STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056148	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASITAS CARE CENTER	**10626 BALBOA BLVD. GRANADA HILLS, CA 91344**

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

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F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to deliver the residents' personal mail on Saturdays, for 2 of eight residents' reviewed for resident rights during a resident group interview. This failure resulted in the residents not having reasonable access to their personal mail to the full extent possible. Findings: On 3/3/20, at 10:32 a.m., the resident council meeting was conducted at the facility. On 3/3/20, during the resident council meeting, 2 residents stated that the mail is not being delivered on Saturdays. The residents stated that they can see the mail is overflowing behind the receptionist's desk during the weekends. During the resident council meeting interview, Resident 36 stated that there was no staff in the front receptionist's desk on Saturdays, and the mail was not distributed. Resident 36 stated there was nobody in charge to distribute mail during the weekends. A review of Resident 36's admission record indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 36's History and Physical (H&P) Examination Record dated 4/20/19, indicated Resident 36 has the capacity to understand and make decisions. A review of Resident 36's Minimum Data Set (Assessment and Care Planning Tool), dated 1/21/20, indicated Resident 36 is cognitively intact. During an interview, on 3/5/20, at 8:14 a.m., with the Social Services Director (SSD), she stated that mail was delivered to the front desk and that she would open the mail with the residents. The SSD stated that mail should be delivered daily to the residents including on the weekends. During an interview on 3/5/20, at 8:26 a.m., with the Business Manager (BM), she stated that residents' mail comes to the office and into the activities box from Monday to Friday. The BM stated the residents' mail goes behind reception desk screen on Saturdays. On Monday morning, the residents' mail is delivered to them. The BM stated that there was not enough staff to deliver the mail to the residents on the weekends. The BM stated that she is going to inform the charge nurse to see if they could have mail sent out to the residents on Saturdays. A review of the facility's policy titled Mail and Electronic Communication, revised on 5/17, indicated Residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email and other electronic forms of communication confidentially. Policy Interpretation and Implementation. Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises to the facility's post office box (including Saturday deliveries).
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information were provided to the residents' and/or responsible parties for two (2) out of 19 residents (Resident 238 and 15) reviewed for the care area of resident rights. This deficient practice violated the residents' and/or representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' and/or responsible party's wishes regarding health care. Findings: a.A review of Resident 238's admission record indicates the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission record also indicates the responsible party is Family Member 1. A review of Resident 238's History and Physical (H&P) dated 2/27/20, indicates the resident does not have the capacity to understand and make decisions. A review of Resident 238's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/26/20, indicates an Advanced Directive is not completed and the Provider Orders for Life-Sustaining Treatment (POLST), to be discussed with the patient or decision maker has not been completed. During a concurrent interview, and record review, Licensed Vocational Nurse (LVN) 1 on 3/3/20 at 8:10 A.M., stated that there was no documentation that Resident 238 or a family member were provided written information regarding the resident's and/or responsible party's right to formulate an advance directive. During the concurrent record review, and interview, the Social Services Director (SSD) confirmed that there was no written information regarding formulating an advance directive. b.A review of Resident 15's admission record, indicates the resident was originally admitted on [DATE] and was readmitted on [DATE], with the [DIAGNOSES REDACTED]. The admission record also indicates the responsible party is Family Member 2. A review of Resident 15's H&P dated 10/26/19, indicates Resident 15 does not have the capacity to understand and make decisions. A review of Resident 15's MDS dated [DATE], indicates Resident 15's cognition is severely impaired. During a record review, on 3/5/20 at 8:06 A.M., there was no documentation that Resident 15 or a family member were provided written information regarding the resident's and/or the responsible party's right to formulate an advance directive. During a concurrent record review, and interview, the Social Services Director (SSD) confirmed that there was no written information regarding formulating an advance directive. A review of the facility's policy and procedure titled Advance Directives revised December 2016, indicates upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. The Policy and procedure also indicates if the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to complete a baseline care plan for one of one resident (Resident 238), reviewed for the care area of assessment. This deficient practice have the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services for Resident 238. Findings: A review of Resident 238's admission record indicates the resident was admitted on [DATE], with the [DIAGNOSES REDACTED]. A review of Resident 238's History and Physical (H&P) dated 2/27/20, indicates the resident does not have the capacity to understand and make decisions. During a concurrent interview, and record review, Licensed

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Vocational Nurse (LVN) 1, on 3/4/20 at 11:08 A.M., stated the facility does not have a baseline care plan for Resident 238. LVN 1 stated the baseline care plan should have been completed within 48 hours of admission. LVN 1 stated with no baseline care plan, the care needs for Resident 238 can be delayed. During a review of the facility's policy and procedure titled Care Plans- Baseline revised December 2016 indicates a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The policy also indicates to assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop a comprehensive care plan for pneumonia (an infection in the lung), for one of one residents (Resident 86) investigated for the care area of care plans. This deficient practice placed Resident 86 at risk for inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services. Findings: A review of Resident 86's admission record indicates the resident was originally admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 86's History and Physical (H&P) dated 2/13/20, indicates the resident was transferred from the general acute care hospital (GACH) after treatment for [REDACTED]. The H&P also indicates the resident does not have the capacity to understand and make decisions. During a concurrent interview, and record review, Licensed Vocational Nurse (LVN) 1, on 3/4/20 at 8:13 A.M., stated the resident was admitted from the hospital with pneumonia. LVN 1 also stated there is no care plan developed for pneumonia. LVN 1 stated with no care plan, Resident 86 may lack necessary care and services. A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered revised December 2016, indicates a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow their own policy to measure a resident's weight upon admission from the general acute care hospital (GACH) for one of one residents (Resident 86) investigated for the care area of Nutrition. This deficient practice had the potential to result in an undetected weight gain or weight loss, and can lead to a delay in or lack of necessary care and services, and malnutrition. Findings: A review of Resident 86's admission record indicates the resident was admitted on [DATE], with the [DIAGNOSES REDACTED]. A review of Resident 86's History and Physical (H&P) dated 2/13/20, indicates the resident was transferred from the general acute care hospital (GACH) after treatment for [REDACTED]. The H&P also indicates the resident does not have the capacity to understand and make decisions. During a concurrent interview, and record review, Licensed Vocational Nurse (LVN) 1, on 3/4/20 at 12:00 P.M., stated Resident 86's weight was not checked upon admission on 2/12/20. LVN 1 stated the resident's weight should have been checked because the facility will not be able to provide the appropriate care and/or know if the resident is gaining or losing weight. LVN 1 also stated, it is the facility's policy that weights are checked upon admission. A review of the facility's policy and procedure titled Weight Assessment and Intervention revised on September 2008, indicates the nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. A review of the facility's policy and procedure titled Nutritional Assessment revised October 2017, indicates the nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the usual body weight.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician's order and an informed consent for the use of side rails for one of five residents (Resident 77), reviewed for the care area of accident hazards. These deficient practices placed the resident at risk for a potential accident, such as a body part being caught between the bedside rails, falls if a resident attempts to climb over, around, between, or through the bedside rails and can lead to injuries. Findings: a. A review of Resident 77's admission records indicated that resident was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 77's history and physical dated 2/22/2020, indicated that the resident has the capacity to understand and make decisions. A review of Resident 77's Minimum Data Set (MDS- care-screening tool), dated 2/13/2020, indicated Resident 77's cognition is intact and required extensive assistance (support) for transfer (moves to and from bed), dressing, eating and toileting. On 3/02/2020 at 8:09 a.m., during an initial tour of facility, Resident 77 was sleeping on her back with two half size bedside rails up extending from her head to stomach. On 3/04/2020 at 7:23 a.m., during a room inspection, Resident 77 was sleeping on her back with two half size bedside rails up extending from her head to stomach. On 3/04/2020 at 7:43 a.m., during a room inspection, and interview, Licensed Vocational Nurse 2 (LVN 2), stated Resident 77 is sleeping on her back with two half size bedside rails up extending from her head to stomach. On 3/04/2020 at 7:57 a.m., during a record review, and interview, Registered Nurse 1 (RN 1), stated there is no physician's order for half size bedrails and no consent for half size bedside rails for Resident 77. On 3/5/2020 at 7:55 a.m., during an interview, and record review, the Director of Nursing (DON), stated Resident 77 should have had a physician order and consent for bedside rails, before having the side rails up. A review of the facility's policy with a revise date of December 2016, titled Proper use of Side Rails, indicates ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraint unless necessary to treat a resident's medical symptoms: Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on interview, and record review, the facility failed to sign the narcotic (controlled medication) reconciliation record after administering medication, in one of two Nursing Stations (Nursing Station 1), reviewed for the care area of pharmacy services. This deficient practice had the potential to cause inability of the facility to readily identify loss and drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: On 3/3/20 at 10:00 A.M., during a record review of the Narcotic Count Sheet for Station 1, and a concurrent interview, with Licensed Vocational Nurse (LVN) 2, the Count Sheet record had a missing signature in the signature box for (NAME)3, 2020 at 9 A.M. LVN 2 stated she forgot to sign the narcotic sheet which can cause confusion later. When asked, LVN 2 explained after administering controlled medications, (drugs considered to have a strong potential for abuse or addiction but have legitimate medical use), she should have signed the narcotic reconciliation record immediately after administering the medication. A record review of the facility's policy and procedure titled Charting and Documentation revised (NAME)2008, indicates all observations, medications administered, services performed, etc., must be documented in the resident's clinical records. A record review of the facility's policy and procedure titled Documentation of Medication administration revised (NAME)2007, indicates administration of medication must be documented immediately after (never before) it is given.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Based on observation, interview, and record review, the facility failed to label food items with an open date for the care area of food procurement and storage for 81 residents who are served food from the kitchen of 87 residents in the facility by failing to: 1. Ensure cereal was labeled with an open date, once the container or package was opened. This deficient practice had the potential to result in foodborne illness (any illness resulting from the spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food), for the residents and placed residents at risk for developing (symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever). Findings: During an initial kitchen tour on [DATE] at 7:30 a.m., with the Dietary Supervisor (DS), there was one clear bin observed, that contained oat cereal and was undated and one clear bin that contained rice cereal and was undated. The DS stated that the oat cereal and the rice cereal in the clear containers should be labeled with an open date including the month, day and year. A review of the facility's policy revised on 2017, titled, Guidelines for the Food and Nutrition Services Department, indicated: All food items are to be dated upon receipt with the month, day and year. All opened and partially used foods shall be dated, labeled and sealed before being returned to the storage area. .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to provide a sanitary environment by having two used baby powder bottles in the medication storage room with no open date. This deficient practice had the potential to transmit infectious microorganisms and can lead to illness for the residents. Findings: During a concurrent observation, and interview, with Licensed Vocational Nurse (LVN) 1, on 3/3/20 at 9:08 A.M., two opened baby powder bottles were in the medication storage room. The bottles were covered with powder and stored on a shelf. LVN 1 stated there was no open date on the bottles. LVN 1 stated the bottles may be carried into a resident's room, causing contamination, and can spread contamination when later stored in the medication storage room. LVN 1 stated the bottles should be discarded. A review of the facility's policy and procedure titled Policies and Practices - Infection Control revised October 2018, indicates this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The policy indicates to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. A review of the facility's policy and procedure titled Storage of Medications revised (NAME)2019, indicates the nursing staff is responsible for maintaining storage and preparation areas in a clean, safe, and sanitary manner.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the Urinary Tract Infection (UTI- an infection in any part of your urinary system) Antibiotic Stewardship Program (ASP- a coordinated program that promotes the appropriate use of antimicrobials, medication that kills germs- including antibiotics used to treat infections) for one of one resident (Resident 42), reviewed for the care area of infection control. This deficient practice resulted in incomplete data entry for the systemic Antibiotic Stewardship Program tracking for UTIs, as indicated in the facility ASP policy and procedures, and had a potential to result in use of inappropriate selection, dosing, route and duration of antimicrobial therapy for Resident 42's UTI and antibiotic use. Findings: On (NAME)3, 2020, at 8:55 a.m., during the initial tour of the facility, Resident 42 was observed lying in bed. Upon further inspection, Resident 42 had a completed an intravenous (I.V.-administered through a vein) piggyback (an I.V. secondary infusion, for the administration of medication that is diluted in a small volume, between 50-250 milliliters (ml's) in a mini-bag) was mounted on an IV pole, on the right side, at the head of Resident 42's bed. On (NAME)3, 2020, at 10:20 a.m., during an interview, the Director of Nursing (DON) stated, Resident 42 just came back (to the facility) from the general acute care hospital (GACH), due to a UTI. A review of Resident 42's Admission (Face sheet), indicated Resident 42 was originally admitted to the facility on (NAME)19, 2019, and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 42's Quarterly Minimum Data Set (MDS) a resident assessment and care screening tool, dated January 22, 2020, indicated Resident 42 was able to make her needs known, and requires extensive physical assistance from staff for activities of daily living (ADL's), such as personal hygiene and bed mobility. The MDS, indicates Resident 42 was assessed as always incontinent of bowel and bladder. A record review of the facility's Census List, indicated on February 24, 2020, at 5:30 p.m., Resident 42 was transferred out of the Skilled Nursing Facility (SNF), to the GACH, with an active Bed Hold order. A review of the facility's physician's orders [REDACTED]. A review of the GACH Cardiology Consultation Note indicated on February 25, 2020, at 5:14 a.m., Resident 42 had the following abnormal final urinalysis result: -Bacteria: Many, (urine is a generally thought of as a sterile body fluid, and evidence of many bacteria in the urine is considered abnormal and may suggest a urinary tract infection including bladder infection ([MEDICATION NAME]), or infection of kidney ([MEDICAL CONDITION]). A review of Resident 42's GACH Physician's Reconciliation Order form indicated on February 27, 2020 at 9 p.m., Resident 42 had the following order: -[MEDICATION NAME] ([MEDICATION NAME]-an antibiotic, medication used to treat infections) 1 gram reconstructed solution in 50 ml of 0.9% (percent) [MEDICATION NAME] solution sodium chloride (a salt solution) via IV daily. A review of Resident 42's GACH Internal Medicine Progress Note dated February 28, 2020, at 8:27 a.m., indicated under Plan of Care, Assessment: Acute urinary tract infection, Plan: IV antibiotics. A record review of the facility's Census List, indicated on February 28, 2020, at 9:39 p.m., Resident 42 was and transferred from the GACH and readmitted to the SNF. A review of the facility's Licensed Nurses Progress Note, dated February 28, 2020, at 9:39 p.m., indicated Resident 42 came from the GACH, admitted for skilled nursing care and management of multiple diagnoses. The Physician services indicated to continue IV antibiotic treatment for [REDACTED]. A review of Resident 42's physician order [REDACTED]. A record review of Resident 43's Plan of Care initiated on February 29, 2020, and revised on (NAME)3, 2020, titled The resident is on Antibiotic Therapy related to infection UTI, indicated interventions as follows: -Administer medication as ordered [MEDICATION NAME] one-gram IV (intravenously) daily -Report pertinent lab (laboratory test) results to MD (physician) -Observe for possible side effects every shift -Monitor every shift for adverse reaction(s): diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions -Antibiotics are non-selective and may result in the eradication of beneficial microorganisms and the emergence of undesired ones, causing secondary infections such as oral thrush, [MEDICAL CONDITION], and vaginitis. The plan of care Goal date was: (NAME)21, 2020, Resident 42 will be free of any discomfort or adverse side effects of antibiotic therapy. A review of the facility's Infection Control (IC) Committee/ATB Stewardship Meeting Minutes, dated February 26, 2020 at 9 a.m., indicated the Summary of IC Surveillance Log and Monitoring Programs, indicated the following: -Five (5) residents had Community Associated Infections (CAIs) in the facility, and Two (2) residents in the facility had Healthcare Associated Infection (HAIs) that met the McGeers Criteria (Surveillance definition of Infections in Long-Term Care Facilities). A review of Resident 42's Surveillance Data Collection-Infection Control: Urinary Tract Infections [MEDICAL CONDITION], dated February 28, 2020, (Resident 42's re-admitted), indicated to please complete this form for all residents suspected to have an infection and/or receiving any Antibiotics, Antifungal, [MEDICAL CONDITION] or Antiparasitic medication, including newly admitted residents, current residents and/or transferred to the GACH due to a possible infection. The resident's data collection information was incomplete as follows: - Symptoms Onset Date and Time: was blank/not documented - Vital Signs: pain scale rating; one out of 10 (1/10) or none: was not documented and was blank - Please review the signs/symptoms listed below, check the ones applying to the above listed resident and submit it to the facility's Infection Preventionist Nurse. Please include these Signs/Symptoms in your nursing document: - Urinary Tract Infections (UTIs): For residents without an Indwelling Catheter: Both Criteria 1 and 2 must be present: 1. At least 1 of the following subcriteria: a. Acute Dysuria or acute pain, swelling, or tenderness (box-not checked/not documented) b. Fever or leukocytosis (see Table 2) and at least 1 (one) of the following localizing urinary tract subcriteria (box-not check/not documented) i. Acute costovertebral angle pain or tenderness (box-not check/not documented) ii. Suprapubic pain (box-not check/not documented) iii. Gross hematuria (box-not check/not documented) iv. New or marked increase incontinence (box-not check/not documented) v. New or marked increase in urgency (box-not check/not documented) vi. New or marked increase in frequency (box-not check/not documented) c. In the absence or fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria (box-not check/not documented) i. Suprapubic pain (box-not check/not documented) ii. Gross hematuria (box-not check/not documented) iii. New or marked increase incontinence (box-not check/not documented) iv. New or marked increase in urgency (box-not check/not documented) v. New or marked increase in frequency (box-not check/not documented) 2. One of the following

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F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) microbiologic subcriteria (box-not check/not documented) a. At least 105 cfu (colony-forming units)/mL of no more than 2 species of microorganisms in voided urine sample (box-not check/not documented) b. At least 102 cfu/mL of any number of organisms in a specimen collected by in-and-out catheter (box-not check/not documented) - Antibiotic Treatment prescribed, Drug/Dosage/Route: Reocephin 1 gram I.V. every day for 7 days, was documented - Date Stated: February 29, 2020, was documented - Suspected Diagnosis: [REDACTED].?: No: was checked - Culture ordered?:No was checked - Enhanced Precaution/Isolation? No was checked - Additional Notes: Resident admitted from GACH with I.V. Antibiotic therapy for UTI, per Physician to continue current treatment order (was documented) and Community Associated Infection (CAI) was checked. On (NAME)4, 2020, at 7:25 a.m., a record review of the facility's Infection Prevention and Control Surveillance Log, dated February 2020, indicated Resident 42's information was not documented to include: -name -room number -onset date -date of admission -Infection Site: -Pre-Disposing Factors: such as; Catheter and/or Trachea (tracheotomy tube) /Vent (Mechanical ventilator) -Signs/Symptoms (S/S), Culture site, Laboratory (Labs), Specimen, Organism Count, Multi-drug resistant organisms (MDRO) or X-rays -Treatment: -Antibiotic (ATB) medication therapy -ATB ordered date -ATB start date -ATB -Number of days on ATB -Physician (prescriber) of ATB -Licensed Nurse that received the ATB order -Other date: How Acquired (community or healthcare acquired infection (HAI)), if McGeer's Criteria (the definition of symptomatic UTI) was met, suspected colonization (the presence of bacteria on a body surface), the date the infection resolved, the duration of infection (days) and any comments. On (NAME)4, 2020, at 7:45 a.m., during an interview with the facility's Infection Preventionist ((IP) the nurse responsible for infection surveillance, and Multi-drug resistant organisms ((MDRO) are common bacteria (germs) that have developed resistance to multiple types of antibiotics), and a record review of the IP's ASP Binder, regarding Resident 42's UTI and antibiotic use, the Staff Developer (a licensed vocational nurse) stated, I missed it. A review of the facility's policy and procedure, titled Antimicrobial Stewardship Program (ASP), dated September 21, 2015, indicated Background: The Centers for disease Control and Prevention (CDC) and World Health Organization (WHO) have reported that Antimicrobial resistance is one of our most serious health threats. Infections from resistant bacteria are now too common, and some pathogens have even become resistant to multiple types or classes of antibiotics undermines our ability to fight infectious diseases and manage the infectious complications, contributing to higher rates of morbidity and mortality. Definition: Anatomic Stewardship Program is an activity that promotes appropriate selection, dosing, route and duration of antimicrobial therapy. Objectives: It is the policy of our facility to implement an Antimicrobial Stewardship Program with the goal of optimizing clinical outcomes, minimize unintended consequences of antimicrobial use, including toxicity, the selection of pathogenic organisms and the emergence of resistance, while reducing treatment-related cost. Composition of the ASP: The following individuals have active participation in the ASP: a. Administrator (or designee); b. Medical Director; c. A supportive physician or pharmacist; d. Director of Nursing Services; e. Infection Preventionist; f. Others as appropriate. Procedures: 1. The Antimicrobial Stewardship is a physician-supervised program, overseen by facility's Medical Director; 2. Clinical support to the Antimicrobial Stewardship Program must be provided by a physician or pharmacist with antimicrobial stewardship training from a recognized profession organization or post graduate program; 3. The facility Infection Preventionist (IP) or designee shall: a. Monitor facility's antibiotics usage patterns by routinely collecting and monthly reviewing: I. Counts of antibiotics(s) prescribed and the number of Residents treated each month; ii.Counts of antibiotics prescribed for Healthcare Associated Infections (HAI) that did not meet McGreer's revised criteria (2012) for initiation of antibiotic therapy; iii.Counts of antibiotics(s) administered to patients per day (Days of Therapy; DOT); iv. Type of antibiotics ordered and route of administration; v. Antibiotic costs; vi. Which physician is ordering each antibiotic; vii. Whether a culture was obtained before ordering antibiotic; vii. whether the antibiotic was changed during the course of treatment. b. obtain and review antibiotics for institutional trends of resistance; c. Monitor antibiotic resistance patterns (MRSA, VRE, ESBL, CRE, etc.) d. Report findings to director of Nursing Services, to the ASP supportive physician or pharmacist and other as appropriate. Findings shall also be reported monthly to facility's infection control Committee; e. Provide education to Residents/Responsible Party, Physicians, Facility's clinical staff and others as appropriate); 4. The Facility's Infection Control Committee shall: a. Review facility's Infection Preventionist (IP) monthly analysis report; b. Review most recent antibiotics for institutional trends of resistance; c. Provide feedback to attending physicians on their individual prescribing patterns of cultures ordered and antibiotics prescribed; d. Make it available to the most recent antibiotics to attending physicians; e. Report monthly to facility's QA committee. And 5. Facility's administration shall provide all necessary logistical support for the Antimicrobial Stewardship Program.