STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicana Nursing and Rehab Center	1710 Lake Worth Road Lake Worth, FL 33460

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observation, interview and record review, the facility failed to ensure personal privacy during medical treatment, of a med (medication) pass for 1 out of 6 sampled residents reviewed for med pass, affecting Resident #88. The findings included: Review of the facility's policy titled, Resident Dignity and Property Privacy with an effective dated of 04/2024, included in part, the following: The center provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. Fundamental Information Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth. Each resident's right to personal privacy includes the confidentiality of his or her personal and clinical affairs. Procedure: 2. Examine and treat residents in a manner that maintains their privacy. a. Use a closed door, a curtain drawn, or both to shield the resident during all personal care and treatment procedures. Record review for Resident #88 revealed the resident was admitted to the facility on [DATE] with the most recent readmission on 12/14/24. The resident's diagnoses included in part, the following: Pancytopenia, Cirrhosis of the Liver, Type 2 Diabetes Mellitus. and Unspecified Dementia. Review of the Minimum Data Set assessment for Resident #88, dated 12/20/24 with a Brief Interview of Mental Status score of 5, indicating severe cognitive impairment. On 01/13/25 at 10:23 AM, an observation of two med passes was performed by Staff A- Licensed Practical Nurse (LPN) for Resident #88. After entering the room, Staff A-LPN, did not provide privacy for the resident. She did not close the door, nor did she pull the privacy curtain around the resident. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 01/13/25 at 10:25 AM with Staff A-LPN, she stated that she has worked at the facility for about 1 month. When asked why she did not provide privacy for the resident during med pass, she said she forgot. During an interview conducted on 01/14/25 at 8:30 AM with Staff B LPN, Charge Nurse, who was asked about providing privacy for resident during med pass, she said we always close the door and pull the privacy curtain.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review, the facility failed to develop a care plan for 2 of 2 sampled residents, with a diagnosis of Post-Traumatic Stress Disorder (PTSD), affecting Resident#1 and #86. The findings included: Review of the facility's policy titled, Comprehensive Person-Centered Care Plans with a revised date of 08/2023, included in part, the following: The center will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Fundamental Information The comprehensive care plan will describe the following: 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required are provided to the resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The comprehensive plan of care will include the following: Residents' individual needs, past trauma, strengths and preferences Identify triggers which may re-traumatize residents with trauma history and implement interventions which minimize or eliminate the effect of the trigger. 1. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, the following: Cerebral Ischemia, Anxiety Disorder Unspecified, Major Depressive Disorder Recurrent Moderate, Primary Insomnia, Post-Traumatic Stress Disorder Acute, Senile Degeneration of Brain and Unspecified Psychosis Not due to Substance or Known Physical Condition. Review of the Minimum Data Set Assessment for Resident #1 dated 10/17/24 documented in Section C a Brief Interview of Mental Status score of 11, indicating moderate cognitive impairment. Review of the Social Services Evaluation for Resident #1 dated 04/24/24 documented under evaluation in section G, TIC (Trauma Informed Care History): 1) Select all that may contribute to the resident - physical abuse 2) Does the event in your past cause you an emotional response, triggered by a sound, smell, touch or circumstance? - Yes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a) Describe triggers- When people approach him too fast. Review of all of the care plans for Resident #1 revealed no care plan established for PTSD, including any triggers. 2. Record review for Resident #86 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, the following: Bullous Pemphigoid, Post-Traumatic Stress Disorder Chronic and Major Depressive Disorder Recurrent Unspecified. Review of the Minimum Data Set Assessment for Resident #86 dated 12/12/24 documented in Section C a Brief Interview of Mental Status score of 13 indicating a cognitive response. Review of the Social Services Evaluation for Resident #86 dated 12/10/24 documented in Section H-TIC-History: 1) Select all that may contribute to the resident: Emotional abuse, Combat exposure/war, and Post-Traumatic Stress Disorder 2) Does the event in your past cause you an emotional response, triggered by a sound, smell, touch or circumstance -no Review of all of the care plans for Resident #86 revealed no care plan established for PTSD including any triggers. An interview was conducted on 01/13/25 at 10:58 AM with Resident #86 who stated he has PTSD and triggers. He explained briefly of his journey in the war. The resident became teary. An interview was conducted on 01/14/25 at 9:00 AM with Staff B, Licensed Practical Nurse / Charge Nurse she stated that she has worked at the facility since October 2024. When asked if a resident has PTSD how does she know what the triggers are? She stated she would have to go review the diagnosis, the doctor needs to diagnose the resident with PTSD. She said she does not know of any of her assigned resident's with PTSD. She added that the resident can have agitation and that can make the patient trigger. An interview was conducted on 01/14/25 at 1:17 PM with the Social Service Manager (SSM), who stated she has worked at the facility for under 1 year. When asked about residents with diagnosis of PTSD, the SSM said they do a Social Service Evaluation to ask about trauma informed care and the questions built into the form addresses triggers. For residents with a diagnosis of PTSD, we will automatically set them up with psych services. The SSM said once the Social Service Evaluation is completed, it will create a care plan for PTSD based on any identified triggers. She said there are specific questions for the triggers and if they are identified by saying yes to the questions, being asked, the system will automatically create a care plan for PTSD with triggers. When asked about Resident #86 if he has triggers, she said he answered no to triggers, so he would not have a care plan. When asked about Resident #1 if he has triggers, she said he also answered no to triggers and therefore no care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 01/14/25 at 12:57 PM with Staff E-Licensed Practical Nurse (LPN) / Resident Care Specialist, who the MDS (Minimum Data Set) assessments. She reported that she does not initiate care plans for residents, she updates and revises them for nursing and social worker and dietary do their care plans. She does oversee the care plans. If they need to be updated or revised she will complete that portion. Staff E was asked about care plans for Post-Traumatic Stress Disorder (PTSD) with triggers identified for Resident #86 and #1. She acknowledged neither resident had a care plan for PTSD with triggers identified An interview was conducted on 01/15/25 at 10:10 AM, with Staff D, Restorative Certified Nursing Assistant, who stated she has worked at the facility for 3 years. When asked if she has any residents that have diagnoses of Post-Traumatic Stress Disorder (PTSD), she said she did not really understand the question. When asked if she knows what PTSD is, she said not really. After it was explained to her, she was asked how she would know what, if any, triggers the resident may have and where she could find them. She said by how the resident acts, by what they tell you they remember, and their attitude. When asked if she would find anything in the resident's chart, she said maybe the chart or Kardex. An interview was conducted on 01/15 25 at 2:00 PM with Staff C Registered Nurse (RN) / Staff Develop Coordinator who stated she has worked at the facility for 3 years. When asked if a resident has PTSD, where she could find out what the triggers are, she said it would be in the care plan.

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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** 36734 Based on record review and interview, the facility failed to ensure antibiotics were administered as ordered for 1 of 3 sampled residents, reviewed for antibiotic therapy (Resident #60). The findings included: Resident #60 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment and was dependent for activities of daily living. a). Review of Resident #60's orders revealed an order dated 12/03/24 for Ertapenem (antibiotic) 1 gram intravenously (IV) every 24 hours for a multi drug resistant organism (MDRO) in the urine for 9 days. The antibiotic order was reduced to 7 days (until 12/10/24) on 12/05/24 per antibiotic stewardship suggestion. Review of Resident #60's medication administration record (MAR) revealed the resident received 8 doses of antibiotics in 7 days (given twice on 12/04/24). b). An order dated 12/15/24 for Ceftriaxone (an antibiotic) was ordered for 1 gram every 24 hours for 5 days for an elevated white blood cell (WBC) count. Review of Resident #60's MAR revealed the antibiotic was administered one time on 12/15/24. No documentation was found regarding the other 4 doses ordered. c). An order dated 12/19/24 for Zyvox (an antibiotic) was ordered for 600 milligrams 2 times a day for Bacteriuria (urine infection) for 7 days. A review of Resident #60's MAR revealed the antibiotic was administered 10 out of 14 times over the 7 day period. Further record review revealed no evidence of the physician notified of the discrepancies of the administration of antibiotics.

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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** 39026 Based on interviews and record review, the facility failed to ensure smoking evaluations were completed for 2 of 9 sampled residents identified as smokers (Residents #66 and #75). The findings included: The facility's policy titled Smoking effective 10/24/22 and revised 09/23 revealed Residents that are active smokers will be identified on admission and reviewed when there is a significant change of status, quarterly, and annually thereafter. 1). Resident # 75 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Myalgia, and Type 2 Diabetes Mellitus. Her Brief interview for Mental Status (BIMS) score was 15 on the quarterly Minimum Data Set (MDS) with an assessment reference date of 12/28/24. This indicated the resident is cognitively intact. Record review revealed on 04/26/24 Resident #75 had a safe smoking evaluation. On 10/31/24 the resident had another smoking evaluation. There were no additional smoking evaluations. The resident did not have a smoking evaluation in July 2024. In an interview with Resident #75 on 01/15/25 at 10:35 AM she stated she does not keep her cigarettes or lighter, they (the facility) keep them in a locked cart. She further reported that when she goes out to smoke, she is given her lighter and cigarette and someone from the facility stays with the smokers. They can't go out alone. An interview was conducted with the Director of Nurses (DON) on 01/15/25 at 2:30 PM. She stated it is the responsibility of the DON, Unit Manager, and MDS for the smoking evaluations. The Social Service Director created the smoking list and makes sure that it is up to date. Nursing will complete the evaluation on the admission assessment. On 01/16/25 at 11:31 AM an interview was conducted with Staff J, Unit Coordinator and Registered Nurse, regarding the smoking evaluations. She stated she does keep track of the evaluation as to when they are due, but only the residents in her unit. She further stated, now that Resident #75 is on her unit, she will be keeping track of it. 2). Record review for Resident #66 revealed the resident was originally admitted to the facility on [DATE] with a most recent readmission on 09/27/24 with diagnoses that included Tobacco Use. Review of the Minimum Data Set for Resident #66 dated 01/03/2025 documented in Section C, a Brief Interview of Mental Status score of 15, indicating a cognitive response. A review of the smoking evaluations for Resident #66 revealed evaluations for 11/01/23, 05/13/24, 09/14/24, and 09/27/24. The resident was hospitalized on [DATE]-[DATE]. The resident did not have a smoking evaluation completed in February 2024 and December 2024.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interview and record review, the facility failed to ensure physician visits were conducted within the required time frame, for 1 of 18 sampled residents (Resident #66). The findings included: Record review for Resident #66 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 09/27/24 with diagnoses that included, in part, the following: Bullous Pemphigoid, Venous Insufficiency (Chronic Peripheral), Elevated [NAME] Blood Cell Count Unspecified, Morbid (Severe) Obesity, Tobacco Use and Chronic Gout. Review of the Minimum Data Set Assessment for Resident #66 dated 01/03/25 documented in Section C, a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician/Practitioner Progress Note for Resident #66 from 01/01/24 to 01/12/25 revealed the following: On 01/22/24 written by Staff F Primary Physician. On 03/19/24 written by Staff F Primary Physician, which documented in part the following: Visit performed by Staff I APRN. On 05/30/24 written by Staff I Advance Practice Registered Nurse (APRN). On 07/26/24 written by Staff I APRN. On 9/17/24 written by Staff I APRN. On 10/04/24written by Staff I APRN. On 12/12/24written by Staff I APRN. This indicated the last time the resident was seen by the primary physician was on 01/22/24 and visits were not altered every 60 days between the Primary Physician and the APRN. During an interview conducted on 01/15/25 at 12:00 PM, with the Administrator, who was asked physician visit frequencies, she stated the resident is to be seen by the physician every 30 days for the first 90 days after admission then every 60 days thereafter and those visits can be alternated with the nurse practitioner. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview conducted on 01/15/25 at 2:34 PM, with Staff F Primary Physician, who was asked how often he visits his residents at the facility, he stated he sees the residents every 30 to 60 days. However, Staff I Advanced Practice Registered Nurse (APRN) is his APRN, and she rounds regularly usually once or twice a week. Staff F Primary Physician said when he rounds he always rounds with Staff I APRN, and they split the census (he was not able to clarify how they split the census). Staff F Primary Physician stated Staff I APRN acts as his scribe and documents on his behalf, he stated he cannot document, and she documents on his behalf. When asked about the Physician/Practitioner Progress Noted for Resident #66 dated 03/19/24 and authored by him, with documentation that included Visit performed by Staff I APRN he could not explain this. During a telephone interview conducted on 01/15/25 at 3:42 PM, with Staff I APRN, who was asked how often she visits the residents, she said she usually sees the residents monthly and as needed. When asked about Staff F Primary Physician visiting the residents, she stated she does most of the documentation for Staff F Primary Physician for the patients seen by him, but he signs. During an interview conducted on 01/15/25 at 4:00 PM with Resident #66 who was asked how often Staff F Primary Physician visits him, he said he does not recognize the name, and asked do you have a picture of him to look at. When asked how often Staff I APRN visits him, he said that name is also not familiar to him and asked do you have a picture of her to look at. When asked how often Staff G Advanced Practice Registered Nurse (APRN) visits, he said he knows her well she comes to see him all of the time. During an interview conducted on 01/15/25 at 4:20 PM with Resident #66 who was shown a photograph of Staff F Primary Physician, the resident said I may have seen him once when I was in the hospital but have not seen him here (in the facility). When Resident #66 was shown the photograph of Staff I APRN, he said he has never seen her. (The photographs shown to the reisdent, were verified by the Administartor on 01/15/25 at 4:15 PM).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility failed to coordinate care with hospice services for 1 of 1 sampled resident reviewed for hospice (Resident #13). The findings included: Record review revealed Resident #13 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and was dependent for activities of daily living. The assessment further documented the resident was receiving hospice services. A review of Resident #13's orders revealed the resident was admitted to hospice services on 11/15/24. Resident #13 was care planned for hospice services. An intervention included to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. A review of Resident #13's hospice record, located in the facility's hospice binder at the nurse's station, revealed missing hospice documentation. Resident #13's binder only included the initial certification for hospice and a plan of care. The binder lacked assessments, visitation notes, and services provided. An interview was conducted with the Nurse Manager (NM) on 01/16/25 at 10:00 AM. The NM stated when hospice personnel visit Resident #13, they usually leave documentation in the binder. The NM acknowledged there was no documentation of services received. The NM stated she would look in medical records to see if any documentation was to be uploaded. An interview was conducted with the Director of Nursing (DON) on 01/16/25 at 12:00 PM. The DON stated she called hospice to get copies of Resident #13's records/visits.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39026 Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate effective plan of actions were implemented to correct an identified quality deficiency in the problem area as evidenced by repeated deficient practice for F656, Comprehensive Resident Centered Care plan. This repeated deficient practice had the potential to affect all 85 residents residing in the facility at the time of this survey. The findings included: Review of the facility's survey history revealed the facility was cited at F656, (Comprehensive Resident Centered Care Plan), during the Recertification and Relicensure survey with an exit date of 09/14/23. Review of the QAPI program with the Administrator revealed the lack of an effective corrective action plan for the above deficiency. During an interview with the facility's Administrator on 01/16/25 at 2:43 PM, the Administrator was apprised that this deficiency would be cited on the current survey. This was acknowledged by the Administrator.

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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** 36734 Based on observation, interview, and record review, the facility failed to follow up for a Vancomycin Resistant Enteroccocus (VRE) (a multi-drug resistant organism) infection and precautions for 1 of 3 sampled residents reviewed for antibiotic therapy (Resident #60), and failed to wear appropriate personal protective equipment (PPE) during of care of resident on enhanced barrier precautions (EBP) (Resident #71). The findings included: 1). Record review revealed Resident #60 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment and was dependent for activities of daily living. Record review revealed Resident #60 was on enhanced barrier precautions for ESBL (a multi-drug resistant organism) in the urine from 12/03/24 - 12/11/24. A review of Resident #60's orders revealed an order dated 12/14/24 for a urinalysis culture and sensitivity. The culture was reported positive for VRE (a multi-drug resistant organism) on 12/18/24. An order dated 12/19/24 for Zyvox (an antibiotic) was ordered for 600 milligrams 2 times a day for Bacteriuria (urine infection) for 7 days. Further record review revealed no evidence of Resident #60 being placed on any precautions, or of any follow-up after the antibiotic was administered. 39167 2) Review of the facility's policy titled, Infection Prevention and Control, dated 06/28/24, revealed, Enhanced Barrier Precautions may be implemented for those with a documented or suspected infection or colonization with a multi-drug resistant organism, or have risk of acquiring infections based on portals of entry or indwelling medical devices such as indwelling urinary catheter; g-tube, central lines, tracheostomy, or wounds requiring a dressing; regardless of infection or colonization status, or reported by the infection preventionist laboratory based on the centers' antibiogram when available. Equipment includes the use of gown and gloves during the direct care of resident that consists of close contact such as: bathing, dressing, incontinent care, transferring, indwelling device care, and other activities that may have the resident in close contact with the staff member. Clinical record review revealed Resident #71 was admitted to the facility on [DATE] and 09/25/24, with a diagnosis that included Diabetes. The quarterly comprehensive assessment with a, reference date of 11/01/24, recorded no brief interview for mental status score, indicating Resident #71 was rarely/never understood. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of additional clinical records evidenced the following physician orders: Dated 12/15/24 for Enhanced Barrier Precautions every 24 hours for Chronic Wound; dated 12/02/24 physical therapy treatment 3 times per week for 12 weeks, for wound care, Low frequency, non-contact, non-thermal ultrasound, Vaporox. Dated 01/01/25 for the right lateral ankle and left heel wound. On 01/15/25 at 12:42 PM, Resident #71 was observed lying in bed, she was receiving wound therapy with the Vaporox machine of the left heel wound. While the surveyor was standing in the room, on 01/15/25 at 12:48 PM, a staff member, Staff K, a physical therapist arrived. Staff K began attending to the Vaporox machine, by removing the bag that covered the left foot, and Staff K raised Resident #71's left foot, and a large wound with drainage was observed to the left heel, during that time, Staff K did not wear a gown while touching Resident #71's foot. On 01/16/25 at 12:37 PM, a phone call was placed to Staff K to inquire about the facility's Enhanced Barrier Precaution (EBP) process and procedure. She voiced that she was aware of the EBP procedure. She acknowledged she didn't wear a gown while providing direct care to the resident. On 01/16/25 at 1:30 PM an interview was held with the Director of Nursing (DON) and she was informed of the breach of infection control by Staff K.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105259	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicana Nursing and Rehab Center	1710 Lake Worth Road Lake Worth, FL 33460

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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 - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility failed to have an effective antibiotic stewardship program for 2 of 3 sampled residents reviewed for antibiotic therapy (Residents #60 and #62). The findings included: A review of the facility's policy titled Antibiotic Stewardship, dated 10/24/17, documented: The facility will establish a multidisciplinary antibiotic stewardship program that defines optimal antibiotic use and provides guidance for optimal antibiotic prescribed by physician/prescribers. The antibiotic stewardship program and its members will have accountability to the facility's quality assurance/performance improvement committee. The members of the antibiotic stewardship committee should include at a minimum the medical director of the facility, the director of nursing services, and the facilities consultant pharmacist. A. The medical director should set the standards for antibiotic prescribing. B. The director of nursing should establish the standards of nursing for assessment, resident monitoring and the communication of changes in condition when an infection is suspected. C. The consultant pharmacist should review antibiotic orders during interim and monthly medication regimen review to ensure antibiotics are ordered appropriately. 1). Resident #60 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment and was dependent for activities of daily living. Review of Resident #60's orders revealed an order dated 12/03/24 for Ertapenem (antibiotic) 1 gram intravenously (IV) every 24 hours for ESBL (a multi drug resistant organism) (MDRO) in the urine for 9 days. An antibiotic stewardship note dated 12/5/24 documented McGreer not met (McGreer criteria (Stone 2012) are used for retrospectively counting true infections. To meet the criteria for definitive infection, more diagnostic information (e.g., positive laboratory tests) is often necessary.) The antibiotic order was reduced to 7 days (until 12/10/24) on 12/05/24 per antibiotic stewardship suggestion. An order dated 12/15/24 for Ceftriaxone (an antibiotic) was ordered for 1 gram every 24 hours for 5 days for an elevated white blood cell (WBC) count. An antibiotic stewardship note dated 12/16/24 documented McGreer not met. An order dated 12/19/24 for Zyvox (an antibiotic) was ordered for 600 milligrams 2 times a day for Bacteriuria (urine infection) for 7 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105259	A. Building B. Wing	01/16/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Nurse Practitioner (NP) that ordered the antibiotics for Resident #60 on 01/15/25 at 11:30 AM. The NP stated she does not use the McGreer criteria to determine if a resident needs antibiotics. The NP stated it is used as a guideline only. The NP further stated she does not attend any meetings with the facility and does not communicate with the attending physicians. An interview was conducted with the Infection Control Preventionist (ICP) on 01/15/25 at 12:00 PM. The ICP stated the facility uses the McGreer criteria for infection surveillance to determine if antibiotic use is required. The ICP stated Resident #60's antibiotics were ordered by a Managed Care nurse practitioner (NP), who is not a staff of the facility. The ICP further stated the interdisciplinary team (IDT) meets monthly to discuss facility infections and use of antibiotics. The ICP stated the Managed Care NP does not attend. The surveyor questioned the ICP if she includes/informs the attending physician of the ordered antibiotic use, and the ICP stated no. An interview was conducted with Resident #60's attending physician on 01/16/25 at 10:00 AM. The physician stated he did not know Resident #60 had tested positive and was treated for ESBL and VRE. The physician stated he would look into it. 2). Record review revealed Resident #62 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and was dependent for activities of daily living. Record review revealed an order dated 11/29/24 for Ceftriaxone (antibiotic)1 gram intramuscularly one time only for abnormal labs (elevated white blood cell count). An antibiotic stewardship note dated 11/29/24 documented McGreer not met. An interview was conducted with Resident #62's attending physician on 01/16/25 at 10:00 AM. The physician stated he was not aware of the one time dose of antibiotics the resident received for an elevated white blood cell count.