STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(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 Investigation of Complaints IN00395747 and IN00394806. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00395747 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00394806 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600 and F607. Survey dates: November 30, December 1 and 2, 2022. Facility number: 000134 Provider number: 155229 AIM number: 100275430 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 13 Medicaid: 38 Other: 15 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 7, 2022.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 12/20/2022.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monica Ogden	RVP	12/23/2022

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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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to prevent staff to resident abuse for 2 of 2 residents reviewed for abuse (Resident G and C). Using the reasonable person concept, it is likely this deficient practice would lead to anxiety and fearfulness (Resident G). Findings include: 1. Resident G's clinical record was reviewed on 12/1/22 at 11:49 a.m. Diagnoses included, but were not limited to, communication deficit, unspecified focal traumatic brain injury without loss of consciousness, sequela, need for assistance with personal care, and major depressive disorder, single episode. Physician orders included citalopram hydrobromide (antidepressant) 20 mg (milligram) daily. A quarterly MDS (Minimum Data Set), dated 10/14/22, indicated he was severely cognitively impaired.	F 0600	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents G and B had an investigation completed per policy and all facility protocols were followed. 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; A facility wide audit was completed 12/05/2022 by Executive Director on grievance logs to ensure there were no issues that were abuse related that had not been reported with no concerns noted. what measures will be put into place or what systemic changes will be made to ensure that the	12/20/2022

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	He had a current care plan, initiated on 11/11/22, for having been traumatized by a staff member and he was trying to cope. He felt bad about himself and felt maybe he was to blame for her dislike for him and maybe he needed to change. His goal was he would find a way to feel good about himself again as evidenced by smiling and getting out of bed more and attending some activities with others. His interventions included to visit and encourage him to be up and out of bed, arrange for him to see the psychiatric nurse practitioner and continue with his weekly routine of seeing the mental health counseling services. A psychosocial note, dated 11/8/22 at 12:26 p.m., indicated he had an incident with a staff member which had upset him the prior morning. The occurrence had been addressed and would not happen again. Resident G was spoken to again this morning, he was still a little worried that the staff member may do something to him, but he was relieved when he was informed that the person was no longer at the facility. No injuries happened as a result of the incident, but it left him with some anxiety which had since been resolved. He exhibited no signs or symptoms of mental or emotional anguish. He would continue to be monitored to ensure no lasting concerns. A psychosocial note, dated 11/9/22 at 4:22 p.m., indicated he was doing well this day. He exhibited no sign or symptoms of mental or emotional anguish this day. He was smiling and stated that he felt good. A psychosocial note, dated 11/10/22 at 5:40 p.m., indicated he asked if CNA 6 was going to come back. He stated he was afraid of her and did not want to see her again. He was afraid she was mad at him and might do something. He was assured		deficient practice does not reoccur ED was educated on customer service and reporting abuse by RVP on 12/15/2022. All management (including ED) and floor staff were in-serviced on Resident Rights and Abuse by Lori Davenport, Director of Regulatory Clinical Affairs at IHCA/INCAL. Training was completed on 12/14/2022. Any staff who were unable to attend the in-service will be in-serviced on this topic and information prior to working the floor. All staff were also educated on customer service on or before 12/20/2022 any staff unable to attend will be in-serviced prior to working the floor. The two CNA's involved in the incidents described in the complaint no longer work at facility. SEE ATTACHED IHCA Training See attached ED education. QAPIs were created after incidents listed in complaints and were investigated and all residents with a BIMS of 9 or higher were interviewed to ensure there were no unknown allegations or concerns with no concerns identified. These interviews were completed by members of the IDT team including the SSD and were completed on 12/16/2022. SEE ATTACHED resident interviews. how the corrective action(s) will be	

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	that he was safe, and no harm would come to him. He was relieved. He exhibited just a little sign of emotional distress. He had apparently been thinking about the whole thing and just wanted to make sure she would not be able to retaliate against him. He was afraid of her. He was seen by the mental health counseling services and she noted that he exhibited moderate depression. She tried to get him to identify a positive about himself and he was unable to. He may have just needed time to get back to his emotional baseline. A cognitive patterns/BIMS (Brief Interview for Mental Status) note, dated 11/11/22 at 9:54 a.m., indicated his BIMS score was 11 (moderately cognitively impaired) this day and stated he felt better and was not so afraid now. He had started to forget about the CNA who didn't like him, but he didn't know what he did that made her not like him. He was assured it was not him and to not take it personally. A mood/PHQ-9 (Patient Questionnaire-9) note, dated 11/11/22 at 1:20 p.m., indicated he had some depression, he felt bad about himself at least 7 out of 14 days. He thought others didn't like him but did not know why. It made him feel bad. He talked with the therapist from the mental health counseling service and stated it made him feel better. Review of CNA 6's employee file, on 12/2/22 at 10:00 a.m., indicated the following: On 8/24/22, she was reprimanded for poor job performance, staff members complained she was rude to residents, was not a team player, and was constantly on her cellphone. On 9/28/22, she was reprimanded for using her		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Department heads will conduct daily compliance rounds (Mon-Fri) that include monitoring of Reporting Allegations of Abuse and Types of Abuse through verbal interviews with 5 residents and 5 staff members weekly x 4 weeks, then 3 times a week for 4 weeks, then 1 time a week x 4 weeks and resident observations to ensure all abuse allegations are being reported. Findings will be presented to QA ongoing. SEE ATTACHED Abuse QAPI.Findings will be presented to QA monthly for a period of 6 months to ensure 100% compliance. Date of Compliance 12/20/2022	

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	cellphone during resident care, poor job performance and not being a team player, and not attending to resident's needs in a timely fashion. The supervisor comments indicated multiple residents had complained she did not attend to needs in timely manner and multiple reports she took excessive breaks. On 10/6/22, she was reprimanded for cellphone use during resident care, not attending to resident needs in timely fashion and being a poor team player. Supervisor comments were multiple residents complained she did not attend to the resident needs in timely manner. She had made comments she was not charting and was not doing showers. During an interview, on 12/1/22 at 12:48 p.m., Dietary Aide 7 indicated CNA 6 was serving meals in the dining room. Resident G was heard to ask for something he didn't have. CNA 6 told him to stop complaining and eat his food. It was alarming to see her say that to him. Dietary Aide 7 had gone with Dietary Aide 10 to report another incident about a week later to the Admissions/Marketing staff member and the Administrator. They had them write statements. CNA 6 was always very short and rude to the residents. While assisting the residents with meals, she would be on her cellphone. A facility investigation was reviewed on 12/1/22 at 12:49 p.m. Other residents had indicated CNA 6 was very rude during care and had yelled at times. She used inappropriate language and behavior when providing care. She had told a resident to sit down now and asked what do you want now, she had just been in the room and she was busy. During an interview, with Dietary Aide 10 on			

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	12/1/22 at 3:30 p.m., she indicated about a week or so prior to what Dietary Aide 7 had witnessed, a resident had been standing with her walker near the service window in the dining room. She looked like she was urinating and CNA 6 had indicated to the resident it was nasty, she was a grown woman and she needed to go to the bathroom. There were other resident's present in the dining room at the time. The dietary aide reported it to the Dietary Supervisor and then went with Dietary Aide 7 to the Administrator's office to report the incidents they both had witnessed with CNA 6. She was asked to write a statement and to slip it under the Administrator's door. CNA 6 seemed like she had an attitude towards the residents when they asked for help. During an interview with Resident G, on 12/2/22 at 9:35 a.m., he knew he had an incident with a staff member but couldn't remember what had happened at the time. During an interview with the Social Service Director, on 12/2/22 at 1:21 p.m., she indicated Resident G was afraid that CNA 6 was going to retaliate against him. He was reassured that would not happen. He was actually afraid of her for two to three days and was visibly upset about it. He was frightened to death. He was bullied in the past and was beat with a baseball bat for trying to defend a girl and had suffered a traumatic brain injury. He had told her he didn't know why she didn't like him. He had indicated to her CNA 6 would get down to his ear and tell him to stop asking for anything else. It was scary for him. At times, even she was afraid of some of the staff. 2. Resident B's clinical record was reviewed on 11/30/22 at 2:07 p.m. Diagnosis included, but were not limited to, depression, bipolar disorder,			

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	current episode depressed, severe, without psychotic features, agoraphobia without panic disorder, anxiety disorder and altered mental status. Her orders included alprazolam (antianxiety) 0.25 mg daily, divalproex sodium (treat bipolar disorder) 500 mg daily, paroxetine (antidepressant) HCL (hydrochloride) 20 mg daily and risperidone (antipsychotic) 0.5 mg daily. An admission MDS assessment, dated 10/24/22, indicated she was moderately cognitively impaired. She had a current care plan, dated 11/17/22, for an event with a staff member which had greatly upset her. Her goal was she would not let the event stop her from living her best life in the facility, as evidenced by going out of her room, socializing with others, attending and participating in activities of her choice. Her interventions were to arrange for her to be evaluated by psychiatric nurse practitioner and weekly visits from the local mental health counseling therapist, monitor her for any negative changes in her moods and report to her physician. As she was a fairly new resident, get her acquainted with others in the facility and have her down for morning coffee and invite her to activities. An event note, dated 11/16/22 at 7:00 a.m., indicated she stated an incident occurred the evening prior with a staff member, resulting in a tiny skin tear between her right thumb and index finger. The small area was cleaned and a band aid was placed on it. She had no complaints of pain or discomfort. The Administrator, DON, medical doctor, and family was made aware.			

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	A psychosocial note, dated 11/16/22 at 10:30 a.m., indicated an event the evening prior had left her upset, and was being investigated by administration. She felt bad about the situation and initially had not wanted to report it. She was in a wheelchair and required assistance from staff for her daily care needs. A cognitive patterns/BIMS note, dated 11/16/22 at 10:37 a.m., indicated she was cognitively intact. She talked about her experience the prior evening with the two staff members and stated how it made her feel. A psychosocial note, dated 11/17/22 at 4:25 p.m., indicated she was very happy, relaxed and glad things were back to normal. She was no longer afraid and was thankful to Social Services and the Administrator for taking care of everything for her. A facility investigation was reviewed on 12/1/22 at 10:49 a.m. It indicated staff had reported CNA 16 could be rude, she cursed in the hall because they were short staffed, and residents needed to be interviewed about her. A resident indicated CNA 16 was not allowed in her room because she had told her to do something "now". During an interview with LPN 4, on 12/1/22 at 3:23 p.m., she indicated Resident C was moved to a new room while her roommate was receiving end of life care. Resident C had been expecting a phone call from her son and was sitting in the doorway to her old room because her phone was in the room. She had tried to remove Resident C from the doorway and she wouldn't move, so she went back to passing medications down the hall. She told CNA 16 about Resident C, so she had tried to remove Resident C from the doorway of			

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	the room. Resident C locked her wheelchair and wouldn't move. CNA 16 tried to pull Resident C from the doorway of the room in her wheelchair and Resident C received a skin tear to her right hand between her thumb and index finger. She did not ask CNA 16 to remove her from the room. During an interview with Resident C, on 12/2/22 at 9:00 a.m., she indicated she had moved rooms while her roommate was in the process of dying, but all her belongings were still in the room with her roommate. She was waiting on a phone call from her son in the doorway to the room. The nurse tried to pull her out of the room and then went back down the hall. The nurse then asked CNA 16 to get her out of the room. CNA 16 came to her and tried to pull her backwards out of the room. She locked her brakes and CNA 16 still tried to pull her out. When she grabbed her wheels, she hurt both her hands but she had a cut on her right hand. She believed CNA 16 no longer worked at the facility. A current facility policy titled, "Abuse - Identification of Types," found on the table on 12/1/22 at 2:00 p.m., indicated the following: "...Policy: It is policy of the facility to identify abuse... This includes but is not limited to, identifying, and understanding the different types of abuse and possible indicators...." This Federal tag relates to complaint IN00394806. 3.1-27(a) 3.1-27(b)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures			

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	that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to ensure abuse was reported to the Administrator immediately for 1 of 2 abuse allegations reviewed. Findings include: During an interview with the Dietary Supervisor, on 12/2/22 at 1:06 p.m., she indicated on November 8, Dietary Aide 7 and Dietary Aide 10	F 0607	**1.** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident G and B Had an investigation completed and all facility protocols were followed. 2. how other residents having the potential to be affected by the same deficient practice will be	12/20/2022

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	had called her at home and told her about CNA 6 and something about milk. She told them if they felt like it was abuse, they should go to the Administrator. Dietary Aide 10 told her she did not feel like it was abuse. Dietary Aide 7 asked her to talk to CNA 6 to see if she was having a bad day because she was acting like she was frustrated, and she was in the dining room by herself. She was told CNA 6 had asked the resident who was walking to go to the bathroom. In her eyes, it wasn't abuse or neglect. During an interview with the Administrator, on 12/2/22 at 12:45 p.m., he indicated if anyone suspected or witnessed abuse, they should report to him immediately. A current facility policy, titled "Abuse - Reporting and Response - Suspicion of a Crime," provided by the Administrator, on 12/2/22 at 12:56 p.m., indicated the following: ...Reporting Procedures: 1. Once an associate... forms a reasonable suspicion that a crime has been committed against a resident... he or she must immediately notify the Executive Director of their suspicion ...." Cross reference F600. This Federal tag relates to complaint IN00394806. 3.1-28(c)		identified and what corrective action(s) will be taken; A facility wide audit was completed on 12/05/2022 by Executive Director on grievance logs to ensure there were no issues that were abuse related that had not been reported with no concerns noted. QAPIs were created after incidents listed in complaints were investigated and all residents with a BIMS of 9 or higher were interviewed to ensure there were no unknown allegations or concerns with no concerns identified. These interviews were completed by members of the IDT team including the SSD and were completed on 12/16/2022. SEE ATTACHED Abuse QAPI. 3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur: ED was educated on customer service and reporting abuse by RVP on 12/15/2022. All management (including ED) and floor staff were in-serviced on Resident Rights and Abuse by Lori Davenport, Director of Regulatory Clinical Affairs at IHCA/INCAL. Training was completed on 12/14/2022. Staff who were unable to attend the in-service will be in-serviced on this topic and information prior to working the floor. All staff were also educated on customer	

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			service on or before 12/20/2022 any staff unable to attend will be in-serviced prior to working the floor. The two dietary aides involved in the failure to report possible abuse concerns timely were also educated on 12/19/2022 on the facility's Abuse Reporting Policy. SEE ATTACHED IHCA Training SEE ATTACHED ED education SEE ATTACHED dietary education. 4. 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 Department heads will conduct daily compliance rounds (Mon-Fri) that include monitoring of Reporting Allegations of Abuse and Types of Abuse through verbal interviews with 5 residents and 5 staff members weekly x 4 weeks, then 3 times a week for 4 weeks, then 1 time a week x 4 weeks and resident observations to ensure all abuse allegations are being reported. Findings will be presented to QA monthly for a period of 6 months or until 100% compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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(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
	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	155229	A. BUILDING 00 B. WING	12/02/2022

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to properly prevent and/or contain COVID-19 by not ensuring housekeeping staff (Housekeeper 1) used appropriate cleaning procedures for COVID-19 positive resident rooms to prevent potential for cross contamination for 2 of 3 random observations. Findings include: During a random observation, on 11/30/2022 at 12:28 p.m., Housekeeper 1 was observed coming out of a resident room (room 28). The door had a hand written note stating "Do not use bleach.	F 0880	1. Housekeepers cited in 2567 were educated immediately on IC practices by the IP 2. Other residents have the potential to be affected therefore IP made random observations to assure no further noncompliance. 3. Ip will educate all of housekeeping on Infection Control including proper donning and doffing of PPE as well as the policy on cleaning isolation rooms, and hand hygiene requirements by 12/20/2022. No housekeeper will	12/20/2022

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	Thank you." The room signage indicated the resident was COVID-19 positive. Housekeeper 1 exited the room carrying a mop and placed it into the mop bucket located on the cleaning cart. They then removed their PPE (personal protective equipment) and indicated there was no trash container in the resident room. Housekeeper 1 disposed of the used PPE in the cleaning cart. No hand hygiene was performed. Housekeeper 1 then entered a resident room (room 25) who was not positive for COVID-19, donned gloves, began sweeping the floor, and then used the same mop used in the COVID-19 positive room to mop the floor. During an interview, on 11/30/2022 at 12:38 p.m., Housekeeper 1 indicated he forgot to perform hand hygiene between cleaning rooms. It was okay to use the same mop in both rooms because he had been using bleach. He used germicidal bleach solutions to mop the floors and changed the mop water every two to three rooms. During an interview, on 12/1/2022 at 10:46 a.m., Housekeeper 2 indicated the Housekeeping Supervisor was not in the facility due to illness. Housekeeper 2 indicated mops should not be shared between COVID-19 positive rooms and non-COVID-19 rooms. Review of a current policy, dated 6/10/2020, titled "Housekeeping Services" indicated the following: "... Cleaning Procedure Summary for Cleaning of Isolation Rooms 1. Clean the isolation room twice daily prior to cleaning any other patient care area and again at the end of the day after cleaning all other patient care areas... c. Use cleaning equipment dedicated to the isolation room... g. Dispose of or reprocess cleaning supplies and equipment immediately after cleaning...."		be allowed to work until this education is completed after date of compliance and this education will be provided on orientation going forward. 4. Housekeeping supervisor will observe 3 housekeepers weekly x 3 months then 2 housekeepers weekly x 3 months to assure compliance. Any concerns will be addressed immediately. Results will be presented to QAPI x 6 months. QAPI will determine the need for further audits 5. Date of Compliance 12/20/2022	

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	3.1-18(a)			
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 facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's			

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	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 obtain consents for influenza and pneumococcal vaccination for 2 of 5 residents reviewed for immunization consents (Residents H and J). Findings include: 1. The clinical record for Resident H was reviewed on 12/1/2022 at 11:11 a.m. Diagnoses included, but were not limited to, diabetes, hypertension and dementia. Review of the immunization record indicated the resident received the Influenza vaccine on 10/6/2022. The clinical record lacked documentation of education provided to the resident or family and no consent was located.	F 0883	1. No residents had any negative outcomes 2. An in house audit was completed by medical records for flu/ pnu consents. Any consents not located have been obtained and signed by date of compliance. 3. Residents that are newly admitted will have the original consents given to the LPN trainer to enter into PCC under immunizations, then they will go to the medical records department to be scanned into the individual's clinical record. A copy of the consent will also be made and put into a binder and kept by the DON ongoing. The original will be placed in the clinical record.	12/20/2022

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	Review of the immunization record indicated the resident refused the Pneumonia vaccine. The record lacked documentation of education provided to the family or the resident and a signed refusal of the vaccine. 2. The clinical record for Resident J was reviewed on 12/1/2022 at 10:30 a.m. Diagnoses included, but were not limited to, anxiety, depression, cerebrovascular accident, diabetes, hypertension and hypothyroidism. Review of the immunization record indicated the resident received the Influenza vaccination on 10/24/2022. The record lacked a consent for the vaccine. Review of the immunization record indicated the resident refused the Pneumonia vaccine. The record lacked documentation of education provided to the family or the resident and a signed refusal of the vaccine. During an interview, on 12/1/2022 at 12:50 p.m., the Infection Preventionist indicated the consents for resident vaccines were kept in a binder in her office. During an interview, on 12/2/2022 at 10:51 a.m., the Director of Nursing indicated the facility did not have vaccination consents or refusals for Resident H and Resident J. The DON was unsure how the facility missed obtaining the consent prior to administering the vaccines. Review of a current policy, dated 7/30/2019, titled "Influenza Vaccine & Pneumococcal Vaccine Policy for Residents" indicated the following: "...Procedure - Influenza Vaccine ... 7. Education, assessment finding, administration, refusal or did		4. An audit will be completed yearly at flu season to assure all residents have had their flu/pnu consents completed, signed, scanned in to PCC, placed in the binder and entered in PCC under immunizations by nursing management ongoing. New admissions will be audited by nursing managers in morning meeting to assure compliance and yearly as well. The medical records manager will audit consents every month to assure compliance ongoing. Results will be presented to QAPI monthly and any concerns addressed immediately. 5. Date of Compliance: 12/20/2022	

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	not receive due to medical contraindications, and monitoring are documented in the resident's medical record... Procedure - Pneumococcal Vaccine... 11. Education, assessment findings, administration, refusal or did not receive due to medical contraindications and monitoring are documented in the resident's medical record. Detailed recommendations are the same as the procedure for the influenza vaccine...." 3.1-13(a)			