STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035289	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Arrowhead, LLC	7201 W Camino San Xavier Ave Glendale, AZ 85308

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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 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. Based on clinical record review, interviews, and facility documentation and policy, the facility failed to ensure that one resident (# 207) was administered medications in accordance with physician's orders. This deficient practice can result in diminished quality of life, and suboptimal clinical outcomes. Findings include: Resident #207 was admitted to the facility August 12, 2024 for a 5-day respite for hospice care with diagnoses that included Cerebrovascular disease, sequelae of cerebral infarction, hypertension, anxiety disorder, atrial fibrillation & depression. A hospice order summary dated August 12, 2024 revealed that the resident was prescribed Lactaid, Glucerna and sliding scale insulin instruction. Review of the August 2024 Medication Administration Record and the Treatment Administration Record revealed insulin was not administered and that fasting or random blood sugars were not completed during the 5-day respite period, that the resident was in the facility. A progress note dated August 12, 2024, indicated that medications to include medication administration times were reviewed with the resident and the resident's family. A progress note dated August 12, 2024, revealed a review of the medication reconciliation sheet dated August 12, 2024 that indicated that the resident's medications were reviewed by the pharmacist and physician's orders were clarified with the hospice agency. The sheet documented that the orders were transcribed and sent to the hospice pharmacy. According to the medication reconciliation sheet, there was no physician's order for insulin. A progress note dated August 14, 2024, the Resident reported to the night nurse that she was supposed to be get insulin. The nurse noted that there were no orders for insulin in the resident's record. The hospice agency was contacted, they stated they would investigate and report back. A progress note dated August 14, 2024, a review of the resident's admission Medication Review Report dated August 12, 2024 was completed and uploaded to the dashboard. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with a Registered Nurse (RN/Staff #93)/Interim Director of Nursing (DON) was conducted on May 1, 2025 at 12:24 PM. she is accompanied by RN Staff #207, Regional Clinical Director. Interim DON has been in position for 1 week. During the interview, staff #207 and #93 confirmed that upon review of resident #207's record, they were unable to locate an order for insulin or insulin administration documentation. Staff #207 stated that insulin was not administered to the resident. Furthermore, during review of the hospice order summary. Both staff members confirmed that the orders included Lactaid, Glucerna, and sliding scale instruction for insulin. However, the staff members noted that the hospice order summary was not uploaded into the resident's clinical record until October 10, 2024 which was after the resident's discharge. According to staff #207, the resident was not administered insulin during her stay. Additionally, staff #207 stated that this does not meet the facility expectations for quality of care. Furthermore, staff #93 noted that hospice is very particular and expects that their physician's orders are to be followed. Staff #93 indicated that the impact of not administering insulin is that it could lead to hyperglycemic events which could result in diabetic keto-acidosis (DKA) and possible diabetic coma. - An interview with a Registered Nurse (RN/staff #7) was conducted on May 1, 2025 at 1:00 PM. Staff #7 stated that for new admits, Medical Records/Admissions are responsible for inputting the resident's initial demographics into the system. The nurse is responsible for reviewing admission paperwork to verify for completion and accuracy. Reviewed documents are uploaded into the system for Provider and Pharmacy review, if discrepancies are noted, they may be addressed with the interdisciplinary team prior to the uploading the records to the electronic health record. Staff #7 advised that once medication reconciliation is completed, it is reviewed the resident and/or resident's family, they are asked to sign it, if it is accurate. The resident's hospice note dated August 13, 2025 was reviewed with staff #7. She stated that she would expect to see blood sugar levels to be completed three times a day if the resident had a diagnosis of diabetes, The RN did not feel comfortable answering further questions regarding medication errors or order completeness. The RN noted that the risk of not taking insulin could lead to Hyper glycemia, DKA or Diabetic Coma. Staff #7 said that she would report a medication error to the provider once it was found, in the event of any adverse reactions. She also noted that she would notify the DON and the resident's family. The medication discrepancy would also be documented in progress notes. An interview with a Licensed Practical Nurse (LPN/staff #54), interim Assistant Director of Nursing was conducted on May 1, 2025 at 2:09 PM. According to staff #54 hospice residents admitted to the facility usually comes from home. Therefore, the hospice facility provide the orders and the medication for the respite stay. According to staff #54's review of the hospice note dated August 12, 2024, per the orders the resident should have been glucose tested four times per day. Staff #54 mentioned that other than diabetes, insulin can also be used for weight loss or if the resident is on steroid therapy. Staff #54 confirmed that the resident did not receive insulin or blood sugar testing during his 5-day respite stay at the facility. The LPN stated that generally speaking this would be considered a medication error, the nurse who was admitting the resident would be responsible for reviewing/checking the incoming residents orders. The risk for the resident could be diabetic coma or ketoacidosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policies Veritas-The Center for Policies and Procedures The facilities Medication Administration policy, issued July 1, 2017, revealed that medications must be administered in accordance with written orders. In addition, all current drugs and dosage schedules must be recorded on the patient's medication administration record (MAR and TAR as appropriate). The facilities Physicians Orders policy, issued: December 4, 2019, revealed that the center will transcribe the Physician's orders and treatments and will be consistent with principles of safe and effective order writing. Additionally, drug and biological orders will be recorded in the patient's medical record on the order sheet; such orders are reviewed monthly by a consultant pharmacist.

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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 observation, clinical record review, staff interview, and facility policy, the facility failed to ensure medications were not left at the bedside for one of 16 sampled residents (#404). The deficient practice could result in medications not being administered correctly, or medications not taken as ordered by the provider. Findings include: Resident #404 was admitted on [DATE] with diagnoses that included fracture of fourth lumbar vertebra and subsequent encounter for fracture with routine healing. During an initial observation conducted on April 29, 2025 at 09:30 AM, of Resident #404's room, a tube of barrier cream and anti-fungal powder were observed on the resident's bedside table unattended. A second observation conducted on April 29, 2025 at 10:45 AM., revealed a tube of barrier cream and anti-fungal powder on the bedside table unattended. Review of physician orders revealed: barrier cream to coccyx and buttock area every shift and PRN dated February 22, 2025. Further review of physician orders revealed no evidence of an order for anti-fungal medications. 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. A care plan initiated on February 22, 2025 revealed no evidence of a focus or intervention regarding medication self-administration. Review of the clinical record from February 22, 2025 through May 1, 2025 revealed no evidence of a mediation self-administration assessment. Immediately after the 2nd observation an interview with Licensed Practical Nurse (LPN/staff #83) was conducted on April 29, 2025 at 10:47 AM. The LPN entered the resident's room and stated that a tube of barrier cream and anti-fungal powder were on the resident's bedside table. The LPN stated that she did not leave the moisture barrier cream at the bedside and that the tube is empty, and she was not sure why it was even in the resident's room. The LPN stated that the Resident's wife left the antifungal powder at the bedside and that the LPN has seen the Resident's wife use it, but thought that the wife took it home with her. The LPN stated that it was not appropriate for the medications to have been left at the bedside unattended. The LPN stated that when family brings in medications, they should give the medications to a nurse. The LPN further stated that the facility policy requires a provider order along with a completed medication self-administration assessment, prior to leaving medication/treatments at the bedside. The LPN removed both medications from the bedside table and placed them in a treatment cart, and notified the charge Registered Nurse (RN). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on May 2, 2025 at 10:31 AM, with LPN (staff #203) who stated that all medications, including topical treatments, are not to be left unattended at the resident's bedside table. She further stated that if a family member brings any medications into the facility, they would need to give the medications to a nurse to place in the treatment cart. The LPN stated that the risks of leaving medications unattended in a resident's room could result in medications not being administered correctly, or someone beside the resident could take the medication. In an interview, conducted on May 2, 2025 at 10:39 AM., with a Certified Nurse Assistant (CNA/staff #204) who stated he accesses the resident's barrier cream from the nurse and leaves the barrier cream in the resident's bedside drawer when he is done. An interview was conducted with the interim Director of Nursing (DON/staff #93) on May 2, 2025 at 01:16 PM, who stated that medications were not to be left unattended on the resident's bedside table, and if family members bring medications into the facility, nursing staff should be notified. The DON further stated that barrier cream is to be kept in the treatment cart, not on the resident's bedside table, or in a drawer. The DON stated that in order for a resident to self -administer medications, an order from the resident's provider, the resident's signature, and a medical self-administration assessment form are to be in the resident's clinical record. The DON reviewed the medical record and stated that there was no evidence of a self-administration assessment form. The DON stated that risk of a medication being left at the bedside without an assessment could result in the resident being injured. A policy titled, Medication Administration, revised August 8, 2022, revealed that medications are to be administered as prescribed by the attending physician. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medications. Medications must be administered in accordance with the written orders of the attending physician. A policy titled, Self-administration of Medications, revised February 8, 2021, revealed that as part of their overall evaluation, the nursing staff will assess each resident's mental and physical abilities to determine whether self-administering medication is clinically appropriate for the resident. Self-administered medications mush be stored in a safe and secure place, which is not accessible by other patients. If safe storage is not possible in the resident's room, the medications of patients permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations and staff interviews, the facility failed to ensure the daily nurse staffing information was complete and accurate for actual hours worked for licensed and unlicensed direct care nursing staff. The deficient practice could result in residents, representatives, and visitors not being informed of accurate and current staffing information in the facility. Findings include: Review of the facility's daily nurse staffing forms for the dates of February 14, 2025 through February 18, 2025 and April 25, 2025 through April 27, 2025 revealed no evidence of actual hours worked by licensed and unlicensed staff. During an observation conducted on April 29, 2025 at 9:07 AM, the daily nurse staff posting form was displayed at the front information desk and form did not include the actual hours worked by licensed and unlicensed nursing staff. An interview was conducted with the Staffing Coordinator (staff # 73) on May 1, 2025 at 1:25 PM who stated that she is responsible for ensuring the daily nurse staffing information is accurate and posted. She stated that she had not been informed to include the actual hours worked on the daily nurse staff posting form. She further stated that she had, never been told that, but that she will update the form and include the actual hours worked going forward. She reviewed the daily nurse staff postings dated February 14, 2025 through February 18, 2025 and April 25 2025 through April 27, 2025 and stated that there was no evidence of the actual working hours worked by licensed and unlicensed nursing staff. An interview was conducted the with Director of Nursing (DON/staff #93) on May 2, 2025 at 12:52PM, who stated that it is staffing's responsibility to complete the staff postings. She further stated that the daily nurse staff posting should be accurate for each day. She reviewed the daily nurse staff postings dated February 14, 2025 through February 18, 2025 and April 25, 2025 through April 27, 2025 and stated that there was no evidence of actual hours worked by licensed and unlicensed nursing staff on the forms. She stated that she did not know the risk associated with including the actual hours worked on the forms. Review of the facility's policy regarding Posted Staffing Numbers revealed the daily posting is to include hours worked by the Registered Nurses, Licensed Practical Nurses, and Nursing Assistants for each shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and facility policy, the facility failed to maintain infection prevention and control when delivering meal trays, providing foley catheter care for one of one sampled resident's (#9), and failing to consistently implement tracking and trending of their infection prevent and control program. The deficient practice could result in transmission of infection within the facility. -Regarding delivering of meal trays: Observations were conducted on April 30, 2025 of a Certified Nursing Assistant (CNA/staff #200) delivering in-room lunch meal trays to four residents on enhanced barrier precautions (EBP). The following was observed: -The CNA entered the first room, moved items on the bedside table and placed a meal tray on a bedside table, and exited the room without sanitizing her hands. -The staff member picked up a meal tray from the dietary cart and entered a second room without sanitizing her hands prior to entering the room. The staff member placed the meal tray on the bedside table, repositioned items on the bedside table then exited the room without sanitizing her hands. -The CNA entered a third room, leaving the meal tray on the bedside table, without sanitizing her hands before entering or after exiting the room. -In a fourth room the staff member entered without sanitizing her hands, placed a meal tray on the bedside table, picked up a coffee cup off the tray, exited the room, filled the coffee cup from a carafe on the dietary meal cart, and re-entered the room with the coffee cup. The CNA exited the room without sanitizing her hands. -The staff member entered the first room, wiped the bedside table with paper towels and exited the room without sanitizing her hands before entering or after exiting. -The staff member re-entered the fourth room with another coffee cup and a styrofoam cup of ice, without sanitizing her hands when entering and exiting the room. -The CNA entered the first room without sanitizing her hands, assisted the resident with eating a bite of the food, then exited the room without sanitizing her hands. An Enhanced Barrier Precautions (EBP) sign that was posted outside of all the resident rooms the CNA entered during tray pass on April 30, 2025, revealed that everyone must: clean their hands, including before entering and when leaving the room. An interview was conducted on April 30, 2025 at 11:32 AM with a registry CNA (staff #200) who stated that she only needed to gown up when entering EBP rooms for catheter or foley care, but the facility policy was to follow the EBP sign instructions posted outside of the rooms. The CNA read an EBP sign posted outside of the doors stating everyone must clean their hands, including before entering and when leaving the room. The CNA stated that she did not sanitize her hands upon entering/exiting the resident rooms with EBP on the door when passing meal trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Interview was conducted on April 30, 2025 at 11:40 AM with a registry Licensed Practical Nurse (LPN/staff #201), who stated that residents requiring EBP precautions have a sign posted by their room. The LPN stated that when staff enter a room on EBP all staff should sanitize their hands when entering/exiting the rooms, and this included passing meal trays. An interview was conducted on April 30, 2025 at 11:44 AM with a CNA (staff #202), who stated that when entering or exiting resident rooms placed on EBP, all staff are required to sanitize their hands, including when they are passing meal trays. An interview was conducted on May 2, 2025 at 12:38 PM with the Interim Director of Nursing (DON/staff #63), who stated that staff should would wash or sanitize their hands before entering/exiting each resident's room, including residents placed on EBP. The DON also stated that this included when staff bring meal trays into resident rooms. She further stated that the meal tray observations for hand hygiene. DON stated that hand hygiene was important to maintain infection prevention/control and prevent the spread of germs and infections. -Regarding Enhanced Barrier Precautions (EBP) and hand hygiene during Foley catheter care: Findings include: Resident #9 was admitted to the facility on [DATE] with diagnoses that included: osteomyelitis of vertebra, acute kidney failure, and cognitive communication deficit. A care plan initiated on April 27, 2025, revealed that Resident #9 had a Foley catheter for acute retention and required catheter care as ordered by the physician and as needed. Review of a care plan initiated on March 26, 2025, revealed that Resident #9 required: EBP related to a Foley catheter and a Peripherally Inserted Central Catheter (PICC), a sign to be placed outside the resident's door, EBP per policy and staff to wear personal protective equipment (PPE) during high contact resident care. Review of an order summary revealed an order dated April 27, 2025. The order prescribed a Foley catheter and Foley catheter care to be performed every shift. The resident also had an order, dated April 27, 2025, for EBP with high contact care activities due to a Foley catheter every shift. During initial observations on April 29, 2025 at 8:35 AM, an EBP sign was observed outside Resident #9's room. The sign instructed all who entered the room to: -clean their hands before entering and when leaving the room, and to -wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, changing linens, changing briefs, device care for urinary catheter, . A cart was observed outside of the resident's room that contained gowns and gloves. During that same observation, it was also noted that Resident #9 had a Foley catheter in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A procedure for Foley catheter care was observed for Resident #9, on April 30, 2025 at 10:55 AM, with Registered Nurse (RN/staff #83). The RN was observed to sanitize her hands with alcohol-based hand rub (ABHR) before entering the resident's room. The RN was not observed to don a gown. The RN donned gloves and closed the door to the resident's room. The RN dipped a washcloth into soapy water and cleaned the resident's groin area. She doffed the gloves and donned a new pair of gloves. The RN was not observed to sanitize her hands between glove changes. The RN (staff #83) then dipped a new washcloth into the soapy water and cleaned the resident's genital area, including the catheter tubing. The RN doffed her gloves and donned new gloves. She was not observed to sanitize her hands between glove changes. The RN (staff #83) proceeded to clean the resident's buttocks, with a new washcloth, as the resident had had a bowel movement. She doffed the gloves and donned new gloves. The RN was not observed to sanitize her hands between glove changes. The RN (staff #83) then put a new brief on the resident and then discarded her supplies. The RN was then observed to wash her hands with soap and water. The RN was not observed to wear a gown throughout the procedure. An interview was conducted with the RN (staff #83) on April 30, 2025 at 11:10 AM. The RN acknowledged that she did not wear a gown and did not sanitize her hands between glove changes. She acknowledged that Resident #9 was on EBP and that she should have been wearing a gown during Foley catheter care and the brief change. She stated she did not wear a gown because she forgot that the resident was on EBP. She also stated she should have sanitized her hands before and after she donned and doffed gloves. She stated she did not sanitize her hands between gloves changes because she did not bring her own ABHR into the room. An interview was conducted with the Assistant Director of Nursing (ADON/staff #54) on May 1, 2025, at 11:35 AM. The ADON stated that for residents on EBP, the expectation was that staff would wear gowns and gloves when performing all cares except bedside meal or fluid delivery. She stated that RN (staff #83) should have worn a gown during Foley catheter care and the brief change for Resident #9. The ADON also stated that Staff #83 should have sanitized her hands between glove changes. Further the ADON stated the risk of not performing hand hygiene and not wearing proper EBP could be the spread of infection. An interview was conducted with the Interim Director of Nursing (DON/staff #93) on May 2, 2025 at 9:21 AM. The DON stated that if a resident was on EBP, staff would be expected to wash their hands and wear a gown and gloves while performing personal cares, according to the sign by their door. The DON acknowledged that RN (staff # 83) did not follow EBP and hand hygiene protocols when she performed Foley catheter care and a brief change on Resident #9. The DON stated the risk of not following EBP and hand hygiene protocols could be infections to both residents and staff. -Regarding the Infection Prevention and Control Program: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Finding include: On May 1, 2025 at 11:35 AM, an interview was conducted with the Assistant Director of Nursing (ADON/staff #54) and the Regional Clinical Director (RCD/staff #205). The ADON and the RCD explained that the ADON was in the process of completing her training as the Infection Preventionist (IP). It was further explained that the previous IP (staff #69) was assisting the ADON with IP tasks approximately three to four hours per week. During the interview on May 1, 2025, the Infection Control Logs for January 2025 through April 2025 were reviewed with the RCD and the ADON. Information regarding infections were listed on the log. However, there was no evidence of trending the information found on the logs. Further, The RCD (staff #205) explained that the data found on the logs regarding infections had not been recorded in real time. She stated that the previous IP (staff #69) had been going back and filling in the logs after the fact. She confirmed that infections were not being tracked and trended from January 2025 through April 2025. The RCD then acknowledged that tracking and trending of infections was not occurring per company policy. The RCD further stated that the risk of not tracking and trending infections could be the spread of infection throughout the facility. A policy titled, Hand hygiene for Clinical Staff, effective date January 29, 2025, revealed that hand hygiene is the process of cleaning hands to remove dirt, organic matter or microorganisms. It includes both handwashing with soap and water and hand antisepsis using alcohol-based hand rub (ABHR). Clinical staff must perform hand hygiene in the following situations: - before patient contact (e.g., entering the room) -after touching surfaces or objects in the patient care area A policy titled, Enhanced Barrier Precautions (EBP), refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms. EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities the provide opportunities for transfer of MDROs (multidrug-resistant organisms) to staff hands and clothing. A policy titled, Infection Prevention and Control Program, reviewed/revised March 14, 2024, revealed that hand hygiene should be performed in accordance with the facility's hand hygiene procedures. It also revealed that a system of surveillance was to be utilized to prevent, identify, report, investigate and control infectious and communicable diseases. A policy titled, Hand Washing, reviewed/revised March 14, 2024, revealed hands should be washed before donning disposable gloves and after gloves are removed.

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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 - Some	Implement a program that monitors antibiotic use. Based on record review, staff interviews, policy review and Center for Disease Control (CDC) guidelines, the facility failed to consistently implement tracking and trending of their antibiotic stewardship program. The facility census was 79 residents. This deficient practice could result in improper antibiotic use and adverse outcomes to residents. Findings include: On May 1, 2025 at 11:35 AM, an interview was conducted with the Assistant Director of Nursing (ADON/staff #54) and the Regional Clinical Director (RCD/staff #205). The ADON and the RCD explained that the ADON was in the process of completing her training as the Infection Preventionist (IP). It was further explained that the previous IP (staff #69) was assisting the ADON with IP tasks approximately three to four hours per week. During the interview on May 1, 2025, the Infection Control Logs for January 2025 through April 2025 were reviewed with the RCD and the ADON. Resident names, types of infections and antibiotics used were listed on the log. However, there was no evidence of trending the information found on the logs. Further, The RCD (staff # 205) explained that the data found on the logs regarding antibiotic use had not been recorded in real time. She stated that the previous IP (staff #69) had been going back and filling in the logs after the fact. She confirmed that antibiotics were not being tracked and trended from January 2025 through April 2025. The RCD then acknowledged that tracking and trending of the antibiotic stewardship program was not occurring per company policy. The RCD explained that an integral part of the program was to track and trend the information. The RCD further stated that the risk of not implementing the antibiotic stewardship program could be that antibiotics are not used correctly. Review of the Infection Prevention and Control Program Policy, revised March 14, 2024, revealed that a system to monitor antibiotic use would be implemented and that the Infection Preventionist would oversee the program.