STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115147	A. Building B. Wing	04/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Richmond, LLC	1227 West Wheeler Parkway Augusta, GA 30909

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observation, resident and staff interviews, record review, and review of the facility's document titled, Patient's Rights, the facility failed to honor one of four sampled residents (R) (R26) the choice for scheduled times to be gotten out of bed to accommodate the preference of the resident. This failure had the potential to affect the resident's psycho-social being. Findings include: Review of an undated document titled, Patient Rights, provided by the facility revealed as a patient of the health care center, patients have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the health care center. Your Rights as a patient - Specifically: Patients are entitled to exercise their personal and legal rights and privileges to the fullest extent (sic) possible. Self-Determination - Residents have the right to self-determination, including but not limited to (sic) the following rights: a. To choose activities, schedules (including sleeping and waking times), health care, and providers of health care services consistent with your interests, assessments, and plan of care. b. To make choices about aspects of your life in the center that are significant to you. Review of R26's face sheet revealed he admitted with the following diagnoses that included generalized muscle weakness, right hand contracture, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review R26's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C-Cognitive Pattern, a Brief Interview of Mental Status (BIMS) score of 15 which indicated little to no cognitive impairment; Section GG-Functional Abilities and Goals revealed he was required assistance with Activities of Daily Living (ADLs) care needs; Function limitation in Range of Motion - upper and lower extremity - impairment on one side. Further review of the Annual assessment with an ARD date of 11/4/2023 Section F- Preferences for Customary Routine and Activities indicated it was somewhat important to him to choose his own bedtime, very important to him to do things with a group of people and to do his favorite activities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26's care plan revealed a problem initiated 10/13/2023 that indicated residents' psychosocial well-being included a variety of activity interests and a general willingness to take part in group programs. GOAL: Resident will choose and participate in activities of choice - Group activities. Interventions included describe activities available and assist patient/ resident to choose activities to match interests and abilities. There was also a problem initiated 12/20/2023 which indicated resident had an ADL deficit due to CVA with right hemiparesis and impaired range of motion (ROM), weakness. Interventions included to provide assistance when needed. Observation and interview 4/26/2024 at 9:03 am with R26 stated, his preferences to get up between the hours of 6am and 6:30 am were not honored. R26 specified he did not like to eat breakfast in bed, he is an early riser, and he desired to get up out of the bed early. R26 stated he had requested to get up prior to the night shift staff leaving the facility, particularly Monday through Friday, but that does not happen. In addition, R26 stated he likes to attend various activities, so he did not desire to be in bed all morning. Resident attributes his choices not being honored to staffing issues. Observation 4/26/2024 at 11:12 am revealed R26 out of bed to wheelchair. Resident informed surveyor the staff finally got him up, shaking his head in dissatisfaction. Review of the facility's Resident Council Meeting Minutes dated 4/23/2024 revealed R26 stated he would like for the third shift to get him up in the mornings. Review of the facility's 11-7 getup list posted on the wall at the nurse's station revealed R26's name listed on the list to be gotten up on the 11-7 list. Review of a Quarterly Social Service Progress Review note dated 8/24/2023 indicated R26 participated in activities. R26 attended all activities offered in the facility, he likes to get up early in the morning. Further review of the Social Service Observation progress notes dated 1/1/2024, 1/31/204, and 2/23/2024 indicated there were no changes in R26's personal interests from the last assessment. Observation and interview with resident 4/27/2024 at 8:34 AM revealed resident lying in bed wearing a hospital gown. Resident informed surveyor that he does not want to get up today. He further stated he does not like to get up early on Saturday and Sunday, however he desires to get up early Monday through Friday. R26 stated he likes to get up early, eat his breakfast and attend various activities during the week. Resident stated the staff does not get him up usually until after 10:00 am and always give him the excuse they do not have enough help. Resident stated he had spoken with the lady who runs the place (Administrator) about the issue, but nothing has changed. Interview 4/28/2024 at 7:54 AM with Certified Nursing Assistant (CNA) HH revealed R26 is supposed to be gotten out of the bed on the night shift. She further stated there had been many times when she arrived at work, and R26 remained in bed. CNA HH further stated R26 complains when he is not up at his scheduled time. She further stated the 11-7 shift does not get him up at times because of staffing issues. Interview 4/28/2024 at 8:01 am with Licensed Practical Nurse (LPN) FF revealed R26 does like to be up early. He further stated the staff should be asking him and getting him up as desired. LPN FF verified R26 is on the facility's 11-7 shift get up list. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 4/28/2024 at 8:17 am with the Social Service Director (SSD) revealed R26 has always desired to get up early. SSD further stated getting up early is the standard norm for resident, it has been for a long time, and that has not changed. Interview 4/28/2024 at 9:08 am with Administrator and Director of Health Services (DHS) revealed R26 had voiced concerns about his desires to get up early and the staff were aware. The administrator stated she had spoken with the staff, and it was her expectation that residents would be assisted as desired. DHS stated R26 recently voiced his concerns in the resident council meeting, and she spoke with the night shift staff about ensuring that he is gotten up as desired.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observations, staff interviews, and review of policy titled, Infection Control Housekeeping Services, the facility failed to ensure a safe, clean, and comfortable home-like environment on one of three halls (Richmond Hall), as evidence by a lingering malodorous smell throughout the hall. Findings: Review of the policy titled, Infection Control - Housekeeping Services, revised 10/16/2023, revealed it is the policy of this facility to ensure housekeeping services will be performed on a routine and consistent basis to ensure an orderly, sanitary, and comfortable environment. Review of the Pre-Survey Report dated 4/22/2024 revealed the urine odor was present in a large portion of the long-term hall (Richmond Hall) during visit. Observation on 4/26/2024 at 8:30 am tour of facility revealed call-lights answered in a timely manner. A strong stale lingering urine odor was noted on Richmond Hall. Staff observed in and out of resident's rooms providing morning care, answering call lights, and engaging with the residents. There were no containers for dirty clothes and linens in the hall. Further observations revealed the strong odors remained on the unit at 11:49 am and 1:48 pm. Telephone interview on 4/26/2024 at 11:25 am with Ombudsman II revealed there was a distinctly strong urine odor on Richmond Hall during her last visit to the facility as noted on the Ombudsman report. Observations on 4/27/2024 at 8:14 am, and from 9:00 am to 10:30 am on the Richmond Unit revealed a strong foul urine odor still noted on the hall. Observation 4/27/2024 at 11:38 am revealed lingering stale urine odors remain on Richmond Hall. The door to the unit is open and the odor lingers into the main hall near the Social Service Director (SSD's) office and continues onto the hall. The odors are consistent throughout the entire Richmond Hall. Interview 4/27/2024 at 12:28 pm with Director of Health Services (DHS) revealed she was aware of the odors on Richmond Hall. She further stated the staff places the residents dirty personal clothing in bags in hampers in resident bathrooms. She stated the dirty clothes are kept in the residents' rooms until the laundry/housekeeping staff removes them to be laundered on the scheduled laundry day and she was unsure of the laundry schedule. DHS further stated the Housekeeping Supervisor and Administrator were dealing with that issue. Interview 4/27/2024 at 12:31 pm with Registered Nurse (RN) KK revealed she had worked on the Richmond Hall for the last 2 months. RN KK further confirmed there is an odor on the hall, but she was unsure of the contributing factor of where the odor originated from. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 4/27/2024 at 12:33 pm with Licensed Practical Nurse (LPN) FF, revealed he works on the Richmond Hall all the time and had become accustomed to the odor on the hall. LPN FF further stated he was not sure if the issue with the smell was a housekeeping or nursing issue. Interview 4/27/2024 at 12:37 pm with Certified Nursing Assistant (CNA) LL revealed she was aware of the odor on the Richmond Hall. CNA LL further stated she was unsure of where the odor was coming from but acknowledged resident's dirty clothes were still being stored in hampers in each residents' room. CNA LL also stated residents dirty clothing was not removed from the hall daily. Interview 4/27/2024 at 12:39 pm with CNA MM revealed she had worked at the facility for [AGE] years. She stated in the last year or so she had noticed urine odors on the unit. CNA MM stated the odors on the hall had not always been this way. CNA MM further stated the odor is different on this hall (Richmond Hall) than the rest of the facility and she does not know why. Interview and rounds (main hall near SSD's office door) on 4/27/2024 at 12:41 pm with the Administrator revealed she was aware of the odors on the Richmond Hall. The administrator stated staff were putting residents' dirty clothes in hampers in the residents' rooms which contributed to the odors. The administrator further stated and acknowledged the odors on the Richmond Hall are bad and she agreed the odors are lingering stale urine odors. Interview 4/27/2024 at 12:45 pm with Laundry Aide (LA) JJ revealed there are two sections on the Richmond Hall (Richmond 1 and Richmond 2). She stated residents on Richmond 1 dirty laundry is pulled and washed each Monday and residents on Richmond 2 dirty laundry is pulled and washed each Tuesday. LA JJ stated the residents' laundry for each unit is only washed once weekly on the scheduled day due to the facility having one industrial washer and dryer in the facility. LA JJ further acknowledged that residents' dirty laundry remains in residents' rooms for a week before being collected and washed. Interview and walking rounds 4/27/2024 at 12:47 pm with Housekeeping Supervisor revealed the odors on Richmond Hall have been an issue since his arrival at the facility. He stated he thought the odors may have been coming from the carpet leading to the unit, so the carpet was deep cleaned, and the issue persisted. The housekeeping Supervisor further stated residents' dirty clothes are kept in resident rooms throughout the facility. The Housekeeping Supervisor verified residents' dirty laundry was still being stored in hampers in residents rooms. He also acknowledged the dirty unbagged laundry was contributing to the odors on the hall.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews, record review, and review of the facility's policy titled, MDS Assessment Accuracy, facility failed to ensure the Minimum Data Set (MDS) assessments were completed and transmitted timely for 13 of 34 Residents (R), (R25, R63, R5, R57, R66, R53, R24, R59, R44, R8, R276, R279, and R22). Findings include: Review of the facility's policy titled, MDS Assessment Accuracy, dated 1/11/2024 Policy Statement revealed, It is the policy of this healthcare center that each Minimum Data Set (MDS) reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. The assessment will be scheduled to accurately account for the acuity and complexity of the patient/resident. 1. Record review revealed the following: R25's admitted to the facility 8/30/2022. Record review showed at least one or more MDS 120 days late due to not completed/transmitted. R25's Quarterly Assessment was due 3/12/2024 and submitted late on 4/20/2024. R63's admitted to the facility 9/18/2023 and record showed at least one or more MDS 120 days late due to not completed/not transmitted. The Quarterly Assessment for R63 was not completed or transmitted. R5 's admitted to the facility was 8/3/2020 and the record showed at least one or more MDS 120 days late due to not completed/transmitted. The Quarterly Assessment for R5 was not completed or transmitted. R57 's admitted to the facility was 9/15/2022 and record showed at least one or more MDS 120 days late due to not completed/transmitted. R57's 9/12/2023 Quarterly Assessment was late, Quarterly Assessment due 6/7/2023 and not completed until 6/12/2023, Annual not completed and transmitted. R66 's admitted to the facility was 7/18/2023 and record showed at least one or more MDS 120 days late due to not completed /transmitted. R66's Admission Assessment was late due 12/20/2023 not signed off until 1/19/2024 and the Quarterly Assessment had not been completed or transmitted. R53 's admitted to the facility was 11/18/2021 and the record showed at least one or more MDS 120 days late due to not completed /transmitted. R24's Quarterly Assessment was due on 3/11/2024 and not completed until 4/24/2024. R24 's admitted to the facility was 6/2/2022 and record showed at least one or more MDS 120 days late due to not completed/transmitted. R24's Quarterly Assessment was due on 12/19/2023 and not completed until 2/15/2024. A Quarterly Assessment due for 3/19/2024 had not been completed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R59 's admitted to the facility was 7/1/2022 and record showed at least one or more MDS 120 days late due to not completed/transmitted. R59's Quarterly Assessment had not been completed or transmitted. Quarterly due 12/02/2023 not completed to 1/19/2024. R44's admitted to the facility was 8/15/2023 and the record showed at least one or more MDS 120 days late due to not completed /transmitted. R44's Quarterly Assessment had not been completed or transmitted. R8 's admitted to the facility was 9/2/2014 and record showed at least one or more MDS 120 days late due to not completed/transmitted. R8 's Quarterly Assessment had not been completed or transmitted. Interview on 4/27/2024 at 1:38 pm, the MDS Coordinator confirmed that all the MDS were late. She reported that the new company took over in October 2023 and at this time the resident 's records are in the previous company's electronic systems. She reported that the shortage of help is a contributing factor to the MDS not being transmitted timely. 42464 2. R276 was admitted to the facility 4/2/2024. Review of Admission MDS revealed it was 'in progress'. R276 Admission MDS assessment had not been completed or transmitted. R279 was admitted to the facility 4/4/2024. Review of Admission MDS revealed it was 'in progress'. R279 Admission MDS assessment had not been completed or transmitted. Interview on 4/27/2024 at 10:41 a.m. MDS Coordinator DD revealed resident assessment should have been completed and transmitted by time of survey. Stated she has not had time to complete resident assessments. Interview on 4/27/2024 at 10:43 a.m. with RN MDS Coordinator EE revealed Admission MDS assessments are due within 14 days after admission 42463 3. Review of the facility's policy titled, MDS Assessment Accuracy, dated 1/11/2024 Policy Statement revealed, It is the policy of this healthcare center that each Minimum Data Set (MDS) reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. The assessment will be scheduled to accurately account for the acuity and complexity of the patient/resident. Review of R22's Admission MDS assessment dated [DATE] for Sections C-Cognitive Patterns revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated she was cognitively intact; Section F-Preference for Customary Routine and Activities, indicated staff should have conducted an interview with the resident for Daily and Activity Preferences however the section was left blank and marked as Not Assessed/no information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/27/2024 at 2:30 pm with Licensed Practical Nurse (LPN) MDS Coordinator revealed she was responsible for completing and making sure MDS assessments were completed accurately on residents. She stated R22 admission assessment was done remotely by a corporate nurse that helped her out during this time. She stated they were to collect data from the resident's electronic medical records (EMR) and through interviews to complete MDS assessment. LPN MDS Coordinator confirmed the resident had not been interviewed and should have been interviewed for Section F to determine her activity preference. She stated her expectations of staff were to gather the information needed so that an accurate assessment could be completed. xxDONEXX

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews, record review, and the facility policies titled, Care Plans and Discharge Planning, the facility failed to develop a baseline care plan which included essential components based on the resident stay for two of eight Residents (R), (R74 and R176). Specifically, the facility failed to ensure R74 had a baseline care plan developed after admission, and R176 had a care plan that addressed the residents' essential care needs as well as to develop a discharge care plan to include residents' goals leading up to discharge from the facility. Findings: Review of the facility policy titled, Discharge Planning review date 1/11/2024 under Procedure: 1. Discharge and care plan goals will be established with the IDT (Interdisciplinary Team), patient/resident, and patient/resident representative at the time of admission based on the patient/resident discharge goals and treatment preferences in conjunctions with needs as identified by the IDT. 2. Discharge Care plans will be updated after the Post Admission Care Conference, reviewed quarterly, prior to the anticipated discharge date , and as needed. Review of the facility policy title, Care Plans, dated 7/27/2023 revealed under New Admission Baseline Plan of Care: 1. Upon a new admission, a baseline care plan will be developed by the admitting nurse in conjunction with other IDT, the patient/resident and/or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. 1. Record review of R74 's Electronic Medical Record (EMR) revealed that resident was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD), anxiety disorder, long term anticoagulant use, chronic respiratory failure (CRF), gastro-esophageal reflux (GERD), and anxiety disorder. The Admission Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. Record review of R74's plan of care revealed an incomplete baseline care plan in the record that did not capture the residents' overall care needs and plan of care for unnecessary medications including psychotropic drugs use of (Seroquel, Zoloft, and trazodone). Interview on 4/27/2024 at 11:00 am, the MDS Coordinator EE confirmed that discharge care plan was not included in the care plan and that the residents' discharge care plan should have been completed within 24 hours of admission. She confirmed that the baseline care plan was completed on 1/17/2024 and that the baseline care plan did not capture the residents' overall care needs based on the resident needs at the time of admission. Further interview also revealed that at the time of R74's admission, the resident would have required a plan of care for the following: communication, Activities of Daily Living (ADL), psychotropic meds, discharge planning, pain due to receiving pain medications, and the use of an anticoagulant medication. She confirmed that in her review the baseline care plan was missing trigger areas. 41165 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for R176 revealed resident was admitted to the facility on [DATE] and discharged to the hospital on 12/31/2023. There was not a baseline care plan developed by the facility staff which included essential components based on the residents' stay. Interview on 4/28/2024 at 11:12 am with MDS Coordinator DD revealed the admitting nurse is responsible for baseline care plans. She stated that baseline care plans are to be completed within 48 hours after admission. She stated that if the base line care plan is not completed it will be caught upon the MDS assessment.

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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** 36377 Based on observations, staff interviews, record review, and review of the facility policy titled, Care Plans, the facility failed to develop a comprehensive care plan to address nutrition, behaviors, and psychotropic medication use for one of five residents (R) (R276) and implement a discharge care plan for one of three residents (R126). The deficient practice had probability of R126 and R276 needs to not be meet by facility staff according to their individual care needs. Findings include: Review of policy titled Care Plans last revised 7/27/2023 revealed: under Policy Statement: It is the policy of the health care center for each patient/resident to have a person centered baseline care plan followed by a comprehensive care plan developed following completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. Baseline Care Plan- Must include the minimum healthcare information necessary to properly care for each patient/resident immediately upon their admission, which would address patient/resident specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. 1. Record review of R126's electronic medical record (EMR) revealed resident was admitted to the facility on [DATE] with the following diagnoses but not limited to unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, interstitial pulmonary disease, hypertension, type 2 diabetes mellitus, and chronic kidney disease. The Minimum Data Set (MDS) dated [DATE] assessed Brief Interview for Mental Status (BIMS) Score of 15 indicating little to no cognitive impairment. Review of the R126 care plan revealed an omission of a plan of care for discharge planning. Interview on 4/28/2024 at 11:30 AM, the MDS Coordinator confirmed that discharge care plan was not created and that this was an oversight. The discharge care plan should have been implemented at the time of the residents' admission by the nurse and MDS Coordinator. She reported that the facility has a remote MDS staff who works in different facilities. This person was responsible for ensuring the care plan was created. 42464 2. R276 was admitted to the facility 4/2/2024 with diagnoses that included but not limited to pseudobulbar affect, mood disorder due to known physiological condition, vascular dementia, and protein-calorie malnutrition. Review of R276 comprehensive care plan revealed no care plans to address nutritional status and needs, behaviors, or the use of psychotropic medications. (continued on next page)

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Pruitthealth - Richmond, LLC	1227 West Wheeler Parkway Augusta, GA 30909

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/28/2024 at 9:10 a.m. with MDS Coordinator DD confirmed R276 did not have a comprehensive care plan developed to address nutrition, behaviors, and psychotropic medication uses.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42464 Based on staff interviews, record review, and review of the facility policy titled, Care Plans the facility failed to revise the comprehensive care plan related to pressure ulcers for one of seven residents (R54). Findings include: Review of the facility policy titled, Care Plans revealed under Care Plan Review and Update: l. Comprehensive care plans should be reviewed not less than quarterly according to the OBRA MDS schedule, following the completion of the assessment. Care plan updates/ reviews will be performed within 7 days of each quarterly assessment, each acute change in condition, and as needed following each hospital stay. 2. Discontinued problems, goals or approaches should be indicated directly on the care plan. A line should be drawn through the discontinued item. Updates to the care plans should be made with any changes in condition at the time the change in condition occurred. For MatrixCare users, all updates are made electronically. 3. All updates to care plans are to be dated and signed. The Master Care Plan will be electronically updated and printed following the completion of Comprehensive OBRA assessments. For MatrixCare users, Care Plans are maintained electronically. 4. Care plans will be updated by nurses, Case Mix Directors (CMD), or any other interdisciplinary team member so that the care plan will reflect the patient/resident's needs at any given moment.' Record review for R46 revealed resident was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, myasthenia gravis, anorexia, and pressure ulcer of unspecified site. Review of R46 comprehensive care plan last revised 4/26/2024 revealed a care plan for 'Resident is at risk for skin breakdown R/T incontinence, impaired mobility, impaired joint ROM. DTPI to left heel.' Review of R46 Electronic Medical Record (EMR) revealed R46 had an unstageable pressure ulcer to the sacrum with an onset date of 3/14/2024. Interview on 4/28/2024 at 8:57 a.m. with Minimum Data Set (MDS) Coordinators DD and EE revealed it is the responsibility of the interdisciplinary team to update care plans. Continued interview firmed residents care plan was not updated to reflect actual wound.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on record review and staff interviews, and review of the facility policy titled, Discharge Planning, the facility failed to reconcile all pre-discharge medications with the resident's post-discharge medications both prescribed and over the counter for one of four residents (R), R126. In addition, the facility failed to provide documentation that R126's medications were transferred with her at the time of discharge. Findings include: Review of the facilities policy titled, Discharge Planning, dated 1/11/2024 revealed Discharge Summary is initiated by the SSD, nurse navigator, or administrator designee upon admission. The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the patient/residents plan of care after discharge, including but not limited to The following: discharge recapitulation of state form, framework link or matrix care continuity of care document (CCD), reconciliation of all pre-discharge with post-discharge medications. A review of the clinical record revealed that R126 was admitted to the facility on [DATE] with diagnoses of but not limited to unspecified fracture of right femur, interstitial pulmonary disease, systemic lupus erythematosus, hypertension, chronic kidney disease, and type 2 diabetes mellitus. On 11/28/2023 resident discharge from the facility to home. Record review of the Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) Score of 15 indicating little to no cognitive impairment. Interview on 4/27/2024 at 2:19 pm R126 reported that the facility nurse failed to give her all her medications. The unidentified nurse reported to her that she should receive her medications two weeks from now by mail. A review of Physician Order form (November 1, 2023 -November 28, 2023) revealed the following orders for R126: folic acid 1 Milligram (mg), gabapentin capsule 300 mg, hydroxyzine HCl 25 mg, Lidocaine Pain Relief Over the Counter (OTC), Methocarbamol 500 mg, Oxycodone 5 mg, Polyethylene glycol 3350 (OTC) powder 17 grams/dose Famotidine (OTC) 20 mg, Ferrosol 325 mg, duloxetine capsule 30 mg, bupropion HCl tablet 150 mg, Atorvastatin 40 mg, and Alendronate tablet 70 mg. Interview on 4/28/2024 at 9:15 am, the Regional Consultant confirmed that there was no evidence that R126 medications were reconciled and given to the resident at the time of discharge. She reported that if meds were given, then there should be documentation in the residents' Electronic Medical Record (EMR) and not in the hard copy record. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/2024 at 9:25 am Register Nurse (RN) NN reported not being able to recall if she provided R126 with her medications. She reported that the procedure is that any discharged to home/community, that residents should only get a 7-day supply of their medications and any narcotics are not transferred with the resident, all narcotics are turned over to the Director of Health Services (DHS). RN NN reported that she did not reconcile the medication with another staff member nor signed off on the medications. She denied receiving any education to sign off that medications were given to the patient and to document in the resident files. Interview on 4/28/2024 at 9:38 am the DHS reported that the correct procedure at the time of any residents' discharge to home/community is the nurse will review the medication with the Medical Director (MD) prior to sending the medication with the resident. If there are narcotics, the nurse will consult with that MD to release the narcotics and review the resident CCD form with the physician. The next step is that the nurse will date and time the medication packages and provide education concerning the medications to the resident/responsible party. She reported that her expectation is that all parties signed the form and nurse file the form in the resident 's EMR.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463 Based on observations, staff and resident interviews, record reviews, and review of the facility's policy titled, "Activities Program the facility failed to ensure one of 23 Residents (R) (R22) reviewed for activities were provided with an individualized activities program to meet their individual needs. Findings include: Review of the facility's policy titled, "Activities Program dated 9/28/2023 under the Policy Statement revealed, The Health Care Center provides, and ongoing program of Activities designed to meet the physical, mental, and psychosocial well-being of each resident while offering a rich array of activities to the residents of the center. Review of R22's Resident Face Sheet revealed she admitted on [DATE] with diagnoses that included but not limited to generalized anxiety disorder, major depressive disorder, single episode, unspecified, depression, suicidal ideations unspecified, schizoaffective disorder, bipolar type, and schizoaffective disorder, unspecified. Review of R22's Admission Minimum Data Set (MDS) for Sections C-Cognitive Patterns revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating little to no Cognitive impairment. Review of R22's Psychiatry Follow Up Note dated 2/13/2024 revealed the Recommendations/Plan included but not limited to continue to encourage participation in recreational activities and patient request coloring book and crayons to provide positive stimulation. Review of R22's Psychiatry Follow Up Note dated 3/13/2024 revealed the Recommendations/Plan included but not limited to continue to encourage participation in recreational activities and patient request coloring book and crayons to provide positive stimulation. Review of R22's Psychiatry Follow Up Note dated 4/9/2024 revealed the Recommendations/Plan included but not limited to continue to encourage participation in recreational activities, patient request coloring book and crayons to provide positive stimulation. Review of the Facility's Activities Calendar from January 2024 through April 2024 revealed one to one activity were provided for residents on Monday, Wednesday, and Fridays. Review of R22's electronic medical records (EMR) revealed there was no evidence that an Activities Assessment had been completed or any documentation related to Activities. During observation and interview on 4/26/2024 at 9:30 am R22 was observed lying in her bed with the television not working. R22 stated she was not happy with the activities at this facility and that the only activity she had was watching television when it worked. She stated she was not sure how long it had been since her television had not been working but would like to have it fixed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/27/2024 at 8:56 am with the Administrator revealed that she had recently hired a new Activities Director, however he was still in the onboarding process. She stated they had been without an Activities Director for about two months, but she was able to fill the role because she was a certified activities director as well. The Administrator stated that Activities Assistant GG helped with providing activities for the residents Monday through Friday and they would rotate coming to work on the weekends if they had something special planned. The Administrator stated they provided one to one activity with residents in their rooms if they were unable to participate with group activities which included hand massages, reading books, word puzzles, word writing, watching television, and listening to music. During observation and interview on 4/27/2024 at 9:03 am, revealed R22 lying in her bed watching television. She reported staff came and fixed her television yesterday, but she would like a coloring book and crayons. She reported staff did not come to her room to offer her activities nor did they offer her a coloring book and crayons. She reported that she received psych services once a month and they told her that they were going to get her a coloring book and crayons but never brought them. During observation and interview on 4/27/2024 at 12:18 pm with the Administrator present revealed R22 lying in bed watching television. R22 stated she did not have a coloring book or crayons but would like to have them. R22 stated staff never offered her a coloring book or crayons. Interview with the Administrator revealed she was not aware the resident wanted a coloring book. She stated Activities Assistant GG usually rolled a cart from room to room with different activities on it such as books, puzzles, and coloring books. During a telephone interview on 4/27/2024 at 12:25 pm with Activities Assistant GG revealed she assisted with activities Monday through Friday at the facility but not on the weekends because she had a second job. She reported she provided one to one activity with R22 daily during the week. When questioned what type of activities she completed with R22 she revealed the resident usually enjoyed conversations with her. Activities Assistant GG revealed she had not completed an activities preference interview with the resident. She stated the Activities Director was responsible for completing those interviews and would communicate that information to her. Activities Assistant GG confirmed she had not offered R22 a coloring book or crayons and that no staff had communicated to her R22's activity preferences. During an interview on 4/27/2024 at 1:55 pm, the Social Services Director (SSD) with the Administrator present revealed R22 received psych services from [Name]. He reported he was responsible for reviewing the psych notes and would communicate to the other departments the recommendations if it pertained to that department. He stated that the Interdisciplinary Team (IDT) reviewed psych notes as well during their weekly meetings. During this time, the Administrator reviewed the R22's Psychiatry Follow Up Note recommendations for coloring book and crayons. Both the SSD and Administrator revealed they did not know that this activity had been recommended. The Administrator confirmed that it had been overlooked. She stated the expectations of staff were to address the needs of residents. During observation and interview on 4/27/2024 at 2:28 pm, R22 was observed lying in bed. She stated she had not received a coloring book or crayons nor had she been offered one to one activity or offered to get up and attend the group activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/2024 at 7:59 am with the Administrator revealed that the activity notes and activity assessments were completed in the EMR. The Administrator confirmed there were no activity notes or activity assessments completed for R22 in the EMR. She stated they went without an Activity Director during R22 stay at the facility and she was filling in and documented the activity notes on paper and kept them in a book in her office. At this time, the activity notes and activity assessments were requested from the Administrator but were not received prior to the survey exit. During observation and interview on 4/28/2024 at 8:12 am, revealed R22 lying in bed with no coloring book or crayons noted. When asked had anyone come and do activities with her or offered her a coloring book and crayons, she stated, no.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41165 Based on staff interviews, record review, and review of the facility's policy titled, Medication Administration: Oral Medications , the facility failed to follow physician orders for one of five Residents (R) (R22). Specifically, the facility failed to administer medication to R22 as prescribed by the physician to take medications whole. Findings include: Review of the facility's policy titled, Medication Administration: Oral Medications effective date 4/1/1998, reviewed 10/17/2023 under Procedures and Key Points revealed nine (9). Crush medication if indicated by Physician's order for this resident only after checking the Crush List. Crush in tablet crusher using the double souffle cup method or other method to prevent tablets from coming into direct contact with the crusher. Medication administration observation on 4/26/2024 at 9:08 am revealed Registered Nurse (RN) KK stated that R22 likes to take her meds crushed but there is no physicians order to crush medications in rsidents medical record. RN KK individually crushed and combined the following medications together pouring them into a plastic 30 Milliliter (ml) medicine cup: Allopurinol 300 Milligram (mg) one tablet Amlodipine 5 mg one tablet Aspirin 81 mg chewable one tablet Bisacodyl 5 mg one tablet Buspar 10 mg one tablet Colace 100 mg one tablet Gabapentin 100 mg one tablet Klonopin 0.5 mg one tablet Metoprolol Tartrate 25 mg one tablet Singulair 10 mg one tablet Oxcarbazepine 150 mg one tablet Oxybutynin Chloride 5 mg one tablet Sodium Chloride 1000 mg two tablets (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Effexor 37.5 mg one tablet Pravastatin 80 mg one tablet Cranberry Extract 200 mg two capsules RN KK opened the capsules and poured the medicine into the cup with the crushed medication. RN KK put 1/2 spoonful of vanilla pudding on top of the medications and stirred them together. RN KK informed R22 of the medications that were in the cup. RN KK administered the medications to R22. Interview with RN KK on 4/26/2024 at 9:40 am revealed that she has been working at the facility for about six months. She stated that she received an in-service on medication administration during orientation upon hire from the clinical manager. During an interview on 4/27/2024 at 10:40 am with the Director of Nursing (DON) revealed her expectations is that medications should be administered as per physician's orders. She stated that if a resident likes their medications crushed the nurse should have called the doctor and get an order to have them crushed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41165 Based on observations and staff interviews, the facility failed to ensure that one of two medication carts on the Richmond Hall were locked and secured when not in use. The facility census was 79 residents. Findings Include: Observation on 4/27/2024 at 8:40 am revealed cart one on the Richmond Hall was observed unlocked and unattended with a plastic 30 Milliliter (ml) medicine cup with pills on top of the cart. The Electronic Health Record (EHR) was open, and the resident's information was visible on the computer screen. Continued observation on 4/27/2024 at 8:44 am revealed Licensed Practical Nurse (LPN) FF, returned to the medication cart and confirmed that he left the medication cart unlocked and unattended with a cup of pills on top of the cart and with the EHR information visible on the computer screen. During an interview with LPN FF on 4/27/2024 at 8:50 am, he stated that he normally does not leave the cart like that. LPN FF stated that he guesses he was a little nervous because the state was there. LPN FF thanked the surveyor for bringing the unlocked cart to his attention. The medication cart remained unlocked and unattended for four minutes. During an interview on 4/27/2024 at 10:40 am, the Director of Nursing (DON) stated that the medication cart should always be locked while unattended. The DON stated that she expects the nurse to administer the medication after it is pulled, and she expects the nurses to lock the medication cart before walking away. She stated that she expects the nurses to cover the computer screen with a piece of paper or log out when not in use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44959 Based on observation, staff interviews, and review of the facility provided recipe titled, Hamburgers, the facility failed to ensure puree recipes were followed to conserve nutritive value of food items served to eight of eight residents receiving a puree consistency diet from the kitchen. Findings include: Review of the facility provided recipe titled, Hamburgers undated, under the Note section revealed, For Pureed: Measure desired # (number) of servings into food processor. Blend until smooth. Add broth or gravy if product needs thinning. Add commercial thickener if product needs thickening. Observation on 4/27/2024 at 11:34 am of Dietary Cook CC revealed she was preparing food for a total of eight residents that received a puree diet. Dietary Cook CC placed 10 pieces of hamburger meat into the food processor and began to puree the hamburger meat for approximately one minute. She then stated that she needed to get some beef gravy and beef base. Dietary Cook CC left the area to get these items from the cooler. Dietary Cook CC returned with a half-filled container of a liquid substance. When asked by the Surveyor what was inside the container, Dietary Cook CC stated that it was a half-cup of beef gravy and a half cup of beef base. There was a black book observed nearby which was identified by the Dietary Manager as a recipe book. The Surveyor did not observe Dietary Cook CC when she poured the liquid in the container because she walked away to the cooler and came back with the liquid nor was the actual measurement of the liquid in the container determined. The Surveyor requested a recipe for puree of the hamburger meat and the facility provided recipe did not specify the amount of meat or liquid needed. However, the puree hamburger meat did not have a puree consistency and appeared thinned and watery. Interview with Dietary Cook CC on 4/27/2024 at 11:40 am revealed she followed the recipe and knew how much liquid she needed to add to the hamburger for a puree consistency. Interview with the Administrator on 4/27/2024 at 2:40 pm revealed her expectations of dietary staff was to follow the recipes. Interview with Dietary Manager on 4/27/2024 at 2:57 pm regarding her expectations of dietary staff was to follow the recipe book for puree food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on observations, staff interviews, and review of the facility's policies titled, Labeling, Dating, and Storage and Cleaning schedule, the facility failed to ensure food items were properly labeled and dated. Specifically, the facility failed to ensure opened food items in the dry storage room were properly labeled and dated and to ensure that kitchen equipment used for food preparation was kept clean and sanitary. The deficient practice had the potential to affect 77 of 79 residents receiving an oral diet from the kitchen. Findings include: Review of the facility policy titled Labeling, Dating, and Storage revised 11/11/2022 under the Policy Statement revealed It is the policy of [Name] for all partners who assist in handling, preparing, serving, and storing food and beverage items to follow the proper procedures for labeling, dating, and storage to ensure proper food and safety. Under the section titled, Procedure revealed, Number one Food and beverage will have an identifying label as well as received date and opened date, as applicable; for items prepared onsite, a 'use by' date will also be indicated. Review of the Cleaning Schedule Policy revised 9/29/2022 under the Policy Statement revealed, It is the policy of [Name] that the Dietary Manager prepare a list of all cleaning tasks and post them in the Dietary Department. It is the Dietary Managers responsibility to develop and enforce the cleaning schedules and to monitor the completion of assigned cleaning tasks to promote a sanitary environment. Under the section titled, Procedure revealed, Number one The cleaning schedule: daily, weekly, and monthly lists all cleaning tasks, specifies frequency of the task, and position (job title) responsible for completion of the task. The dietary partner will initial the form once the cleaning task is completed. Observations on 4/26/2024 at 8:00 am during the initial walk thru with the Dietary Manager (DM) revealed three white containers in the dry storage room with dry food items, two of the three containers were labeled flour and sugar with no opening or discard date, and one container had no label or date on it. The DM identified the item in one of the containers as breadcrumbs. A sticky black substance was observed inside one of the ovens and a white, powdered substance was observed on the second oven. Follow-up observation on 4/27/2024 at 8:15 am with the DM revealed all previously identified concerns were still observed. The DM acknowledged that the three white containers with dry food items were not dated or labeled on the container. The DM acknowledged that one oven had a sticky, black substance inside the oven and the other oven had a white, powdered substance. She stated that someone may have poured something into the oven to clean it but forgot about it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/27/2024 at 2:40 pm with the Administrator revealed that she expected dietary staff to follow food policies on labeling and dating food items, cleaning kitchen equipment, and preparing pureed foods. She stated that they have had a lot of turnovers in the Dietary Department and have had several in-services with dietary staff regarding food labeling and dating as well as cleaning kitchen equipment and preparing pureed foods. She stated that she expected dietary staff to follow the cleaning schedule to clean after use of any kitchen equipment. Interview on 4/27/2024 at 2:57 pm with the DM revealed that she expected dietary staff to label and date all food items and include when to discard the food items. She revealed that she expected dietary staff to clean the kitchen equipment right after use. She stated that she interacts with staff every day about cleaning equipment after use and to date and label food items.

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Pruitthealth - Richmond, LLC	1227 West Wheeler Parkway Augusta, GA 30909

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42463 Based on record review, staff interviews, and review of the Payroll Based Journal (PBJ) [NAME] Report for the first quarter (Q1) of Fiscal Year 2024, the facility failed to accurately report direct care staffing data to the Centers for Medicare and Medicaid (CMS). The facility census was 79 residents. Findings include: Review of the PBJ [NAME] Report for October 1 through December 31, indicated as Q1, documented the following triggered metrics: One-Star Staffing Rating Excessively Low Weekend Staffing Interview on 4/27/2024 at 8:15 am with the Administrator revealed the facility recently had a change in management. She stated the Director of Partner Services at the corporate office submitted the staffing data that was retrieved from the time clock system. She stated salaried employees do not always clock in and out and that the agency staff were not clocking in and out through the facility time clock system until February of this year. She stated the agency staff, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs) used timesheets. She stated the invoices and timesheets from the staffing agency came to the facility however she did not know how to convert the hours electronically into the new time clock system that was used by the corporate office to upload the agency nursing hours to include in the PBJ Report. Telephone interview on 4/27/2024 at 8:45 am with the Director of Partner Services confirmed he was responsible for reporting the data for PBJ report. He stated he generated a report directly from the time clock system, and that was how he got the staffing hours to report. He could not confirm if all the agency staffing hours were included.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115147	A. Building B. Wing	04/28/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 45813 Based on staff interviews, record review, and review of the facility policies titled, Infection Prevention and Control Program Surveillance Reporting, and Antibiotic Stewardship Program the facility failed to provide evidence of a process for periodic review of antibiotic prescribing practices, and to document follow-up measures in response to the data for three of twelve months of infection control data reviewed (January 2024 through March 2024). The deficient practice had the potential to prevent an action plan from being developed related to identified infection concerns within the facility by the Infection Control Committee. Findings include: Review of the facility's policy titled, Infection Prevention and Control Program Surveillance Reporting revised 11/30/2023 revealed: It is the policy of this facility to establish and maintain an Infection Control Program that includes detection, prevention, and control of the transmission of disease and infection among patients/residents and partners. Under Procedure: 1. Patient/resident infections cases are monitored and documented by the Infection Preventionist (IP). The IP review cases of infections, including tracking and analysis of the findings and develops an action plan to resolve identified concerns. 2. A report of residents' infections, Epidemiology Report, and monthly Tuberculosis (TB) reports are submitted. Monthly to the Administrator and Director of Health Services (DHS) Quarterly to the Infection Control Committee. Review of the facility's policy titled; Antibiotic Stewardship Program revised 11/30/2023 revealed: Under Accountability: a. The Antibiotic Stewardship Program (ASP) Team will be established to be accountable for promoting and overseeing antibiotic stewardship activities. b. The ASP Team will monitor and review the following data: I. Infection and antibiotic usage patterns on a regular basis. ii. Antibiogram reports for trends of antibiotic resistance. iii. Antibiotic resistance patterns for multidrug resistant organisms, (e.g., MRSA, VRE, ESBL, CRE, C auris, etc.) and Clostridium difficile infections. iv. Number of antibiotics prescribed (e.g., days of therapy) and the number of residents treated each month. v. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infection. Under Tracking: a. The IP will be responsible for infection surveillance and multi-drug resistance organism (MDRO) tracking. b. The IP, along with the DHS, will collect and review the following data such as: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	I. Documentation of completion of antibiotic choice, dosage, duration, indication and route of administration. ii. Whether appropriate tests, such as a lab and/or cultures, were obtained before ordering antibiotic. Iii. Whether the antibiotic was changed during the course of treatment. Review of the facility's Antibiotic Stewardship Log revealed that the facility's policy is not being utilized. Review of the data collected for the months of January, February, and March 2024 revealed The Infection Control Report Tracker listed residents who received antibiotic therapy who met and did not meet the McGeers criteria for true infections. Review of the Monthly Healthcare Associated Infection Summary Reports revealed all resident who received antibiotic therapy names were listed on The Infection Control Report Tracker and were calculated into the facility's monthly infection rate. Further review of the reports revealed there was a lack of documentation of surveillance data. There was no evidence of communication with the physician related to residents receiving antibiotic therapy who did not meet the McGeers criteria. Review of the mapping of infections revealed the tracking did not match the monthly reports. Interview 4/27/2024 at 1:55 pm with Director of Health Services (DHS) revealed the facility uses the McGeer infection Report from electronic medical records system. She stated the electronic system indicates whether the infection meets the criteria or not on the report based on the data entered. DHS verified that she enters all residents who received antibiotics on the monthly Healthcare associated Infection Summary Report. DHS further clarified she list all residents who were started on antibiotic therapy to include residents in the facility, admitted from the hospital, and those who the report indicated it did not meet the criteria and are calculated into the monthly infection rate. She stated the physician is not notified if the resident is on an antibiotic and it does not meet the criteria for a true infection. DHS further stated she was aware that the McGeers criteria is not met, it is not a true infection and should not have been counted in the monthly infection rate. She looked at the infection control book and confirmed mapping trending and surveillance of the program are not being monitored. Interview 4/28/2024 at 9:15 am with Administrator revealed she expects the staff to follow the CDC guidelines and facility policy with the Antibiotic Stewardship Program