STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146057	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monmouth Nursing Home	117 South I Street Monmouth, IL 61462

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33970 Based on record review and interview the facility failed to allow one resident (R11) to choose her own doctor of 12 residents reviewed for choices in a total sample of 26. Findings Include: The Illinois Long-Term Care Ombudsman Residents' Rights for People in Long Term Care Facilities documents You have the right to choose your own doctor. R11's Nurse's Notes dated 7/21/24 at 5:45 PM documents Resident told this nurse that she did not want to be seen by (V10/Doctor) any longer. On 12/19/24 at 8:45 AM R11 confirmed that she did not want (V10) as her doctor. I just don't care for him. R11 stated I have told them (facility staff) but (V10) still comes to see me. I don't like him. On 12/19/24 at 9:00 AM V4 (Social Service Director) confirmed that all residents can pick their own doctor and that no one had notified V4 that R11 wanted to switch doctors.

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on record review and interview, the facility failed to ensure residents electronic medical records and care plans matched the Physician's Order for Life-Sustaining Treatment (POLST) for Cardio-Pulmonary Resuscitation (CPR) code status for three of five residents (R4, R6, R22) reviewed for Advanced Directives in the sample of 26 residents. Findings include: The Advanced Directives policy reviewed ,d+[DATE] documented the facility will gather information about whether or not the resident has executed an advanced directive and place this information in the medical record. The plan of care for each resident will be consistent with the resident's treatment preferences and/or advanced directives. The resident has the right to refuse treatment and will not be treated against his or her own wishes. If the resident or representative refuses treatment, the facility will document specifically what the resident is refusing. Advanced directives are written instructions for healthcare relating to the provisions of health care when the individual is incapacitated. The state's Uniform Practitioners Orders for Life-Sustaining Treatment (POLST) Form indicates whether the resident in cardiac arrest wishes to have cardiopulmonary resuscitation performed/full code or to not attempt resuscitation efforts/do not resuscitate/DNR. The POLST also has three options for a resident not in cardiac arrest: full treatment which the primary goal is to attempt to prevent cardiac arrest by using all indicated treatments; selective treatment which the primary goal is to treat medical conditions with limited measure, do not intubate or use mechanical ventilation, may use non-invasive forms of positive airway pressure, administer intravenous fluids, antibiotics, cardiac medications and transfer to hospital if needed; comfort focused treatment which the primary goal is maximizing comfort through symptom management, allow a natural death, do not use treatments listed in the full treatment or selective treatment unless consistent with comfort goal. 1. R4's Physician's Order dated [DATE] documented R4 was a full code. R4's Current Care plan documented Advanced Directives will be honored through the end of the review period, although does not specify specific resuscitative wishes per the POLST. R4's POLST dated [DATE] and signed by R4's Power of Attorney (POA), documented R4 chose comfort-focused treatment only/DNR. 2. R6's Physician's Order dated [DATE] documented R6 was a DNR. R6's Current Care plan did not document any advanced directive preferences. R6's POLST dated and signed by R6 on [DATE], documented R6 chose Selective Treatment. 3. R22's Physician's Order dated [DATE] documented R22 was a DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Current Care plan documented R22 was a DNR. R22's POLST dated [DATE] and signed by R22's POA, documented R6 chose Selective Treatment. On [DATE] at 1:30 PM, V1 (Administrator) stated the care plans should identify the resident's Advanced Directive and the physician orders should match the POLST form.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33970 Based on record review and interview the facility failed to report an in injury of unknown origin to the state reporting agency for one resident (R192) of two reviewed for accidents in a total sample of 26. Findings Include: The Facility's Abuse,Prevention and Prohibition policy dated 2021 documents The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. such reports may also be made to the local law enforcement agency in the same manner. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the administrator. The person made aware of allegations of abuse or neglect or the administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. If the event that cause the allegation do not involve abuse and do not result in bodily injury, these will be reported to the administrator immediately and to the State Survey Agency no later than 24 hours. R192's Nurse's Notes dated 11/3/24 at 1:47 PM documents, resident (complained of) left knee pain. very faint bruise noted to knee cap, when asked how it happened she gave 3 different stories to 3 different people. R192's MDS (Minimum Data Set) dated 12/17/2024 documents a BIMS (Brief Interview for Mental Status) score of 15/15 points, indicating R192 is cognitively intact. On 12/17/24 at 9:00 AM R192 stated that her left knee is bruised. R192 stated, I'm not sure how that happened. One time during a (mechanical lift transfer) my leg was caught under my room mate's bed but I don't remember any specific injury with that. R192's New Skin Issue notation dated 11/4/23 documents that the staff members that had cared for R192 all reported no knowledge of resident's knee being bumped during transfers on any object as resident states. CNA (Certified Nurse Aid) and Nurses report that resident often voices pain during movement. On 12/18/24 at 1:20 PM V1 (Administrator) confirmed that R192's bruise should have been considered an injury of unknown origin and report to the state agency per the facility's policy.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on interview and record review, the facility failed to accurately document the assessment for a resident receiving hospice services in the Minimum Data Set (Minimum Data Set/MDS-a federally mandated assessment) for one of two residents (R3) reviewed for hospice services in the sample of 26 residents. Findings include: The MDS/Minimum Data Set documented R3 was admitted on [DATE] with the diagnoses of Traumatic Brain Injury, Mood Disorder, Anxiety Disorder, Dementia and Major Mood Disorder. A physician's order dated 3/27/23 ordered to admit R3 to hospice services. R3's record included a notice of admission to hospice services effective 3/27/23. The care plan dated 9/27/24 documented R3 had hospice services. The quarterly MDS dated [DATE] and 9/27/24 Section O 0110: Special Treatments, Procedures, and Programs documented R3 was not on hospice services. On 12/18/24 at 1:45 PM, V5 (Licensed Practical Nurse/LPN, Care Plan/MDS Coordinator) stated R3 elected hospice services on 3/27/23 and currently remained on hospice services. V5 stated the MDS entries on 6/28/24 and 9/27/24 were entered in error and should have indicated R3 received hospice services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on observation, interview, and record review, the facility failed to ensure hospice coordinated communication and the plan of cares were available and accessible to facility staff. This deficiency affects two of two residents (R3, R29) reviewed for Hospice care services in the sample of 26 residents. Finding include: The Hospice service agreements documented a copy of the plan of care will be furnished to the facility at the time of admission and when updated, of all cares provided, physician orders, election of benefits form, advanced directives, physician certification and recertification of terminal illness, a list of names and contact information for hospice personnel and hospice medication information specific to each hospice patient. 1. R3's Admission Record documented R3 was admitted to the facility on [DATE] with diagnoses of intracranial injury with loss of consciousness, mood disorder, anxiety disorder and dementia. An active physician's order to admit R3 to hospice was dated 3/27/23. The Hospice Admission Agreement dated 3/27/23 and Hospice Admit Letter dated 3/27/24 were the only hospice related documentation scanned into the electronic medical record. The current care plan stated Advanced Directive/End of Life Care Plan. (R3) has (name of hospice service) Hospice Services. The care plan lacked any other documentation about hospice services provided, frequency of services or specific interventions related to hospice cares. 2. R29's Admission Record documented R29 was admitted to the facility on [DATE] with the diagnoses of infective endocarditis from methicillin-resistant staphylococcus aureus, osteomyelitis of vertebrae, discitis of the cervical region and prostate cancer. An active physician's order to admit R29 to hospice was dated 10/11/24. The Facility Notification of Admission to the hospice dated 10/11/24 was the only hospice related documentation scanned into the electronic medical record. The current care plan documented D/T (due to) a decline in condition, (R29) has been admitted to (name of hospice service) Hospice services. The care plan lacked any other documentation about hospice services provided, frequency of services or specific interventions related to hospice cares. On 12/18/24 at 11:20 AM, V9 (Licensed Practical Nurse/LPN) stated there were hospice binders at the nurse's station. V9 found one hospice binder although the binder was observed to have no resident records. V9 stated and demonstrated a dashboard in the electronic medical records that listed the hospice residents and name of provider. V8 stated the staff don't have access to hospice records and just go off of our (facility) care plan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 1:45 PM, V5 (Licensed Practical Nurse/LPN, Care Plan Coordinator) stated the facility does not have a hospice policy and the hospice agreements are used to outline the hospice and facility's responsibilities. V5 stated if the hospice provided the facility with a hospice care plan or any other records/forms of communication, V5 would scan it into the computer (electronic medical record). V5 stated hospice staff reviews the facility's care plan and that is how care is coordinated between the hospice and the facility. V5 reviewed R3 and R29's facility's care plan and confirmed the facility's care plan did not include specific intervention pertaining to hospice care. On 12/19/24 at 1:30 PM, V1 (Administrator) verified the facility should obtain and have the hospice's plan of care for staff to review and the facility's care plan should have specific intervention for the care of a hospice resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970 Based on interview, observation, and record review the facility failed to provide appropriate indication for use of antipsychotic medications, attempt gradual dose reductions, and limit the use of as needed psychotropic medications to 14 days for four of five residents (R5, R16, R19, R26) reviewed for unnecessary medications in a sample of 26. Findings include: The facility's policy titled Psychotropic Medication Use, reviewed 01/2017, documents, Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. Residents who are admitted from the community or transferred from the hospital and who are already receiving psychotropic medications will be evaluated for the appropriateness and indications for use. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-effective disorder; c. Schizophreniform disorder; d. Tourette's Disorder; e. Huntington Disease. Diagnoses alone do not warrant the use of psychotropic medications. Gradual dose reductions of psychotropic medications will be done as outlined per federal regulations. 1. R5's Admission Record documents that R5's date of admission to the facility was 7/25/24 and R5's diagnoses on admission include but not limited to Alzheimer's Disease with Late Onset and Dementia in other Diseases Classified Elsewhere, Moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R5's Minimum Data Set (MDS) assessment, dated 11/1/24, documents Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. R5's Physician Order, dated 7/25/24, documents R5 has an order for Quetiapine/Seroquel (Antipsychotic medication) 25 milligrams(mg) by mouth at bedtime related to Dementia in other Diseases Classified Elsewhere, Moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R5's current care plan documents R5 receives antipsychotic medication related to dementia. R5's Consent for treatment with an Atypical Antipsychotic, dated 7/25/24, documents consent for Seroquel 25mg use for Dementia without behaviors. R5's Behavior Monitoring and Interventions Report, dated 8/17/24, 8/18/24, 8/27/24, and 12/3/24, documents no behaviors observed. No further behavior documentation available in R5's medical record. On 12/17/24 at 11:50am, R5 standing at vanity in room, dressed in clean clothes, well groomed. R5 was grabbing for [NAME] pins to place in her hair. R5 is calm when speaking and pleasant. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 at 10:33am, R5 standing in room, dressed, well groomed, calm looking in mirror. On 12/19/24 at 08:33am, R5 sitting in wheelchair at dining room table eating breakfast. R5 is calm and conversing with tablemate's. On 12/19/24 at 10:00am, V2 (Director of Nursing/DON) stated that R5 was admitted to facility on 7/25/24 on Seroquel for Dementia in other Diseases without Behavioral Disturbance. V2 (DON) stated R5 has had no behaviors nor has R5 had a gradual dose reduction attempted. V2 (DON) stated that it is typically the practice of the facility to refer all residents on psychotropic medications to behavioral health but R5 was missed so referral was placed 12/18/24. V2 (DON) would not confirm or deny that the indication for use of R5's Seroquel (Antipsychotic medication) was inappropriate but did state she (V2/DON) is familiar with Centers for Medicare and Medicaid Services (CMS) guidelines. 2. R16's Admission Record documents that R16's date of admission to the facility was 4/04/24 and R16's diagnoses on admission include but not limited to Depression, Acute Myocardial Infarction, Chronic Kidney Disease, Stage 3A, and Type 2 Diabetes Mellitus without Complications. R16's Minimum Data Set (MDS) assessment, dated 10/25/24, documents Brief Interview for Mental Status (BIMS) of 10 indicating moderate cognitive impairment. R16's Physician Order, dated 4/19/24, documents R16 has an order for Aripiprazole/Abilify (Antipsychotic medication) 2 milligrams(mg) give 2 tablets by mouth one time a day related to Depression. R16's Physician order, dated 4/19/24, documents R16 has an order for Escitalopram/Lexapro (Antidepressant medication) 20mg give 1 tablet by mouth one time a day related to Depression. R16's current care plan documents R16 receives antipsychotic medication related to Depression and antidepressant medication related to Depression. R16's Consent for treatment with an Atypical Antipsychotic, dated 4/5/24, documents consent for Abilify 4mg to enhance antidepressant. R16's Consent for treatment with an Antidepressant, dated 4/4/24, documents consent for Lexapro 20mg for depression. R16's Treatment Administration Record, dated August 2024 thru December 2024, documents no behaviors. On 12/17/24 at 10:10am, R16 is observed lying in bed dressed in clean clothes, well groomed, and calm. On 12/18/24 at 2:07pm, R16 is observed up in wheelchair, dressed in clean clothes, well groomed, and smiling as she talked to her roommate. On 12/19/24 at 8:13am, R16 is observed sitting at dining room table, calm, smiling and talking with table mates. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 9:45am, V2 (Director of Nursing/DON) stated that R16 was admitted on Abilify (Antipsychotic medication) on 4/4/24 for Myocardial Infarction then diagnosis was changed on 4/6/24, due to not being an appropriate diagnosis. V2 (DON) stated diagnosis was changed to enhance effectiveness of antidepressant, then R16 went to hospital and returned with diagnosis for use for Abilify as Depression. V2 (DON) also stated that R16 has not had any behaviors since admitting to facility and she is not followed by behavioral health, but the facility typically gets residents on psychotropic medications referred to behavioral health. V2 would not confirm or deny that indication for use of R16's Abilify is not appropriate. 3. R19's Physician Orders document that she takes Olanzapine 20 mg (milligrams) every day for Schizophrenia and Bupropion 150 mg every day for Major Depressive Disorder. R19's current care plan documents that on 02/22/2021 the resident has a mood problem and receives daily anti-psychotic medication. She voices complaints of having little interest in doing things, she feels down and depressed, she feels tired and has little energy, she feels bad about herself and feels she would be better off dead. The care plan documents on 4/26/23 (Resident) has had improvement in mood. No further documentation or mention of any other behaviors. R19's Task: Behavior Monitoring documents the behaviors being monitored were refusal of cares and agitation. R19 did not have any behaviors documented in the behavior tracking record for September, October, and November 2024. R19's Pharmacy review dated 02/1/2024 documents Resident receives the following medication used for depression: Bupropion ER (Extended Release) 150 mg (Milligrams) QD (every day). The Centers for Medicare and Medicaid Services (CMS) requires attempts at dosage reductions on antidepressant medications used for managing behavior, stabilizing mood, or treating psychiatric disorders twice a year, in two separate quarters with at least one month between attempts), within the first year of admission or initiation, and annually thereafter unless clinically contraindicated. Resident is due for an evaluation. Pharmacist Recommended dose reduction to Bupropion ER everyday Monday through Saturday and Bupropion ER 100 mg every Sunday. V13 (Psychiatric Nurse Practitioner) marked the second available option on the form Further dose reduction is clinically contraindicated due to: The resident's target symptoms returned or worsened after the most recent GDR (Gradual Dose reduction within the facility. V13 wrote on the bottom See Psych(iatric) note 3/1/24. R19's Psychiatric Note dated 3/1/24 documents Behaviors reported include increased confusion and ongoing refusal of cares. The note also documents Resident reported no symptoms of depression. Resident described having no hallucinations. On 12/18/24 at 1:00 PM V9 (Licensed Practical Nurse) stated (R19) is pretty calm. When she is having a bad day, we can leave her alone if she is agitated and then go back and she will usually be calm and cooperative. On 12/19/24 at 11:00 AM V2 (Director of Nursing) stated that the facility does not have any documentation of any failed gradual dose reductions for R19. 4. R26's Physician Order document that on 4/1/24 R26 was prescribed Lorazepam .5 mg (milligrams) every 6 hours as needed for anxiety. This order did not have a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 at 2:30 PM V2 (Director of Nursing) stated I don't know how (R26's Lorazepam order for as needed Lorazepam) got missed. Everyone here knows that we can only do (as needed) psychotropic medications for 14 days. 50962

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 33970 Based on record review and interview the facility failed to ensure that resident's met the standards for infections for 2 residents (R4 and R23) and the facility failed to have standards in place for residents who were experiencing infection symptoms but did not meet the standards to be infections. The facility also failed to educate health care providers about Antibiotic Stewardship. This failure has the potential to affect all 40 residents who reside in the facility. Findings Include: The Facility's undated The Core Elements of Antibiotic Stewardship for Nursing Homes documents Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The Centers for Disease Control and Prevention (CDC) recommends that all acute care hospitals implement an antibiotic stewardship program (ASP) and outlined the seven Core elements which are necessary for implementing successful ASPs. CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. The Facility's undated The Core Elements of Antibiotic Stewardship for Nursing Homes policy documents Standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available. On 12/18/24 at 9:00 AM V2 (Director of Nursing) stated that the facility uses the MCGeer Criteria to determine if a resident has an active infection. The McGeer's Criteria Tool provided by V2 (Director of Nursing) documents that for a UTI (Urinary Tract Infection) without indwelling catheter Must fulfill both 1 and 2. At least one of the following sign or symptom: acute dysuria or pain, swelling, or tenderness of testes, epididymis or prostate; fever or leukocytosis, and (more than) one of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency. If no fever or leukocytosis, then (more than) 2 of the following: suprapubic pain, gross hematuria, new or marked increase in urgency, new or marked increase in frequency. At least one of the following macrobiotic criteria: (greater than) 1,000,000 cfu (colony forming unit)/ml (milliliter) of any organism(s) in a specimen collected by an in and out catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146057	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monmouth Nursing Home	117 South I Street Monmouth, IL 61462

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 - Many	The McGeer Criteria Tool documents for a UTI (Urinary Tract Infection) with indwelling catheter Must fulfill both 1 and 2. 1. at least one of the following sign or symptom: fever, rigors, or new-onset hypotension, with no alternate site of infection, either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis, new onset suprapubic pain or costovertebral angle pain or tenderness, purulent discharge from around the catheter or acute pain, swelling or tenderness of the testes, epididymis or prostate. 2. Urinary catheter specimen culture with (greater than) 1,000,000 cfu (colony forming units)/ml (milliliter) of any organism. The Facility's Infection Control Log dated October 2024 documents that on 10/22/24 R4 was prescribed Ceftriaxone 500 mg (milligrams) daily for 7 days for UTI (Urinary Tract Infection). R4's Infection Screening Evaluation dated 10/22/24 documents R4's symptoms of infection were urinary frequency, urinary incontinence and urinary urgency. R4's Infection Screening Evaluation also documented that McGeer Criteria for UTI without a catheter were met to determine that R4 did have an infection. The Facility's Infection Control Log dated October 2024 documents that on R23 was prescribed Nitrofurantoin 100 mg twice daily for 7 days for a Urinary Tract Infection. R23's Infection Screening Evaluation dated 10/23/24 documents R23's symptom of infection were urinary frequency, urinary incontinence and urinary urgency. R23's Infection Screening Evaluation also documented that McGeer Criteria for UTI with an indwelling catheter were met to determine that R23 did have an infection. The Facility's Infection Control Log dated October 2024 documents on 10/31/24 R34 was prescribed Cephalexin 500 mg three times a day for ten days for cellulitis. The Facility's Infection Control Log dated November 2024 documents that on 11/30/24 R23 was prescribed Levofloxacin 250 mg daily for 6 days for a Urinary Tract Infection. R23's Infection Screening Evaluation dated 11/30/24 documents R23's symptoms of infection were delirium, new onset of confusion, urinary frequency, urinary incontinence and urinary urgency. R23's Infection Screening Evaluation also documents that McGeer Criteria for UTI with an indwelling catheter were met to determine that R23 did have an infection. On 12/18/24 at 11:00 AM V2 (Director of Nursing) stated that the facility did not have any written or verbal standards or policies to follow for the residents when they do not meet the definition of an infection. The doctors order the antibiotics when we call them with symptoms. We have to give them. V2 could not provide any documentation of education given to health care providers regarding antibiotic stewardship. V2 confirmed that R4 and R23's infections in October and November did not meet the McGeer Criteria for infections. The Facility's Resident Census and Condition Report dated 12/17/2024 documents 40 residents that currently reside in the facility.