STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155171	A. BUILDING 00 B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN MEADOWS	1285 W JEFFERSON ST FRANKLIN, IN 46131

(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 IN00439041, IN00441099, IN00442457, and IN00442312. Complaint IN00439041 - No deficiencies related to the allegations were cited. Complaint IN00441099 - No deficiencies related to the allegations were cited. Complaint IN00442457 - No deficiencies related to the allegations were cited. Complaint IN00442312 - No deficiencies related to the allegations were cited. Survey dates: September 24, 25, 26, 27, and 30, 2024 Facility number: 000087 Provider number: 155171 AIM number: 100289890 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 3 Medicaid: 67 Other: 15 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please find enclosed the Plan of Correction to the annual survey, Survey Event ID RSH311, that was conducted on September 30, 2024, resulting in an F-623 Citation, an F-625 citation, an F-641 citation, an F-644 citation, an F-849 citation, and a F-883 citation. This letter is to inform you that the plan of correction attached is to serve as Franklin Meadow's credible allegation of compliance. We allege compliance on 11/1/2024. Submission of this plan of correction does not constitute an admission by Franklin Meadows or its management company that the allegations contained in the survey report are a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We cordially ask for a desk review of these alleged deficient practices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Kennedy	Executive Director	10/18/2024

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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F 0623 SS=D Bldg. 00	Quality review completed October 1, 2024. 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure that the written Notice of Transfer and Discharge was provided to the resident, the resident's representative, and to the Office of the State Long-Term Care Ombudsman for 2 of 4 residents reviewed for transfers. (Resident 34, Resident 90) Findings include: 1. On 9/26/24 at 10:19 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and chronic cholecystitis with chronic cholecystitis-Pulled chole drain (condition that causes cholesterol to build up in the gallbladder forming polyps). A progress note, dated 4/22/24 at 8:12 p.m., indicated Resident 34 was transferred to the hospital emergency department. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written Notice of Transfer or Discharge document was provided to Resident 34, the representative, or the Office of the State Long-Term Care Ombudsman for the hospital transfer on 4/22/24. 2. On 9/26/24 at 1:00 p.m., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to, COPD, kidney disease, and diabetes.	F 0623	F623 Notice Requirements Before Transfer/Discharge **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Ombudsman/Resident/Family Representative notified of Resident 34 & 90, of discharge **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other residents who have hospital transfer have the potential to be affected by the alleged deficient practice. A facility audit was completed to ensure the ombudsman had been notified of all residents discharges. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	11/01/2024

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	A progress note, 7/31/24 at 4:07 p.m., indicated Resident 90 was transferred to the hospital emergency department on 7/31/24. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written Notice of Transfer or Discharge documents were provided to Resident 90, the representative, or the Office of the State Long-Term Care Ombudsman for the hospital transfer on 7/31/24. During an interview on 9/27/24 at 11:20 a.m., the Corporate Nurse Consultant indicated the facility lacked verification that the written notification of the transfer and discharge notice was given to the residents, the representatives, and to the Office of the State Long-Term Care Ombudsman. On 9/27/24 at 8:00 a.m., the Director of Nursing Services provided a copy of the American Senior Communities Hospital Discharge/Transfer policy, dated February 2019, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Nursing will contact the responsible party/family member to inform them of the pending discharge/transfer to the acute care hospital ...transfer notification will be reviewed with the responsible part at the time of notification and documented in the medical record ..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)		ED/Designee to educate social service team on ombudsman notification of residents with hospital transfers utilizing “Emergency Transfer Notifications” policy. Education to be given by 11/01/2024. All discharges to be reviewed monthly by ED/Designee with social services to ensure Notice requirements to Ombudsman/Resident/Family Representative have been given. (G) **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 POC QAPI Tool (A) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director¿ If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance¿	

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			Plan of Correction Date: Date of compliance 11/1/2024 The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure written bed hold notifications were provided to the resident and the resident's representative for 2 of 4 residents reviewed for transfers. (Resident 34, Resident 90) Findings include: 1. On 9/26/24 at 10:19 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), congestive heart failure (a condition that occurs when the heart can't pump enough blood to meet the body's needs), and atrial fibrillation (an irregular heartbeat). A progress note, dated 4/22/24 at 8:12 p.m., indicated Resident 34 was transferred to the hospital emergency department. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the	F 0625	F-625 Notice of Bed Hold Policy Before/Upon Transfer **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility failed to ensure written bed hold notifications were given to Resident 34 & Resident 90, or their appointed family representatives, at time of transfer. Residents 34 & Resident 90, and appointed family members, were provided with a copy of the bed hold policy. Additionally, the facility documented in Resident 34 and Resident 90 EMR confirmation that they were received. **How will you identify other**	11/01/2024

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	written bed hold notification was provided to Resident 34 or the representative for the hospital transfer on 4/22/24. 2. On 9/26/24 at 1:00 p.m., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to, COPD, type 1 diabetes mellitus, and congestive heart failure. A progress note, dated 7/31/24 at 4:07 p.m., indicated Resident 90 was transferred to the hospital emergency department on 7/31/24. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written bed hold notification was provided to Resident 90 or the representative for the hospital transfer on 7/31/24. During an interview on 9/27/24 at 11:20 a.m., the Corporate Nurse Consultant indicated the facility lacked verification that the written bed hold notification was given to the resident and their representative. On 9/27/24 at 8:00 a.m., the DON (Director of Nursing) provided a copy of the American Senior Communities Bed Hold policy, dated November 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated that the resident and the resident's representative will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave and that the facility will document the notification to the resident and resident representative of the bed hold policy. 3.1-12(a)(25) 3.1-12(a)(26)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other residents that transfer out of the facility have the potential to be affected by the alleged deficient practice. Facility audit will be completed to determine if a copy of the Bed Hold Policy was given and the facility documented confirmation of the residents, and/or POA, receiving the policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee to provide education to licensed nurses and social services regarding issuing a copy of the Bed Hold Policy to the resident and the family representative immediately upon transfer. Education to be given by 11/01/2024. All discharges to be reviewed the following business day by DNS/Designee to ensure Notice of discharge/transfer and bed hold policy were provided. (G) BOM/Designee to mail notice of discharge transfer and bed hold policy if not provided at	

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			the time of discharge **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 POC QAPI Tool (B) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director¿ If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance¿ **Plan of Correction Date:** Date of compliance 11/1/2024 The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, interview, and record review, the facility failed to ensure the accuracy of an Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for dental. The resident had ill fitting dentures that were not coded. (Resident 21) Finding includes: On 9/24/24 at 11:18 a.m., observed Resident 21 sitting on her bed watching television. Resident 21 had no bottom front teeth. On 9/26/24 at 9:45 a.m., observed Resident 21 sitting on her bed visiting with her spouse. Resident 21 was observed to have no bottom front teeth. During an interview at that time, the resident indicated she had a partial set of dentures. She indicated they did not fit her anymore, the dentures were in the top drawer of her dresser. On 9/26/24 at 10:00 a.m., Resident 21's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus. An Admission (MDS) assessment, dated 8/30/24, indicated Resident 21 had no dentures or partials. During an interview on 9/26/24 at 9:47 a.m., the MDS Coordinator indicated the assessment should have indicated Resident 21 had missing bottom front teeth. During an interview on 9/26/24 at 10:20 a.m., the Director of Nursing indicated an oral exam should have been completed during Resident 21's admission assessment.	F 0641	F641 Accuracy of Assessments **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 21's MDS was modified to reflect the dental/ ill-fitting dentures **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other residents having dentures have the potential to be affected by the alleged deficient practice. Facility audit was completed on all residents having dentures to ensure reflection on residents MDS assessment. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/designee to provide education to MDS coordinator regarding coding: dental, section L, per RAI manual. Education to be given by 11/01/2024.	11/01/2024

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	During an interview on 9/26/24 at 11:33 a.m., the Director of Nursing indicated the facility did not have a specific policy for the Minimum Data Set assessment. The facility utilized RAI manual. On 9/26/24 at 12:00 p.m., the RAI Manual, dated 10/2024, was reviewed. A review of the manual indicated "Required Tracking Records: A comprehensive assessment is required upon admission and annual. "...3. If the resident has dentures or partials, examine for loose fit..." 3.1-31(d)		Daily Meeting with MDS coordinator to discuss all dental related coding to ensure accuracy from previous business day. (G) **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 POC QAPI Tool (C) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director¿ Regional RAI specialist to audit MDS assessments submitted on residents who receive dental/dentures weekly for accuracy If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance¿ **Plan of Correction Date:** Date of compliance 11/1/2024	

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			The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on record review and interview, the facility failed to ensure a resident was referred to the State-designated authority contractor for a Level II (PASRR) for new mental health diagnosis for 1 of 1 residents reviewed for PASRR. (Resident 80) Finding includes: On 9/26/24 at 1:00 p.m., Resident 80's clinical record was reviewed. Resident 80 had a new diagnosis of psychoactive disorder on 6/18/24 without a referral for a Level II PASRR evaluation. During an interview on 9/25/24 at 1:35 p.m., the Director of Nursing indicated that a PASRR Level II referral was not completed and it should have been updated for Resident 80 after the new diagnosis of psychoactive disorder. On 9/26/24 at 9:10 a.m., the Director of Nursing Services (DON) provided a copy of an American Senior Communities PASRR Policy, dated 11/2017, and indicted that it was the current policy in use by the facility. The policy indicated it was the policy of the facility to ensure that any Pre-Admission Screening and Resident Review	F 0644	F-644 Coordination of PASARR and Assessments **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility failed to ensure a resident was referred to the State-designated authority contractor for a Level II for new mental health diagnosis. Facility has corrected Resident 80's PASARR Level II. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other residents that have a new mental health diagnosis have the potential to be affected by the alleged deficient practice. An audit	11/01/2024

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	(PASRR) recommendations which impact those with intellectual and mental disability or related conditions were completed as prescribed and PASRR assessments were updated with significant changes in mental or physical status. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		of residents will be completed to identify if any other residents need a new PASARR Level II for new mental health diagnoses. Any concerns identified will be corrected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee will provide education to Social Services regarding the policy on initiating new PASARR Level II's for any new mental health diagnosis. Education to be given by 11/01/2024. Daily meeting discussion to review all psych diagnosis changes will be implemented to ensure all needed PASARR's are completed from previous business day. (G) **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 POC QAPI Tool (D) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the	

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			Quality Assurance and Performance Improvement Committee overseen by the Executive Director¿ If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance¿ **Plan of Correction Date:** Date of compliance 11/1/2024 The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services Based on observation, interview, and record review, the facility failed to ensure a resident's hospice communication binder contained the on-going communication and collaboration between the facility and the hospice staff for 1 of 3 residents reviewed for hospice services. The hospice communication binder lacked any hospice documentation of services provided to the resident. (Resident 8) Finding includes:	F 0849	F849 -Hospice **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Documentation relating to the hospice services of Resident 8 was placed in the designated hospice binder. **How will you identify other**	11/01/2024

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	During an interview on 9/24/24 at 12:05 p.m., Resident 8 indicated he was receiving hospice services. On 9/25/24 at 1:23 p.m., Resident 8's clinical record was reviewed. The diagnosis included, but was not limited to, bladder cancer. Physician orders, dated 8/30/24 with no end date noted, indicated Resident 8 had elected to receive hospice services due to bladder cancer. The Significant Change Minimum Data Set (MDS) assessment, dated 9/6/24, indicated Resident 8 was moderately cognitively impaired and had a diagnosis of bladder cancer. Resident 8 had elected to receive hospice services. During an observation on 9/25/24 at 2:30 p.m., Resident 8's hospice communication binder, located at the nurse's station, was observed and reviewed. On the outside of the binder the following information was observed: Resident 8's name and room number and the hospice provider's name and contact information. Observed inside the binder was a type-written Table of Contents document which listed the various documents that were to be in the binder. A review of the document included but was not limited to: consents; physician orders; nursing notes; hospice aide assignment and notes; social worker notes; medication profile; and chaplain notes. No resident information or provider documentation was found inside the communication binder. During an interview at that time, RN 3 indicated Resident 8's hospice provider employees were to place their documentation into the hospice communication binder. The binder was a tool to ensure the facility was kept up to date on the resident's hospice status. RN 3 indicated she was		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Other residents on hospice services have the potential to be affected by this deficient practice. Audit on all current hospice patients will be completed by Social Services/Designee to ensure required documentation is in resident hospice binder. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/Designee to provide education to social services team of ensuring all current hospice residents have proper hospice binders containing required documentation. Education to be given by 11/01/2024. Social Services/Designee to complete a daily rounding tool (G) reviewing required documentation is in all current hospice residents binders will be implemented from previous business day. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	unaware that the binder lacked the hospice provider's documentation. On 9/27/24 at 9:10 a.m., the Director of Nursing Services (DNS) provided a copy of Medicaid Hospice Election document. A review of the document indicated Resident 8's appointed Power of Attorney opted for Resident 8 to receive hospice services as of 8/30/24. The document was signed by the Power of Attorney on 8/30/24. Resident 8's hospice communication binder and electronic clinical record lacked an on-going communication and collaboration records were shared between the facility and the hospice staff. During an interview on 9/25/24 at 2:40 p.m., the DNS indicated she was unaware that the hospice communication binder and the facility's electronic clinical record lacked Resident 8's hospice provider documentation. During an interview on 9/26/24 at 1:45 p.m., the DNS indicated the facility's hospice communication binder was to contain Resident 8's hospice provider's documentation to ensure communication and collaboration between the provider and the facility. On 9/26/24 at 9:10 a.m. the DNS provided a copy of the "One Time Nursing Facility and Hospice Services Agreement" dated 8/29/24 and indicated it was the current facility and hospice agreement in use by the facility. A review of the document indicated, "...Coordination of Responsibilities: the parties agree to accept responsibility for the provision of all necessary care and services...in accordance with each party's policies and procedures...liaisons to facilitate cooperation and communication between the parties..." The		**assurance program will be put into place?** The POC QAPI Tool (E) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Plan of Correction Date:** Date of compliance 11/1/2024 The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155171	A. BUILDING 00 B. WING	09/30/2024

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	document was executed on 8/29/24 as indicated by the signature of both parties. On 9/26/24 at 2:44 p.m., the DNS provided a copy of the Hospice Policy, dated September 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "it is the policy of this facility that when a resident elects hospice benefit, the contracted hospice company and facility will coordinate to establish ...a pattern of communication between the hospice company, healthcare professionals, facility staff and resident/representative..." 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 follow vaccination administration guidelines for the pneumococcal vaccine. The appropriate pneumococcal vaccine was not given for residents who had consented to receive their pneumococcal vaccinations per CDC (Centers for Disease Control and Prevention) guidelines for 2 of 8 residents reviewed for immunizations. (Resident 41, Resident 78) Findings include: 1. On 9/24/24 at 1:00 p.m., Resident 41's clinical record was reviewed. Resident 41's diagnoses included, but were not limited to, unspecified dementia, chronic atrial fibrillation (a type of irregular heartbeat), type 2 diabetes, and chronic kidney disease. -Resident 41's immunization records indicated	F 0883	F-883 Influenza and Pneumococcal Immunizations **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility failed to follow vaccination administration guidelines for the pneumococcal vaccine for Resident 41 and Resident 78. Resident 41 and Resident 78 have both received the pneumococcal vaccine. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	11/01/2024

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	Resident 41 received a PCV (pneumococcal conjugate vaccine) 13 on 9/12/16 but lacked any documentation for a PPSV (pneumococcal polysaccharide) vaccine. -Resident 41 was of 65 years of age or older. On 9/25/24, the DON (Director of Nursing), provided a copy of Resident 41's pneumococcal vaccination consent form which was marked as resident wished to receive pneumococcal vaccinations per the recommendations of the CDC's pneumococcal vaccine timing for adults. The form was unsigned but was dated for 8/21/24 at 1:00 p.m. 2. On 9/24/24 at 1:30 p.m., Resident 78's clinical record was reviewed. Resident 78's diagnoses included, but were not limited to, unspecified dementia, COPD (a lung disease that makes it difficult to breathe), and old myocardial infarction (a heart attack). -Resident 78's immunization records lacked any documentation for either a PCV type or a PPSV type pneumococcal vaccine. -Resident 78 was of 65 years of age or older. On 9/25/24, the DON, provided a copy of Resident 78's pneumococcal vaccination consent form, which was marked as resident wished to receive pneumococcal vaccinations per the recommendations of the CDC's pneumococcal vaccine timing for adults. The form was signed by resident or by resident's responsible party and was dated for 2/8/24 at 1:57 p.m. During an interview on 9/25/24 at 1:25 p.m., the DON indicated that the appropriate pneumococcal		**taken?** An audit of all resident vaccine consents have been reviewed to identify if any other residents were affected by the alleged deficient practice. Any issues identified were corrected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will provide education to infection preventionist and backup to the infection preventionist. regarding the facilities policy on providing proper vaccination requests by any resident. Education to be given by 11/01/2024. Daily clinical meetings with Infection Prevention nurse to discuss all pending vaccinations to be given and status of each vaccine to ensure vaccines are given per administration guidelines as per resident consents from previous business day. (G) **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?**	

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	vaccinations should have been given for both residents. On 9/24/24 at 10:05 a.m., the DON provided an undated policy titled, "Pneumococcal Vaccination", and indicated it was the policy currently in use. The policy stated that the facility utilized CDC guidance for pneumococcal vaccine recommendations per the CDC's pneumococcal vaccine timing for adults. On 9/27/24 at 10:30 a.m., a review of the CDC guidelines at the following website regarding pneumococcal vaccine times for adults (https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf), last updated on 9/12/24, indicated that diabetes mellitus, chronic lung diseases, and chronic heart diseases are all chronic health conditions where pneumococcal vaccinations are recommended for adults 19 through 64 years old in addition to being recommended for adults 65 years old and older. 3.1-13(a)		The POC QAPI Tool (F) will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director¿ If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance¿ **Plan of Correction Date:** Date of compliance 11/1/2024 The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	