STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115293	A. Building B. Wing	06/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Pooler Inc	508 South Rogers Street Pooler, GA 31322

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463 Based on observations, resident and staff interviews, record review, and review of the facility's policies titled Medication Orders and Storage of Medications, the facility failed to ensure unauthorized medications at the bedside were safely stored and failed to obtain a physician order for self-administration of medications for one of three residents (R) (R223) observed during medication administration. This deficient practice placed R223 at risk for unsafe medication use. Findings include: A review of the facility's undated policy titled Medication Orders revealed the section titled Supervision by a Physician stated, 4. If resident regularly self-administers medication and requests to continue, a self-administration of medication assessment must be completed, and MD [Medical Doctor] must write order as such. The section titled Recording Orders stated, 8. Self-Administration of medication, after assessment completed MD must write order enabling resident to self-administer. A review of the facility's undated policy titled Storage of Medications revealed the section titled Policy Interpretation and Implementation stated, 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location. Medications must be stored separately from food and must be labeled accordingly. A review of R223's Admission Record revealed diagnoses including, but not limited to, pneumonia, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, pulmonary hypertension, morbid obesity due to excess calories, acute pulmonary edema, and obstructive sleep apnea. A review of R223's Admission Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Cognitive Status (BIMS) score of 15, which indicated he was cognitively intact. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/15/2024 at 8:05 am, observation of medication administration and interview with Licensed Practical Nurse (LPN) AA, as she prepared to administer R223's 9:00 am scheduled medications, revealed an Anoro Ellipta inhaler [a medication used to treat COPD] was self-administered by the resident and kept at the bedside. When questioned if the resident had been assessed to self-administer medications, LPN AA stated, he does what he wants to do. LPN AA entered R223's room to administer medications. During this time, a plastic bag containing three medications (an Anoro Ellipta inhaler, an Ozempic pen-injector [a medication used to help lower blood sugar], and an albuterol inhaler [a medication used to treat asthma and COPD]) was observed in the unlocked top drawer of the nightstand at the bedside. The manufacturer's instructions on the box containing the Ozempic pen read, REFRIGERATE-DO NOT FREEZE. An interview during this time with R223 revealed he was admitted to the facility two weeks ago and that the medications were brought from home by a family member. R223 revealed he self-administered these medications that were kept at the bedside. A review of R223's Self-Medication Evaluation, dated 6/3/2024, revealed all questions were marked Can Not Do. The evaluation tool was used to determine if a resident was capable of self-administering medications. A review of R223's June 2024 Physician Orders revealed orders dated 6/3/2024 of Anoro Ellipta inhalation aerosol powder breath activated 62.5-25 mcg (microgram)/ACT (umeclidinium-vilanterol) one inhalation, inhale orally one time a day for PNA (pneumonia), 6/3/2024 for albuterol sulfate powder two puffs inhale orally every four hours as needed for dyspnea, and 6/3/2024 for Ozempic (0.25 or 0.5 mg (milligram)/dose) subcutaneous solution pen-injector two mg/three ml (milliliter) (semaglutide) inject 0.25 mg subcutaneously one time a day every Monday for DM (diabetes mellitus). Further review revealed there were no orders for R223 to self-administer or store medications at the bedside. A review of R223's care plan dated 6/4/2024 revealed a focus area of having medications noted in his room, stated to be brought in by (a family member). The goal was that R223 will not keep medications in his room. The interventions included educating R223 and (family member) on proper storage of prescribed medications, such as in the nurses' cart, educating R223 and his family on the risks of R223's self-medication up to and including overdose, coma and death, and evaluating as needed for possible self-administration of medications. Interview on 6/15/2024 at 1:15 pm with the Director of Nursing (DON) and the Administrator, when questioned how many residents at the facility self-administer medications, they revealed two residents at the facility that had been assessed to self-administer and store medications at the bedside. The DON revealed if a resident wanted to self-administer a medication, the nurses would complete a self-administration tool which would include a return demonstration, in addition to a care plan would be put in place. Interview on 6/15/2024 at 1:20 pm with LPN/Unit Manager (UM) BB, with the DON present, revealed two residents at the facility who self-administered medications. When questioned if R223 self-administered medications, they both stated, No. During the interview, R223's self-medication evaluation assessment and orders were reviewed. Both the DON and LPN/UM BB verified the assessment determined he could not self-administer medications and there were no physician orders to self-administer and store medications at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/15/2024 at 1:25 pm with the DON and LPN/UM BB of R223's room revealed a plastic bag in the unlocked top drawer of the nightstand at the bedside. The plastic bag contained three medications (an Anoro Ellipta inhaler, an Ozempic pen injector, and an albuterol inhaler). An interview with the DON and LPN/UM BB revealed they were unaware R223 had these medications at the bedside. The DON confirmed that R223 should not have been allowed to self-administer and store medications at the bedside, the nightstand drawer should have been locked, and the Ozempic should have been refrigerated. Interview on 6/16/2024 at 8:17 am with the DON revealed her expectations of staff were if a resident wanted to self-administer medications, staff should complete a self-medication evaluation assessment, obtain a physician's order for the resident to self-administer the medications, safely store medications, and make sure a care plan was in place for self-administration of medications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 39786 Based on observations, resident and staff interviews, and review of the policies titled Maintenance Department Policy and Procedures and Cleaning and Disinfection of Environmental Surfaces, and review of the facility document titled Room Cleaning Step by Step, the facility failed to ensure that resident rooms were clean, homelike, and in good repair on two of three halls (Hall B and Hall C). The deficient practice placed residents at risk of residing in an unsanitary living environment and the potential for a diminished quality of life. Findings included: A review of the facility's undated policy titled Maintenance Department Policy and Procedures revealed the Objectives stated 1. Direct and coordinate the operations and activities of the physical plant maintenance, including but not limited to: . building and grounds maintenance; . and environmental compliance. A review of the undated facility policy titled Cleaning and Disinfection of Environmental Surfaces revealed the Policy Interpretation and Implementation stated, 9. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g. daily, three times per week) and when surfaces are visibly soiled. 11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. A review of the undated facility document titled Room Cleaning Step by Step revealed Step 1 included room high-dusting (anything above the shoulders) and filter/ceiling vent cleaning. Step 2 included refilling the paper towel dispenser and sweeping/mopping. Step 3 included everything on the ground must be moved for sweeping and mopping. Observations on 6/14/2024, beginning at 8:00 am and 6/15/2024, beginning at 7:50 am revealed the following: Room C9/C11 adjoining bathroom had stained ceiling tiles and dust on the ceiling ventilation unit. Room C14 had dirty privacy curtains, dirty window blinds, and stained ceiling tiles. Room C17 had broken sheetrock on the walls. Room C18 had a large area of sheetrock that had been plastered but not painted and a missing doorknob on one of two closet doors. 41914 Observations on 6/14/2024 at 8:30 am and 6/15/2024 at 7:30 am of room B11 revealed there was no paper towel dispenser in the bathroom, and paper towels were stored on the back of the toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 6/14/2024 at 8:45 am and 6/15/2024 at 7:45 am of room B12 revealed there was no paper towel dispenser in the bathroom and no paper towels for use. Observations on 6/14/2024 at 9:00 am and 6/15/2024 at 8:00 am of room C1 bed A area revealed a nightstand cluttered with paper, a meal tray top from breakfast, and a bag of miscellaneous items. The wall behind the bed had scraped marks with the sheetrock showing. There were two chairs in the middle of the room with clothes and a large clear bag of miscellaneous items noted in the bag. Observations on 6/14/2024 at 8:45 am and 6/15/2024 at 8:15 am of room C1 bed C area revealed it was cluttered with five cardboard boxes stacked on each other. The nightstand was cluttered with a bag of briefs and other items. The area in the middle of the room had clutter noted on top of the counter area, and on the floor underneath the counter, there were five different boxes with various items in them and a stack of books on the floor. Observations on 6/14/2024 at 9:00 am and 6/15/2024 at 8:30 am of room C4 revealed the counter in the middle of the room had resident items in two hospital bags, and a top from a meal tray was on the counter. Observations on 6/14/2024 at 9:30 am and 6/15/2024 at 8:35 am of room C5 revealed the privacy curtain for A bed had brown stains throughout the curtain. There was trash on the floor in front of the nightstand, the nightstand was cluttered with various items including a folded lap blanket, a brown paper bag, and a dirty washcloth. Bed B area was noted to have a box on the floor by the bed with various items in it. There was a deflated air mattress on the floor by the window and a pile of coffee ground-like substances on the floor in front of the air conditioning unit. The toilet had brown stains noted in the base of the bowl. The urinal on the back of the toilet seat was unlabeled and unbagged. Observations on 6/14/2024 at 10:00 am and 6/15/2024 at 8:40 am of room C6 bed A area revealed on the wall coming into the room, there was an area of missing paint with a brown layer of the wall exposed. The wall to the right of the resident's bed had scraped areas at the base of the wall with missing paint and with the sheetrock visible. The wall to the left of the room by the base board had areas of sheet rock visible and peeling paint noted. An interview on 6/16/2024 at 8:21 am with the Housekeeping Supervisor revealed there were several open positions in the department, and they were working short-staffed. The Housekeeping Supervisor stated the residents' rooms were deep cleaned daily, and during the deep clean, all the furniture was removed from the room, and the room was cleaned from top to bottom. Further interview revealed the floors were buffed and cleaned with a scrubber, and the bathrooms were cleaned with a disinfectant cleaner with dwell time of three to five minutes. The Housekeeping Supervisor stated during the deep clean, the privacy curtains were changed if they were soiled or needed repair. Observation walking rounds were conducted on 6/16/2024 at 8:24 am with the Administrator, Maintenance Director, and Housekeeping Supervisor, and all observations were confirmed at the time of the walking rounds. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/16/2024 at 8:45 am with the Maintenance Director revealed the Maintenance logbook was kept at the reception desk for staff to log in any repairs needed. The Maintenance Director stated the logbook was reviewed daily and the repairs were done by priority. The Maintenance Director further stated daily rounds were made for any immediate needed repairs as well. An interview on 6/16/2024 at 9:15 am with the Administrator revealed that she was aware of the repairs that needed to be completed within the facility and will continue to work on completing the repairs and replacing the privacy curtains when they are available. During the interview, it was also disclosed that the corporate office was aware of the needed repairs within the facility, and she was currently working with them to get things done for the improvement of the residents' environment.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41914 Based on staff interviews, family interview, record reviews, and a review of the facility policy titled Bed Hold Acknowledgement Form: Georgia, the facility failed to provide bed hold information, in writing, at the time of transfer or within 24 hours, for four of six residents (R) (R50, R66, R13, and R11) reviewed for transfer to the hospital. This failure had the potential to contribute to possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings included: A review of the facility's undated policy titled Bed Hold Acknowledgement Form: Georgia under Policy: Bed Holds revealed, Two notices related to the healthcare center's bed hold policy will be issued. The first notice of the bed hold policies is given during the admission, which is well in advance of any transfer. The second notice, which specifies the bed hold policy's duration, will be issued at the time of any transfer. 1. Record review for R50 revealed the resident was transferred to the local hospital on 6/6/2024. A review of the facility's Notice of Transfer or Discharge form for R50 did not indicate that the resident or resident representative was notified of the rates at which the bed hold would be contingently held, nor did it indicate when the bed hold would begin or end for R50 while out of the facility. 2. Record review for R66 revealed the resident was transferred to a stabilization unit on 1/17/2024 for medication regimen stabilization and to the local hospital on 4/17/2024. A review of the facility's Notice of Transfer or Discharge form for R66 did not indicate that the resident or resident representative was notified of the rates at which the bed hold would be contingently held, nor did it indicate when the bed hold would begin or end for R66 while out of the facility. An interview on 6/15/2024 at 8:57 am with Licensed Practical Nurse (LPN) AA revealed that when residents are transferred to the hospital, they are supposed to have the bed hold policy sent with them at the time of transfer. LPN AA stated the Unit Manager (UM) is responsible for ensuring that all documents for resident transfer are completed, including the medication list, history and physical, and the bed hold policy. An interview on 6/15/2024 at 9:01 am with UM BB revealed when residents are transferred, the UM completes the paperwork to send with the resident through the week, and the Weekend Supervisor completes the paperwork on the weekends. The UM stated the documents sent with the resident include the face sheet, list of medications, history and physical, and the bed hold. During the interview, it was confirmed that the bed hold policy did not disclose the amount of the bed hold or provide an area for the resident or the resident's representative to acknowledge and/or agree or disagree with the terms of the bed hold. The bed hold also did not disclose the amount per day for the bed hold. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	39786 3. Record review for R13 revealed discharges to the hospital with return anticipated on: 10/5/2022, 1/3/2023, 8/4/2023, 9/20/2023, 10/6/2023, and 4/9/2024. A review of the electronic medical record revealed one form titled Notice of Transfer or Discharge. The form did not include information about the room rate per day or other required information. 41165 4. Record review for R11 revealed the resident was transferred to the local hospital on 6/14/2022, 8/11/2022, 6/23/2023, and 7/3/2023. A review of the facility's Notice of Transfer or Discharge form for R11 for the above transfer dates revealed the form did not indicate that the resident or resident representative was notified of the rates at which the bed hold would be contingently held, nor did it indicate when the bed hold would begin or end for R11 while out of the facility. An interview on 6/15/2024 at 9:12 am with the DON revealed there is not a separate bed hold policy. She stated that the information about the bed hold is documented at the bottom of the Notice of Transfer or Discharge form. The DON stated that when residents are admitted into the facility, they sign a bed hold agreement during that time. Further interview also revealed that there is not a bed hold agreement that is utilized by the facility that indicates the room rate for the bed hold or that requires a signature by the resident or the resident representative to either agree to hold the bed or to be admitted back into the next available room.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41165 Based on staff interviews, record review, and a review of the facility policy titled Preadmission Screening and Resident Review (PASRR) Level I and II Policy, the facility failed to submit for a PASRR Level II for one resident (R) (R32) after a new mental illness diagnosis was added and failed to implement recommendations of a PASRR Level II for one resident (R16). This deficient practice had the potential to affect the appropriate level of care and services provided for R32 and R16. The sample size was 42. Findings included: A review of the facility policy titled Preadmission Screening and Resident Review (PASRR) Level I and II Policy revealed the Policy Statement of (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that all applicants to a Medicaid-certified nursing facility: 1. Be evaluated for mental illness, intellectual disability, and/or related condition 2. Be offered the most appropriate setting for their needs 3. Receive the services they need in those settings The facility will utilize the admitted PASRR. However, if there is a noted psychological change in condition with behaviors impacting resident day to day care, this will prompt the IDT (Interdisciplinary Team) to review for a new screening. Residents will be monitored for behaviors. Facility will continue to meet highest level of psychological needs and will offer psychology and psychiatry services as needed for emotional support. Behaviors are monitored on all residents regardless of PASRR level to determine if there is a need for review. Residents noted with a need for review will be referred to the Medical Director /IDT to have a new PASRR submitted. 1. A review of the clinical record revealed that R32 was admitted to the facility on [DATE] with diagnoses including, but not limited to, anxiety disorder and depression. On 1/4/2023, a diagnosis of schizophrenia was added. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Section I (Active Diagnosis) revealed schizophrenia, anxiety disorder, and depression (other than bipolar) were checked. During an interview on 6/15/2024 at 9:10 am, the Director of Nursing (DON) reviewed R32's medical diagnoses and confirmed that R32 had a current diagnosis of schizophrenia. The DON stated that R32 was not taking any medications for schizophrenia and did not have a Level II PASRR. The DON further stated the Social Service Director (SSD) was responsible for PASRRs and her expectation was for the SSD to submit for Level II PASRRs timely. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/15/2024 at 2:20 pm, the SSD revealed a submission for a PASRR Level II screening was not done after R32's new diagnosis of schizophrenia and should have been. She stated that she was responsible for submitting for Level II PASRR to Georgia Medicaid Management Information System (GAMMIS). 42464 2. Record review revealed R16 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, major depressive disorder, post-traumatic stress disorder (PTSD), and antisocial personality disorder. A review of the annual MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognition. Section I (Active Diagnosis) revealed anxiety, depression, bipolar, and PTSD were checked. A review of the PASRR Level II dated 6/10/2021 with a start date of 6/2/2021 and an expiration date of 12/31/2099 revealed OBRA status code and definition: 1:1 skilled nursing facility (SNF) approval, appropriate for SNF level of care; has serious mental illness (SMI), needs specialized services for SMI. Further review of R16's medical records revealed no specialized services were being offered for SMI. An interview on 6/16/2024 at 9:23 am with the SSD revealed R16 has a PASRR Level II and was receiving psychiatric services. The SSD stated the Unit Manager kept up with the documentation. An interview on 6/16/2024 at 10:05 am with Unit Manager DD revealed R16 resident was never referred to psychiatric services after admission. Unit Manager DD stated the resident was admitted with PASRR Level II and should be receiving psychiatric services. An interview on 6/16/2024 at 10:10 am with the DON revealed it was her expectation for residents requiring specialized services to receive those services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41914 Based on observations, staff interview, record review, and review of the facility policy titled Oxygen Therapy Policy, the facility failed to ensure oxygen equipment was safely stored for two of 19 residents (R) (R50 and R223) who received oxygen therapy. The deficient practice had the potential to increase the probability of respiratory infection for R50 and R223. Findings include: Review of the facility policy titled Oxygen Therapy Policy, last review date 8/23/2023, revealed the Procedure section included 11. When not in use, the nasal cannula or oxygen mask will be placed in a plastic bag. 1. Record review for R50 revealed the resident was admitted to the facility with the diagnoses of, but not limited to, acute and chronic respiratory failure with hypoxia, pneumonia, dysphagia, bronchitis, disease of the jaw, paralysis of vocal cords and larynx. Observation on 6/14/2024 at 9:50 am revealed a nebulizer mask was noted in the recliner on the seat and not covered. 2. Record review for R223 revealed resident was admitted to the facility with diagnoses of, but not limited to, pneumonia, chronic obstructive pulmonary disease, morbid obesity due to excess calories, acute pulmonary edema, obstructive sleep apnea, and acute or chronic diastolic congestive heart failure. Observation on 6/14/2024 at 9:02 am revealed a nebulizer mask not bagged or labeled. Observation on 6/15/2024 at 7:43 am revealed a nebulizer mask lying on the resident's chest of drawers, not bagged or labeled. An interview on 6/15/2024 at 8:42 am with the Director of Nursing (DON) revealed that all nebulizer masks should be stored in a plastic bag after each use by the charge nurse. Further interview also revealed that the nebulizer masks should never be left lying around on the residents' bedside table without being covered. The DON was notified by the Surveyor that the resident's nebulizer masks were not safely stored for two consecutive days and the DON acknowledged the observations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41165 Based on staff interviews, record review, and review of facility policy titled Infection Control, the facility failed to maintain an effective infection prevention and control program that demonstrated ongoing surveillance, recognition, investigation, and control of infection to prevent the onset and spread of infection. This deficient practice had the potential to increase all residents' exposure to communicable illnesses. The facility census was 77. Findings include: A review of the facility's undated policy titled Infection Control revealed the Policy section stated, It is the policy of our facility to adhere to the basic infection control guidelines to limit or prevent residents and staff from the onset of or spread of microorganisms. The Purpose section stated, To comply with the Department of Health Guidelines and prevent the spread of infection, and maintain a safe, sanitary, and comfortable environment. The Policy Interpretation and Implementation section titled Objectives of Infection Control Policies and Procedures stated, The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility. b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. c. Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard precautions. d. Maintain records of incidents and corrective actions related to infections. e. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. A review of the facility's infection surveillance revealed that the McGeer criteria, or other standardized criteria, was not used for infection surveillance and control in January 2024 and February 2024. There was no documentation of ongoing surveillance, recognition, investigation, and control of infection to prevent the onset and spread of infection for January 2024 or February 2024. An interview on 6/15/2024 at 2:00 pm with Infection Control Preventionist (ICP) CC revealed she uses the McGeer criteria, but she counts all of the infections and everyone that is on antibiotics on her infection control report. The ICP CC stated that she knew to use the McGeer criteria and would go back and use it to track infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115293	A. Building B. Wing	06/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Pooler Inc	508 South Rogers Street Pooler, GA 31322

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 6/16/24 at 7:29 am with ICP CC revealed she took over the infection control program in January 2024 and did not use McGeer criteria until March 2024. She stated she had completed training to include using McGeer criteria and knew she should use it. In an interview on 6/16/2024 at 7:58 am, the Director of Nursing (DON) stated that she trusted that ICP CC was using the McGeer criteria and stated that she did not review the infection control book to make sure that the McGeer criteria was being used. The DON verified that there was no documentation of ongoing surveillance, recognition, investigation, and control of infection to prevent the onset and spread of infection for January 2024 or February 2024. The DON further stated that her expectation was for ICP CC to follow the McGeer criteria for counting true infections.