STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395285	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARNES-KASSON COUNTY HOSPITAL	2872 TURNPIKE STREET SUSQUEHANNA, PA 18847

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on a review of the employee personnel files, staff interview and the facility's Abuse and Neglect Policy and staff interview, it was determined that the facility failed to implement established procedures for screening potential employees including efforts to obtain information from previous employers and/or current employers for two out of five employment records (Employees 1 and 4). Findings include: Review of the facility's policy entitled Resident Rights-Abuse and Neglect,, last reviewed by the facility on April 16, 2019, indicated that the facility may review the employment history, information from former employers. Review of the employment record of Employee 1 (Assistant Director of Nursing) revealed that the employee was hired on February 6, 2020. There was no documented evidence that attempts were made to obtain previous employment verification/ reference check on the employee prior to employment. Review of the employment record for Employee 4 (Licensed Practical Nurse) revealed the employee was hired on February 22, 2020. There was no documented evidence that attempts were made to obtain previous employment verification/ reference check on the employee prior to employment. Interview with Employee 2 (Human Resources) on March 13, 2020, at 12:54 PM confirmed that the there was no documented evidence that employment verification/ reference checks were completed on the above employees. 28 Pa. Code 201.14(a)(c) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 201.19 Personnel policies and procedures
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a review of clinical records and staff and resident interviews it was determined that the facility failed to provide necessary and prescribed treatment and services to promote healing and prevent infection for one out of 19 residents reviewed (Resident 28). Findings include: A review of the clinical record revealed that Resident 28 was admitted to the facility on [DATE], with a community acquired pressure wound on his coccyx {facility documentation refers to area as sacrum in later documentation} that measured 5.5 centimeters (cm) in length, 4 cm in width and 4 cm in depth. According to the wound documentation, the wound bed was pink, 100% granulated (new) tissue, there was no odor or swelling and the wound edges were macerated (softening and breaking down of skin resulting from prolonged exposure to moisture). The clinical record revealed that on February 5, 2020, a wound culture completed of the Resident 28's wound on his sacrum due to the presence of green drainage from the wound. The culture of the wound was positive [MEDICAL CONDITION] ([MEDICAL CONDITION]-resistant Staphylococcus aureus; a bacterium with antibiotic resistance) and the physician prescribed antibiotic therapy for 10 days. Further review of the clinical record revealed that on February 26, 2020, the sacral wound presented with yellow drainage and another wound culture was requested. On March 3, 2020, the wound culture results continued to be positive [MEDICAL CONDITION] and the resident was prescribed alternate antibiotic therapy for 4 weeks. Interview with Resident 28 on March 10, 2020, at approximately 11:27 a.m. revealed that he was scheduled to have surgery to close the sacral wound, but the infection was preventing him from having the procedure done. A review of Resident 28's clinical record revealed a physician order [REDACTED]. The resident had physician order [REDACTED]. Observation of wound care on March 13, 2020, at approximately 10:39 a.m. performed by Employee 1, Registered Nurse, revealed that the current measurement of sacral wound was 8 cm in length x 7 cm in width and 4 cm in depth. There was a moderate of tan drainage observed on the dressing that Employee 1 removed from the wound. The wound edges remained excessively moist. During observation of the wound care, Employee 1 failed to cleanse the wound with normal saline as ordered, prior to application of the clean dressing as ordered. Interview with Employee 1 on March 13, 2020, at approximately 11:15 a.m. confirmed that the physician order [REDACTED]. 28 Pa. Code 211.12 (a)(c)(d)(3)(5) Nursing Services.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record and select policy review and staff and resident interview, it was determined that the facility failed to ensure the provision of necessary services to maintain, improve or prevent a decrease in range of motion for one of three residents sampled (Resident 22). Findings include: A review of a facility policy for Restorative Nursing Program, last reviewed by the facility April 16, 2019, revealed the purpose of the restorative program is to ensure residents have a better quality of life by being as independent as possible in taking care of themselves. When a a resident is discharged from restorative nursing, a physician's orders [REDACTED]. A review of Resident 22's clinical revealed a physician's orders [REDACTED]. Review of a physician order [REDACTED]. Interview with Employee 3 (Licensed Practical Nurse- for restorative nursing program) on March 12, 2020, at 2:23 PM, revealed tht the employee stated that Resident 22's 90 day restorative program had been completed after the 3 month period. Employee 3 further stated that the physician orders [REDACTED]. Employee 3 was unaware if after the 90 days of restorative services a discharge nursing evaluation of the resident's current status was conducted along with a discharge summary or maintenance plan developed with instructions for direct care nursing staff to assist the resident in maintaining his/her current level of independence and functioning. Interview with Resident 22 on March 12, 2020 at 12:45 PM, revealed that the resident stated that the facility staff no longer walk her throughout the halls and the resident stated that she hopes not to loose the ability to walk. 28 Pa. Code 211.5(f)(h) Clinical records 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(a)(c)(d)(5) Nursing services
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and select facility policy, observation and staff and resident interview, it was determined that the facility failed to follow physicians orders for oxygen therapy for one (Resident 16) and failed to store respiratory equipment in a sanitary manner for one resident out of three residents sampled receiving oxygen therapy (Resident 44). Findings include: A review of a facility policy for Concentrators and Nebulizer kits on skilled units, dated as reviewed by the facility April 2019, revealed that all (respiratory) tubing will be placed in a covered container or bag when not in use. During the initial tour of the nursing unit March 13, 2020 at approximately 10 AM, in Resident 44's room, oxygen tubing was observed connected to an oxygen concentrator, which was not use. The plastic bag for storage of this tubing was observed empty in the drawer of the resident's nightstand. The tubing for the resident's nebulizer respiratory treatments was also observed unbagged/uncovered in this drawer. A review of the clinical record revealed that Resident 16 had a current physician order, initially dated December 22, 2018, for oxygen, on at bedtime, off in the AM, running at 4 liters per minute. An observation conducted on March 11, 2020 at 12 PM, revealed that Resident 16 was seated in his wheelchair in his room. Resident 16's oxygen concentrator was running at the rate of 3.5 liters per minutes. The oxygen

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

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

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) tubing was draped over the end of the bed with the nasal cannula observed directly on the floor. The resident stated that the nurse aide came into the room, took him to the bathroom after taking off the nasal canula, put him back into the chair, but did reapply the nasal cannula on the resident. At 12:15, Employee 5 placed the nasal canula on the resident. The oxygen rate continued to be at 3.5 liters per minute. The physician order [REDACTED]. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(c)(d) Resident care policies
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.** Based on review of facility narcotic records and select facility policy, observation and staff interview, it was determined the facility failed to implement procedures for timely and accurate disposition of controlled medications. Findings include: A review of facility policy for Medication Disposition of Controlled Drugs, reviewed April 2019, revealed the facility maintains a record of the receipt by pharmacy of controlled drugs returned for disposition. This is accomplished through the use of the controlled substance and narcotic disposition form which is initiated by the licensed nurse and forwarded along with the controlled drugs to the pharmacy. The nurse enters the following data on the form: 1. Date 2. Name, strength and form of the drug 3. Quantity 4. Residents name 5. Attending physicians name The narcotic and controlled medications will be stored in a double locked room. When the container is full, it will be stored in a double locked room until incineration. Controlled drugs are destroyed by placing the drugs in a chemo waste container, sealing the container, as witnessed by two licensed personnel, placing the container in the facility's locked bio-hazardous waste storage area and shipping the container via the facility's bio-hazardous waste hauler for incineration. Both the witnesses shall sign the disposition form of the receipt by pharmacy of controlled drugs returned for disposition, showing their signatures and titles. A review of facility lock box log-controlled medication forms dated September 4, 2019, through March 12, 2020, reveled there were 80 entries of narcotic medications listed for disposal. This form identified the need for the signatures of two nurses placing the narcotic medication in the box and the additional signatures of the Director of Nursing (DON) and an additional witness signature and the date signed. An observation conducted on March 13, 2020, at approximately 12 PM revealed a locked box, inside a locked cabinet, in the Director of Nursing's office. Inside the locked box was the noted 80 medication cards, bottles and patches referenced above for disposal. It was difficult to close the door of the cabinet in which the box was stored because the medications were tightly compacted within the cabinet and the box fell out when the door was opened. During an interview at the time of the observation, the DON confirmed that the narcotic medications were not disposed of timely. 28 Pa Code 211.14 (c)(d)(1)(3)(5) Nursing services 28 Pa Code 211.9 (i)(j)Pharmacy services
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that for one resident out of 19 residents sampled was free from unnecessary drugs (Resident 45). Findings include: A review of the clinical record of Resident 45 revealed admission to the facility on [DATE], with [DIAGNOSES REDACTED]. Nursing documentation dated December 22, 2019, at 7 AM indicated that Resident 45 had an increased temperature. The physician ordered a urinalysis (a test of your urine used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes; urinalysis involves checking the appearance, concentration and content of urine) with a culture (used to diagnose a urinary tract infection [MEDICAL CONDITION] and to identify the bacteria or yeast causing the infection) and sensitivity (Sensitivity analysis helps find the most effective antibiotic to kill an infecting microorganism; sensitivity analysis is a test that determines the sensitivity of bacteria to an antibiotic. It also determines the ability of the drug to kill the bacteria. The results from the test can help your doctor determine which drugs are likely to be most effective in treating your infection) along [MEDICATION NAME](an antibiotic that can treat and prevent urinary tract infections) 500 mg, one tablet by mouth twice a day for UTI (urinary tract infection) for 7 days was ordered. The results of the urine culture and sensitivity and nursing documentation dated December 24, 2019, revealed the presence of 100,000 CFU/ML Escherichia coli (a fecal related bacteria), which was resistant to the drug Cipro, but sensitive to [MEDICATION NAME] (an antibiotic). The physician was contacted on December 24, 2019, and discontinued the antibiotic [MEDICATION NAME] ordered [MEDICATION NAME] 100 mg by mouth, give one capsule twice a day for 10 days. A review of medication administration records dated December 2019 revealed that Resident 45 received four doses [MEDICATION NAME] mg tablet, before the culture identified that the resident's infection was resistant to [MEDICATION NAME] therapy. During an interview March 13, 2020 at approximately 1 PM, the Assistant Director of Nursing confirmed that Resident 45 received 4 doses of the Cipro, to which the identified bacteria was resistant. 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services 28 Pa. Code 211.2(a) Physicians services
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on a tour of the food and nutrition services department, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for microbial growth in food, which increased the risk of food-borne illness. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). During the observation of the food and nutrition services department on March 11, 2020, at approximately, 11:15 a.m., with the Dietary Supervisor, the following sanitation issues, with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: Beneath storage shelves in the dry storage area, packages of un-opened cookies, condiments, and garbage were observed directly on the floor. Boxes of souffle cups were observed stored on the floor. Empty boxes and plastic ware stored on the floor. A thick layer of dust and lint was observed on the floor beneath the ice machine located in the facility cafeteria that is utilized by the staff for the food and nutrition services department had and behind the machine. Interview with the Dietary Supervisor at the time of these observations confirmed the above food safety and sanitation concerns. Observation conducted on March 13, 2020, at 12 PM revealed that the floor underneath and to the sides of the ice machine was littered with dirt and paper debris. The vent on the side of the ice machine was covered with a thick layer of dust. The drain lines coming out of the back of the ice machine leading into the floor drain were covered with a sticky, black substance and dust and dirt debris. There was no noted air gap (an area measuring approximately 1 and 1/2 inches between the end of the drain pipe and the drain on the floor) to prevent potential backwash contamination. This observation was confirmed at the time by the Nursing Home Administrator. 483.60(i)(2) Food safety requirements 28 Pa. Code 211.6(c)(d) Dietary services. 28 Pa. Code 207.2(a) Administrator's responsibility.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Dispose of garbage and refuse properly.** Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage and provide a sanitary environment on the facility grounds. Findings include: Observation of the Food and Nutrition Services Department on March 11, 2020, at 12:30 p.m. in the presence of the Dietary Supervisor, revealed a plastic garbage bin located in a storage area that was designated for the kitchen and facility garbage. The bin contained two black bags of garbage and uncovered. Further observation of the plastic garbage bin revealed that there was a lid attached to the bin that was able to be opened and closed. Observation of the garbage storage area on March 12, 2020, at approximately 9:35 a.m. in the presence of the Dietary Supervisor again revealed the plastic garbage storage bin was overfilled with overflowing black bags of garbage and cardboard boxes. The plastic storage garbage was unable to be closed due to being overfilled. Interview with the Dietary Supervisor on March 12, 2020, at approximately 9:35 a.m. revealed that the facility dumpsters are now located on a separate location on the facility property. The plastic garbage storage bin is utilized

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F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) until emptied by the maintenance department and taken to the dumpsters. Interview with the Dietary Supervisor at this time confirmed that garbage and refuse should be properly contained and covered to maintain sanitary conditions. 28 Pa. Code 207.2(a) Administrator's responsibility
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** Based on observations, review of clinical records and interviews with residents and staff it was determined that the facility failed to maintain accurate clinical records for one of 19 sampled residents (Resident 27). Findings include: A review of the clinical record of Resident 27 revealed current physician orders [REDACTED].m-2:00 p.m.-10:00 p.m.) and Prevalon boots to bilateral feet for pressure relief (apply at 6:00 a.m.). A review of the treatment administration record for the time period from March 1, 2010, until March 12, 2020, revealed staff documentation that the oxygen and Prevalon boots were in place on every shift as evidenced by the initials of licensed nursing staff. Resident 27 was observed in her room on multiple occasions during the days of the survey on March 10, 2020, March 11, 2020 and March 12, 2020. Upon each observation she was not receiving oxygen via a nasal canula. The oxygen tubing was observed laying on the resident's bed or on the floor during these observations. An interview conducted with the resident on March 13, 2020, at 10:00 a.m. revealed that she only uses oxygen when she becomes short of breath. The resident stated that she keeps it within her reach on bed, but does not use it at night because she feels like it chokes her. Observations of Resident 27 throughout the days of the survey, on March 10, 2020, March 11, 2020 and March 12, 2020, revealed that she was not wearing Prevalon boots (pressure relief) on her feet. When discussing the prescribed Prevalon boots the resident stated I hid them. The resident explained that they make her feet too hot especially at night. During the day she participates in physical therapy and was observed on a daily basis during the survey wearing sneakers during the day tour of nursing duty. The facility failed to ensure the resident's clinical record accurately reflected the care and services provided to the resident. The licensed nurses failed to ensure that oxygen and Prevalon boots were in place prior to documenting the resident's continuous and consistent use. 28 Pa. Code 211.5 (f)(g)(h) Clinical records. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's infection control log and staff interview, it was determined that the facility failed to maintain a comprehensive program to monitor and prevent infections in the facility and failed to adhere to infection control practices in the use and care of oxygen delivery devices and urinary catheters for three residents out of 19 sampled (Resident 48, 16, 35). Findings included: A review of the facility's compiled infection control data conducted at the time of the survey ending March 13, 2020, revealed that the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. There was no evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of facility infection control logs for the month of October 2019 indicated that among the facility residents there were 5 urinary tract infections [MEDICAL CONDITION] in the facility. November 2019 logs indicated that there were 2 upper respiratory infections (URI) and 7 urinary tract infections [MEDICAL CONDITION] in the facility. December 2019 logs indicated that there were 11 upper respiratory infections (URI) and 4 urinary tract infections [MEDICAL CONDITION] in the facility. January 2020 logs indicated that there were 9 upper respiratory infections (URI) in the facility and 11 urinary tract infections [MEDICAL CONDITION]. February 2020 logs indicated that there were 3 upper respiratory infections (URI) in the facility and 6 urinary tract infections [MEDICAL CONDITION]. The facility's infection control log revealed no documented evidence that the facility tracked these infections to identify any patterns or trends. There was also no evidence of the measures the facility had developed and implemented among staff and residents to deter the spread of these types of infection. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infection. A review of the clinical record revealed that Resident 48 was admitted to the facility March 20, 2019, with [DIAGNOSES REDACTED]. A review of a laboratory report dated March 9, 2020, revealed that Resident 48 was positive for Influenza A. Resident 48 was placed on droplet precautions and her bed and recliner chair were transferred from her room [ROOM NUMBER]-3 (a 4-bedded room) to room [ROOM NUMBER], a private room. At the time of the transfer, room [ROOM NUMBER] (the private room) was occupied by Resident 36. He, along with his bed were transferred to room [ROOM NUMBER]-2. No additional belongings were moved with either resident. There was no indication of the facility's cleaning procedures for the residents' personal belongings upon these room changes. An observation March 10, 2020, at approximately 1 PM revealed that Resident 36 wheeled into his prior room, 236, a private room. Resident 48 was seated in her recliner chair located next to the door. The door to the room was observed to be open. Resident 36 wheeled in front of Resident 48 (currently positive for Influenza A infection), sat for a few minutes and was redirected out of the room by nursing staff. Resident 48 was actively coughing at the time of the observation. An observation March 11, 2020, at 12 PM Resident 16 was seated in his wheelchair in his room. His oxygen concentrator was running and the oxygen tubing and the nasal canula (the end of the plastic tubing that fits into the nose that delivers the oxygen) was draped over end of the resident's bed with nasal cannula resting directly on the floor. Resident 16 stated that the nurse aide came into the room, took him to the bathroom after taking off the nasal canula, put him back into the chair and did not reapply the nasal cannula on the resident. Continued observation on March 11, 2020, at 12:15 PM revealed that Employee 5 (nurse aide) picked up the nasal cannula from the floor and reapplied the cannula in the resident's nostrils. This observation was confirmed at the time of the observation by Employee 6 (RN) and Employee 3 (LPN). An observation on March 29, 2020, at 11:00 AM of Resident 35 in his wheelchair, on the blue unit of the facility, revealed that the resident's urinary catheter bag was dragging on the floor as he was self-propelling about the facility. The observation was confirmed by Employee 8 (Registered Nurse). 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(d)Resident care policies
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility's infection control policies and staff interview it was determined the facility failed to to establish and implement a functional antibiotic stewardship program, which includes procedures for monitor antibiotic usage as evidenced by one of 19 sampled residents (Resident 45). Findings include: Review of the facility policy entitled Antibiotic Stewardship Program dated as reviewed by the facility April 16,2020, revealed that the facility will maintain an Antibiotic Stewardship program to promote the appropriate use of antibiotics, improve resident outcomes, reduce antibiotic resistance and decrease the spread of infections by multidrug-restant organisms. At the time of the survey ending March 13, 2020, the facility had not developed and implemented procedures according to adhere to the facility policy for an antibiotic stewardship program. The facility's existing Infection Control Policies and Practices revealed that the facility's had not established written antibiotic use protocols and criteria for use. There were no protocols developed to review clinical signs and symptoms and laboratory reports to determine if the antibiotic therapy is indicated or if adjustments to therapy should be made and to identify the specific infection assessment tools or management algorithms to be used for one or more types of infections. At the time of the survey ending March 13, 2020, there was no documented evidence of a functioning process for periodic review of antibiotic use by prescribing practitioners or protocols, which had been developed to optimize the treatment of [REDACTED]. The facility's existing system did not include measures to provide feedback reports on antibiotic use and antibiotic resistance patterns within the facility. In an interview on September 12, 2020, at 1:45 PM the Infection Control RN stated the facility had not yet developed specific protocols relating to antibiotic use and was unable to provide evidence of a functioning antibiotic stewardship program in the facility at the time of the survey. Interview with the Nursing Home Administrator (NHA) on March 13, 2020, at 1:45 PM revealed that the facility had designed an outline for developing an antibiotic stewardship program, but had not yet implemented operational procedures for the necessary components. The NHA was unable to provide documented evidence that the program was in use within the facility at the time of the survey. A review of the clinical record of Resident 45 revealed admission to the facility on [DATE], with [DIAGNOSES REDACTED]. Nursing documentation dated December 22, 2019, at 7 AM indicated that Resident 45 had an increased temperature. Nursing contacted the physician and a urinalysis (a test of your urine used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes;

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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 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) urinalysis involves checking the appearance, concentration and content of urine) with a culture (used to diagnose a urinary tract infection [MEDICAL CONDITION] and to identify the bacteria or yeast causing the infection) and sensitivity (Sensitivity analysis helps find the most effective antibiotic to kill an infecting microorganism; sensitivity analysis is a test that determines the sensitivity of bacteria to an antibiotic. It also determines the ability of the drug to kill the bacteria. The results from the test can help your doctor determine which drugs are likely to be most effective in treating your infection) was ordered along [MEDICATION NAME](an antibiotic that can treat and prevent urinary tract infections) 500 mg, one tablet by mouth twice a day for UTI (urinary tract infection) for 7 days was ordered. The results of the urine culture and sensitivity and nursing documentation dated December 24, 2019,, revealed the presence of 100,000 CFU/ML Escherichia coli (a fecal related bacteria), which was resistant to Cipro, but sensitive to [MEDICATION NAME] (an antibiotic). The physician was contacted December 24, 2019 and discontinued [MEDICATION NAME] ordered [MEDICATION NAME] 100 mg by mouth, give one capsule twice a day for 10 days. A review of medication administration records dated December 2019 revealed that Resident 45 received four doses [MEDICATION NAME] mg tablet, prior to culture results, that identified that the resident's infection was resistant to [MEDICATION NAME] therapy. During an interview March 13, 2020 at approximately 1 PM, the Assistant Director of Nursing confirmed that Resident 45 received 4 doses of the Cipro, to which the identified bacteria was resistant. 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services 28 Pa. Code 211.2(a) Physicians services 28 Pa. Code 201.18(e)(2)(3) Management 28 Pa. Code 211.10(a) (d) Resident care policies
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, CDC guidelines and select policy review and staff interview, it was determined that the facility failed to ensure that one resident out of 19 sampled residents (Resident 48) was offered the opportunity to receive an alternative form of influenza immunization to meet the resident's individual health care needs. Findings include: A review of a facility policy for Influenza vaccine and management of influenza, updated March 9, 2020, revealed under vaccine information that all eligible residents will be administered the flu vaccine unless contraindicated. The vaccine is not indicated if the following exists: A. Residents who have a severe allergy to chicken eggs. Each resident is offered an influenza immunization from September 1 through March 31 annually unless the immunization is medically contraindicated or the resident has already been immunized during this time period. A review of the clinical record review revealed that Resident 48 was admitted to the facility March 20, 2020, with [DIAGNOSES REDACTED]. A significant change Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 19, 2019, revealed a BIMS score of 15 (The BIMS is conducted periodically to assess cognition over time) indicating that the resident was cognitively intact and was not eligible to receive the influenza vaccine. A review of a facility consent/education for flu vaccine dated November 5, 2019, revealed that Resident 48 did not want the flu vaccine due to an egg allergy. It was noted that the resident did not receive the flu vaccine at that time. According to the Centers for Disease control and prevention, Special Consideration Regarding Egg Allergy, People with egg allergies [REDACTED]. People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting and supervised by a health care provider who is able to recognize and manage severe allergic reactions. Recombinant influenza vaccines are produced using recombinant technology. This method does not require an egg-grown [MEDICAL CONDITION] and does not use chicken eggs in the production process. Currently, the recombinant influenza vaccine and the cell culture-based influenza vaccine are the only egg-free influenza vaccines licensed for use in the United States. Flublok Quadrivalent is a quadrivalent recombinant influenza vaccine that was first licensed by the FDA in the United States for use in adults [AGE] years and older in 2017. A review of a laboratory report dated March 9, 2020, revealed that Resident 48 was positive for Influenza A. During an interview March 15, 2020 at approximately 9 am, the Nursing Home Administrator confirmed that Resident 48 was not offered an alternative form of the flu vaccine. 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies