STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155373	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUFFTON REGIONAL MEDICAL CENTER CARE CENTER	**303 S MAIN ST BLUFFTON, IN 46714**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure pressure area monitoring and changes were reported to physician for 1 of 2 residents reviewed. Resident 57 Findings include: On 3/11/2020 at 2:00 p.m., the record of Resident 57 was reviewed. [DIAGNOSES REDACTED]. An Admission Minimum Data Set Assessment ((MDS) dated [DATE] indicated the following: the resident was of independent cognition; was at risk to develop pressure sores and was receiving nutritional or hydration interventions to manage skin problems. The wound care note dated 3/4/2020, indicated the resident wore a boot to LLE (left lower extremity) and splint to RLE (right lower extremity) at all times, to remove for skin care.The residnet had a red area to top of left foot with small purple area, possible deep tissue injury in the center. The redness surrounding was blanchable. Meplix borders (type of dressing) was in place to both areas to help prevent further injury. The Incision/Wound log for a top left foot indicated the following: On 3/4/2020: deep tissue injury (a pressure related injury to subcutaneous tissues under intact skin). On 3/5 and 3/6/2020 noted deep tissue injury. Documentation was lacking on 3/7/2020 of wound condition. On 3/8/2020 documentation indicated the area was a pressure ulcer. Documentation was lacking of initial assessment of the open area measurements of the area. Documentation on 3/9 and 3/10/2020 indicated the area was a pressure ulcer and lacked documentation of measurements. A Nursing Note dated 3/6/2020 at 9:13 a.m. indicated the resident wore a boot to LLE (left lower extremity). The boot and splint were to be removed daily for skin assessment andcare. A plan of care, dated 3/9/2020, regarding skin integrity indicated a goal of no pressure wounds. Interventions included, but were not limited to, the following: skin evaluation and dressing change per orders. A Nursing Note dated 3/10/2020 at 9:52 p.m. indicated the resident was to wear a boot and splint or ace wrap, remove for skin care/cleansing, [MEDICATION NAME] dressings change, and the observation indicated the pressure area was improving. The Incision/Wound log for the top of the left foot indicated 3/11/2020 the pressure ulcer area had a measurement of width 1.5 (cm), length 2 cnm and depth of 0.1 cm. The was no documentation to indicated the physician had been notified the area was now open. On 3/11/2020 at 11:00 a.m., the resident was observed in bed with a boot to his left lower leg and foot. RN 2 Wound Nurse was observed to remove the boot. The area to the top of the left foot was observed to be a small open area, the size of a pencil eraser. The RN said this was a blister that opened. She indicated the areas to the resident's feet were present when he arrived at the facility on 2/25/2020 as he has had the boot on either and/or both feet for about 2 months. She indicated the wounds were measured weekly. The DON (Director of Nursing) provided a copy of the IDT (Interdisciplinary Team) conference dated 3/11/2020 and indicated the following: Team meeting notes: The physician was updated on the resident's pressure area on the top of the left foot, stage II (open area which expands into layers of the skin), no new orders were received, would continue current wound care and update if there were further changes. A patient care note dated 3/12/2020 at 12:02 p.m., indicated nursing was assessing the resident's pressure wounds on BLE (bilateral lower extremities) for s/s (signs and symptoms) of healing and deterioration. On 3/12/2020 at 1:55 p.m., the Director of Nursing (DON) was interviewed. She indicated the wounds were measured on admission and then weekly on Wednesdays. She indicated RN 2 was the wound nurse. She indicated the reason the wound was not measured on 3/8/2020 with the change of a deep tissue injury to a stage 2 open pressure area, was because they do measurements on Wednesdays, which would have been 3/11/2020. When the DON was queered if the physician had been notified on 3/8/2020 of the change in status of the wound, the DON indicated he was not. The DON indicated it was the same wound and this was why they initiated weekly measurements by the wound nurse, for consistency. The DON indicated a deep tissue injury is a pressure injury. She indicated as far as measuring the wound, they go on a case by case basis. On 3/12/2020 at 2:57 p.m., the Director of Acute and Post Acute Services (DAPACS) was interviewed. She indicated the physician should have been notified of the pressure wound changing from a closed wound to an open wound on 3/8/2020. On 3/13/2020 at 9:11 a.m., RN 2/Wound Nurse was interviewed. She indicated the following: She reviewed the resident's wound record and indicated on 3/4/2020 the wound was not open as no depth was charted and the wound had been classified as a a Deep Tissue Injury. Documentation on 3/5 and 3/6/2020 indicated the wound was considered a deep tissue injury. Documentation was lacking on 3/7/2020 of an assessment of the area. She indicated according to the documentation, on 3/8/2020, the resident had a pressure injury which would mean the area was open. RN 2/Wound Nurse indicated she thought the floor nurse that documented the initial observation of an open pressure area would notify the physician of the change in the wound from closed to open status. She indicated this resident was at risk for pressure areas. She indicated on 3/8/2020 the pressure area was observed to be open per the documentation. She indicated the physician was not notified on 3/8/2020 when the pressure area went from a deep tissue injury to an open pressure area. She indicated if a pressure wound changed from being closed to an open wound, they probably should notify the physician. She indicated based on documentation, she was not sure when the wound opened as there was no documentation on 3/7/2020 for the wound. She indicated wounds are always measured upon admission and weekly thereafter. She indicated the wounds were measured on Wednesdays (3/4/2020, 3/11/2020). RN 2/ Wound Nurse was queered regarding the wound being not measured on changing from closed to open status, what was the way she would she know if the wound was better or worse. She indicated I guess it should be measured. Typically the wound would be measured when the status changed from closed to open. On 3/13/2020 at 10:12 a.m., Director of Quality Management (DQM) and the Director of Acute and Post Acute Services (DAPACS) were interviewed. They were made aware aware the pressure area to the top left foot was not assessed and/or measured when the status changed from a deep tissue injury to an open area. They were also made aware of missing documentation on 3/7/2020 assessment and the physician not being notified. They indicated the area should have been assessed and/or measured with the change of status and the physician should have been notified. 3.1-40(a)(2)
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure recommended [MEDICAL TREATMENT] monitoring was in place for 1 of 1 residents reviewed. Resident 60 Findings include: On 3/10/2020 at 10:00 a.m., the record of Resident 60 was reviewed. [DIAGNOSES REDACTED]. A History and Physical, dated 3/4/2020 included the following: history of end stage [MEDICAL CONDITIONS] ([MEDICAL TREATMENT] Monday - Wednesday - Friday). Case management was attempting to find a [MEDICAL TREATMENT] center closer to the resident. The resident was cooperative and with normal cognition, had a left upper arm AV (arteriovenous) shunt (provides access for [MEDICAL TREATMENT]), positive for bruit/thrill (audible vascular sound associated with turbulent blood flow/when palpated turbulent blood flow). A nursing note, dated 3/6/2020 at 11:39 a.m., indicated the resident received [MEDICAL TREATMENT] 3 times week. Nursing was to monitor the fistula site in left forearm. On 3/10/2020 at 2:46 p.m., the Director of Nursing (DON) provided copies of the resident's notes from the [MEDICAL TREATMENT] unit. She indicated the facility had to call the [MEDICAL TREATMENT] unit to obtain the notes. The date of service of the notes was 3/6/2020 and 3/9/2020 with a fax date and time of 3/10/2020 at 2:31 p.m. stamped on them The notes included pre and post [MEDICAL TREATMENT] blood pressure, weight and temperature an area for new complaint or observation which developed during [MEDICAL TREATMENT] and/or nursing evaluation (fluid assessment). On 3/11/2020 at 9:41 a.m., DAPAC

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 0698

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 1)

provided copies of documentation the staff checked the thrill and bruit for Resident 60. She indicated this assessment of the thrill and bruit had not been completed daily since the resident was admitted to the facility on [DATE]. She provided documentation the thrill and bruit was assessed on the following dates: 3/5/2020 at 3:00 a.m. and 9:31 a.m.; 3/6/2020 at 11:44 a.m. and 3/10/2020 at 1:42 a.m. On 3/12/2020 at 12:00 p.m., the facility provided a current copy of the Long Term Care (LTC) Facility Outpatient [MEDICAL TREATMENT] Services Coordination Agreement. This agreement had been signed by the facility on 3/11/2020 nor by the the [MEDICAL TREATMENT] unit as of 3/11/2020. The agreement included, but was not limited to, the following information: This agreement is made by and between (name of health system) and (name of [MEDICAL TREATMENT] provider), effective upon the date of last signature. Whereas, Long Term Care Facility has [MEDICAL CONDITION] (end stage [MEDICAL CONDITION]) residents who have end stage [MEDICAL CONDITION] and wish to receive outpatient [MEDICAL TREATMENT] and whereas LTC facility desires to enter into an arrangement with company to obtain professional and timely services that the LTC facility does not furnish independently. Obligation of LTC facility: the LTC facility shall provide for the interchange of information useful and/or necessary for the care of the [MEDICAL CONDITION] Residents, including a contact person at the LTC facility whose responsibilities include assisting with the coordination of [MEDICAL TREATMENT] Services. The LTC facility shall be responsible for ensuring that the [MEDICAL CONDITION] residents are medically stable to undergo such transportation and medically suitable to receive treatment at the [MEDICAL CONDITION] unit; The LTC facility must receive confirmation from the [MEDICAL CONDITION] [MEDICAL TREATMENT] unit that it shall accept the [MEDICAL CONDITION] Resident, and all necessary admissions documentation must be completed be the LTC facility and sent in advance to the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit. ??? Obligations of the [MEDICAL CONDITION] unit included, but were not limited to, the following: to provide to the LTC facility information on all aspects of the management of the [MEDICAL CONDITION] Resident's care related to the provision of [MEDICAL TREATMENT] Services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of [MEDICAL TREATMENT]; Written protocols: the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit shall develop written protocols governing specific responsibilities, policies and procedures to be used in rendering [MEDICAL TREATMENT] services, including but not limited to, the development and implementation of a care plan relative to the provision of [MEDICAL TREATMENT] Services. Mutual Obligation: Collaboration of Care: Both parties shall ensure there is documented evidence of collaboration of care and communication between the LTC facility and [MEDICAL CONDITION] [MEDICAL TREATMENT] unit. Documentation shall include, but not limited to, participation, as members of an interdisciplinary team, in care conferences, continual quality improvements program, annual review of infection control of policies and procedures and the signatures of team members from both parties on a short term care plan and long term care plan. Team members shall include the physician, nurse, social worker and dietician from the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit and a representative from the LTC facility. The [MEDICAL CONDITION] [MEDICAL TREATMENT] unit shall keep the original STCP ad LTCP in the medical record of the [MEDICAL CONDITION] Resident and the LTC facility shall maintain a copy. On 3/13/2020 at 10:50 a.m. the DAPAS provided copies of documentation of the resident prior to leaving the facility for [MEDICAL TREATMENT]. On 3/6/2020 at 5:59 a.m. the notes indicaaed the resident was taken by wc (wheelchair) to lobby to be picked up to go to [MEDICAL TREATMENT]. On 3/11/2020 at 6:05 a.m. the residnet wastaken by w/c for transport to [MEDICAL TREATMENT]. On 3/13/2020 at 6:07 a.m.: the resident was taken by w/c van for transport to [MEDICAL TREATMENT]. Documentation was lacking in the record of the resident condition prior to transport for [MEDICAL TREATMENT] on the following dates: 3/6, 3/9, 3/11/2020. On 3/13/2020 at 2:00 p.m., the DON provided copies of the Treatment sheet for [MEDICAL TREATMENT] dated 3/11/2020 and 3/13/2020. These documents had a fax date and time of 3/13/2020 at 11:28 a.m. and 11:29 a.m. On 3/10/20 at 9:18 a.m., Resident 60 was interviewed. She indicated she had a [MEDICAL TREATMENT] access shunt to her left forearm and went to [MEDICAL TREATMENT] three times a week. On 3/10/2020 at 2:50 p.m., the DON was interviewed. She indicated the facility reviewed the [MEDICAL TREATMENT] documentation, looked at the resident's lab values, vital signs, pre and post [MEDICAL TREATMENT] weights. She indicated this was their means of communication in addition to speaking with the resident's family. She indicated the facility would call and request documentation if they hadn't received it. She indicated the facility would either call the [MEDICAL TREATMENT] unit and/or the [MEDICAL TREATMENT] unit would contact the facility for any new orders or changes in orders and/or conditions. On 3/10/2020 at 3:25 p.m., the Director of Quality Management (DQM) and the Director of Nursing were interviewed. They indicated the facility currently had one resident who received [MEDICAL TREATMENT] services outside the facility. They indicated they currently did not have a [MEDICAL TREATMENT] contract for this resident. The DQM indicated when this resident was admitted to the facility on [DATE], she was already an established patient with the [MEDICAL TREATMENT] unit. The DQM indicated the family and/or community service transported the resident to [MEDICAL TREATMENT]. They indicated they considered the [MEDICAL TREATMENT] a leave of absence. Documentation was lacking of a [MEDICAL TREATMENT] contract. On 3/10/2020 at 3:44 p.m., the Director of Acute and Post Acute Care (DAPAC) was interviewed. She reviewed the electronic record and indicated they didn't have an order in the record for [MEDICAL TREATMENT]. She indicated the only order that pertained was the admission order, dated 3/4/2020 for ongoing [MEDICAL TREATMENT]. The DAPAC reviewed the resident's plans of care and indicated documentation was lacking as to a care plan to address [MEDICAL TREATMENT]. She indicated she was not currently able to locate documentation where the nurses were documenting the assessment of the thrill and the bruit. She indicated there was no order to check the thrill and the bruit. The DAPAC contacted the DON regarding if the staff was documenting their assessment of the thrill and bruit from the access site fistula. The DON indicated to the DAPAC, the nursing staff was performing this assessment. At this time, the record was reviewed. Documentation was lacking in the clinical record of the fistula access site, thrill and bruit having been assessed on the dates of 3/7, 3/8, 3/9, and day shift of 3/10/2020. On 3/10/2020 at 3:46 p.m., the DON was interviewed. She indicated she was unable to locate documentation of the thrill or bruit having been assessed on 3/7, 3/8, 3/9, and day shift of 3/10/2020 . She indicated she knew it had been assessed as she received this information in report from the day shift nurse. She indicated she was working on the unit as staff tonight. When queered regarding how she was aware what care to perform with a resident with a [MEDICAL TREATMENT] shunt and she indicated we just do it. She indicated they check the bruit and the thrill, and check the site after [MEDICAL TREATMENT]. She indicated the fistula would be assessed every 24 hours with their daily assessments as well as the access site. She indicated they would lift the access site dressing to assess it but just leave the dressing in place. The DON indicated she was unable to locate documentation of the access site and/or thrill and bruit having been assessed from 3/7 to 3/10/2020. On 3/12/2020 at 10:50 a.m., RN 1 was interviewed. She indicated Resident 60 was alert and oriented. She indicated she checked the resident's fistula with the head to toe assessment, which was completed once a day. She indicated the night shift sent the resident to [MEDICAL TREATMENT], and the resident left the facility around 6:00 a.m. RN 1 indicated she was not sure what, if any paperwork was sent with the resident to [MEDICAL TREATMENT]. RN 1 indicated the resident usually returned to the facility around 11:00 a.m. She indicated the resident's family brings her back to the facility from [MEDICAL TREATMENT]. RN 1 indicated at that time, she would check the resident's blood pressure before she gave the resident her morning medications, did a general assessment checking for shortness of breath, pain, checked her fistula and dressing and documented this in the resident's record. She indicated she documented the condition of the fistula under the devices section in the record and this was to be completed once a shift. On 3/12/2020 at 10:53 a.m., RN 1 was interviewed. She indicated sometimes the [MEDICAL TREATMENT] unit faxed notes, but doesn't remember if they did or not yesterday. RN 1 indicated she didn't review any notes from [MEDICAL TREATMENT] yesterday. RN 1 indicated the resident would tell the facility if [MEDICAL TREATMENT] went ok and/or the resident's daughter would tell facility how [MEDICAL TREATMENT] went for the resident. RN 1 indicated in the past, if there was a change in a [MEDICAL TREATMENT] resident, the [MEDICAL TREATMENT] unit might send paperwork back to the facility. RN 1 indicated the current [MEDICAL TREATMENT] unit had the phone number of the facility so they would call with any changes. RN 1 indicated if they don't hear anything from the [MEDICAL TREATMENT] unit, they assumed all the resident's care and condition remained the same, but they do vital signs at the facility routinely on evenings and nights. She indicated she sometimes obtained an apical pulse and may listen to the resident's lungs but not routine. She indicated the resident usually went toa dffferent [MEDICAL TREATMENT] facility, but currently went to one located in the town. She indicated both [MEDICAL TREATMENT] units were managed by the same ownership. RN 1 indicated the [MEDICAL TREATMENT] had the facility phone number and the [MEDICAL TREATMENT] unit had not provided information regarding care and management for bleeding of the access site. RN 1 indicated regarding the care of the site, they leave the dressing in place and just look at it to monitor it. RN 1 indicated Resident 60 was very with it would call if there were any issues. On 3/13/2020 at 9:20 a.m., the RN 2 was interviewed. She indicated she was Resident 60's nurse on the day shift last week on Friday, 3/6/2020, She indicated the resident goes to [MEDICAL TREATMENT] on Mondays, Wednesdays and Fridays. She indicated last week when the resident returned from [MEDICAL TREATMENT] on 3/6/2020, the resident did not

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F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) bring any paperwork back with her. She also indicated the [MEDICAL TREATMENT] unit did not contact her at all after the resident's [MEDICAL TREATMENT] treatment. She indicated she did not have any information provided to her regarding how the resident did in [MEDICAL TREATMENT], pre and post weight, wet and dry weights and/or any issues. RN 2 was queered regarding communication between [MEDICAL TREATMENT] and the facility in regard to the resident. RN 2 indicated well, they have our number, I'm sure they would call us. On 3/13/2020 at 10:12 a.m., the DON, the DQM and DAPAS were interviewed. They were made aware of the concern of the resident not having a plan of care to address [MEDICAL TREATMENT], no [MEDICAL TREATMENT] contract, no specific orders or directives regarding the care of the fistula access site and/or lack of communication between the the [MEDICAL TREATMENT] unit and the facility. They indicated the Case Manager worked with the family to coordinate the activity. They were made aware of lack of documentation of the resident's condition prior to leaving for [MEDICAL TREATMENT] as well as upon return to the facility. On 3/13/2020 at 11:05 a.m. the DAPAS was interviewed. She indicated she was unable to provide documentation of the resident's condition prior to leaving for [MEDICAL TREATMENT] and/or upon return to the facility. She indicated the resident leaves the facility around 6:00 a.m. and returns to the facility around 10:30 a.m. to 11:00 a.m. She indicated the thrill and bruit were to be checked each day. On 3/13/2020 at 11:19 a.m., the Case Manager (CM) was interviewed. She indicated the resident had transferred to the facility from the hospital. She indicated the resident typically attended a [MEDICAL TREATMENT] unit in different location when she was home. She indicated the resident's family had been worried about resident's discomfort in traveling to her typical unit, due to her pelvic fracture. The CM indicated, prior to discharge from the hospital on [DATE], the family had contacted the [MEDICAL TREATMENT] unit the resident typically attended and that [MEDICAL TREATMENT] unit in turn, contacted this local [MEDICAL TREATMENT] unit in the same town as the facility. The CM indicated she had nothing to do with the scheduling of the [MEDICAL TREATMENT]. The CM indicated the local [MEDICAL TREATMENT] unit contacted the facility to instructed them to have resident at their [MEDICAL TREATMENT] unit on what day at what time. The CM indicated she had not provided any information to the local [MEDICAL TREATMENT] unit at all as it was same corporation of [MEDICAL TREATMENT] units as the resident attended from her home. The CM indicated the resident had received [MEDICAL TREATMENT] at the hospital prior to admission to the facility on [DATE]. The CM indicated she spoke to someone on the phone at the local [MEDICAL TREATMENT] unit regarding the resident not being able to tolerate a long ride due to her fractured pelvis. The CM indicated other than this phone conversation, the facility had not provided copies of the resident's record and/or any other health information to the local [MEDICAL TREATMENT] unit. On 3/10/2020 at 4:10 p.m., a current copy of the facility policy and procedure titled [MEDICAL TREATMENT] dated 10/15/2019. The policy included the following: The facility will arrange for safe provisions of [MEDICAL TREATMENT] services to residents; [MEDICAL TREATMENT] services are provided through a contractual arrangement with an outpatient facility which operates as a [MEDICAL TREATMENT] facility; the need for [MEDICAL TREATMENT] services will be determined by the attending nephrologist and treatment approved by the Nursing Facility Administrator; the facility will ensure that all appropriate medical and administrative information accompanies the resident at the time of transfer, the information will include at a minimum: treatment presently being provided to the resident including medications. changes and/or decline in resident condition unrelated to [MEDICAL TREATMENT] including fall risk; advance directives executed by the resident; the facility and [MEDICAL TREATMENT] center will have ongoing communication and collaboration for the development and implementation of the [MEDICAL TREATMENT] care plan. Included in this will be consideration of nutritional/fluid management including documentation of weights; In order to assure that the [MEDICAL TREATMENT] needs of the resident are met in case of an emergency, the care plan should identify acute care settings that would be able to meet the resident's need for [MEDICAL TREATMENT]; the facility will ensure the resident is medically stable prior to transport and treatment at the [MEDICAL TREATMENT] center; the [MEDICAL TREATMENT] center will provide the facility with information on care and management of the resident related to the provision of [MEDICAL TREATMENT] services including directions on medical and non-medical emergencies including but not limited to: bleeding/hemorrhage, infection, care of the [MEDICAL TREATMENT] and disinfection of [MEDICAL TREATMENT]; Upon the resident's return to the facility, the [MEDICAL TREATMENT] center will provide the facility with information regarding the [MEDICAL TREATMENT] treatment provided and the resident's response, including declines in functional status, identification of symptoms such as anxiety, that interfere with treatments, [MEDICAL TREATMENT] adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site. The facility staff will provide immediate monitoring and documentation of the status of the resident's access site(s) upon return from the [MEDICAL TREATMENT] treatment to observe for bleeding or other complications. 3.1-37(a)
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 immunizations were provided for 2 out of 5 residents reviewed. Findings include: 1. A review of Resident 60's record on 3/13/2020 at 1:17 p.m., indicated [DIAGNOSES REDACTED]. Resident 60 was [AGE] years old. The Immunization Forecaster section of the record indicated Resident 60 had a pneumococcal [MEDICATION NAME] 23 immunization admisnistered on 11/19/2006, and that the pneumococcal conjugate was overdue. The Admission Assessment, dated 3/4/2020, indicated the resident had received the vaccine prior to admission. There was no documented note that Resident 60 was offered another immunization due to the length of time was over 5 years since the previous administered immunization. 2. A review of Resident 58's record on 3/13/2020 at 1:20 p.m., indicated [DIAGNOSES REDACTED]. Resident 58 was [AGE] years old. The Immunization Forecaster section of the record indicated Resident 58 had a pneumococcal [MEDICATION NAME] 23 immunization administered on 11/7/2014, and that the pneumococcal conjugate was overdue. The Admission Assessment, dated 2/29/2020, indicated the resident had received the vaccine prior to admission. There was no documented note that Resident 58 was offered another immunization due to the length of time was over 5 years since the previous administered immunization. During an interview on 3/13/2020 at 2:30 p.m., the Director of Nursing indicated she was unsure if Resident 58 and Resident 60 were offered another immunization or if they had refused the immunization. During an interview on 3/13/2020 at 2:55 p.m., the Quality Director indicated they should have caught the dates that were over 5 years from the prior immunization. She indicated the residents would not have refused, they had not been offered another immunization, and there was no documentation. A current facility policy, Pneumococcal Vaccine Administration, dated 1/2016, provided by the Director of Nursing on 3/9/2020 at 3:20 p.m., indicated the following: .1.1 To reduce the incidence of morbidity and mortality due to pneumococcal disease by administering pneumococcal vaccines to eligible patients at this facility. 2.1 All eligible patients will be offered the pneumococcal vaccine, unless contraindicated due to health history. The admitting nurse for inpatients or long-term residents will screen patients by completing the Immunization module of the Horizon Health Summary Admission Assessment to determine eligibility. 3.1.1. Admitting nurse will assess patient and complete the Immunization module of the Horizon Health Summary Admission Assessment. A reasonable attempt will be made to determine prior vaccination history. 3.3 Patients will be eligible to receive the appropriate pneumococcal vaccine per protocol, except when the patient refuses, proof of prior immunization exists, physician's orders [REDACTED]. 3.3.1. For those not vaccinated, the reason will be documented . 3.1-13(a)