hair (above the upper lip) approximately one-half inch in length and hair in front of the ears and at the neckline approximately one-inch in length. The Maintenance Director's hair was observed to not be covered. e. The steam table had 4 steam wells holding the noon meal during the plating process. The following was observed: The mechanical soft meat, pureed meat, pureed greens, and mashed potatoes steam table pans were located in the far-left steam table well. Those food items were observed to have been temped at 125 F (Fahrenheit); 120 F; 150 F; and 150 F respectively. During an interview at that time, Cook 4 indicated the temperature control knob for the far-left steam table well was broken. "It's very difficult to turn the knob and to adjust the temperature in order to maintain the appropriate food temperatures." Cook 4 indicated the starting temps for the foods should have registered at least 180 F. f. The steam stable well, located to the right of the far-left well held a large steam table pan full of greens. The steam table well was damaged at one end which prevented the food tray from being able to firmly sit in the well and maintain a consistent temperature.		Hair Restraint and Dietary Equipment Audits will be conducted by the Administrator/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved.	

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During an interview at that time, the Dietary Manager (DM) indicated the steam table well had been broken "for about a year."

During an interview, at that same time, the Maintenance Director indicated "the steam table was old, needs repaired or replaced and it had been like that for at least 3 months."

3. During a follow up kitchen observation, on 6/12/23 from 1:00 p.m. to 1:15 p.m., the following was observed:

a. Dietary Aide 2 was observed walking through out the kitchen area where the noon meal was being plated and was observed assisting with the food tray preparation. Dietary Aide 2 was observed to have facial hair (beard and mustache) approximately one-fourth inch in length. Dietary Aide 2's facial hair was observed to not be covered.

b. Dietary Aide 3 was observed walking through out the kitchen area where the noon meal was being plated and was observed assisting with the food tray preparation. Dietary Aide 3 was observed to have facial hair (above and below the lips) approximately one-half inch in length. Dietary Aide 3's facial hair was observed to not be covered.

c. Cook 4 was observed at the steam table where the noon meal was being plated. Cook 4 was observed to have loose hairs above the ears and at the neckline approximately one-inch in length. Cook 4's hair was observed to not be covered.

d. The Maintenance Director was observed working on the refrigerator unit located to the left

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	of the stove/oven unit located approximately 4 feet from the steam table where the noon meal was being held. The Maintenance Director was observed to have facial hair (above the upper lip) approximately one-half inch in length and hair in front of the ears and at the neckline approximately one-inch in length. The Maintenance Director's hair was observed to not be covered. 4. During a follow up kitchen observation, on 6/14/23, at 8:45 a.m., the kitchen steam table was observed. The steam table had 4 steam wells. The far-left well was missing the control knob and the well to the right was damaged which prevented the food pans to firmly sit in the well and maintain a consistent temperature. 5. During a follow up kitchen observation, on 6/14/23 from 11:45 a.m. to 12:20 p.m., the following was observed: a. Dietary Aide 2 was observed walking through out the kitchen area where the noon meal was being prepared and plated and was observed assisting with the food tray preparation. Dietary Aide 2 was observed to have facial hair (beard and mustache) approximately one-fourth inch in length. Dietary Aide 2's facial hair was observed to not be covered. b. Dietary Aide 3 was observed walking through out the kitchen area where the noon meal was being prepared and plated and was observed assisting with the food tray preparation. Dietary Aide 3 was observed to have facial hair (above and below the lips) approximately one-half inch in length. Dietary Aide 3's facial hair was observed to not be covered. c. The Maintenance Director was observed			

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	working on the refrigerator unit located to the left of the stove/oven unit located approximately 4 feet from the steam table where the noon meal was being held. The Maintenance Director was observed to have facial hair (above the upper lip) approximately one-half inch in length and hair in front of the ears and at the neckline approximately one-inch in length. The Maintenance Director's hair was observed to not be covered. d. The DM was observed walking through out the kitchen area where the noon meal was being prepared and plated. The DM was observed to have hair braids located on the left side of her head and above the ear. The DM's hair was observed to not be covered. e. The steam table's far left well control knob was missing and the well contained approximately one-inch of water that temped at 130 F. The well was holding a medium-sized steam table pan of mechanical soft chicken which temped at 159 F. d. The steam table well, 3rd from left had approximately one-inch of water in the well and temped at 118 F. The well was holding a large-sized steam table pan of chicken parmesan. The initial food temp was 130 F. 6. During a follow up kitchen observation, on 6/14/23 from 12:45 p.m. to 1:20 p.m., the following was observed: a. Dietary Aide 2 was observed walking through out the kitchen area where the noon meal was being plated and was observed assisting with the food tray preparation. Dietary Aide 2 was observed to have facial hair (beard and mustache) approximately one-fourth inch in length. Dietary Aide 2's facial hair was observed to not be			

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	covered. b. Dietary Aide 3 was observed walking through out the kitchen area where the noon meal was being plated and was observed assisting with the food tray preparation. Dietary Aide 3 was observed to have facial hair (above and below the lips) approximately one-half inch in length. Dietary Aide 3's facial hair was observed to not be covered. During an interview on 6/13/23 at 2:05 p.m., the DM indicated all staff hair was supposed to be covered while in the kitchen. During an interview, on 6/14/23 at 3:05 p.m., the Administrator (ADM) indicated she was unaware that the steam table was not fully functional. During an interview, on 6/16/23 at 12:30 p.m., the ADM indicated the facility was unable to locate the steam table manufacturer's manual. During an interview, on 6/16/23 at 12:50 p.m. the ADM indicated the steam table was to be monitored for preventative maintenance at least monthly and as needed. On 6/14/23 at 10:30 a.m., the Administrator provided a copy of the Nutritional Services Operations Policy # 1.2 Dress Code policy, dated 3/27/12, and indicated it was the current policy in use by the facility. A review of the document indicated, "...to present a safe, sanitary and professional appearance...food employees wear a hair covering which covers all hair completely. Beard guards must be used for employees with facial hair..." On 6/15/23 at 10:04 a.m. the ADM provided a copy			

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	of the Preventive Maintenance Program Life Safety Code Documentation, dated 10/17/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...if an issue is urgent in nature, it will be addressed immediately...Dietary - monthly inspections: steam table - check unit for proper operation...check thermostat, switches and wiring, check for leaks..." On 6/16/23 at 10:38 a.m., the DNS provided a copy of the Serving Food and Beverages policy, dated 2010, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...all steam table units shall be checked to assure proper heat maintenance...problems with heating shall be reported to Maintenance immediately...the steam table will be turned on before serving to allow enough time to ensure proper heating..." On 6/16/23 at 10:38 a.m., the DNS provided an undated copy of Monitoring Food Temperatures for Meal Service policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all hot foods will be kept in covered steam table pans on the steam table..." On 6/16/23 at 3:15 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food...equipment shall be maintained in a state of repair and condition that meets the requirements...shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications..."			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the dumpster container top lids and a side panel door were kept closed when not in use and failed to ensure the dumpster container area was free of debris, for 2 of 2 observations. Findings include: 1. During the initial facility tour with the Dietary Manager (DM), on 6/12/23 from 8:15 a.m. to 8:20 a.m., the dumpster container area, located across the parking area from the kitchen's back door, was observed. The dumpster container had 2 top lids. Two of two lids were observed to not be closed. The dumpster container also had two sliding side panel doors. One of two sliding side panel doors was observed to not be closed. Inside the dumpster were multiple filled trash bags and other debris. The ground surrounding the dumpster area was littered with debris (used plastic gloves, plastic eating utensils, plastic cups, paper plates and other unidentifiable items). Behind the dumpster was a wooden fence. Two boards were observed to be broken with trash and debris observed between the broken boards and the ground next to the dumpster container area. At that time, while at the dumpster area, an unidentifiable staff member was observed carrying an untied large plastic trash bag that was filled with trash. The staff member threw the untied trash bag into the opened dumpster container and	F 0814	**What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice:** No resident was found to be affected by this alleged deficient practice. The trash and debris was picked up between the broken boards and on the ground next to the dumpster container.The broken boards in the fence were replaced.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**No other residents were found to be affected by this alleged deficient practice.**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance Supervisor or designee will inspect the dumpster area for trash and debris and the fence to ensure it remains in good condition as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate.	07/22/2023

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	then returned to the facility. The staff member failed to close the opened dumpster lids or sliding side panel door. During an interview at that time, the DM indicated the dumpster lids and doors were to be kept closed. The area around the dumpster was to be kept free of debris. No other staff were visible near the dumpster area during that time. 2. A follow up dumpster container area observation with the DM, was conducted on 6/14/23 at 8:50 a.m. Behind the dumpster was a wooden fence. Two boards were observed to be broken with trash and debris observed between the broken boards and the ground next to the dumpster container area. No staff were visible near the dumpster area. On 6/14/23 at 10:30 a.m., the Administrator provided a copy of the Nutritional Services Operations Policy #2.19 Trash Disposal policy, dated 5/24/15, and indicated it was the current policy in use in the facility. A review of the document indicated, "...The food service department will dispose of trash appropriately and maintain the dumpster area for cleanliness and prevention of rodents...the food service department are dispose of all trash from the food service department in enclosed trash bags...the food service department will assure dumpster lid is closed when disposing of trash and no trash is on ground surrounding dumpster..." On 6/16/23 at 10:45 a.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004,		If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Dumpster and Fence Audits will be conducted by the Administrator/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved.	

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	indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(5)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The			

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	facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to follow vaccine administration guidelines for the pneumococcal vaccine. The pneumococcal vaccine was not given for residents who had consented to receive the vaccinations for 3 of 8 resident reviewed for vaccines. (Resident 5, Resident 26, Resident 52) Findings include: 1. On 6/14/23 at 10:40 a.m., Resident 5's clinical record was reviewed and indicated the following: Resident 5's immunization records indicated	F 0883	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #5 has consented to and received a physician's order for the pneumococcal conjugate to be administered. Resident #26 has consented to and received a physician's order for the pneumococcal conjugate to be administered.	07/22/2023

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	Resident 5 received a pneumococcal polysaccharide 23 (PPSV 23) vaccine on 8/3/16 and on 3/13/17 but lacked documentation of any subsequent pneumococcal conjugate (PCV 13, 15, or 20) vaccines. Resident 5's diagnoses included, but were not limited to, chronic obstructive pulmonary disorder (COPD, a group of diseases that cause airflow blockage and breathing-related issues), hypertension (high blood pressure), and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). Resident 5 had an admission date of 5/18/23 and was of 65 years of age or older. 2. On 6/14/23 at 11:00 a.m., Resident 26's clinical record was reviewed and indicated the following: Resident 26's immunization records indicated Resident 26 received a pneumococcal polysaccharide 23 vaccine on 2/26/17 and on 1/8/19 but lacked documentation of any subsequent pneumococcal conjugate vaccines. Resident 26's diagnoses included, but were not limited to, alcoholic cirrhosis of the liver (alcohol induced hardening and swelling of the liver making it less able to function), type 2 diabetes mellitus, hypertension, and coronary atherosclerosis (the build-up of fats, cholesterol, and other substances in the walls of arteries causing obstruction of blood flow). Resident 26 had an admission date of 4/11/23 and was under the age of 65. 3. On 6/14/23 at 11:15 a.m., Resident 52's clinical record was reviewed and indicated the following: Resident 52's immunization records indicated		Resident #52 has consented to and received a physician's order for the pneumococcal conjugate to be administered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**? All residents immunization history and consents were reviewed. Consenting residents have received the Pneumococcal vaccine and/or subsequent pneumococcal conjugate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Documentation in the resident' medical record of the information/education provided regarding the benefits and risks of immunization and the administration or the refusal of or medical contraindications to the vaccine(s). The policy and procedure for pneumococcal immunization was reviewed with the Quality Assurance Committee. Social Services Designee receives consent at the time of admission.	

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	Resident 52 received a pneumococcal conjugate vaccine of an unknown type on 5/26/1979 but lacked documentation to clarify the type of conjugate vaccine given and lacked documentation of any subsequent pneumococcal polysaccharide vaccines. Resident 52's diagnoses included, but were not limited to, type 2 diabetes mellitus and hypertension. Resident 52 had an admission date of 2/1/23 and was under the age of 65. On 6/13/23 at 9:00 a.m., the DON provided a list of residents who smoke in the facility; the list designated Resident 5, Resident 26, and Resident 52 as residents who smoke. During an interview on 6/15/23 at 11:25 a.m., the DON indicated that pneumococcal vaccinations should be given per CDC guidelines. On 6/12/23 at 12:00 p.m., the DON provided a policy, dated for 1/1/17, and titled, "Influenza and Pneumococcal Immunization", and indicated it was the policy currently in use. The policy stated that, "It is the intent of this facility to minimize the risk of residents acquiring, transmitting, or experiencing complications from Influenza and Pneumococcal pneumonia." On 6/16/23 at 9:45 a.m., a review of the CDC guidelines at the following website regarding pneumococcal vaccine times for adults (https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf), updated on 3/15/23 indicated: Adults older than 65 years old who have had a dose of the PPSV 23 should have an additional dose of either the PCV 20 or PCV 15. Adults 19-64 years of age with diagnoses including but not limited to, diabetes mellitus or		The admission nurse receives the order as consented by the resident or authorized representative and the pneumococcal immunization is administered as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON or qualified designee will audit for pneumococcal immunizations weekly for 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	

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	smoking who have had a dose of PPSV 23 should also have a dose of either PCV 20 or PCV 15. 3.1-13(a)			