STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105448	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titusville Rehabilitation & Nursing Center	1705 Jess Parrish CT Titusville, FL 32796

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 35199 Based on interviews from the Resident Group Meeting and record reviews, the facility did not promote an environment for residents to voice grievances about care and treatment without fear of discrimination, and/or reprisal. Findings include: During an interview with the Resident Council President on 06/05/24 at 11:15 AM, they said usually 5-6 people attended the Resident Council meetings. They suggested Thursday, 6/06/24 at 9:30 am would be a good time to meet with the residents. The Resident Council President said there was no place to meet privately with a group of residents except in his room. The regular meetings were held in the atrium on the back of the 200 hall closest to his room, but he explained it wasn't private, with staff standing around listening to what was said. During an interview with the Activity Director on 6/05/24 at 11:35 AM, he stated, There is no private area for the Resident Group meeting to be held, so we will hold it at the back of the 200-hall atrium as that is the only place available. The Resident Council Group Meeting was held on the 200-hall atrium, on 06/06/24 at 9:30 AM, in an open area 15 feet away from the nurse's station. At the time of the meeting, there were 5 staff members located around the nurse's station. This large open common area was centrally located in the middle of the atrium. On 06/06/24 at 9:51 AM, residents attending the meeting were asked if they felt like they could not complain about care or treatment. By a show of hands 20 residents indicated they feared retaliation if they brought up a complaint or complained about their care. The individuals did not wish to be identified for fear of retaliation from the facility staff. Record review of Resident Council minutes provided from March 2024 to June 2024 revealed few voiced concerns.

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.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 35199 Based on Resident Group interview, and record review, the facility failed to properly and promptly respond to Resident Council concerns and grievances. Findings: During a record review of the June 2023 to June 2024 Resident Council minutes provided by the Activity Director revealed documentation the Council did not believe their previously initiated concerns/grievances were addressed or resolved for the following dates: June 2023, August 2023, December 2023, April 2024, May 2024 and June 2024. The minutes indicated a new Administrator was introduced on 4/16/24 and told the Council that all concerns were being taken care of and the facility was working on them, but the minutes for May and June 2024 indicated the Council continued to feel their concerns were not addressed by the facility. On 6/05/24 at 11:35 AM, the Activity Director stated they worked alone in the Activity Department from Monday through Friday. The Activity Director explained the Activity Department had no volunteers so when they had been out sick in the hospital for a week, there were no activities in the facility during that time. The Activity Director confirmed the concerns from the Resident Council Meeting on 4/08/24 were not addressed or resolved. During the Resident Group Meeting held on 06/06/24 at 9:41 AM, 11 resident responded there was no facility follow up to the Resident Council Group Concerns. During an interview with the Activity Director on 06/06/24 at 1:15 PM, the Activity Director explained the Resident Council concerns were given to the department involved/concerned, with a two week follow up by the Activity Director who received the resolutions verbally. The Activity Director would notify the Resident Council at the next meeting. The Activity Director was not aware there were any issues the Resident Council felt had not been resolved.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 35199 Based on Resident Group meeting, review of Resident Council Minutes, and interview, the facility staff failed to review and inform residents of their rights in the facility. Findings include: The Resident Group meeting was held on the 200-hall atrium, on 06/06/24 beginning at 9:30 AM, in an open area that was 15 feet away from the nurse's station. At the time of the meeting, there were 5 staff members sitting and standing around the nurse's station that was centrally located in the middle of the atrium. The meeting was held in this large open common area. During the Resident Group meeting, held on 06/06/24 beginning at 9:30 AM, seven residents and family representatives responded they did not know what their resident rights were, were not provided a copy of their rights either at admission or during their stay, and that resident rights were not reviewed during the Resident Council meeting. Even the Resident Council President said resident rights had not been reviewed in the Resident Council meetings. In review of the Resident Council minutes for a year from June 2023 to June 2024, the agenda indicated that resident rights reviewed (choose 1-2 monthly) and was expanded upon as answer of yes, but never identified what rights were reviewed. In the last year of Resident Council minutes, there was not an attachment or pamphlet of the [NAME] of Rights handed out or reviewed. Interview with the Activity Director on 06/06/24 at 1:15 PM, the Activity Director confirmed he was responsible to be the liaison and helped to facilitate the Resident Council meetings since he started February 27, 2024. He was unable to say whether resident rights had been reviewed during those Resident Council meetings, nor could he provide documentation that resident rights information had been provided at those meetings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview and record review, the facility failed to refer residents with a newly evident mental disorder for Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination and failed to request a Level 1 PASARR evaluation for resident with new mental disorder diagnosis for 2 of 6 residents reviewed for PASARR, (#1, & #72), of a total sample of 68 residents. Findings: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, cerebral infarction, encephalopathy and cognitive communication deficit. Review of the Minimum Data Set (MDS) significant change in status assessment with assessment reference date (ARD) of 4/25/24 revealed resident #1 had a Brief Interview for Mental Status (BIMS) score of 07 which indicated he had severe cognitive impairment. The document indicated his active diagnoses included anxiety disorder and depression. Review of resident #1's care plan revealed a psychotropic medication use care plan initiated 7/31/18 which indicated he received antidepressant medication to manager his depression and anxiety. The care plan included interventions for psychological and psychiatric services as ordered and as needed. Review of resident #1's electronic medical record (EMR) revealed a diagnosis of schizophrenia with an onset date of 12/06/18, recurrent depressive disorders with an onset date of 12/06/18 and anxiety disorder with an onset date of 12/06/18. The record contained a Level I PASARR screening form dated 5/30/18 which did not indicate the resident had a mental illness (MI) or suspected MI. The form indicated resident #1 had a condition that was likely to continue indefinitely and resulted in substantial functional limitations of his capacity for independent living. The form further indicated there was an indication he had or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for his developmental stage. The record did not contain an updated Level I PASARR or a Level II PASARR screening form after the resident received the new MI diagnoses. On 6/06/24 at 3:26 PM, the Director of Nursing (DON) reviewed resident #1's PASARR and compared it to diagnoses in EMR. She verified the PASARR was not updated by the facility when the resident was diagnosed with schizophrenia, anxiety and depressive disorder over 6 months after the previous Level I PASARR. She acknowledged the Level I should have been updated and referred for a Level II if it was indicated. 48878 2. Review of the medical record revealed resident #72 was admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Her diagnosis included bipolar disorder, cognitive communication deficit, metabolic encephalopathy, and need for assistance with personal care. She had a new diagnosis of major depressive disorder on 5/04/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72's Entry MDS with an ARD of 5/30/24 revealed the resident was admitted from the hospital on 5/30/24. The MDS Admission with an ARD of 6/05/24 was in progress. Resident #72's Order Summary Report and the Medication Administration Record showed resident #74 had physician orders for medications related to diagnoses including bipolar disorder and major depressive disorder. On 6/06/24 at 2:57 PM, the Interim DON stated it was the DON's responsibility to ensure the resident's Level I and Level II PASARRs were completed and submitted timely. She conveyed the DON would review the PASARRs prior to admission and resubmit them if they were inaccurate. She also conveyed if a resident was diagnosed with a new mental illness, the DON would complete another Level I and submit a request for a Level II PASARR if indicated. She verified resident # 72 had a Level I PASARR submitted on 5/03/24 that included only the bipolar diagnosis. The DON also verified the resident received a new diagnosis of major depressive disorder on 5/04/24 but confirmed a new Level I PASARR was not performed. She acknowledged the resident should have had another Level I PASARR completed due to a new major mental disorder diagnosis and said she did not know how it was missed. The facility's PASARR policy read, Preadmission screening for mental illness and intellectual disability is required to be completed prior to admission to a Nursing Home .A resident review must be completed when there has been a significant change in a resident mental or physical condition .Social Services or RN will review to determine if a Serious Mental Illness (SMI) and Intellectual Disability (ID) or both exists while reviewing the PASRR form.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35199 Based on record review and interview, the facility failed to ensure a Level 1 Preadmission Screening and Resident Review (PASARR) evaluation was accurate upon admission for 1 of 1 residents reviewed for PASARR accuracy, of a total of 68 residents, (#93). Findings: Review of the medical record revealed Resident #93 was admitted to the facility from the hospital on 4/23/24 with a discharging diagnosis of schizophrenia. Record review of the Level 1 PASARR completed on 3/29/24 by the hospital social worker inaccurately omitted the diagnosis of schizophrenia. On 06/04/24 at 5:29 PM, the interim Administrator said Social Services was responsible for completing PASARRs. The Social Service Director on 6/06/24 at 2:22 PM, related the Director of Nursing (DON) was responsible for the review and accuracy of the PASARRs. The Interim DON on 6/06/24 at 3:22 PM, said she was surprised resident #93 was admitted on [DATE] with a diagnosis of schizophrenia which would require a level 1 PASARR. She confirmed the Level 1 PASARR was not checked for the schizophrenia diagnosis by the hospital which was important to ensure accuracy to determine if further screening with a Level II PASARR was necessary. The Interim DON confirmed it was her responsibility to ensure the accuracy of the Level 1 PASARRs and explained if the diagnosis was not accurate another Level 1 PASARR should have been performed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35199 Based on observation, interviews and record review, the facility failed to provide ongoing program of activities designed to meet the interests, and physical, mental, and psychosocial well-being of the residents for 3 out of 3 residents sampled for activities, of a total sample of 68 residents, (#10, #39, and #80). Findings: 1. Resident #10 was observed in bed on 6/03/24 and 6/04/24. On 06/05/24 at 12:53 PM, resident #10 was again observed in bed. The Activity Director was observed to look in the room from the door way and went into the room for less than 3 minutes. On 06/06/24 at 2:08 PM, The Activity Director started the group activity bingo in the 200-hall atrium, where resident #10 lived, but resident #10 was not at the bingo game. During an interview with the Activity Director on 06/06/24 at 3:57 PM, the Activity Director was unable to show any participation by resident #10 in either small group or independent 1:1 programming. The Activity Director confirmed resident #10 spent all his time in bed. When the Activity Director delivered the mail, he opened the letters for him. He explained some days resident #10 could turn on the TV, other days he could not. The Activity Director said, I leave him by himself. 2. Resident #39 was most recently admitted on [DATE] with diagnosis including cerebral infarction (stroke), vascular dementia, depression, and anxiety disorder. A record review of progress note dated 4/06/2024 at 11:18 PM, revealed resident #39 was alert and aware to self, and spoke Spanish. A record review of a note dated 4/09/2024 at 3:59 PM, revealed resident #39's mental status was oriented to person and place. A record review of a progress note dated 5/20/24, revealed resident #39's Brief Interview for Mental Status (BIMS) score was 6/15 which indicated severe cognitive impairment. The document indicated the Interdisciplinary team suggested resident #39 be out of bed for meals. On 06/04/24 at 1:49 PM, resident #39 was not observed in any activity or program appropriate for residents with cognitive impairment. On 06/05/24 at 12:51 PM, the Activity Director was in resident # 39's doorway interacting with the roommate, but not resident #39. On 06/05/24 at 5:00 PM, resident # 39 was observed in a reclining chair just outside his door facing the room, pushing himself back and forth in his chair. Resident #39 did not face the TV or out towards the nurses' station, instead he faced his own bedroom door. On 06/06/24 at 3:43 PM, the Activity Director said he did activities with resident #39 but did not have any documentation of the activities provided. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #80 was admitted on [DATE] with diagnoses to include depression, anxiety and psychosis. Her Admission Minimum Data Set assessment dated [DATE] revealed her BIMS was 12/15 which indicated mild cognitive impairment. During an interview on 06/03/24 at 12:33 PM, resident #80 shared she was under [AGE] years old and, There is nothing to do in the facility, except watch TV movie marathons. She continued, This afternoon, we should have bingo for the first time in a few weeks because the Activity Director has been on leave and no one filled in for him during the 2 weeks he was gone. On 06/05/24 at 11:35 AM, the Activity Director said he was the only staff who worked in the Activity department, Monday through Friday. He explained he was on leave and there were no activities in the facility during that time. On 06/06/24 at 3:47 PM, the Activity Director said resident #80 smoked and liked live entertainment. He said it was hard to get things done himself. He explained, I'm not saying I'm doing 100%. I would like to spend more time one-to-one just to make sure residents that were stuck in bed that don't have TV's at least have radios to listen to music. The Activity Director said he had been at this facility since February and in the morning he went around the whole facility spending about 10 minutes with each resident. He said he put morning activities on the calendar, but the residents did not attend. The Activity Director said the number of residents that required one to one visits was at least one whole hall of residents or perhaps even more. He did not have a list of residents who required one-to-one visits or have descriptions of the one-to-one programs so he could not give the number of one-to-one visits needed each week. It was pointed out to the Activity Director that if he spent 10 minutes with 101 residents, it would take over 16 hours per day just doing rounding visits for each resident. He stated he could not possibly do that. He explained the facility did not have any volunteers and reiterated that he was the only staff employed to do activities 8 hours per day Monday through Friday. He indicated he was also expected to attend Department head meetings, Care Plan meetings, and write progress notes for the residents, and was presently involved in trying to hire a beautician for the facility residents. On 6/07/24, the last day of survey the Activity Director was unable to provide the Resident Assessment forms and was unable to provide 3 months of group participation records or one-to-one visit documentation for resident #10 and resident #39.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32131 Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available to ensure residents received the nursing care and related services required to timely administer medication and failed to provide sufficient nursing staff to meet the residents' individualized care needs on all shifts on 2 of 3 Wings, (100, 200). Findings: Cross Reference F 755 1. Medication administration observations conducted with Registered Nurse (RN) K, and Licensed Practical Nurse (LPN) H on the 100 Wing on 6/03/24, showed scheduled 9 AM medications were prepared to be administered at 11:46 AM, and at 11:54 AM for residents # 20, and #3a, approximately three hours after the scheduled time, and not according to established medication administration principles of within one hour before or one hour after the scheduled time. On 6/03/24 at 12:21 PM, LPN H stated she was on the split assignment, and had residents on the 100, and 200 Wings. She stated medication administration was going very slowly and said it was a lot, but due to the facility's census, they were not allowed to have more nurses. LPN H verbalized she still had nine more residents to give scheduled 9 AM medications to. On 6/03/24 at 12:26 PM, RN K stated she still had three more residents to give scheduled 9 AM medications to. The RN said there was one nurse on each Wing, with one nurse on a split assignment between the 100 and 200 Wings. On 6/04/24 at 10:05 AM, and at 10:30 AM, the RN/Unit Manager (UM) for the 100 and 300 Wings was observed on the medication cart administering medications to residents. She stated she was assigned to work on the medication cart, while also performing UM responsibilities for the 100 and 300 Wings. Observations on the 100 Wing on 6/04/24 at 10:32 AM, 10:38 AM, 11:09 AM, and 11:25 AM showed nurses at their medication carts providing the late 9 AM medications for residents. On 6/04/24 at 1:52 PM, RN K verbalized she had been working at the facility for thirty years, and staffing was not like that before. She said there has been issues since the 300 Wing was opened, and nurses had a split assignment between the 100 and 200 Wings. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/06/24 at 2:42 PM, the Staffing Coordinator explained that duties included in her role and responsibilities were to ensure staffing hours were accounted for, and the facility had adequate staff on each shift. The Staffing Coordinator stated the facility had three Wings, 100, 200, and 300, and had three shifts for nurses and Certified Nursing Assistants (CNA). She verbalized that the facility did not have an evening or night supervisor but had a weekend supervisor. The Staffing Coordinator explained staffing was completed based on the facility's census and was reviewed daily by the Director of Nursing (DON). She indicated on the 7 AM to 3 PM shift, and the 3 PM to 11 PM shifts, four nurses were scheduled. One nurse for each Wing, and the fourth nurse would do a split assignment between the 100 and 200 Wings. On the 11 PM to 7 AM shift there were three to four nurses in the building, depending on the facility's census. She stated she would be happy if things moved back to the previous assignment plan, when there were two nurses scheduled on each Wing. On 6/06/24 at 3:16 PM, LPN L stated she worked on the 3 PM to 11 PM shift and had 23 to 47 residents on her assignment. She verbalized she currently had 35 residents on her assignment, and the other nurse had the split assignment. The LPN stated sometimes only one nurse was scheduled for each Wing. She said it was a lot and nurses had to efficiently manage their time. On 6/06/24 at 6:22 PM, the Director of Nursing (DON) stated she had been working at the facility for three weeks. She stated staffing was reviewed with the Staffing Coordinator every morning, and the facility was staffed based on census, and adjusted for acuity. The DON stated nurses worked the split assignment based on the census. She explained the nurse doing the split assignment would have thirteen residents on the 100 Wing, and fifteen residents on the 200 Wing. The DON acknowledged nurses shared a medication cart for the split assignment, and nurses had to wait until the nurse with the split assignment had completed her medication administration, before getting the shared medication cart, because two nurses could not be on the same medication cart at the same time. On 6/07/24 at 9:40 AM, the DON stated the facility was in the process of reviewing the nurse's assignments that were built into the electronic medical record (EMR) system and were looking at medication administration times. She stated she had been discussing with the Assistant DON and staffing coordinator to review the nurses, identify best place/ assignment for them according to their skill set and/or experience, in order for nurses to have a consistent assignment. She stated that due to challenges with staffing it was not always possible. The DON stated there had been a couple days when the facility had concerns regarding nurses' workload and UMs were asked to pick up a few residents and assist with treatments. She said she would like to have two nurses on the 100 and 200 Wings, and one nurse on the 300 Wing. Stating that level of staff would enhance care, and nurses would be able to give more individualized attention to residents in their assignment. On 6/07/24 at 10:06 AM, RN K recalled that on 6/03/24, and 6/04/24 she had thirty-four residents in her assignment and one nurse was on the split assignment. She stated she was unable to give her medications within the expected timeframe since she had to wait until the nurse was off the medication cart, to complete medication administration for her assigned residents. RN K stated on the night shift sometimes they had a nurse on the split assignment and verbalized that on 6/06/24 on the 100 Wing, the nurse was on her own with a census of forty-seven residents on the 11 PM to 7 AM shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/07/24 at 12:52 PM, the Registered Nurse/Unit Manager (RN/UM) for the 100 and 300 Wings stated staffing could be difficult sometimes. She said, if the facility did not have a nurse on a split assignment, it would be much better. She acknowledged that there could be a delay in medication administration, as nurses had to share a medication cart, and could not work on the medication cart at the same time. Review of the Medication Administration Audit Report for residents assigned to RN K, LPN H, and the RN/UM for the 100 and 300 Wings revealed thirty-one residents received their scheduled medications outside of the time parameters for medication administration. This was acknowledged by the DON. 48878 2. On 6/05/25 at 8:45 AM, LPN H stated she had been assigned to a maximum of 30 residents when assigned to the 200 unit on the 7a-3p shift. She acknowledged it was impossible to administer the residents' 9 AM medications on time because of the need to share a medication cart with another nurse. She admitted she frequently would not finish administering the 9 AM medications until 11:30 AM. She also stated when she was the split nurse and had assignments simultaneously on both the 100 and 200 units, she could not accommodate the immediate needs of her residents on the unit opposite to where she was administering medications. The 100 and 200 units were situated on opposite sides of the building. On 6/06/24 at 6:20 PM, LPN I stated the highest number of residents assigned to her was 42 residents on the 11PM-7AM shift. She acknowledged her workload remained unmanageable even when assigned to fewer residents during the 3PM-11PM shift, owing to the acuity of the residents. She mentioned that on the 200 unit, there were four residents who received tube feeding and one resident who had a tracheostomy. She expressed she had previously raised her concerns about the residents' quality of care to management but received no feedback. She indicated when nurses called off, management often could not be reached, and failed to provide relief at the end of their shift, which often resulted in nurses either working a double shift or face the risk of abandoning their residents. On 6/07/24 at 10:20 AM, the 200 wing RN UM stated he occasionally administered medications and was assigned up to 40 residents. He acknowledged when there was a third nurse assigned to both the 100 and 200 units, all three nurses could not administer the 9 AM medications simultaneously because they had to share a medication cart. He explained one nurse could not administer medications to the residents until the other nurse completed their medication pass which caused delays. On 6/07/24 at 10:40 AM, the 100/300 wing RN UM stated she had administered medications on occasion and was assigned a maximum of 30 residents. She explained there were often three nurses for the 100 and 200 units. She conveyed the third nurse was assigned residents on both the 100 and 200 units simultaneously, leading the nurse to run back and forth between the two units. The UM acknowledged one nurse had to wait to administer their assigned residents' medications until the other nurse finished their medication pass since they must share the medication cart. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/06/24 at 10:55 AM, LPN J mentioned she worked the 7 AM-3 PM shift and floated to all the units but was usually assigned to the 200 unit. She stated the maximum number of residents she had been assigned to was 42. She also stated when one of the three nurses called off, she would have all 42 residents on her assignment until another nurse came in to cover. She expressed how challenging it was to manage her workload and provide safe care due to the high number of assigned residents, which included four residents who required tube feeding and one that needed tracheostomy care. The LPN indicated it was impossible to administer the medications on time, with the 9:00 AM medications often not being completed until 12:00 PM. She acknowledged one nurse must often wait to administer the residents' medications because they shared a medication cart when there were only three nurses on the 100 and 200 units. The LPN reiterated that despite raising concerns about the unmanageable workload, its impact on the residents' care, and timely medication administration, management had provided no feedback, and no action had been taken to address the issues.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32131 Based on observation, interview, and record review, the facility failed to ensure scheduled medications were administered within parameters on the 7 AM to 3 PM shift for 31 residents on the 100 Wing, of a total sample of 68 residents, (#3a #20, #77, #354, #3b #16, #33, #26 #68 #84, #5, #59, #56,#88, #34, #50, #95, #47, #19, #58, #651 #52 #55 #37, #38, #91,#89, #35,#23,#64, and, #14). Findings: On 6/03/24 at 11:37 AM, Registered Nurse (RN) K stated she was still doing scheduled 9 AM medication administration and was giving the priority medications first. On 6/03/24 at 11:46 AM, medication administration observation was conducted for resident #20 with RN K. Review of the Medication Admin (Administration) Audit report revealed documentation to indicate resident #20 received his scheduled 9 AM medications on 6/03/24 at 11:52 AM. The resident's administered medications included Coreg 3.125 milligram (mg) twice daily, Norvasc 10 mg daily for high blood pressure, Gabapentin 300 mg twice daily for pain, and Aldactone 25 mg daily for congestive heart failure (CHF). On 6/03/24 at 11:54 AM, medication administration observation was conducted for resident #3a with Licensed Practical Nurse (LPN) H. Review of the Medication Admin Audit Report revealed documentation to indicate the resident's scheduled 9 AM medications were administered at 12:11 PM, and included Buspirone 30 mg daily for anxiety, Divalproex 125 mg twice daily for depression, Furosemide 40 mg daily for edema, Lisinopril 40 mg daily for high blood pressure, and Lamotrigine 200 mg twice daily for anticonvulsant. In an interview conducted with LPN H after the medication administration, the LPN stated she was on the split assignment between the 100 and 200 Wings, and medication administration was going very slowly. LPN H said it was a lot, but due to the facility's census, they were not allowed to have more nurses. She said she still had to give 9 AM medications to nine more residents. On 6/03/24 at 12:26 PM, RN K stated she still had three more residents to give their 9 AM medications. The RN stated there was one nurse on each Wing, with one nurse on a split assignment between the 100 and 200 Wings. She said medication administration was not like giving candy, because she had to ensure medications were accurate. On 6/04/24 at 10:05 AM, and at 10:30 AM, the RN/Unit Manager (UM) was observed on the medication cart providing medication administration for residents. She stated she was on the medication cart, while also providing UM responsibilities for the 100, and 300 Wings. On 6/04/24 at 10:32 AM, RN K stated she had residents in four rooms to administer their 9 AM medications. RN K explained due to the split assignment, two nurses shared a medication cart, and could not be on the same cart at the same time, so she had to wait on the RN/UM to complete medication administration for her assigned rooms, before she could get medications for her remaining residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/04/24 at 10:38 AM, and 10:41 AM, the RN/UM for the 100 and 300 Wings stated she had two more residents to complete the 9 AM medications for. She verbalized she would go over to the 200 Wing to check if the nurse working the split assignment had completed medication administration, so she could assume care on the 100 Wing. On 6/04/24 at 11:09 AM, RN K was observed on her medication cart, still giving scheduled 9 AM medications. On 6/04/24 at 11:10 AM, the RN/UM for the 100, and 300 Wings stated residents #34, and #58 still had not received their 9 AM medications. On 6/04/24 at 11:13 AM, resident #34 stated she had not received her 9 AM medications and was not told why her medications were late. On 6/04/24 at 11:17 AM, resident # 64 stated he had not received his 9 AM medications. He stated medications were late sometimes. On 6/04/24 at 11:25 AM, LPN G stated this was her first nursing job, and she was called in this morning due to a call out. She verbalized she came to work at approximately 9 AM, and her assignment included six rooms on the 100 Wing, and six rooms on the 200 Wing. The LPN stated when she left the 100 Wing to go to the 200 Wing, the other nurse on the unit would then have access to the medication cart she used, since the nurse also had her residents' medications on that cart. LPN G stated the facility policy was for medications to be given one hour before, or one hour after the scheduled time. On 6/04/24 at 1:52 PM, RN K stated she completed administration of her 9 AM medications before noon. She said medications should be given one hour before or one hour after scheduled time per facility policy. RN K said she tried to prioritize residents and give them their medications first. Review of the Medication Admin Audit Report revealed the following residents on the assignments for the RN/UM for the 100 and 300 Wings, RN K, and LPN H received their scheduled 9 AM medications outside of the recommended parameters on the 7 AM to 3 PM shifts on 6/03/24, 6/04/24, and on 6/05/24. Resident # 77 received his scheduled 9 AM medications on 6/03/24 between 10:14 AM and 10:18 AM including Metoprolol 50 mg twice daily for high blood pressure, Zoloft 100 mg daily for depression, Buspirone 5 mg twice daily for anxiety, and Gabapentin 800 mg three times daily for pain. A second dose of Gabapentin was administered four hours later at 2:17 PM. Resident # 354 received her scheduled 9 AM medications on 6/03/24 between 10:15 AM and 10:32 AM, and on 6/05/24 between 11:57 AM and 12:03 PM, including Gabapentin 300 mg three times daily for nerve pain, Metoprolol 50 mg daily, Lasix 20 mg daily for high blood pressure, and Paxil 40 mg daily for depression. Scheduled 7:30 AM medications on 6/05/24 were administered at 12:03 PM, including Gabapentin 300 mg, Amiodarone 100 mg daily for heart rhythm, and Lasix 20 mg daily. Resident # 3b received his scheduled 9 AM medications on 6/03/24 between 10:40 AM and 10:42 AM, and on 6/04/24 between 11:14 AM and 11:18 AM, including Midodrine 10 mg three times daily for low blood pressure, Citalopram 20 mg daily for depression, and Farxiga 10 mg daily for diabetes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 16 received his scheduled 9 AM medications on 6/03/24 between 10:52 AM and 10:55 AM, and on 6/04/24 between 10:28 AM and 10:30 AM, including Lamictal 100 mg daily, Dilantin 100 mg in the morning for seizures, Depakote 500 mg, and 250 mg to equal 750 mg twice daily for mood disorder, and Baclofen 20 mg twice daily for muscle relaxant/contractures. Resident # 33 received her scheduled 9 AM medications on 6/03/24 between 11:12 AM and 11:19 AM, including Sertraline 25 mg daily for depression, Losartan Potassium 50 mg daily, Metoprolol Extended Release (ER) 25 mg daily for high blood pressure, Meloxicam 15 mg daily for pain, and Dilaudid 4 mg three times daily for cerebral atherosclerosis. Resident # 26 received his scheduled 9 AM medications on 6/03/24 between 11:17 AM and 11:18 AM, including Alprazolam 0.25 mg daily for anxiety/agitation, Celebrex 200 mg daily for non-acute pain, Metformin 1000 mg twice daily for diabetes and Escitalopram 5 mg daily for depression. Resident # 68 received his scheduled 9 AM medications on 6/03/24 between 11:21 AM and 11:22 AM, including Risperidone 0.25 mg twice daily for mood disorder. Resident # 84 received his scheduled 9 AM medications on 6/03/24 between 11:29 AM and 11:35 AM, including Metoprolol 25 mg daily for high blood pressure, and Nifedipine ER 60 mg daily. Resident # 5 received her scheduled 9 AM medications on 6/03/24 between 11:47 AM and 11:51 AM, including Zoloft 100 mg daily for depression, Depakote 250 mg twice daily for behavior, Levetiracetam 500 mg twice daily for seizure, and Buspirone 5 mg twice daily for anxiety. Resident # 59 received his scheduled 9 AM medications on 6/03/24 between 12:06 PM and 12:13 PM, on 6/04/24 between 10:07 AM and 10:13 AM, and on 6/05/24 at 10:20 AM including Duloxetine 30 mg twice daily for depression, Apixaban 5 mg twice daily for atrial fibrillation, Buspirone 15 mg twice daily for anxiety, and Amlodipine 5 mg daily for high blood pressure. Resident # 56 received his scheduled 9 AM medications on 6/03/24 between 12:21 PM and 1:34 PM, and on 6/04/24 between 10:06 AM and 10:26 AM, including Depakote 125 mg twice daily, Levetiracetam 1000 mg twice daily for seizures, and Dabigatran Etexllate Mesylate150 mg twice daily for atrial fibrillation. Resident # 88 received her scheduled 9 AM medications on 6/03/24 between 12:26 PM, and 12:28 PM, including Lisinopril 20 mg daily for high blood pressure, and Citalopram 40 mg daily for depression. Resident # 34 received her scheduled 9 AM medications on 6/03/24 between 12: 33 PM and 12:40 PM, including Hydrochlorothiazide 25 mg daily, Lisinopril 5 mg daily, Metoprolol ER 25 mg give 3 tablets daily for high blood pressure, and Divalproex ER give 3 tablets twice daily for bipolar disorder. Resident # 50 received her scheduled 9 AM medications on 6/03/24 between 12:41 PM and 12:45 PM, including Citalopram 10 mg, give 0.5 tablet daily for depression, Lisinopril 5 mg daily, and Atenolol-Chlorthalidone 50-25 mg daily for high blood pressure. Resident # 95 received her scheduled 9 AM medications on 6/03/24 at 12:57 PM, including Verapamil 120 mg daily for high blood pressure, and Celexa 1 tablet daily for depression. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 47 received her scheduled 9 AM medications on 6/03/24 between 12:57 PM and 12:58 PM, including Amlodipine 10 mg daily, and Lisinopril 10 mg daily for high blood pressure. Resident # 19 received her scheduled 9 AM medications on 6/03/24 at 1:01 PM, and on 6/04/24 between 11:55 AM and 12:02 PM, including Symbicort Aerosol 160-4.5 mcg (microgram) daily for chronic obstructive pulmonary disease (COPD). Resident # 58 received his scheduled 9 AM medications on 6/03/24 between 1:02 PM and 1:05 PM, including Morphine Sulfate 15 mg twice daily for pain, Eliquis 5 mg twice daily for atrial flutter, Coreg 12.5 mg twice daily, and Nifedipine ER 30 mg daily for high blood pressure. Accu-check scheduled for 11:30 AM was documented as administered at 1:26 PM. Resident #651 received his scheduled 9 AM medications on 6/03/24 at 1:02 PM, including Carvedilol 6.25 mg twice daily for high blood pressure. Resident #52 received her scheduled 9 AM medications on 6/03/24 between 1:03 PM and 1:11 PM, and on 6/04/24 between 10:55 AM and 11:06 AM, including Metformin 1000 mg twice daily for diabetes, Celexa 10 mg daily for depression, Norvasc 10 mg daily, Lisinopril 40 mg daily for high blood pressure, and Symbicort Aerosol 160-4.5 mcg 1 puff twice daily for shortness of breath/COPD. Resident #55 received his scheduled 9 AM medications on 6/03/24 between 1:07 PM and 1:10 PM, and on 6/04/24 between 10:07 AM and 10:09 AM, including Donepezil 5 mg twice daily for dementia. Hydralazine 100 mg three times daily for high blood pressure was documented as given on 6/03/24 at 1:07 PM, and a second dose was administered at 1:10 PM. Resident #37 received her scheduled 9 AM medications on 6/03/24 at 1:17 PM, and on 6/04/24 between 11:48 AM to 11:52 AM, including Zoloft 50 mg, and Zoloft 25 mg daily to equal 75 mg for depression, and Seroquel 75 mg daily for Huntington's Disease. Resident #38 received her scheduled 9 AM medications on 6/03/24 at 1:27 PM, including Doxycycline 100 mg, Cefuroxime Axetil 500 mg every twelve hours for respiratory infection, Amiodarone 200 mg daily for atrial fibrillation, Toprol ER 25 mg daily for high blood pressure, and Prednisone 20 mg twice daily for COPD. Resident #91 received her scheduled 9 AM medications on 6/03/24 at 1:52 PM, including Seroquel 25 mg every 12 hours for psychosis. Resident #89 received her scheduled 9 AM medications on 6/03/24 at 2:16 PM, and on 6/04/24 at 10:25 AM, including Valproic acid 250 mg three times daily for convulsions, and Apixaban 5 mg twice daily for blood clot prevention. on 6/03/24, documentation revealed the resident's scheduled 9 AM and 1 PM doses of valproic acid 250 mg three times daily for convulsion were given at same time at 2:16 PM. Resident #3a received her scheduled 9 AM medications on 6/04/24 at 10:36 AM, including Buspirone 30 mg daily for anxiety, Divalproex 125 mg twice daily for depression, Furosemide 40 mg daily for edema, Lisinopril 40 mg daily for high blood pressure, and Lamotrigine 200 mg twice daily for anticonvulsant. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35 received his scheduled 9 AM medications on 6/04/24 between 11:06 AM and 11:12 AM, including Glipizide 2.5 mg with meals, Metoprolol ER 25 mg daily for high blood pressure. On 6/03/24 the resident's scheduled 12:00 PM Glipizide was administered at 2:20 PM, and on 6/04/24 a second dose of Glipizide 2.5 mg was given at 1:21 PM, one hour and fifteen minutes after the first dose was given. Resident #23 received his scheduled 9 AM medications on 6/04/24 between 11:21 AM and 11:22 AM, including Lasix 20 mg daily for edema, Clonidine 0.2 mg twice daily for high blood pressure, and Wellbutrin 150 mg every morning and at bedtime for depression. Resident # 64 received his scheduled 9 AM medications on 6/04/24 at 11:27 AM, including Furosemide 20 mg daily for diuretic, and Empagliflozin 10 mg daily for diabetes. Resident #14 received his scheduled 9 AM medications on 6/04/24 at 11:40 AM, including Ativan 1 mg daily to be given with meals in the AM, and Depakote 125 mg, give 500 mg twice daily for mood disorder. On 6/06/24 at 6:22 PM, the Director of Nursing (DON) stated nurses worked on a split assignment because of the facility's census and explained nurses doing the split assignment would have thirteen residents on the 100 Wing, and fifteen residents on the 200 Wing. She acknowledged when there was a nurse working on the split assignment, nurses shared a medication cart, and had to wait to give medications until the nurse sharing the cart had completed medication administration for residents in their assignment. The DON stated medications were to be given one hour before, and one hour after the scheduled time. She said if medications were going to be late, staff should inform the physician, follow orders from the physician, document the late medication administration in the resident(s) Electronic Medical Record (EMR), and notify the resident/responsible party. The DON acknowledged that documentation to indicate the residents, their physicians, or responsible parties were notified of the late medication administration was not identified in the residents' clinical records. On 6/07/24 at 3:12 PM, the Medical Director stated medications should be given at particular times, and splitting assignment of nurses between two wings should be discouraged. The Policy Medication Administration General Guidelines dated 09/18 read, Medications are administered in accordance with written orders of the prescriber .Medications are administered within 60 minutes of scheduled time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to ensure Medical Records were complete and accurate pertaining to a change in condition for 1 of 5 residents reviewed for Advance Directives, (#100), and failed to accurately document medication administration for 1 of 1 resident reviewed for accuracy of medical record, (#25), of a total sample of 68 residents. Findings: 1. Resident #100, a-[AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included anemia, type II diabetes, stenosis of the carotid artery, and repeated falls. The resident was admitted to hospice services with start of care date of [DATE] with a diagnosis of moderate protein-calorie malnutrition. A progress note documented by Licensed Practical Nurse (LPN) A was dated [DATE] at 6:29 AM, and read, Patient has expired Hospice notified MD (Medical Doctor) notified. Review of the resident's clinical records revealed there were no other documentation to indicate when the change in condition was identified for resident #100. No documentation was noted regarding the actions taken prior to the progress note documented on [DATE] at 6:29 AM. On [DATE] at 5:25 PM, the 200 Wing Registered Nurse/Unit Manager (RN/UM) stated if a resident was found unresponsive, after staff assessment and response, a progress note was to be documented in the resident's electronic medical record (EMR) with the relevant information. Resident #100's clinical records were reviewed with the RN/UM, he acknowledged the progress note dated [DATE] at 6:29 AM, and confirmed no additional documentation could be identified, prior to the progress note which indicated the resident expired. On [DATE] at 6:13 PM, in a telephone interview, LPN A confirmed she was resident #100's primary nurse on [DATE]. She recalled Certified Nursing Assistant (CNA) B did her last round on the resident about 5:30 AM and reported to her the resident appeared expired. The LPN stated when she went into the resident's room he did not have a pulse. She stated information and actions taken regarding resident #100's change in condition were documented on the Cardiopulmonary Resuscitation (CPR) log and given to the former DON. She acknowledged the information was not documented in the resident's clinical record. On [DATE] at 4:40 PM, CNA B confirmed she worked on the 11 PM to 7 AM shift on [DATE] through [DATE], and resident #100 was in her assignment. She recalled she checked on the resident somewhere between 2:30 AM and 3 AM, found him unresponsive, and reported the change in condition to LPN A. Review of the medical record revealed this information was not documented in the resident's clinical records. Review of the Code Blue Worksheet for resident #100 dated [DATE] revealed documentation which indicated resident 100 was found unresponsive at 6:15 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospice transcript of the call from the facility on [DATE] revealed LPN A called at 6:09 AM to report patient expired at 0600. Interviews conducted with LPN A, and CNA B, review of the Code Blue Worksheet, and statements obtained from LPN A and CNA B revealed information pertaining to the resident's change in condition, and LPN A's communication between the facility and providers was not documented in the resident's clinical records. On [DATE] at 5:43 PM, the Director of Nursing (DON), and the Regional Consultant Risk Management Specialist explained the facility had a code worksheet on the crash cart staff would utilize to record pertinent details of the code event, including the time the resident was found without pulse and respiration, the time 911 was called, who initiated CPR, who assisted, 911 response time, and time 911 assumed care of the resident. They stated the code sheet was a tool to aid documentation in the resident's clinical record. The resident's clinical records were reviewed with the DON, and she acknowledged the progress note documented on [DATE] at 6:29 AM, was the only documentation by nursing staff identified regarding the change in the resident's condition. On [DATE] at 11:28 AM, and on [DATE] at 11:44 AM, the Corporate Director of Risk Management (RM) stated that in reviewing the incident, the facility identified an opportunity for improved documentation. The Regional Consultant Nurse stated LPN A verbalized information in her documentation was in error and should have been documented appropriately in the resident's clinical record. When asked why documentation was not completed, LPN A said she was tired. The RM stated the facility identified discrepancies on the Code Blue worksheet, documentation in the resident's EMR, hospital records, and the Emergency Medical Services run report. She acknowledged the facility had a responsibility to ensure documentation was complete and accurate. Essential duties and responsibilities listed on the Job description for DON dated [DATE] indicated the DON was to ensure, Adherence by staff pertaining to proper documentation of patient care. Essential duties and responsibilities listed on the Job description for LPN with date of [DATE] included, Maintains accurate, detailed reports and records. 45646 2. Resident #25 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, chronic atrial fibrillation, cardiac arrhythmia, unspecified glaucoma, hypertension and generalized anxiety disorder. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date of [DATE] revealed resident #25 had a Brief Interview for Mental Status score of 13 which indicated she was cognitively intact. She did not exhibit any behavioral symptoms and did not reject care that was necessary to achieve her goals for health and well-being. The document revealed resident #25 had a diagnosis of unspecified glaucoma. A care plan for potential for impaired visual function related to history of glaucoma was initiated on [DATE] and revised [DATE]. Interventions included, Administer medication as ordered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #25's EMR revealed a physician order dated [DATE] for 1 drop of Combigan Ophthalmic solution 0XXX,d+[DATE].5% (Brimonidine Tartrate-Timolol Maleate) to be instilled in both eyes two times a day for glaucoma. On [DATE] at 12:00 PM, daughter to resident #25 stated she did not receive medications in a timely manner. She stated the resident was supposed to get eyes drops 3 times a day. Resident #25 confirmed she had not received any eye drops today. She stated the nurse told her there were no eyes drops on her list of medications to be administered. Review of the Medication Administration Record (MAR) for [DATE] at approximately 12:25 PM, revealed eye drops were documented as given for the 9:00 AM administration. On [DATE] at 1:05 PM, LPN G was observed on 100 unit. LPN G verified she had a split assignment between 100 and 200 units. She explained she had left the 200 unit and was on the 100 unit passing medications. LPN G stated she had not administered the eyes drops to resident #25. She explained she preferred to administer eye drops at the end of her medication pass. LPN G reviewed her MAR documentation and verified she documented the eyes drops were already administered. She stated she did not remember documenting the administration. LPN G acknowledged it was not good practice to check off medications as given prior to actual administration. On [DATE] at 3:31 PM, the DON stated she spoke to LPN G and provided one on one education. The DON verified LPN G should not have documented administration of medication when she had not given the medication. The DON acknowledged by doing so, you would not be able to accurately identify which medications had or had not been administered. The facility's policy and procedure for Medication Administration dated [DATE] indicated medications were to be administered within 60 minutes of scheduled times. The policy read, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105448	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titusville Rehabilitation & Nursing Center	1705 Jess Parrish CT Titusville, FL 32796

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45646 Based on interview and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the facility's QAPI Plan revealed each Performance Improvement Project (PIP) subcommittee would identify areas for improvement. The subcommittee would collect and analyze data to determine the effectiveness of change. The PIP subcommittee would provide the QAA Committee with a summary report, analysis of activities and recommendations. The QAA Committee would monitor progress to ensure interventions or actions were implemented and effective in making and sustaining improvements. The facility had a deficiency cited at F 609, for failing to report during the previous recertification survey conducted 6/13/22 through 6/16/22. During this survey, the facility was found again to be in noncompliance with F 609 for failing to report. As a result of the repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the repeat citation. On 6/07/24 at 4:27 PM, the Administrator stated the QAA Committee usually set up action plans/PIPs for 3 months but reviewed and revised as needed based on findings from audits. She explained after the 3 months, if the issue was resolved, the plan was considered complete but could be re-opened if the issue was brought up again. The Administrator was unable to answer whether or not audits were still being conducted for citations from previous survey. She explained she had only been at the facility about a month. The Administrator could not say why the process failed, resulting in a repeat violation. She acknowledged the system failed, otherwise there would not be a repeat citation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 49840 Based on interview and record review, the facility failed to provide documentation of education, proof of consent, or medical contraindication for both influenza and pneumococcal vaccines for 4 of 5 residents reviewed for influenza and pneumococcal immunizations, of a total sample of 68 residents, (#5, #10, #44, and #55). Findings: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, obstructive sleep apnea, dementia, type II diabetes, and heart failure. Review of resident #5's immunization report revealed no documentation of education, consent, refusal or medical contraindication for pneumococcal vaccine. 2. Resident #10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included metabolic encephalopathy, acute and chronic respiratory failure with hypoxia, encounter for attention to gastrostomy, and dementia. Review of resident #10's immunization report revealed he received the influenza vaccine on 10/09/2023, but there was no documentation of education, or consent for the influenza vaccine. 4. Resident #44 was admitted to the facility on [DATE] with diagnoses of muscle wasting and atrophy, metabolic encephalopathy, type II diabetes, and pneumonia. Review of resident #44's medical record revealed no documentation of education, consents, refusal or medical contraindication for either influenza or pneumococcal vaccines. 5. Resident #55 was admitted to the facility on [DATE] with diagnoses of hypertensive emergency, non-pressure chronic ulcer of back with fat layer exposed, and stage 4 chronic kidney disease. Review of resident #55's immunization report revealed he received the influenza vaccine on 10/09/2023 but had no documentation of education, consents, refusal or medical contraindication for either influenza or pneumococcal vaccines. Interview with the Director of Nursing (DON) on 06/07/2024 at 5:20 PM, revealed the facility was unable to provide the record of education or documentation of consent/refusal/contraindication for administration of the influenza or the pneumococcal vaccine for residents #5, #10, #44, or #55. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Policy and Procedure for Immunizations- Pneumococcal, Influenza, and other recommended vaccinations, revealed all residents would be offered the Pneumococcal Polysaccharide Vaccine (PPV) unless there was documented evidence of prior administration, documented medical contraindication, refusal or no order. Influenza vaccine would be offered and administered during the optimal time for immunization, which was usually October to March. Furthermore, the document directed the facility staff to screen all newly admitted residents for previous PPV administration, obtain consent for immunization or immunization declination on the pneumococcal and annual influenza vaccination, obtain physician's order, review vaccine information sheet with resident or resident representative prior to administration, and finally document in the medical record.