STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORRISTOWN MANOR	**868 S WASHINGTON ST MORRISTOWN, IN 46161**

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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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accuracy regarding discharge location and the medications received by a resident on MDS (Minimum Data Set) assessments for 2 of 25 residents reviewed for MDS accuracy. (Resident K and Resident M) Findings include: 1. The clinical record for Resident K was reviewed on 03/10/20 at 1:04 p.m. The resident's [DIAGNOSES REDACTED]. He was admitted to the facility on [DATE] and discharged on [DATE]. The social services note, dated 2/21/20, indicated Resident scheduled to discharge 2/22/20 to live with his (relationship of family member) in (county name) county. Resident and family agree with this date of discharge and (relationship of family member) stated that she will be involved in transport home. Resident's (relationship of family member) requested that (name of home health company) be arranged for his discharge .This request has been fulfilled. Resident's (relationship of family member) stated that resident currently has appropriate DME (durable medical equipment) at this time for discharge. The nurse's note, dated 2/22/20, indicated Resident alert/oriented. Went over discharge medications and instructions with (relationship of family member,) (name of family member,) and resident. Resident discharged with all medication per order. Follow up appointment on instructions and gone over with resident. All belongings sent with resident. No questions at this time and were encouraged to call with any issues or questions. Ambulated with rollator walker to car and self transferred with 1 person assist mostly stand by without issues. discharged at 11:45 a.m. The home discharge summary and instructions, dated 2/22/20, indicated Resident K discharged by car with a family member. The Discharge MDS assessment, dated 2/22/20, indicated Resident K discharged to an acute hospital. An interview was conducted with the MDS Navigator on 3/10/20 at 1:30 p.m., she indicated the MDS was incorrect and should have been coded 01, that he discharged to the community. The facility used the RAI (Resident Assessment Instrument) as their MDS policy. 2. The clinical record for Resident M was reviewed on 03/09/2020 at 02:08 p.m. The resident's [DIAGNOSES REDACTED]. The clinical record contained a Quarterly MDS Assessment, completed 12/24/2019, indicated she received an anticoagulant for 7 days. The clinical record did not contain a physician's orders [REDACTED]. During an interview on 3/12/2020 at 10:44 a.m., the DON (Director of Nursing) indicated Resident M had not received an anticoagulant during December 2019. During an interview on 3/12/2020 at 10:52 a.m., the CNC (Clinical Nurse Consultant) indicated anticoagulants should not have been included on the Quarterly MDS Assessment, completed 12/24/2020. The Centers for Medicare and Medicaid Services Long Term Care Facility RAI 3.0 User's Manual Version 1.16 Section A2100 Coding Instructions indicated to code 01 if the resident's discharge location was a private home, apartment, board and care, assisted living facility, or group home.
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** Based on interview and record review, the facility failed to ensure a level II was obtained for 1 of 1 residents reviewed for Pre-Admission Screening and Resident Review (PASRR). (Resident P) Findings include: The clinical record for Resident P was reviewed on 3/9/20 at 3:30 p.m. The [DIAGNOSES REDACTED]. A PASRR level I dated, 5/31/18, indicated Resident P was required a level II. An interview was conducted with the Social Services Director (SSD) on 3/9/20 at 3:27 p.m. She indicated she had found the level I that was obtained in May 2018, for Resident P. The level I did indicate a recommendation of a level II to be conducted. A level II had not been completed. She would have to start over and do another level I. A PASRR level I dated 3/11/20, was provided by the SSD on 3/12/20 at 8:45 a.m. It indicated a recommendation of a level II would need to be conducted.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a resident bathing per her plan of care for 1 of 3 residents reviewed for ADLs (activities of daily living.) (Resident J) Findings include: The clinical record for Resident J was reviewed on 3/10/20 at 9:45 a.m. The [DIAGNOSES REDACTED]. The Quarterly MDS (Minimum Data Set) assessment, dated 2/4/20, indicated Resident J required physical help of one person in part of bathing and was cognitively intact. The CNA (Certified Nursing Assistant) assignment sheet indicated Resident J was to receive bathing in the spa room on Mondays, Wednesdays, and Saturdays. An interview was conducted with Resident J on Tuesday, 3/10/20 at 10:00 a.m. She indicated she hadn't received bathing in the spa room on her last 2 scheduled bathing days, Monday, 3/9/20 and Saturday, 3/7/20. The March, 2020 bathing verification log was provided by the DON (Director of Nursing) on 3/11/20 at 8:45 a.m. It indicated she did not receive bathing 3/7/20 and her last bathing was provided in the form of a bed bath on 3/9/20. An interview was conducted with Resident J on 3/11/20 at 9:59 a.m. She indicated she was not provided a bed bath on 3/9/20. Staff assisted her to the restroom on 3/9/20 to wash her back and bottom, but that was it. They did not wash any other part of her body. Her last shower was on 3/4/20, a week ago, and no one had mentioned a shower since. She had arthritis and the spa bathing helped with the arthritis in her knees. She would have been okay with receiving a shower or bed bath in her room on 3/7/20 and 3/9/20, but she hadn't had any form of complete bathing since 3/4/20. An interview was conducted with the SDC (Staff Development Coordinator) on 3/11/20 at 9:50 a.m. She indicated Resident J informed her the previous day that she wasn't receiving her spa bathing. Resident J should have received bathing since 3/4/20 and she was unsure why she didn't. The Supporting Activities of Daily Living policy was provided by the SDC on 3/11/20 at 10:30 a.m. It indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care.) 3.1-(b)(2)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assure Ted hose were applied, to inform the physician of a weight gain and to administer a resident's medication, as ordered, for 1 of 2 resident's reviewed for [MEDICAL CONDITION] and 1 of 1 resident reviewed for respiratory care. (Resident H and Resident N) Findings include: 1. The

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) clinical record for Resident N was reviewed on 3/9/2020 at 11:09 a.m. The resident's [DIAGNOSES REDACTED]. On 3/9/2020 at 11:09 a.m., Resident N was observed sitting in her wheelchair in the hallway. She had swelling in both of her lower legs and they appeared tight and shiny. A physician's orders [REDACTED]. A physician's orders [REDACTED]. The weight record for Resident N was reviewed on 3/10/2020 at 2:10 p.m. The resident's weight was 142.2 pounds on Friday, 2/28/2020, and 148.7 pounds on Tuesday, 3/3/2020. There was no indication in the clinical record that the physician had been notified of the 6.5 pound weight gain. On 3/10/2020 at 1:17 p.m., Resident N was observed sitting in her wheelchair in the hallway. She had on white ankle socks and shoes. She was not wearing Ted hose. On 3/11/2010 at 10:30 a.m., Resident N was observed sitting in her wheel chair in the activity room. She was wearing white ankle socks and shoes. She was not wearing Ted hose. During an interview on 3/11/2020 at 10:38 a.m., LPN (Licensed Practical Nurse) 12 indicated the Ted hose had been documented as being applied that morning. She was unsure why Resident N was not wearing them. During an interview on 3/11/2020 at 10:45 a.m., CNA (Certified Nursing Assistant) 2 indicated she was assigned to care for Resident N. She had not removed her Ted hose and that they had not been on when she began caring for her that morning. During an interview on 3/11/2020 at 11:45 a.m., the DON (Director of Nursing) indicated the physician should have been notified of Resident N's weight gain on 3/3/2020 and that her Ted hose should have been applied, as ordered by the physician. 2. The clinical record for Resident H was reviewed on 3/9/20 at 10:30 a.m. The resident's [DIAGNOSES REDACTED]. The nurse's note, dated 3/7/20, indicated While doing treatment noted resident coughing repetitively and productive with clear mucous. Resident stated the cough started last evening and she just doesn't feel well. Afebrile at this time. New orders for [MEDICATION NAME] 4 times daily X (times) 7 days, [MEDICATION NAME] 10mL po (by mouth) 4 times daily X 7 days and 02 (oxygen) as needed to maintain sats > (saturations above) 90%. The nurse's note, dated 3/8/20, indicated res (resident) tested positive for Flu A, standing orders added to mar (medication administration record .) The physician's orders [REDACTED]. They indicated for 10 mL of cough syrup to be administered 4 times daily for 7 days from 3/9/20 through 3/16/20. The March, 2020 MAR indicated Resident H received no administrations of [MEDICATION NAME] on 3/9/20 and only one administration of cough syrup on 3/9/20. On 3/11/20, she received only one administration of cough syrup, because the medication was unavailable for the other 3 doses. An interview and observation was conducted with LPN (Licensed Practical Nurse) 11 on 3/12/20 at 10:30 a.m. She reviewed the MAR and indicated she was unsure why Resident H only received one administration on 3/9/20 and 3/11/20. She removed Resident H's cough syrup from the medication cart. The label was dated 3/11/20. An interview was conducted with UM (Unit Manager) 15 on 3/12/20 at 10:59 a.m. She indicated the pharmacy changed the order in the computer from [MEDICATION NAME] to cough syrup on 3/9/20 and when doing so, made the first dose of cough syrup not due until 7:00 p.m., which caused the first 3 doses of the day to be missed, and on 3/11/20, the medication was unavailable for administration of the first 3 doses. Resident H should have received all 4 doses on 3/9/20 and 3/11/20. The Medication Administration: General Policies & Procedures were provided by UM 15 on 3/12/20 at 12:00 p.m. The policy indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 3.1-37(a)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure preventative interventions were in place for a resident for mobility related to contact guard assistance for 1 of 3 residents reviewed for accidents. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/11/20 at 2:30 p.m. The [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) Assessment, dated 2/18/20, for Resident D indicated the resident's functional status that included transfer, walk in room, walk in corridor, locomotion on and off unit was limited assistance staff provide guided maneuvering of limbs or other non-weight bearing assistance with one staff person assistance. Resident D was coded as not steady and needed assistance for balance during transitions and walking, moving from seated position, walking with assisted device, and turning. The resident's cognition was intact. The care plan, dated 2/17/20, indicated Resident D was .at risk for falling and fall related injuries related to weakness r/t (related to) UTI (Urinary Tract Infection) .Approach start date, 2/17/20, assist with ADLs (Activities of Daily Living) as needed to meet needs .Approach start date, 2/17/20, assist with transfers as needed .Approach start date 2/17/20, cue/remind resident to utilize call light to seek assist as needed .Approach start date 2/17/20, hang sign in room to remind pt (patient) to call for assistance before transferring or ambulating alone . The ADL care plan, dated 2/17/20, indicated .resident (D) is unable to independently perform late loss ADLs r/t UTI, and requires assistance/encouragement for bed mobility, transfers, toileting and eating .Approach start date 2/17/20, assist/encourage resident in proper transfer, bed mobility, toileting/hygiene and eating techniques as needed .Approach start date 2/17/20, follow PT (Physical Therapy) / OT (Occupational Therapy)recommendations .Approach start date 2/17/20, Provide assistance for transfers as indicated . The Physical Therapy Plan of Care, dated 2/17/20, indicated .Treatment Diagnosis: [REDACTED].Reason of Referral: Pt referred to PT services following recent hospitalization due to altered mental status and UTI indicated need of skilled PT interventions to address weakness and decline in safe functional mobility .Therapy Necessity: Therapy necessary for strengthening, to improve balance, to improve gait stability, and reduce fall risk .Precautions: .fall risk, impulsive, impaired safety awareness .Initial Assessment: .current level was high risk for falls .Mobility I. Walk .Supervision or touching assistance. Helper provides verbal cues and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently . The Physical Therapy Note, dated 2/17/20, indicated Resident D required minA(minimal assistance) /CGA with cues for safety and sequencing for standing balance. Performed gait training with RW (rollator walker) requiring minA (requires 25% assistance or less or support to safely complete a task/transfer/ ambulation) and cues for safety and sequencing due to impulsiveness and balance impairments . The Physical Therapy Note, dated 2/19/20, indicated Resident D had complaints of being tired during therapy session and refused to continue with therapy. During session, she was able to ambulate with contact guard assistance. The Physical Therapy Note, dated 2/20/20, indicated Resident D was needing minimal assistance to maintain balance. The resident standing balance of reaching for object, stepping forward, throwing object, and then returning to neutral stand requiring min A (minimal assistance) to maintain balance . The Physical Therapy Note, dated 2/21/20, indicated Resident D's gait training required contact guard assistance. The therapist worked on safety awareness to decrease impulsiveness and required verbal cues to lock brakes on walker prior to sitting . Resident D completed transfer training from walker, recliner, and commode with CGA and verbal cues for safety . A nursing progress note, dated 2/18/20, indicated Receives therapy on day shift r/t weakness & UTI .Assist of one staff for ambulation, dressing, hygiene, bathing and ADLs . A nursing progress note, dated 2/19/20, indicated A/O with confusion. Assist of 1 for transfers and ADLs but is non-complaint and will get up on own .Continues on antibiotics for UTI .Therapy for weakness r/t UTI. A nursing progress note, dated, 2/21/20 at 3:23 p.m., indicated A/O X 3 with confusion. Assist of 1 for transfers, toileting and ADLs. Resident does get up on own to go to bathroom using walker and found in dining room during breakfast using w/c (wheelchair) like a walker to get coffee. Was reminded it is unsafe to use a w/c in this way and needs have someone with her. Requested pain med x (times) 1 at 1:30 p.m. This RN (Registered Nurse 10) was at her med cart when approached. Resident was using walker. She sat down on her walker waiting for medication. Handed her medication and she leaned forward to throw away med cup and walker rolled out from under her and she fell to floor. Resident did not hit her head but rolled from bottom to back. She immediately c/o (complaints of) lower back pain .Assessed lower back and no areas noted but resident said painful to very light touch. PT (Physical Therapy) and nurse manager present and assisted resident to w/c in sitting position .called and order for X-ray lumbar, pelvic and Bil Hips .Resident receives therapy for weakness r/t UTI. The Fall Assessment, dated 2/21/20, indicated .Resident was reaching forward from sitting position on rollator bench to throw med cup away and rollator rolled back and resident lost balance and fell backwards on bottom, She forgot to lock rollator and it rolled away and she fell . A Computed Tomography (CT) scan, dated 2/24/20, indicated Resident D had CT scan completed due to pain after a fall that occurred on 2/21/20. The results indicated acute fracture superior portion of L2 (second vertebrae in the lumbar spine). An interview was conducted with RN 10 on 3/12/20 at 10:09 a.m. She indicated Resident D had ambulated using her rollator to the medication cart and asked her for a pain pill. The resident at that time was standing with her rollator. RN 10 turned to the cart and pulled the medication for the resident. RN 10 turned back to Resident D and had noticed the resident had transferred herself to the seat of the rollator. RN 10 then administered the medication to the

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) resident in the seated position. She did not notice the rollator was unlocked. RN 10 then reached out her hand to take the empty cup, and Resident D indicated she could do it herself. The resident then leaned over to throw away the empty medication cup in the trash, and as she reached out she rolled down the rollator as it rolled backwards. An interview was conducted with Resident D on 3/12/20 at 10:20 a.m. She indicated she had sat on her rollator at the medication cart to take some medication. After taking the medication, she went to throw away her cup in the trash. As she reached to throw the cup away she fell out of the rollator as it moved backwards. She had not locked the rollator prior to sitting and neither did RN 10. I'm in a lot of pain, cause now my back is broke. An interview was conducted with the Physical Therapist Supervisor on 3/12/20 at 10:34 a.m. She indicated to safely transfer using a rollator, step one was to lock the brakes while standing prior to transferring to the seat. The abbreviation CGA stands for contact guard assistance. CGA required stand by assistance with staff present with minimal touching of the resident. The staff's hands are on the resident with contact guard assistance. The therapy department was currently working with Resident D using the rollator for safety awareness. She just gets up and does not lock the brakes. She needs verbal cuing to lock the breaks of the rollator. An interview was conducted with Physical Therapist 15 on 3/12/20 at 10:43 a.m. He indicated he had been working with Resident D using a rollator. She uses a rollator at home, and she could use a rollator better than a rolling walker. The rollator was stored in the resident's room in the bathroom. The resident had fallen on 2/20/20, due to the rollator was not locked. Resident D does need cueing. She was noncompliant with asking for staff assistance. There are times she locks the rollator and other times she does not. Resident D was known for impulsiveness of getting up without assistance and unsafe transfers. The type of assistance needed was communicated to the nursing staff. Resident D's assistance needed using her rollator was minimal assistance and contact guard assistance. A Safety and Supervision of Residents policy was provided by the Nurse Consultant on 3/12/20 at 1:52 p.m. It indicated .Policy Statement. Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation .Individualized, Resident-Centered Approach to Safety .3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce resident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff;c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness or new or revised interventions .Systems Approach to Safety. 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a system approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety . A policy titled Fall Prevention Policy and Procedure, dated May of 2016, was provided by the DON on 3/11/20 at 12:25 p.m. The policy indicated the following, .The purpose of this policy is to provide CarDon communities with best practices and evidence-based approaches to prevent falls and protect residents who are at risk for falling .Accurate documentation of fall risks and falls provides a clinical picture of a resident and is utilized in developing their plan of care .Fall prevention and fall intervention educational material will be made available to all direct care associates on an ongoing basis This federal tag relates to Complaint IN 235. 3.1-45(a)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper infection control practice while delivering room trays to a room where contact precautions were in place for 2 of 3 residents observed with room trays. (Resident F and Resident G) Findings include: An observation was conducted of room trays, on 3/10/20 at 1:05 p.m., with Certified Nursing Assistant (CNA) 2. CNA 2 obtained a room tray for Resident G from the main dining room. CNA 2 proceeded to take the tray into Resident G's room, with no gloves or gown in place, and set the tray down. There was a cart containing gloves, wipes, and gowns noted prior to entrance into Resident G's room. CNA 2 left Resident G's room without performing hand hygiene. CNA 2 went back into the main dining room and washed her hands at the sink. CNA 2 obtained a room tray for Resident F and set the tray down in Resident F's room, which is shared with Resident G. CNA 2 did not have a gown or gloves in place while delivering the tray to Resident F. CNA 2 left Resident F's room without performing hand hygiene. CNA 2 went back into the main dining room and utilized hand sanitizer before obtaining water for Resident F and taking it back into Resident F's room without utilizing a gown or gloves. CNA 2 left Resident F's room, without conducting hand hygiene, and went back into the main dining room and washed her hands with soap and water at the sink that resides in the main dining room. The clinical record for Resident F was reviewed on 3/11/20 at 10:00 a.m. The [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. There was no stop date to the physician's orders [REDACTED]. A policy titled Infection Control Precautions, dated October of 2014, was provided by the Administrator on 3/10/20 at 1:55 p.m. The policy indicated the following, .Handwashing .performed before and after any direct patient contact and between patients, whether or not gloves are worn. Immediately after gloves are removed . After touching blood, bodily fluids, secretions, excretions, non-intact skin, and contaminated items, even if gloves are worn .Contact precautions: are intended to prevent transmission of (known or suspected) infectious agents .Personal protective equipment should be removed while in the resident's room and disposed of in the normal trash receptacle .A gown and gloves must be worn at all times while tending to the resident in contact isolation if any contact is going to be made with the resident or the environment 3.1-18(a)
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 record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance by prescribing and administering antibiotics for not true infections based on the McGreers Criteria, and not having quarterly meeting, which included the Medical Director, to review the use of antibiotics for 2 of 5 residents reviewed for Antibiotic Stewardship. (Resident L and Resident R) Findings include: 1. The record for Resident L was reviewed on 3/12/20 at 11:59 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The resident's medication administration review (MAR), completed on 3/12/20 at 11:59 a.m., indicated Resident L had received daily doses of Keflex for the months of December 2019, January 2020, February 2020 and up to current March 2020. An order placed on 6/17/2017, indicated Resident L had a code status of Do Not Resuscitate with post orders of: limited additional interventions, use antibiotics for infection only if comfort cannot be achieved fully through other means, no artificial nutrition. An interview with the Staff Development Coordinator (SDC) on 3/12/20 at 11:09 a.m. indicated the facility uses the McGreers Criteria as the basis for the antibiotic stewardship program and that the McGreers criteria does not indicate the use of antibiotics for [MEDICATION NAME] use nor indefinite use. SDC stated, I should have reached out to the physician to talk about the continued use of an antibiotic for [MEDICATION NAME] measures. The facility was unable to provide any lab cultures indicating the positive presence of an organism within the coccyx pressure wound for the past year. 2. The clinical record for Resident R was reviewed on 3/10/2020 at 2:30 p.m. The resident's [DIAGNOSES REDACTED]. Resident R was admitted to the facility on [DATE]. Hospital records, dated 5/6/19, indicated the resident had a [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. There was no stop date for the order. A physician's orders [REDACTED]. The antibiotic was discontinued on 2/8/20. A physician's progress note, dated 7/3/19, indicated Resident R had recurrent UTIs and was on [MEDICATION NAME] daily. The antibiotic was to be continued. A physician's optum progress noted, dated 2/3/20, indicated Resident R was seen due to confusion. She had urinary cultures completed and results obtained with Escherichia coli (E. coli) bacteria. Resident R currently on a daily preventive dose of [MEDICATION NAME] for recurrent UTIs . The February 2020 Medication Administration Record [REDACTED]. The February 2020 MAR indicated [REDACTED]. An interview was conducted with Staff Development Coordinator (SCD) on 3/10/20 at 2:38 p.m. She indicated Resident R had been placed on [MEDICATION NAME] for prevention of UTIs since admission in July. The resident currently was still on it for prevention. SCD handled the antibiotic stewardship program, but had not addressed the resident's antibiotic usage that had been administered [MEDICATION NAME]. Resident R had a urine culture obtained in February and was placed on the antibiotic [MEDICATION NAME] to treat the infection. During an interview on 03/12/20 at 11:45 a.m., the SDC indicated that meeting of the Infection Prevention and Control Committee, which included the Medical Director, were not being held quarterly to review antibiotic use patterns, culture results, and antibiotic resistance. The Infection Prevention and Control Program was provided by the Administrator on

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F 0881 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) 3/9/20 at 3:00 p.m. It indicated .1. Coordination and Oversight. The Infection Prevention and Control Program is coordinated and overseen by an infection prevention specialist .C. The Infection Prevention and Control Committee is responsible for reviewing and providing feedback on the overall program. 1. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: a. Whether physician management of infections is optimal; b. Whether antibiotic usage patterns need to be changed because of the development of resistant strains; c. Whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion, and d. Wheather there is appropriate follow-up of acute infections. 2. The committee meets regularly, at least quarterly, and consists of team members from across disciplines, including the Medical Director . 3.1-18(b)(1)