STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525292	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONROE HEALTH SERVICES	516 26TH AVE MONROE, WI 53566

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 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 interview and record review, the facility did not ensure each residents drug regimen is free from unnecessary drugs in 1 of 14 residents reviewed (R26). An unnecessary drug is used in the presence of adverse consequences, which indicate the dose should be reduced or discontinued, or without adequate indications for use. R26 was re-prescribed a medication after a previous adverse reaction to the same medication. Evidenced by: The facility's Medication Reconciliation Guideline, with a last review date of 11/11/2015, states, in part: Guideline Statement: Medication Reconciliation is intended to eliminate medication errors or discrepancies during care transitions by generating a complete and accurate list of the resident's current medications. --Medication reconciliation is completed within 24 hours of admission --Information needed for medication reconciliation: - Hospital Discharge orders or other transferring center's orders -admission orders [REDACTED]. --The nurse performing the Medication Reconciliation will compare each component of every Hospital Discharge Order with the corresponding handwritten admission orders [REDACTED]. --The nurse performing the Medication Reconciliation will then compare the admission orders [REDACTED]. --The admitting nurse will contact the admitting physician to clarify any discrepancies, as necessary, and will document the necessary order clarification in the admitting orders as well as in PointClickCare. He/She will report any clarifications to the Director of Nursing and to the pharmacy, as needed . Example 1 R26's initial admitted to the facility was 10/16/19, and [DIAGNOSES REDACTED]. R26's Quarterly Review Assessment Minimum Data Set (MDS), with a target date of 1/29/20, indicates a Brief Interview for Mental Status (BIMS) summary score of 14, cognitively intact. On 3/10/20 at 4:25 PM, Surveyor interviewed R26 during the initial screening process and asked if she had been hospitalized in the last 4 months. R26 stated that she believes she received a medication for her [MEDICAL CONDITION] that wasn't right, and was sent to the hospital because she was hallucinating. R26's nursing notes dated and timed 10/17/19 at 6:24 PM note, in part: It was reported to me that the res had [MEDICAL CONDITION] behavior at lunch: blank stare, dropping her face for a few second. The res became more lethargic. Responding to tactile stimuli .Orders to sent to res to ER to evaluation (sic) . R26's Hospitalist Service H & P (History and Physical) dated 10/18/19, notes in part: .HPI (History of Present Illness) .Throughout the day today and appears patient had multiple episodes of [MEDICAL CONDITION] activity where she tested her head to the side and then had a blank stare. These episodes lasted about 5 minutes and started after lunch . (sic) Hospital Plan: Altered mental status: I suspect the patient's altered mental status is due to [MEDICATION NAME] . The Hospitalist Discharge Summary, dated 10/22/19, notes in part: .HPI: .admitted [DATE] with mental status changes thought due to [MEDICATION NAME] .Hospital Course: .[MEDICATION NAME] held and she is more alert . (Of note, [MEDICATION NAME] is not listed on list of discharge medications to continue.) R26's Admission Physician Orders, with a reviewed date of 10/17/19, reflect the following: [MEDICATION NAME] 10mg tab - 2 tabs (20mg) TID (three times a day) - AM; NOON: PM . (Of note: the allergy section is blank) R26's Re-admission Physician order [REDACTED]. (Of note: the allergy section is blank) R26's October 2019 MAR (Medication Administration Record) notes the following: [MEDICATION NAME] 10 mg tab - 2 tabs (20mg) po (by mouth) TID - AM; NOON; PM. There are three doses signed out by nursing staff: 10/16/19 - PM; 10/17/19 - AM; and 10/17/19 - NOON. (Of note: the allergy section of the October MAR indicated [REDACTED].discovered that MD (Primary Physician Name) had sent e-message on [DATE] re: December 2019 med lists from (Ortho Department Name) and Primary Clinic (Primary Clinc Name) not correlating. (Primary Physician Name) MD response: For now, lets add the medications from (Ortho Department Name) ortho . -- 12/25/19 at 11:07AM note, in part: Resident had new orders for medication that were previously not put on MAR (Medication Administration Record). Was able to give [MEDICATION NAME] . -- 12/26/19 at 8:00AM note, in part: CNA (Certified Nursing Assistant) noted change in mental condition and alerted this writer. Found resident in bed. Very lethargic, speech more thick garbled than usual, diff following commands. Left arm somewhat flaccid. Unable to lift/bend knees/legs .Ambulance called . R26's Hospital Discharge Summary datesd 12/26/19 to 12/31/19, notes in part: .Principle Problem: Altered mental status due to absence [MEDICAL CONDITION] vs [MEDICATION NAME] side effects (10/17/19) .History .During her admission in [DATE], [MEDICATION NAME] was thought to be the cause of her altered mental status because pt (patient) had rapid improvement after it was stopped. But at NH (Nursing Home) it was restarted again yesterday and pt got 20 mg TID .Hospital Course: .Stopped [MEDICATION NAME] and added on allergy list to prevent this from happening again . R26's Physician order [REDACTED].(Of note: Allergy section notes [MEDICATION NAME]) R26's December 2019 MAR (Medication Administration Record) notes the following: [MEDICATION NAME] 20mg po (by mouth) TID - AM; NOON; HS. There are three doses signed out by nursing staff: 12/25/19 - AM; 12/25/19 - NOON; and 12/25/19 - HS. (Of note: the allergy section of the December MAR indicated [REDACTED]? ADON C stated that they use the discharge summary or the after visit summary to reconcile the medication list. ADON C stated that it depends on when they come into the facility as to who completes this, but a lot of times he will start the reconciling. Surveyor asked ADON C when he would not be the one completing this. ADON C stated, if the resident came in after he had left or when he wasn't in the building it would then be the responsibility of whoever is on the unit where the resident is being admitted or going back to. At the time of the hospitalization s for R26, the previous DON was responsible for reconciling the medication list and reviewing the discharge summary. DON B stated, their process is the nurse reconciling reads the summary and then the second nurse only notes the medications. Surveyor asked ADON C if he reviews the allergies [REDACTED]. ADON C stated, yes, but the discharge paperwork said no known allergies [REDACTED].? Both were in agreement the same nurse that completes the reconciliation. Surveyor asked, who would be responsible for reconciling a new allergy or medication intolerance upon return from the hospital? DON B and ADON C were in agreement that the same nurse completing the reconciliation would be responsible to add the allergy or intolerance and would need to contact the doctor to get permission to add it. Surveyor started to ask, DON B and ADON C, in regard to R26, when she was admitted to the facility on [DATE] and was on [MEDICATION NAME], DON B stated, yes, the resident came to the facility and was getting [MEDICATION NAME] and then went out to the hospital. Surveyor asked DON B, if when R26 returned from the hospital on [DATE], would she have expected the [MEDICATION NAME] to have been added to the facility allergy list. DON B stated, yes. Surveyor asked DON B and ADON C, if in December R26 was put back on the [MEDICATION NAME] and again was sent to the hospital after receiving it. DON B stated, Correct and then the doctor added it to the allergy list, yes.
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 observation, interview, and record review, the facility did not establish and maintain an Infection Prevention and Control Program to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, which has the potential to affect all 38 residents. The facility did not calculate or track monthly segregated rates for each specific type of infection in the facility or complete mapping for all infection types to track and trend potential concerns. The monthly infection control line list also classified numerous infections for residents who have resided in the facility long term to be community acquired. Tracking of signs or symptoms of potential infection is not evident, only those that are prescribed an antibiotic. The facility did not set up conferred

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) rights to comply with the mandate for data sharing access for DPH (Department of Public Health) related to CRE reporting (Carbapenem-resistant [MEDICATION NAME]) to NHSN (National Healthcare Safety Network). R37 was not placed on precautions, despite a [DIAGNOSES REDACTED]. The facility did not follow their isolation policy and place R37 on precautions with an active case [MEDICAL CONDITION] and did not follow up with the hospital and receive crucial lab results related to infections. Poor hand hygiene was observed during wound care for R36 and R6. R29 was observed to have used urinal unemptied on his nightstand and visible liquid residue on the nightstand under on multiple occasions. R29 was also observed to have urine on the floor in his room with evidence that he had wheeled through it and staff members had walked through it. This is evidenced by: The facility policy titled Infection Control Prevention Program, with a date of 1/2017, which states 1. Coordination and Oversight A. Infection Control Officer (ICO) - The center will designate an Infection Control Officer. The ICO assumes responsibility of oversight of the Infection Control (ICP) program on a day to day basis. Daily tasks listed include, 1. Infection Control Log, 2. Facility Spot Map, 3. Infection Report (for each infection) using the Criteria for Determining an Infection - a. File report in the clinical record/scan to the EMR (Electronic Medical Record). The facility policy, titled Guidelines [MEDICAL CONDITION], dated 2017 indicates The main mode of transmission [MEDICAL CONDITION] is via hands (especially health care workers' hands) which may become contaminated by contact with a) colonized or infected residents, b) colonized or infected body sites of the personnel themselves, or c) devices, items, or environmental surfaces contaminated with body fluids [MEDICAL CONDITION]. Contact Precautions are recommended by the CDC (Center for Disease Control) to control the spread [MEDICAL CONDITION]. The facility policy also indicates transfer of a resident on Contact Precautions, Limit the movement and transport of the resident from the room to essential purposes only. If the resident is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment. The facility policy titled Handwashing/Hand Hygiene, dated 2001 and last revised August 2012, reads, This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation state, in part . Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . c. Before and after direct resident contact . h. Before and after assisting a resident with personal care . k. Before and after changing a dressing; l. Upon and after coming in contact with a resident's intact skin . n. Before and after assisting a resident with toileting . r. After handling soiled or used linens, dressings, bedpans, catheters and urinals; s. After handling soiled equipment or utensils . u. After removing gloves or aprons. The policy indicates that alcohol-based hand rub is the preferred method of hand hygiene in most situations. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations . These include: before and after direct contact with residents; before donning sterile gloves; before performing any non-surgical invasive procedures; before preparing or handling medications; before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and after removing gloves. 7. Hand Hygiene is always the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene. Example 1 On 3/12/20 at 9:30 AM, Surveyor spoke with ADON C, who took over as the facility Infection Control Officer beginning the first of this month. Reviewed that several residents on the line list were marked to have community acquired infections, not healthcare-associated infections (HAI) despite being a long term resident. Surveyor asked how this was determined for a resident and ADON C stated, I wasn't doing infection control at that time, so I can't answer that. Surveyor reviewed facility infection control maps with ADON C, who stated he was not sure why all infections had not been mapped throughout the facility previously, but that he plans to include those that were not done previously. Surveyor requested infection rates. ADON showed Surveyor monthly infection summary logs, which had calculated rates for infections as a whole. Surveyor asked if the facility was tracking segregated rates, and ADON C stated they were not at this time. Example 2 Surveyor reviewed for R37's most recent hospitalization . Hospital records from discharge indicate R37 was on antibiotics for pneumonia with [MEDICAL CONDITION] and sputum cultures were pending. Surveyor requested a copy of sputum cultures that were not available in R37's chart. On receiving and reviewing sputum cultures the report indicates that R37 is positive [MEDICAL CONDITION] ([MEDICAL CONDITION]-resistant Staphylococcus aureus). R37 was not put on transmission based precautions upon returning to the facility. R37 was observed coughing on multiple occasions without covering a productive wet sounding cough. The facility did not do any training or education with R37 in proper cough etiquette and R37 was not currently using cough etiquette, such as, coughing into a tissue or basic hand hygiene. On 3/12/20 at 1:43 PM, Surveyor interviewed ADON C. Surveyor asked ADON C if he had ever received or reviewed R37's sputum cultures from the hospital prior to this discussion. ADON C stated, No. Surveyor then asked ADON C if R37 was placed on precautions at any time following his return to the hospital on [DATE]. ADON C stated, No. Surveyor asked ADON C if R37 should have been placed on precautions. ADON C stated, Absolutely. Example 3 On 3/12/20 at 9:35 AM, Surveyor observed LPN D complete a dressing change to R36's right gluteal fold, with the assistance of CNA E. R36 was positioned on her right side. LPN D unstrapped R36's incontinent brief and tucked soiled the brief under R36. LPN D then removed her gloves and did not perform hand hygiene. LPN D touched the towel in the dressing bin and said she did not bring in a bag for waste. LPN D touched the doorknob, went out to medication cart, and returned to the room with a bag. LPN D then washed her hands and put on new gloves. Without first cleaning the scissors, LPN D cut open a collagen packet to use for R36's wound treatment order. LPN D cleansed the wound per order and then removed gloves. Without performing hand hygiene, LPN D put on new gloves and completed the treatment. LPN D then moved soiled brief out of the way to reposition R36. CNA E, who was in the room to assist with positioning, picked up the soiled brief with gloves on and threw it away, then removed her gloves. CNA E then proceeded to position pillows under resident prior to washing her hands. Meanwhile, LPN D removed dressing supply bin from the resident's room and placed it on the medication cart. Surveyor asked if each resident had their own supply bin and LPN D stated, We try to. Surveyor asked what they do with the bin and items in it after dressing changes. LPN D indicated they are taken back to the 300/400 wing nurses' station to store and be re-stocked. Surveyor did not observe LPN D clean scissors before or after dressing change. Example 4 On 3/10/20 at 9:47 AM, Surveyor observed a dressing change for R6 with LPN D (Licensed Practical Nurse). After removing old dressings, cleansing each wound and applying new dressings, LPN D removed gloves and put on new gloves. With 3 of 10 glove changes LPN D did not wash hands and on 5 others LPN D washed hands for approximately 5 seconds before drying hands and putting on new gloves. On 3/10/20 at 10:03 AM, an interview was conducted with LPN D. LPN D was asked if hands should be washed and sanitized with each glove change. LPN D stated, Yes. Surveyor asked LPN D how long you should wash hands for when using soap and water. LPN D stated, 15-20 seconds. Example 5 R29 was observed to have used urinal unemptied on his nightstand and visible liquid residue on the nightstand under on multiple occasions. R29 was also observed to have urine on the floor in his room with evidence that he had wheeled through it and staff members had walked through it. On 3/10/20 at 10:19 AM, Surveyor observed R29 sitting in his room with a used urinal on his nightstand, which was visible from the hallway. R29 has a BIMS (Brief Interview of Mental Status) score of 13, indicating intact cognition. Surveyor asked R29 about using the urinal and if staff help him to the restroom. R29 stated, I get too many water pills. I have to go all the time. R29 said he doesn't put the call light on because by the time they come I wouldn't make it in there. Surveyor asked if staff empty his urinal for him and he stated, Yes. They come in every so often and empty it. R29 was attempting to put new batteries in his hearing aid at the time and requested assistance. On 3/10/20 at 10:24 AM, ADON C assisted R29 with batteries, and at 10:25AM, ADON C left R29's room. R29's urinal remained on the nightstand with yellow urine inside. Surveyor made a closer observation of the nightstand and observed visible liquid-like, partly dried residue under urinal opening. On 3/10/20, at 11:08 AM, Surveyor walked past R29's room and observed R29's roommate, R19, to now be sitting up in wheelchair. R29's urinal remained on nightstand with yellow urine inside it, visible from the hallway. R19 is dependent on staff for transfers, indicating facility staff had been in the room and did not empty R29's urinal. On 3/10/20, at 2:26 PM, Surveyor observed urinal and yellow urine inside of it from the hallway again. Surveyor knocked and entered room to speak with R29 who indicated no one had come in to empty the urinal yet today. Surveyor observed the drying liquid residue on nightstand to be about the size of a baseball. On 3/10/20, at 3:37 PM, Surveyor observed the urinal with approximately twice the amount of urine in it as the previous observation. At 3:58 PM, Surveyor asked R29 what he does if the urinal gets too full and he stated he just dumps it out in the sink. R29 shares a room and the sink is in the main living quarters, as the shared restroom only contains a toilet. On 3/11/20 at 7:25 AM, Surveyor observed urinal sitting on R29's nightstand with yellow urine. At 4:08 PM, Surveyor was in R29's room to make observation of his roommate, R19. Three CNAs (Certified Nursing Assistants) were in the room at this

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) time. Surveyor observed R29's urinal sitting on nightstand with urine in it. After the CNAs were finished with transferring R19, all three left the room without anyone emptying the urinal. On 3/12/20 at 7:50 AM, Surveyor observed R29's urinal on his nightstand with urine in it. At 10:23 AM, Surveyor observed approximately three times the amount of urine in R29's urinal as previously observed, sitting on the night stand. Surveyor observed yellow liquid on the floor near the sink at R29's closet. On 3/12/20, at 10:47 AM, Surveyor spoke to Housekeeping F, who indicated that she observes R29's urinal with urine in it unemptied on a daily basis. Observed dirty nightstand and floor both with apparent liquid and liquid residue, which Housekeeper indicated was pee and that area is where R29 pees. She states housekeeping is not supposed to clean up bodily fluids, but she plans to mop the floor and hasn't gotten to that side (of the hallway) yet. Surveyor observed wheelchair tracks through the urine on the floor. On 3/12/20, at 11:05 AM, Surveyor spoke with CNA E, who informed Surveyor that the CNA assigned to each specific hallway is responsible for dumping out a resident's used urinal, but if they are independent, the resident can do it themselves. Surveyor asked where a resident would dump out their own urinal and CNA E said, In the toilet. On 3/12/20, at 11:14 AM, Surveyor spoke with DON B regarding infection control concerns with R29's urinal. Together Surveyor and DON B observed R29's nightstand and floor. DON B acknowledged they were dirty and that she would take care of it right away. Informed DON B of multiple observations of unemptied urinal, staff in room without assisting R29 with urinal, and that R29 indicated he dumps it in the sink if it gets too full. Example 6 On 3/12/20 at 9:45 AM, Surveyor spoke with ADON C regarding CRE reporting to NHSN. ADON C believed the previous DON (Director of Nursing) used to do this. On 3/12/20 at 10:00 AM NHA A (Nursing Home Administrator) informed Surveyor that the facility was in the process of enrolling a current staff member to report to NHSN. Surveyor contacted DPH (Department of Public Health) to verify whether facility had been reporting CRE prior to change in DON position and found that the facility did not have conferred rights.
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 interview and record review, the facility did not ensure that their Antibiotic Stewardship Program included a system for antibiotic use protocols or to monitor for appropriate antibiotic use, which has the potential to affect 38 of 38 residents in the facility. The facility did not have a process in place to contemporaneously monitor resident symptoms of an infection, culture results or analyze if criteria was met for residents prescribed with antibiotics. R26 was readmitted to the facility after a hospital stay on an antibiotic for UTI (Urinary Tract Infection) despite provider hospital notes stating they didn't feel R26 had a UTI. There is no documentation to indicate the facility contacted the provider to determine if it was appropriate to continue the antibiotic and to provide a rationale. R37 received orders for urine labs and antibiotic without meeting criteria and the facility did not request a rationale from the provider. R100 did not meet infection criteria to have urine tested for UTI (Urinary Tract Infection) and started an antibiotic for UTI prior to culture results, leading to her getting an inappropriate antibiotic which the pathogen was resistant to. R18 started an antibiotic in February 2020 for UTI prior to culture results without rationale requested from provider, and in November 2019, R18 was put on an antibiotic and continued on it without a request for rationale after it was documented R18 had returned to baseline. R30 received orders for urine labs and antibiotic without meeting criteria and the facility did not request a rationale from the provider. This is evidenced by: The facility policy titled, Infection Prevention and Control Manual Antibiotic Stewardship & MDROs, dated 2017. The policy states, Antibiotic stewardship refers to systematic efforts to optimize the use of antibiotics - not just reduce the total volume used - to maximize their benefits to patients, while minimizing both the rise of antibiotic resistance as well as adverse effects to patients from unnecessary antibiotic therapy. The policy goes on to state, Stewardship involves identifying the microbe responsible for disease, utilizing evidence based definitions when indicated; selecting the appropriate antibiotic along with documentation indicating the rational for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed. The policy lists steps of the procedure related to antibiotic stewardship, which includes: 1. When the nurse suspects that the resident has an infection, the nurse will perform an evaluation of the resident that includes: a. Resident signs and symptoms i. Complete set of vital signs ii. Interview of resident for symptoms iii. Assessment 2. The Nurse will utilize (McGeer's) infection criteria protocol to determine if it is necessary to treat with antibiotics or if adjustments in therapy need to be made. 3. Notify physician/practitioner of resident change of condition and evaluation information. The nurse to communicate to physician of infection criteria protocol to treat the respective infection. 4. When diagnostics are ordered by the practitioner, the nurse will contact the lab/radiology to notify of physician order. a. Physician will be notified of results of diagnostics to ensure resident is taking the appropriate antibiotic or if antibiotic needs to be discontinued or changed. 5. If indicated, based upon (identified) criteria, an antibiotic is ordered, the practitioner will identify the diagnosis/indication, the appropriate antibiotic, proper dose, duration and route. a. In the event that the prescribing physician orders [REDACTED]. The Medical Director will be contacted for further direction. 6. If the resident was admitted to the facility with an antibiotic ordered, the nurse is to identify: a. Indication for use (diagnosis, lab/radiology results, symptoms, etc.) b. Documentation for dose, route and duration (ensuring stop date) 7. The nurse will observe and document effectiveness of antibiotic, side effects and potential adverse consequences. a. Resident evaluation, vital signs and observations for symptoms will be identified and documented. b. Resident will be evaluated for signs/symptoms of [DIAGNOSES REDACTED]icile infection c. Resident will be observed for potential side effects of the antibiotic. 8. The antibiotic will be discontinued when no longer necessary. 9. The pharmacy consultant will review the antibiotic use for each resident on the Medication Regimen Review. 10. The Infection Preventionist will track antibiotic use and monitor adherence to evidence-based criteria, including: a. Documentation related to antibiotic selection and use b. Tracking antibiotics used to review patterns of use and determination of the impact of the antibiotic stewardship interventions c. Clinical outcomes such as rates of [DIAGNOSES REDACTED]icile infections, antibiotic-resistant Monitoring for organisms or adverse drug events d. Reporting of communicable disease per State Law e. Assist prescribing practitioners in choosing the right antibiotic using antibiograms f. Provide reports related to monitoring antibiotic usage and resistance data to the QAA committee 11. During the quarterly QAA Committee Meeting, The Pharmacist, Medical Director, Infection Preventionist and IDT will analyze the antibiotic use in the facility to collaborate with nursing and clinical leaders for identification of potential QAPI proess action plan related to analysis of the tracking and trending of data for quality outcomes. According to the Center for Disease Control and Prevention (CDC), Any medication can have serious side effects. For antibiotics, those side effects can include adverse drug reactions and [MEDICAL CONDITION] infection (CDI). Patients who are unnecessarily exposed to antibiotics are placed at risk for serious adverse events with no clinical benefit. The misuse of antibiotics has also contributed to the growing problem of antibiotic resistance, which has become one of the most serious and growing threats to public health. Example 1 The facility did not ensure complete tracking and monitoring of infections and antibiotics, as evidenced by incomplete monthly infection control logs (line lists). The monthly line list indicates insufficient monitoring of the use of McGeer's Criteria for ordering antibiotics. In November 2019, the line list showed the 200 wing had six treated infections, with five of those not indicating whether or not Infection Definition was met, while on the 300 wing 8 out of 10 treated infections were left blank in the column listed Infection Definition Met? In November, the 400 wing line list was also incomplete, showing a blank for the type of organism causing a UTI in one resident. In December the incomplete column listed Infection Definition Met? for 1 of 3 residents on the 100 wing, 3 of 3 residents on the 200 wing, and 5 of 6 residents on the 300 wing. In December there were two line list blanks for organism causing a UTI, one on the 300 wing and one on the 400 wing. Example 2 On 11/7/19, R100 was started on Bactrim 800/160mg one tab by mouth twice a day for three days for UTI. Nursing documentation in the electronic charting system and the facility form, Criteria for Infection Report Form - Urinary Tract Infections, indicate R100 had no fever, therefore criteria had not been met to warrant an antibiotic or order a urine culture. There is no documentation to indicate the provider was requested by nursing staff to identify rationale from the provider for ordering either. On 11/8/19 at 9:36 AM, the provider documented a note that R100's urine culture showed a resistance to Bactrim and that the order will switch [MEDICATION NAME] 3 days. Note indicates this will be sent to pharmacy and facility and Please d/c Bactrim. Despite this documentation, R100 still received both doses (AM and PM) of Bactrim on 11/8/19. The order [MEDICATION NAME] one tab by mouth daily x three days was started on 11/9/19. Example 3 On 2/6/20, R18 was placed on [MEDICATION NAME] 100mg 1 tab by mouth twice daily x 7 days for UTI, prior to urinalysis or urine culture results, but this order was discontinued on 2/10/20. Urinalysis notes on

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) 2/6/20 indicated the urine looked contaminated, cultures were pending, and Would wait till results available prior to prescribing anything. There is no documentation to indicate the provider was requested by nursing staff to identify rationale for ordering lab work or antibiotic. On 12/24/19, R18 was placed on [MEDICATION NAME] 200mg by mouth daily x 6 days after a visit to the ER. In the ER, R18 was diagnosed with [REDACTED]. On R18's return to the facility, there is no documentation of discussing antibiotic stewardship policy with provider or requesting a rational from the provider on rationale for beginning antibiotic. The facility did not document any further nurse's notes on R18 until 12/27/19. On 12/27/19, Nursing reported back to provider that R18 was back to baseline mental status, discussed urine culture result and continued antibiotic order. There is no documentation that nursing staff requested a rationale from provider for continuing the antibiotic despite the R18 not exhibiting any urinary symptoms and returning to her baseline. Example 4 On 2/18/20, R30 was placed on [MEDICATION NAME] 250mg 1 tab by mouth twice daily x 7 days for UTI. There is documentation that R30 had a fever, no urinary symptoms charted in nursing notes, and only dysuria listed on the February 2020 Monthly Infection Surveillance Log. The facility Criteria for Infection Report Form - Urinary Tract Infections does not show a fever or any other symptoms to indicate infection criteria was met, although it does note results of a urine culture. There is no documentation to indicate the provider was requested by nursing staff to identify rationale for ordering lab work or the antibiotic without meeting criteria. Example 5 On 12/31/19, R26 returned to the facility from the hospital on an antibiotic. R26 had an order for [REDACTED]. There is no documentation to indicate the provider was contacted or asked to provide a rationale for continuing antibiotic treatment upon return to the facility. Example 6 On 1/31/20, R37 was placed on [MEDICATION NAME] 100mg 1 cap by mouth daily x 7 days for UTI. The facility form Criteria for Infection Report Form - Urinary Tract Infections and nurse's notes do not indicate that R37 exhibited a fever. R37 did not meet criteria to warrant an order for [REDACTED]. Surveyor asked what the facility's process is for reporting symptoms or changes in a resident to provider when they could lead to an antibiotic order. ADON C stated, Whenever signs and symptoms come up we might contact the doctor to update on symptoms, make sure they fit into the criteria, see what cultures or UA (urinalysis) might be ordered. Surveyor asked what steps the staff would take if criteria for ordering labs or antibiotics is not met and the provider orders them anyway, and ADON C stated the facility would be expected to contact the provider with an update that the resident doesn't have they symptoms or criteria met and if they still wanted the order, ask them why and document it. Surveyor asked ADON C what the process is for residents admitted or readmitted to the facility on an antibiotic, and he indicated he would look in EPIC (hospital charting system) and the C&S (culture and sensitivity lab) results, look at allergies [REDACTED]. If the resident has no symptoms, ADON C stated he would contact the provider.
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 record review and interview, the facility did not offer each resident influenza immunizations and did not document in the resident's medical record, at a minimum, that the resident or the resident's representative received education on the benefits and potential side effects of the immunization for 1 of 5 residents (R32) reviewed for immunizations. The facility had no evidence that R32's HCPOA (Health Care Power of Attorney) was provided with information or the opportunity for R32 to receive the influenza vaccine for the 2019-2020 Flu Season. This is evidenced by: The facility's policy titled, Influenza Vaccine, last revised in December 2012 states, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives); for example, risk factors that have been identified for specific age groups . The policy indicates, in part . 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized . 4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. (See current vaccine information statements at www.cdc.gov/vaccines/pubs/vis/default.htm for educational materials.) . 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. According to the Center for Disease Control (CDC), people [AGE] years and older are at high risk of developing serious complications from flu, in part due to the immune system becoming weaker with age. In recent years, the CDC has estimated that between 70-85% of seasonal flu-related deaths have been in people age 65 and older, while those in this age group account for 50-70% of flu-related hospitalization s. R32 is a [AGE] year resident of the facility, with an admission date of [DATE]. R32's most recent annual MDS assessment (Minimum Data Set) revealed R32 had a BIMS score (Brief Interview of Mental Status) of 1, indicating severe cognitive impairment. R32 has an activated HCPOA. There is no evidence in R32's medical record that HCPOA G was provided information or the opportunity for R32 to receive the annual influenza vaccine. On 3/12/20 at 9:30 AM, Surveyor spoke with ADON C who indicated the facility did not have documentation that HCPOA G was offered or declined the vaccine for R32. ADON C did provide a form titled Pneumococcal and Annual Influenza Information and Request, which states the information was provided to R32 on 10/20/19, not to HCPOA G. On 3/12/20 at 3:15 PM, Surveyor spoke to HCPOA G on the telephone. Surveyor asked HCPOA G if she had been provided with information on the influenza vaccine for the current flu season and if she would have liked for R32 to have received the flu shot. HCPOA G stated, I think it is a good thing. I would want it. I think everyone should have a flu shot. People come and go in the nursing home. I think it is a good thing. I would say yes. I would want it. The facility has not experienced an influenza outbreak in the 2019-2020 season, and R32 has not displayed signs or symptoms of influenza.