STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145136	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Auburn	304 Maple Avenue Auburn, IL 62615

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to prevent resident to resident abuse for 3 of 5 residents (R24, R36, R109) reviewed for abuse in the sample of 34. Findings Include: R20's Face Sheet, undated, documents R20 has the following diagnoses: Anxiety Disorder, Depression and Unspecified Dementia with Behavioral Disturbance. R20's Minimum Data Set, MDS, dated [DATE], documents R20 has severe cognitive impairment and displays verbal, physical, and other behaviors. R20's Care Plan, dated 3/29/23, documents R20 has a behavior problem of becoming physically aggressive towards others, becoming aggressive when anxious becoming verbally aggressive and has a mood problem. R20's Progress Note, dated 7/16/24 at 4:40 PM, documents the following: R20 grabbed another resident (R109) by the right arm, shirt area. No signs of injury noted. The State Agency and local PD (Police Department) notified. The facility's Preliminary Report, dated 7/16/24, documents the following: R20 grabbed R109's shirt in the right arm area. Staff intervened and the residents were separated. R20's Progress Note, dated 7/26/24 at 11:14 AM, documents the following: Based on the results of the investigation the facility has found evidence to support the allegation. The facility's Final Report, dated 7/23/24, documents the following: Facts determined: R20 grabbed R109's shirt. Staff was interviewed and stated R20 came up and grabbed R109's right arm, it appeared that he only grabbed her shirt, no red marks were observed on R109. Based on the results of the investigation the facility has found evidence to support the allegation of physical abuse. SSD will follow up with R20 and R109 for any psychosocial needs that arise. Care plans were reviewed and updated accordingly. Staff were in-serviced on the Abuse policy. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's Progress Note, dated 9/16/24 at 10:00 AM, documents the following: IDT (Interdisciplinary Team) met to discuss the alleged physical altercation between R20 and another resident (R24). Root cause - a resident (R24) was sweeping the dining room floor and R20 came into the dining room. Intervention R20 asked to leave the dining room during clean up after meals. The facility's Final Report, dated 9/19/24, documents the following: R24 was interviewed and voiced he was sweeping in the dining hall and R20 tried to take his broom and then came up behind him and put his arms around his head/ear. R24 reported he had an abrasion to the right ear from R20 putting his arms around him. V9, Licensed Practical Nurse, LPN, stated she came to the dining hall after being alerted of an alleged altercation between R20 and R24 and saw R20 with his hands and arms around R24's neck and face. V9 stated she separated the two residents and observed an abrasion to R24's right side of his face below his ear and provided first aid. Intervention: R24 enjoys sweeping and will sweep while staff are present. Staff will encourage R20 to leave the dining room during clean up. Care plans were reviewed and adjusted as needed. The facility's Final Report, dated 12/13/24, documents the following: V8, AD (Activity Director), stated she heard someone say stop and when she turned around, she saw spilled coffee and R24 put his arm up as if to block the coffee, then R20 hit R24 in the left forearm. V8 stated she separated the two residents. R24 stated he does not know why R20 did this, he did not do anything to R20. Intervention: R20 will be seen by psychiatry services on 12/24/24. Review and revise care plans accordingly. R20's Progress Note, dated 12/29/24 at 5:27 PM, documents the following: Writer observed resident (R20) ramming his wheelchair into the back of another resident's (R36) wheelchair in the dining area. R36 asked resident (R20) to stop, and resident (R20) became aggressive and grabbed her (R36) arm and attempted to yank/pull her arm away from her. Female resident (R36) began to scream in pain and yell at R20. At this time, writer came into the dining area and separated both residents. Writer assessed female resident (R36) and found no injuries. Offered analgesic, which she declined. Call placed to administrator to notify of incident. The facility's Final Report to the State Agency, dated 1/3/25, documents the following: V4, LPN (Licensed Practical Nurse), stated R36 said to R20 Grandpa, don't bump my chair. R20 then grabbed R36's arm. R36 stated she didn't know why R20 did this, he was bumping into her wheelchair, so she asked him to stop, when she said that, he grabbed her upper left arm and then staff came to help and took R20 out of the dining room. No injuries noted. Intervention: R20 was redirected by staff from the dining room after displaying behaviors, review, and update care plan accordingly. On 2/6/25 at 12:31 PM V7, Social Services Director, (SSD), stated R20 has agitation due to his Dementia. V7 stated R2 becomes agitated when it is louder than he would like, when someone bumps into him or his wheelchair or when he feels like he is being yelled at. V7 stated in response, he will intentionally bump into the other person or grab them, trying to get them. V7 stated as an intervention she will try to talk with R20 or if he is having a rough day, try and find out why and R20 likes hot chocolate so they will offer that to him. The Abuse Prevention and Reporting Policy, dated 11/2016, documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services or mistreatment.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50840 Based on interview, observation, and record review the facility failed to act immediately after determining a resident was unresponsive, did not check for a pulse until prompted by the survey team and initiate CPR immediately to a resident in medical distress for 1 of 1 resident (R257) reviewed for CPR in the sample of 34. This failure resulted in an Immediate Jeopardy that began on [DATE] at 10:09AM, when R257 was identified to be unresponsive to verbal stimuli and staff failed to check for a pulse until prompted by the survey team and immediately initiate CPR (Cardiopulmonary Resuscitation). On [DATE] at 3:07PM V5, Regional Director of Operations and V18, Regional Director of Clinical Operations were notified of the Immediate Jeopardy. The survey team confirmed through observations, interview, and record review, that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training and quality assurance. Findings Include: On [DATE] at 10:05 AM, R257 was lying on her back, in bed in flat and was unarousable to verbal stimuli. On [DATE] at 10:09 AM, V15, CNA (Certified Nursing Assistant) was observed walking into R257's room, V15 was asked if she could arouse R257. V15 tried to arouse R257 by calling out name and touching R257. V15 was unable to arouse R257 at this time. V3, ADON (Assistant Director of Nursing) was in the hallway and asked to come into R257's room by the survey team. V3 tried to arouse R257 by calling her name and shaking R257's chest. V3 stated, She is diabetic. I'm going to do an accucheck. She stated to the CNA, Get a set of vitals on her. V3 left the room to get a glucometer and V15 got an electronic vital signs machine and put the blood pressure cuff on the resident and hit the start button. The machine was not registering a pulse or blood pressure and I (surveyor) asked the, How do you usually check for a pulse? and she (V15) stated she (V15) usually checks for a pulse on a resident's wrist (radial) and surveyor asked her to please do that no one had stated, Call a code . additional staff came into the room at this point and V3 DON did walk up the hall with the crash cart On [DATE] at 10:11 AM. V15, CNA, came into R257's room with vitals machine and tried to obtain vitals. V15, CNA, was unable to obtain blood pressure reading. V15 was asked by the survey team if she could feel a pulse. V15 stated she was unable to feel a pulse. On [DATE] at 10:12 AM, V3, ADON tried to obtain vital signs on R257. V3 unable to obtain blood pressure reading. V3 stated R257 had shallow breathing with a pulse oximeter reading of 76%, and she could feel a faint pulse. V3 stated she did not count R257's pulse but could feel a faint one. V3 obtained a blood sugar reading of 139. On [DATE] at 10:13 AM, V2, DON (Director of Nursing) walked into R257's room and V3, ADON advised V2 that R257 needed oxygen. V2 left room and came back with the crash cart containing the oxygen and applied it to R257 per nasal cannula. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 10:15 AM, V16, RN (Registered Nurse) listened to R257. V16, RN, stated she could not hear any breath sounds but could feel a faint pulse. On [DATE] at 10:16 AM V16, RN, started chest compression and V3, ADON administered breath per resuscitation bag. On [DATE] at 10:17 AM, V7, SSD (Social Service Director) stated R257 is a full code and emergency services were already called by nursing staff. On [DATE] at 10:18 AM, V14, LPN/MDS (Licensed Practical Nurse/Minimum Data Set) took over chest compressions on R257. On [DATE] at 10:22 AM, First Responders arrived to the facility. On [DATE] at 10:24 AM, First Responders applied AED (Automated External Defibrillator) machine. No heartbeat noted on machine, first responders took over CPR from facility staff. On [DATE] at 10:47 AM, Emergency Medical Services declared R247's date/time of death. R257's Face Sheet, undated, documents R257's medical diagnoses includes Orthopedic Aftercare, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia, Hypothyroidism, Congestive Heart Failure and Chronic Kidney Disease. R257's POLST (Practitioner Order For Life-Sustaining Treatment) form, dated [DATE], documents R257 is a Full Code. Attempt cardiopulmonary resuscitation (CPR). Utilize all indicated modalities per standard medical protocol. On [DATE] at 11:44 AM V17, Medical Director stated CPR should have been started on R257 right away when staff noticed R257's condition. The Facility CPR Policy, dated ,d+[DATE], documents the facility will provide basic life support, including CPR, when a resident requires such as emergency care, prior to the arrival of emergency medical services, subject to the physician order and resident choice indicated in the resident's advanced directive. Abatement Plan [DATE] Description of occurrence:Cardio-pulmonary Resuscitation Action Taken Completion Date 1) Facility reviewed code blue procedure and emergency procedures with all staff. Initiated on [DATE] by V18, Regional Director of Clinical Operations. o Weekly random code blue mock drill to be completed by administrator or designee. o All staff educated to stay with unresponsive person and call for help. If qualified, staff to check for pulse, if pulseless initiate CPR immediately, if required by V14, LPN/MDS, on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Any staff that are not in in the facility were notified via phone, if not reachable will be educated prior to taking shift by DON or designee. o Signage placed at time clock and nurses' station with the above education. o All nursing staff is being required to attend CPR refresher course. Courses starting [DATE]. Weekly audits to be completed by DON or designee. o Ad hoc QA (Quality Assurance) with IDT (Interdisciplinary Team) to review code blue policy by V18, Regional Director of Clinical Operations, on [DATE]. o Emergency code blue drill ran on [DATE] at 5:40 PM to ensure compliance by V5, Regional Director of Operations and V3, ADON. 2) Facility reviewed for POLST and advance directives polices with IDT. Initiated on [DATE] by V18, Regional Director of Clinical Operations. o Social services to audit twice a week to ensure POLST forms are in place for all residents. o Ad Hoc QA with IDT to review POLST/advance directives and educate if any changes to educate staff on [DATE] o Audit of all residents POLST and verification that code status is showing on EMR (Electronic Medical Record) home sheet to easily read- audited by V7, Social Services Director, on [DATE]. o Administrator and/or designee will audit all POLST and verification that code status is on (EMR) home sheet to easily read weekly beginning on [DATE].

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50840 Based on observation, interview, and record review the facility failed to provide surgical site care on 1 of 3 residents (R257), reviewed for quality of care in the sample of 34. Findings include: On 2/5/25 at 1:00 PM R257's left hip dressing, undated, was observed with the outer layer of the dressing torn away, exposing gray layer of dressing. R257's Face Sheet, undated, documents R257's medical diagnoses includes Orthopedic Aftercare, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia, Hypothyroidism, Congestive Heart Failure and Chronic Kidney Disease. R257's Care Plan, dated 1/24/25, documents R257 is at risk for skin impairment with interventions to monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD (Medical Doctor). R257's Admission Assessment, dated 1/24/25, documents R257 is cognitively intact, alert to person, place, time, and situation. Left trochanter (hip) Incision line well-approximated with 24 staples. No redness or drainage noted. Measures 18 cm in length. R257's Physician Order, dated 1/24/25, documents to schedule a follow up appointment with the Orthopedic Surgeon 2 weeks from surgery. R257's Hospital Discharge Plan, dated 1/24/25. documents discharge wound instructions: treatment: do not submerge incision in water. Do not apply ointments, creams, or lotions. R257's Wound Rounds Assessment History, dated 1/27/25, documents R257 has surgical site to left hip measuring 22 cm (centimeters) x 5 cm and unable to determine if infection is present. R257's Wound Rounds Assessment Details Report, dated 2/4/25, documents R257 has dressing to left hip surgical site with light amount of serosanguinous drainage present and unable to determine if signs of infection present, measuring 22 cm x 5 cm, unable to remove dressing at this time. R257's Nursing Note, dated 2/5/25 at 1:29 PM, documents the following Writer phoned (Orthopedic Surgeon) to inquire about when follow up appointment was scheduled for. It is scheduled for 02/06/2025 at 1400. Writer also inquired to the nursing staff re: dressing & drainage. Informed that dressing pad was almost completely saturated with exudate. Writer asked if MD would like for dressing to be changed before appointment or wait until tomorrow. Nurse stated that if dressing is leaking, staff may change the dressing before the appointment. On 02/05/25 at 1:00 PM R257 stated the facility has not done anything with her left hip dressing or surgical incision. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 11:10 AM V3, ADON (Assistant Director of Nurses) stated R257 has follow up appointment with the Orthopedic Surgeon on 2/6/25 at 2:00 PM On 2/5/25 at 11:34 AM V3, ADON stated R257's Orthopedic Doctor monitors R257's left hip surgical incision and bandage. On 2/5/25 at 1:32 PM V3, ADON stated she has not seen R257's left hip surgical incision and does not know what it looks like. When asked about physician orders for R257's left hip surgical incision, V3, ADON stated the facility has orders from R257's hospital discharge regarding the incision. V3, ADON stated it is normal standard practice not to remove a surgical dressing, when the resident has their follow up orthopedic appointment the dressing will be removed. On 2/5/25 at 1:58 PM V13, RN (Registered Nurse) at Orthopedic Doctor's Office stated the physician expects the facility to be checking the resident's surgical incision and site for any signs and symptoms of infection. V13 stated if a patient is discharged to a facility after surgery, the physician will have the facility check and take care of the patient's surgical wound and dressing. V13 stated R257's physician notes documents to have the surgical dressing remain clean, dry, and intact until follow up appointment and may reinforce and change as needed. V13 stated the facility should be checking R257's surgical dressing every shift, monitoring for any signs and symptoms of infection. V13 stated if R257's dressing is saturated and does not get changed, then the surgical site could get infected. V13, stated the facility contacted the physician's office on 2/5/25 reporting R257's dressing was saturated and soiled. V13 stated the facility was informed they can change R257's dressing due to it being saturated. V13 denied any other documented phone calls from the facility regarding R257's surgical incision and dressing. On 2/5/25 at 2:30 PM V3, ADON asked if she would be changing R257's left hip dressing and V3, ADON stated she would not be changing the hip dressing because it was not leaking. V3, ADON stated the physician's office stated the facility could change the dressing if it was saturated or leaking. On 2/5/25 at 1:28 PM V2, DON (Director of Nurses) stated when a resident is admitted to the facility following a surgery, she expects the resident to have orders documented regarding surgical incisions and care to be provided. The Facility's Skin Condition Assessment & Monitoring Non-Pressure Policy, revised 6/2018, document's purpose: to establish guidelines for assessing, monitoring and documenting the presence of non-pressure skin conditions and assuring interventions are implemented. Dressings which are applied to incisions shall include the date of the licensed who performed the procedure. Dressing will be checked daily for placement, cleanliness and signs and symptoms of infection. A licensed nurse shall observe condition of wound incision daily or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling or pain will be documented in the nurse's notes.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 42834 Based on interview and record review, the facility failed to have a system in place to monitor and track, infections in the facility for 5 of 5 (R3, R8, R47, R30, and R22) residents reviewed for antibiotic stewardship/ Infection control in a sample of 34. Findings include: 1. R3's Physician order sheet dated 8/19/2024 documents Fosfomycin Tromethamine Oral Packet 3 gram (GM). Give 3 gram by mouth one time only for Urinary Tract Infection (UTI) for one day. R3's Medication Administration Sheets (MARS) dated 8/1/2024 - 8/31/2024 documents Fosfomycin Tromethamine Oral Packet 3 GM. Give 3 gram by mouth one time only for Urinary Tract Infection for one day. Date of administration 8/19/2024. Facility's infection control log dated 8/19/2024 documents Fosfomycin, Urinary Tract Infection. No organism documented. R3's Nursing Notes dated 8/19/2024 at 1:40PM documents daughter called requesting R3 be placed on an antibiotic for UTI. Nurse Practitioner, NP, notified and ordered Fosfomycin 3 GM by mouth times one. Daughter called back and made aware. 2. R8's Physician order sheet dated 12/20/2024 documents Amoxicillin Oral Capsule 500 MG (Amoxicillin). Give one capsule by mouth in the morning for cellulitis for 30 Days. R8's Physician order sheet dated 1/25/2025 documents Amoxicillin Oral Capsule 500 MG (Amoxicillin). Give one capsule by mouth one time a day for preventative cellulitis. R8's Medication Administration Sheets (MARS) dated 12/1/2024-12/31/2024 documents Amoxicillin Oral Capsule 500 MG. Give one capsule by mouth in the morning for cellulitis for 30 Days Start Date-12/21/2024 at 6:00AM. Dose administered 12/21/2024-12-31-2024. R8's Medication Administration Sheets (MARS) dated 1/1/2025-1/31/2025 documents Amoxicillin Oral Capsule 500 MG. Give one capsule by mouth in the morning for cellulitis for 30 days. Start Date-12/21/2024 at 6:00AM. Dose administered 1/1/2025-1/19/2025. Facility's Infection Control Log dated 12/20/2024 documents for R8: Ceftriaxone, Bacterial, Cellulitis. Facility's Infection Control Log dated 1/27/2025 documents for R8: Amoxicillin. Infection unknown. R8's Nurse's Notes dated 12/21/2024 at 8:53PM document continue on intravenous Ceftriaxone and by mouth Amoxicillin for cellulitis to left lower extremity with no adverse reactions noted. Fluids encouraged and taken well. PICC line in place to right upper arm with no signs or symptoms of infection noted. No redness, edema, or warmth noted to left lower extremity. Voices no complaints of pain. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Nurse's Notes dated 1/25/2025 at 2:15PM documents Call received from Nurse Practitioner, NP at Infectious Disease. R8 is to start Amoxicillin 500 MG daily. Antibiotic will have no stop date. This is a preventative medication to help prevent cellulitis from returning. NP gave OK to start medication in the AM. 3. R47's Physician Order Sheet dated 1/25/2025 documents Cephalexin (Keflex) capsule. Give 500 MG by mouth two times a day for UTI for 5 days. R47's Medication Administration Sheets dated 1/25/2025 Cephalexin (Keflex) capsule. Give 500 mg by mouth two times a day for UTI for 5 Days. Start Date-01/25/2025 at 4:00PM. Doses administered 1/25/2025-1/30/2025. R47's Nursing Note dated 1/25/2025 at 3:45PM documents Physician here in building. Aware of urinalysis being obtained but lab being unable to pick urine up until Monday. R47's urine is cloudy and has sediment. Orders received to start Keflex 500 MG by mouth twice daily for 5 days for possible UTI. First dose obtained from back up for R47. Facility Infection Control log dated 1/24/2025 documents for R47: Acyclovir, Bacterial, UTI. 4. R22's order sheet dated 1/2/2025 documents Levofloxacin Oral Tablet 500 MG (Levofloxacin). Give one tablet by mouth one time a day for Cellulitis until 01/12/2025 11:59PM. R22's Medication Administration Sheets dated 1/1/2025-1/31/2025 documents Levofloxacin Oral Tablet 500 MG(Levofloxacin). Give one tablet by mouth one time a day for Cellulitis until 1/12/202523:59-Start Date 1/02/2025 4:00PM. Doses administered 1/2/2025-1/12/2025. R22's Nursing Notes dated 1/2/2025 at 5:40AM documents R22 has redness, slight swelling to left lower extremity, warmth noted, pain noted. Physician notified. New orders given for antibiotic. Will continue to monitor. Facility infection control log dated 1/2/2025 documents for R22: levofloxacin, bacterial skin infection. 5. R30's Physician Order Sheets dated 11/22/2024 documents Sulfamethoxazole-Trimethoprim Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim). Give one tablet by mouth every morning and at bedtime for prophylactic until 11/29/2024 11:59PM. R30's Medication Administration Sheets dated 11/1/2024-11/30/2024 documents Sulfamethoxazole-Trimethoprim Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give one tablet by mouth every morning and at bedtime for prophylactic until11/29/2024 at 11:59PM. Start Date 11/22/2024 at 8:00AM. Doses administered 11/22/2024-11/29/2024. R30's Nursing Notes dated 11/22/2024 at 12:45PM documents R30 returned via facility transport from OCI. New order received for Bactrim DS one tablet by mouth twice daily times seven days for prophylactic use. Soft care on left arm. May remove for hygiene. Complaints of pain to bilateral arms. Will continue to monitor. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility infection control log dated 11/26/2024 documents for R30: Sulfamethoxazole. Bacterial cellulitis. On 2/6/2025 at 10:00AM V2, Director of Nursing, DON, stated We have a computer program that we track and trend with. If a resident comes into the facility on an antibiotic but no culture, we have to try to get it. Facility policy dated 2025 states The facility is dedicated to implementing an Antibiotic/Antimicrobial Stewardship program to reduce the unnecessary use of antibiotics. This program help ensure that our residents get the right antibiotics at the right tie for the right duration and can improve individual patient outcomes prevent deaths from resistant infections, slow antibiotic resistance, decrease Clostridium difficile infections, and reduce healthcare costs.