STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505331	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKFIELD HEALTH AND REHAB OF CASCADIA	510 NORTH PARKWAY BATTLE GROUND, WA 98604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to provide information regarding Pneumococcal 13-valent conjugate vaccine (Prevnar 13) and failed to have an informed consent completed, including the risk and benefits, for [MEDICAL CONDITION] medications for 2 of 5 sampled residents #142 & 242) reviewed for unnecessary medications and immunizations. This failure placed residents at risk of contracting pneumonia, potential illness, not being informed about medications and a decreased quality of life. Findings included . 1) Resident #142 admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 01/23/2020, documented the resident was cognitively intact and able to make independent decisions. The Center for Disease Control & Prevention's (CDC) 2019 Updated Pneumococcal Vaccine Recommendations documented, Prevnar 13 vaccination recommendations have changed: 1 dose before 65 for immunocompromised patients (HIV, chronic kidney failure, [MEDICAL CONDITION], etc.) . For healthy, immunocompetent patients, 1 dose after 65 is no longer recommended, but can still be given based on a shared clinical decision. The resident's pneumococcal immunization informed consent form, dated 12/23/2019, included information regarding the PPSV23 vaccine; and for Prevnar 13 vaccine, the informed consent did not include information or documentation the resident was offered, received or declined the Prevnar 13 vaccine. On 03/05/2020 at 12:48 PM, Staff B; Director of Nursing Services, Infection Control and Registered Nurse; said the facility's pneumococcal vaccine informed consent form covered both the Pneumococcal [MEDICATION NAME] Vaccine (PPSV23) and the Pneumococcal 13-valent conjugate vaccine (Prevnar 13). Staff B said she could not provide documentation showing Resident #142 was offered, received or declined the Prevnar 13 pneumonia vaccine. 2) Resident #242 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An informed consent was not found for [MEDICATION NAME] in the resident's medical record indicating the resident was informed of the risks and benefits, options, and alternatives to the medication. A fax to Resident #242's physician, dated 02/20/2020, documented We have some questions we are hoping you can assist with regarding her [MEDICAL CONDITION] medications (medications that affects behavior, mood, thoughts, or perception), which she states are managed by your office . [MEDICATION NAME] ([MEDICATION NAME]) for [MEDICAL CONDITION] D/O (disorder). On 03/04/2020 at 10:17 AM, Staff C, Licensed Practical Nurse and Charge Nurse, said consents should be obtained on any [MEDICAL CONDITION] such as antidepressants, antianxiety medications, or anything that could cause a change in their mental status. When asked if a medication used to treat [MEDICAL CONDITION] disorder should have an informed consent signed by the resident, Staff C stated, Yes, it should have a signed consent. At 11:17 AM, Staff B said consent should be obtained for all [MEDICAL CONDITION] medications. When asked if a medication used to treat [MEDICAL CONDITION] disorder should have a consent signed by the resident, Staff B stated, Absolutely. If there is a [DIAGNOSES REDACTED].
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to routinely review and adjust Advance Directives to reflect resident desires for 1 of 7 sampled residents (#18) reviewed for advance directives. This failure placed residents at risk of not receiving their desired interventions in a healthcare emergency and a decreased quality of life. Findings included . Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set, an assessment tool, dated 0[DATE], documented the resident had moderate cognitive impairment. A physician's progress note, dated 0[DATE], documented Resident #18 was discharged from a hospital stay on 02/12/2020 with a referral to hospice and was on comfort measures. The resident's medical record showed no documentation Resident #18 had a legal representative, Power Of Attorney (POA) for healthcare or court approved guardian in place. Medical record documentation showed the resident's daughter signed the acknowledgement for receiving facility policies related to AD's on the resident's admission in 2013. The resident's medical record did not include an advance directive or documentation showing the facility offered the resident or a legal representative an opportunity to re-assess the resident's goals and wishes on a routine basis as the resident's medical condition changed. On 03/06/2020 at 8:13 AM, Staff K, Social Services Director (SSD), said she was not offering advance directive information or discussing legal representation needs for residents at care conferences. Staff K said she would add discussing advance directive and healthcare POA discussions to her care conference interview form. Staff K said she did not feel the resident would currently be able to sign legal documentation to appoint someone as her POA. On 03/10/2020 at 10:04 AM, Staff A, Administrator, said the SSD would be responsible for monitoring a resident's POA and guardian status. Staff A said Resident #18 did not currently have a POA for healthcare and would not be able to sign any legal documents for appointing a medical POA at this time. Reference WAC 388-97-0280 (3)(C)(i-ii) .
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to provide written notice of transfer to residents and/or resident representatives for 2 of 3 sampled residents (#18 & 142) reviewed for hospitalization . This failure placed residents at risk of not being informed of their condition, unmet care needs and a diminished quality of life. Findings included . 1) Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], documented the resident was severely cognitively impaired. A nursing progress note, dated 01/28/2020 at 3:49 PM, documented Resident #18 was transferred to the hospital at 3:39 PM. The medical record showed a written notification of reason for transfer was not provided to the resident and/or resident's representative for the 01/28/2020 transfer to the hospital. 2) Resident #142 was admitted to the facility on [DATE]. The MDS, an assessment tool, dated 01/23/2020, documented the resident was cognitively intact and able to make independent decisions. A nursing progress note, dated 01/13/2020 at 5:17 PM, documented Resident #142 was transferred to the hospital and admitted for generalized weakness and a blood transfusion. The resident's medical record showed a written notification of reason for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) transfer was not provided to the resident for his 01/13/2020 transfer to the hospital. On 03/06/2020 at 7:39 AM, Staff J, Business Office Manager, said she could not provide documentation showing a written notice of reason for transfer was provided to Resident #18 or representative for her 01/18/2020 transfer to the hospital and to Resident #142 for his 01/13/2020 hospital transfer. At 8:01 AM, Staff K, Social Services Director, said she could not provide documentation showing a written notice of reason for transfer was provided to Resident #18 or her representative for the 01/18/2020 transfer to the hospital and to Resident #142 for his 01/13/2020 hospital transfer. At 8:26 AM, Staff B, Director of Nursing Services and Registered Nurse, said she could not provide documentation showing a written notice of reason for transfer was provided to Resident #18 or her representative for the 01/18/2020 transfer to the hospital and to Resident #142 for his 01/13/2020 hospital transfer. Reference WAC 388-97-0140 (1)(a)(b)(c)(i-iii) .
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to provide bed hold policies including the reserve bed payment (cost per day to hold the bed) and copies of the bed hold policy to the resident or resident representative for 2 of 3 sampled resident's (#142 & 18) reviewed for hospitalization . These failures placed resident's at risk of not being informed regarding their right to hold their bed and cost of holding their bed while hospitalized . Findings included . The facility's bed hold agreement form, undated, documented, I (the resident/representative) am responsible for payment of the basic per-diem rate. The bed hold agreement form did not include the facility's current daily cost for holding a resident's bed when transferred/admitted to an acute care facility. 1) Resident #142 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 01/23/2020, documented the resident was cognitively intact and able to make independent decisions. The resident's medical record showed the resident was the responsible party, had no court appointed Guardian and no other individual was Power Of Attorney (POA) for making health care decisions for the resident. A nursing progress note, dated 12/27/2019 at 11:44 PM, documented Resident #142 was transferred directly to the hospital from the resident's [MEDICAL TREATMENT] center and admitted for low blood pressure and dizziness. A bed hold agreement, dated 12/30/2019, three days after the resident's hospitalization , was signed by the resident's significant other, did not include the facility's per-day bed reserve bed payment cost and did not show the resident was provided a copy of the bed hold agreement. A nursing progress note, dated 01/13/2020 at 5:17 PM, documented Resident #142 was transferred to the hospital and admitted for generalized weakness and a blood transfusion. A bed hold agreement, dated 01/13/2020, signed by the resident's significant other, did not include the facility's per-day bed reserve bed payment cost and did not show the resident was provided a copy of the bed hold agreement. A nursing progress note, dated 01/24/2020 at 1:07 AM, documented, Per resident's significant other, Resident (#142) was admitted to (the hospital) following doctor's appointment . Significant other came to facility . and signed bed hold agreement . A bed hold agreement, dated 01/24/2020, signed by the resident's significant other, did not include the facility's per-day bed reserve bed payment cost and did not show the resident was provided a copy of the bed hold agreement. 2) Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS, dated [DATE], documented the resident had moderate cognitive impairment. A nursing progress note, dated 12/06/2019 at 7:01 PM, documented Resident #18 was transferred to the hospital and admitted for decreased blood pressure and increased lethargy (abnormal drowsiness). Resident #18's bed hold agreement, dated 12/06/2019, did not include the facility's per-day bed reserve bed payment cost. A nursing progress note, dated 12/15/2019 at 6:38 AM, documented Resident #18 was transferred to the hospital for increase in change of condition . The bed hold agreement, dated 12/15/2019, did not include the facility's per-day bed reserve bed payment cost. A nursing progress note, dated 01/28/2020 at 3:49 PM, documented Resident #18 was transferred to the hospital at 3:39 PM. The bed hold agreement, dated 01/28/2020, did not include the facility's per-day bed reserve bed payment cost. On 03/06/2020 at 7:39 AM, Staff J, Business Office Manager, said Resident #142's 12/30/2019, 01/13/2020 and 01/24/2020 bed hold agreements; and Resident #18's 12/06/2019, 12/15/2019 and 01/28/2020 bed hold agreements; did not include a specific daily rate for holding a resident's bed while hospitalized . On 03/10/2020 at 10:04 AM, Staff A, Administrator indicated a resident's bed hold agreement should include the per-day reserve payment costs. Staff A said the facility's policy was for a resident or representative, if indicated, to sign the bed hold agreement prior to leaving the facility. If that was not possible, designated staff were to go to the hospital, have the resident or representative review/sign the form and provide them with a copy. Staff A said Resident #142 should have been provided the bed hold information and signed the bed hold agreement form. Reference WAC 388-97-0120 (4) .
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** . Based on interview and record review, the facility failed to ensure Licensed Nurses (LNs) had specific competencies and skills to provide care and services for each resident in accordance with the facility assessment and resident specific care needs for 2 of 5 sampled staff members (Staff D, RN & Staff E, RN) reviewed for competent nursing staff. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . The Facility Assessment, dated 11/11/2019, did not show specific competencies, skills sets and types of trainings necessary to care for the residents needs. Review of employee records did not show staff demonstrated competency in areas including preventing and reporting abuse, neglect and changes in resident condition. 1) Staff D, Registered Nurse (RN), was hired by the facility on 04/19/2019. A form entitled, RELIAS transcript for (Staff D), had several dates showing completion of an online training. The form did not include documentation on how Staff F was assessed to be competent in the skills reviewed. The training records did not show documentation of a performance evaluation. 2) Staff E, RN, was hired by the facility on 09/01/2017. A form entitled, RELIAS transcript for (Staff E), had several dates showing completion of an online training. The form did not include documentation on how Staff F was assessed to be competent in the skills reviewed. The training records did not show documentation of a performance evaluation. On 03/06/2020 at 1:19 PM, Staff A, Administrator, said performance evaluations were supposed to be done annually. Staff A said the facility fell behind on performance evaluations, so employees may or may not have them in their file. Staff A said management staff should have completed performance evaluations. At 1:29 PM, Staff C, Licensed Practical Nurse and Charge Nurse, said staff skills were evaluated upon hire and annually after hire. Staff C said pertaining to return demonstration, a lot of education was not repeat demonstration. A lot of education was more verbal demonstration, such as reviewing policies. Reference WAC 388-97- 1080 (1), 1090 (1) .
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** . Based on interview and record review, the facility failed to complete performance reviews for 1 of 2 Certified Nursing Assistants (Staff F) reviewed for staffing. This failure placed residents at risk for receiving care from unskilled staff. Finding included . Staff F's personnel file did not have documentation of a performance review for the past year. On 03/06/2020 at 2:16 PM, Staff A, Administrator, said most of the nurse aides' performance reviews had not been completed. Reference WAC 388-97-1680 (1), (2)(a-c) .
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to develop parameters for the administration of pain and fever medication for 2 of 5 sampled residents (#242 & 36) reviewed for unnecessary medications. This failure placed residents at risk for receiving unnecessary medication, experiencing side-effects and a diminished quality of life. Findings included . 1) Resident #242 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. There was no indication at what level of temperature would be considered a fever, and no parameters for what level of pain to give the medication. A physician's orders [REDACTED]. There were no parameters for what level of pain to give the medication. 2) Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS, dated [DATE], documented the resident had an absence of spoken words, was usually understood and usually understands others. A

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) physician's orders [REDACTED]. There were no parameters for what level of pain to give the medication. A physician's orders [REDACTED]. There were no parameters for what level of pain to give the medication. A physician's orders [REDACTED]. There were no parameters for what level of pain to give the medication. Review of the Physician's standing orders, undated, documented, Tylenol 650 mg PO/PR (oral or rectal route) Q4H (every 4 hours) PRN (as needed) for fever/pain, not to exceed 3000 mg in any form per 24 hour period. There was no indication at what level of temperature would be considered a fever, and no parameters for what level of pain to give the medication. On 03/04/2020 at 10:14 AM, Staff C, Licensed Practical Nurse and Charge Nurse, said to determine which pain medications to administer to the resident with multiple pain medications ordered, there were a couple different options. Staff C said if the resident was alert, she would ask the resident what medication they wanted. Staff C said if the resident was non-verbal, she would give Tylenol for a 1-4 pain out of 10. Staff C said for pain rating higher than 4 she would try the higher level pain medication. Staff C said a lot of it was knowing the residents and their pain, and to try to use the lesser pain medication. Staff C said there was no policy in place stating with a 1-4 out of 10 pain rating to try Tylenol. Staff C said Tylenol would be given for a fever of 100.5 F (Fahrenheit). At 10:28 AM, Staff G, RN, said to determine which pain medications to administer to the resident with multiple pain medications ordered, she would start with something small like Tylenol. Staff G said if she had worked with the resident already and she knew their pain, she would go to the stronger pain medication. Staff G said as far as parameters, the orders just say for pain; not mild, moderate, severe pain. Staff G said there were no orders to determine what pain medication to give at what pain level. Staff G said Tylenol would be given for a fever of 100.3 F. At 11:04 AM, Staff B, RN and Director of Nursing Services, said to determine which pain medications to administer to the resident with multiple pain medications ordered, it would be up to the resident to decide. Staff B said if the resident was verbal she would expect staff to ask if they wanted one medication or another. Staff B said if the resident was non-verbal she would expect nurses to give the lowest pain medication, Tylenol; and if it was not effective then go up to a higher level pain medication. Staff B said the facility did not have parameters for pain because pain was resident driven. At 11:09 AM, Staff H, RN and Corporate Resource, said she called the pharmacy to clarify the parameters for giving Tylenol for fever. Staff H stated, Tylenol was given according to doctor's parameter for fever, and individually as a resident tolerated. Staff H said for temperatures of 99 F and above, the facility could give Tylenol. At 11:13 AM, Staff B said nurses were expected to use their nursing judgement for fever parameters. Reference WAC 388-97-1060 (3)(k)(i) .
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** . Based on interview and record review, the facility failed to ensure a thorough facility-wide assessment was completed that incorporated the components to meet each resident's care and service needs. This failure placed residents at risk for unidentified and unmet care needs and a diminished quality of life. Findings included . The facility assessment, dated November 2019, did not address the following areas: *The staff competencies that were necessary to provide the level and care needed for the resident population. *Facility resources including all personnel: staff, contracted staff, volunteers, and their education and training of competencies related to resident care. *Facility resources which included supplies, equipment or other services necessary to provide for the needs of residents. *An evaluation of the physical environment necessary to meet the needs of the residents, including an evaluation of how the facility needed to be equipped and maintained to protect and promote the health and safety of residents *Contracts, memorandums of understanding or other agreement with third parties to provide services during both normal operations and emergencies. *Health information technologies resources regarding systems for managing electronic health records and sharing information with other organizations. On 03/06/2020 at 2:40 PM, Staff A, Administrator, said he and Staff B, Registered Nurse and Director of Nursing Services and Staff C, Licensed Practical Nurse and Charge Nurse, reviewed the facility assessment. Staff A said the facility assessment did not go into great detail of what the staff competencies were. Staff A said the facility assessment did not list facility resources. When he and the facility team were filling out the assessment, it did not provide a space to list facility resources. No Associated WAC .
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure procedures for maintaining hospice care records were in place for 1 of 1 sampled residents reviewed for hospice services. This failure placed residents at risk of unmet care needs and not receiving necessary and end of life services. Findings Included . Resident #31 was admitted to the facility on [DATE]. The Minimum Data Set, an assessment tool, dated 01/21/2020, indicated the resident was moderately cognitively impaired and was able to make her needs known. The medical record showed Resident #31 was admitted for hospice services on 01/22/2020. The electronic health record did not have documentation of hospice services being provided since 02/05/2020. On 03/06/2020 at 12:41 PM, Staff B, Director of Nursing Services and Registered Nurse, said Resident #31 was receiving Hospice services weekly. Staff B said the Hospice provider left notes after their visit with Resident #31 and was recently given access to the facility's electronic documentation system (EDS). Staff B said the notes should be scanned into EDS for reading. When asked if she could locate the hospice notes, Staff B said the last one she could find was from 02/05/2020. No WAC Reference .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** . Based on interview and record review, the facility failed to ensure a complete water management program to reduce the growth and spread of Legionella (a bacteria found in water that can cause a serious type of pneumonia) was developed. This failure placed residents at risk of infection, and a diminished quality of life. Findings included . On 03/06/2020 at 9:43 AM, the facility's Legionella water management program was showed their plan did not include written documentation of the following program elements: >Identification of where Legionella could grow and spread on the flow diagram. >Implementation of program monitoring by someone other than individual responsible for the activity being monitored. >How facility would communicate the water management plan to residents, staff and/or others. >How staff, responsible for implementing and monitoring the program, would be trained. >Policies and Procedures related to processes identified in the water management program. >A facility risk assessment identifying where legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system. On 03/06/2020 at 9:50 AM, Staff A, Administrator, said he could not provide written documentation of a flow diagram including where Legionella could spread. Staff A said monitoring control measures and program effectiveness were both performed by the facility's maintenance manager. Staff A said the water management program did not identify how the facility communicated the program to residents, staff and others. Staff A was unable to provide documentation identifying what training the facility provided staff who implemented and monitored the program. Staff A said the facility did not have any Legionella water management related policies in place, and a infection control/Legionella risk assessment was not done and included in the facility assessment. Reference WAC 388-97-1320 (1)(a) .
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Implement a program that monitors antibiotic use.** . Based on interview and record review, the facility failed to ensure an Antibiotic Stewardship Program (ASP) was completed implemented. This failure placed residents at risk of receiving unnecessary and/or incorrect antibiotics and a diminished quality of life. Findings included . Record review of staff training and competency records did not include antibiotic stewardship related training documentation. The facility's ASP did not include documentation of how the facility would educate staff on the facility's ASP policies and procedures related to antibiotic stewardship, protocols for facility antibiotic use and how the facility would evaluate the ASP's effectiveness. On 03/06/2020 at 10:05 AM, Staff B; Infection Control, Director of Nursing Services and Registered Nurse; was unable to provide documentation of staff training on the ASP. Staff B was unable to provide facility policies, procedures and protocols addressing how the facility would monitor to ensure antibiotics were prescribed for correct indication, dose and duration. Staff B said no evaluations had been done to determine if the facility ASP was effective. Refer to F726 No Associated WAC .

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F 0881 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3)
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure Prevnar 13 pneumonia vaccines were offered for 1 of 5 sampled residents (#142) reviewed for influenza and pneumonia vaccinations. This failure placed residents at risk of contracting and spreading pneumonia and a decreased quality of life. Findings included . The Center for Disease Control & Prevention's (CDC) 2019 Updated Pneumococcal Vaccine Recommendations documented, Prevnar 13 vaccination recommendations have changed: 1 dose before 65 for immunocompromised patients (HIV, chronic kidney failure, [MEDICAL CONDITION], etc.) . For healthy, immunocompetent patients, 1 dose after 65 is no longer recommended, but can still be given based on a shared clinical decision. The facility's Pneumococcal Program, dated 10/31/2017, documented, If not previously received provide PCV13 upon admission . Resident #142 was admitted to the hospital on [DATE] with [DIAGNOSES REDACTED]. The medical record showed Resident #124 was under the age of 65. The medical record did not show documentation the resident was offered, received or declined to receive a Prevnar 13 pneumococcal vaccine upon or after admission to the facility. On 03/04/2020 at 4:17 PM, Staff B, Registered Nurse and Director of Nursing Services, said the facility stopped offering the Prevnar 13 vaccines to new residents a couple of months ago due to the new CDC guidelines. Staff B said she was aware Resident #142 was receiving [MEDICAL TREATMENT] (treatment that filters and purifies blood using a machine to help keep fluids and electrolytes in balance when the kidneys do not function). On 03/06/2020 at 10:02 AM, Staff A, Administrator, said the facility pneumococcal vaccination policy was not changed and the resident should have been offered the Prevnar 13 vaccination. Reference WAC 388-97-1340 (1), (2), (3) .