

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2024
NAME OF PROVIDER OR SUPPLIER  Mount Vernon Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 Country Club Rd Mount Vernon, IN 47620	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057</b></p> <p>Based on interview, record review, and observation, the facility failed to ensure a person-centered comprehensive care plan was developed for 1 of 3 residents reviewed for unnecessary medications receiving diuretics. (Resident 34)</p> <p>Finding includes:</p> <p>On 8/1/24 at 1:03 P.M., Resident 34's clinical record was reviewed. Resident 34 was admitted on [DATE]. Diagnoses included, but were not limited to congestive heart failure (CHF) and chronic respiratory failure.</p> <p>An Admission MDS (Minimum Data Set) Assessment, dated 6/26/24, indicated Resident 34 was cognitively intact and was received a diuretic medication in the last seven days. Resident had used oxygen while a resident.</p> <p>Current physician orders included, but were not limited to:</p> <p>furosemide (diuretic medication) tablet 40 mg once a day, start 6/20/24.</p> <p>Current care plans included, but were not limited to:</p> <p>Resident has potential for impaired gas exchange related to: Chronic respiratory failure with hypoxia, Acute bronchitis, Panlobular emphysema, Chronic diastolic heart failure; Notify MD of respiratory distress; dated 6/27/24.</p> <p>Resident is at risk for ineffective tissue perfusion related to: Chronic diastolic heart failure, paroxysmal atrial fibrillation, abdominal aortic aneurysm</p> <p>Administer oxygen as ordered; dated 6/27/24.</p> <p>Observe for and document: pallor, cyanosis, dizziness, syncope, shortness of breath, bounding/thready pulse, headache, variations in blood pressure, abnormal lung sounds, abnormal oxygen saturations, poor capillary refill, abnormal skin color, edema. Notify MD; dated 6/27/24.</p> <p>Monitor Weight (no frequency indicated), Notify MD of significant weight change; dated 6/26/24.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The clinical record lacked an order or care plan relating to the monitoring of side effects directly related to CHF/fluid volume overload, such as daily weight change/gain, or side effects diuretic medication.</p> <p>During an interview on 8/2/24 at 10:20 A.M., Resident 34 indicated she is short of breath and dizzy all of the time and sometimes receives nausea medication but only provides temporary relief.</p> <p>During an observation on 8/2/24 at 10:27 A.M., QMA 5 was assisting Resident back to her room and Resident 34 indicated she was having trouble breathing and was nauseous. QMA 5 assisted Resident 34 to her bed and attached her nasal cannula to her oxygen concentrator in her room.</p> <p>During an interview on 8/2/24 at 10:30 A.M., the Director of Nursing (DON) indicated Resident 34's dizziness/nausea is an ongoing issue and shortness of breath due to bronchitis.</p> <p>8/6/24 10:11 A.M., the DON indicated not all high risk medications are included on the care plan or orders for side effects of diuretics because staff should just know side effects of the medications and only chart based on acceptations if abnormal symptoms present, and it would be up to the provider to determine if the side effects like shortness of breath and nausea and dizziness were side effects of CHF or the diuretic medication.</p> <p>On 8/6/24 at 4:06 P.M., the DON indicated the facility only monitors Resident 34's weight monthly, and only checks for edema weekly during skin assessments.</p> <p>On 8/6/24 at 4:06 P.M., the DON provided a Comprehensive Care Plan Policy, revised 8/2023, that indicated The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning</p> <p>3.1-35(a)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>46758</p> <p>Based on interview and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 2 of 6 days during the annual survey period. (8/1/24, 8/2/24)</p> <p>Finding includes:</p> <p>On 8/1/24 at 8:05 A.M., a posted staffing sheet was observed sitting on the receptionist desk. The sheet included, but was not limited to:</p> <p>Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Aide).</p> <p>Total number of RN, LPN, and CNA for each shift.</p> <p>Total hours of RN, LPN, and CNA for each shift.</p> <p>The form indicated that 4.5 CNAs worked the evening shift (2:00 P.M. to 10:00 P.M.) but did not specify which half of the shift worked.</p> <p>On 8/2/24 at 8:10 A.M., a posted staffing sheet was observed sitting on the receptionist desk. The sheet included but was not limited to:</p> <p>Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Aide).</p> <p>Total number of RN, LPN, and CNA for each shift.</p> <p>Total hours of RN, LPN, and CNA for each shift.</p> <p>The form indicated that 5.5 CNAs worked the evening shift (2:00 P.M. to 10:00 P.M.) but did not specify which half of the shift the CNA worked.</p> <p>During an interview on 8/02/24 at 9:19 A.M., the scheduler indicated she was not aware 1/2 shift coverage hours should have been listed on the posted staffing forms.</p> <p>On 8/2/24 at 11:45 A.M., the Administrator provided a current Posted Nurse Staffing Data policy, dated 7/2019 that indicated .the purpose was to allow public access to posted nursing staffing data per federal regulations .the total hours should be broken by total hours worked by RN, LPN, and CNA .the Posted Nurse Staffing form should also reflect staff absences on each shift due to call-offs and the Total Hours adjusted accordingly .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46758</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for 4 of 4 medication carts observed and 2 of 2 treatment carts.(Plaza Cart 101-113, Plaza cart 114-140, Cottage Short Hall, Cottage Long Hall, Plaza Treatment Cart, Cottage Treatment Cart)</p> <p>Findings include:</p> <p>On 7/30/24 at 10:03 A.M., the following was observed in the Plaza medication cart (for rooms 101-113):</p> <p>3 jars of CBD (Cannabidiol) with Resident 26's name handwritten on it with no other label</p> <p>1 package of donuts and a drink with no labels. At that time, QMA (Qualified Medicine Aide) 23 indicated they belonged to him.</p> <p>On 7/30/24 at 10:15 A.M., the following loose pill was observed in the Plaza medication cart (for rooms 114-140):</p> <p>1 white oblong pill with marking ML8</p> <p>On 7/30/24 at 10:30 A.M., the following loose pills were observed in the Cottage Short Hall medication cart:</p> <p>1/2 round orange pill</p> <p>1 white oblong pill with marking ATV 20</p> <p>On 7/30/24 at 10:40 A.M., the following was observed in the Cottage Long Hall medication cart:</p> <p>2 daily medication containers with several loose pills that had no name, labels, or identifiers. At that time, QMA 7 indicated the containers belonged to Resident 29 and staff administered medications to the resident from the containers.</p> <p>On 7/31/23 at 7:40 A.M., the treatment cart for Cottage Unit was observed to have the following:</p> <p>1 tube of antifungal with no label</p> <p>1 opened tube of Skin Therapy with no label</p> <p>3 cans of opened deodorant with no labels</p> <p>1 tube of (name of lotion) with no label</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/31/24 at 7:58 A.M., the treatment cart on the Plaza Unit was observed to have the following:</p> <p>1 tube of Triamcinolone cream (Steroid Cream) with no label</p> <p>1 bottle of antifungal powder with no label</p> <p>During an interview on 7/30/24 at 10:08 A.M., QMA 24 indicated there should be no loose pills or food in the medication carts.</p> <p>During an interview on 7/30/24 at 10:42 A.M., QMA 7 indicated they were unaware that the containers for Resident 29 were not labeled.</p> <p>During an interview on 7/31/24 at 7:45 A.M., LPN (Licensed Practical Nurse) 15 indicated resident names should be on the bottles in the treatment cart, and shaving cream and deodorant should not be in the treatment cart.</p> <p>During an interview on 7/30/24 at 11:10 A.M., the DON (Director of Nursing) indicated Resident 29 was on VA (Veteran Affairs) Respite and would be reimbursed by the VA for medications. She indicated Resident 29's son brought the medications in the containers and did not leave the bottles but that staff had compared the bottles with the orders. At that time, she indicated there should have been a label on the containers.</p> <p>3.1-25(b)(4)</p> <p>3.1-25(j)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46758</p> <p>Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Resident use equipment was not cleaned for 2 of 2 random observations of vitals during medication administration, staff did not change gloves during resident care for 3 of 5 residents observed for care, and failed to track all infections for 10 of 10 residents reviewed for infections. (Resident 49, Resident 33, Resident 22, Resident 18, Resident 53, Resident 42, Resident 25, Resident 161, Resident 15, Resident 36, Resident 12, Resident 53, Resident 5, Resident 51, Resident 2, Resident 7)</p> <p>Findings include:</p> <p>1. On 7/30/24 at 10:30 A.M. during a medication pass, QMA (Qualified Medication Aide) 23 was observed to take Resident 49's blood pressure, then take Resident 33's blood pressure with the same cuff. The blood pressure cuff was not sanitized prior to or after either resident.</p> <p>2. On 8/2/24 at 10:04 A.M., CNA (Certified Nurse Aide) 6 and CNA 14 were observed performing incontinence care for Resident 22. Neither CNA washed their hands prior to putting on gloves to start the care. CNA 16 removed the resident's visibly soiled shirt, placed it in the dirty linen, placed a clean shirt on the resident, then assisted the resident into a sit to stand sling without changing gloves. The CNAs raised the lift, and removed the soiled brief. Both CNAs removed their gloves and put on clean gloves without hand hygiene in between, and a clean brief was placed on the resident. Resident 22 was then transferred to a wheelchair, and both CNAs removed their gloves. The sit to stand lift was not cleaned after use. CNA 14 then washed hands for 30 seconds with soap and water, and CNA 16 washed hands for 9 seconds with soap and water.</p> <p>48057</p> <p>3. On 8/5/24 at 9:12 A.M., CNA (Certified Nurse Aide) 16 and CNA 9 entered Resident 53's room and CNA 16 shut the door. CNA 9 used hand sanitizer and rubbed her hands together for three seconds, and CNA 16 got hand sanitizer and rubbed her hands together for six seconds. CNA 9 pulled the privacy curtain, put gloves on, used the bed remote to lay the resident in a flat position; CNA 16 put gloves on, pulled the resident's blankets back and moved the pillows at the head of bed while CNA 9 began to remove the resident's brief. CNA 16 began wiping the front of the resident with wipes, then rolled the resident on her right side facing CNA 9. CNA 16 then removed the soiled brief out from under the resident and used wipes to clean the resident's bowel movement. CNA 16 put a new brief under the resident, removed her gloves and used hand sanitizer for five seconds and put on new gloves. CNA 9 handed CNA 16 barrier cream and CNA 16 put barrier cream on the resident's bottom. CNA 9 assisted the resident in rolling back to her back and fastened her brief. CNA 16 removed her gloves and rubbed hand sanitizer on her hands for four seconds. CNA 16 and CNA 9 grabbed the residents bedsheets and pulled the resident up in bed. CNA 9 removed her gloves and rubbed hand sanitizer on her hands for five seconds.</p> <p>48147</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 8/2/24 at 10:29 A.M., Certified Nurse Aide (CNA) 14 and CNA 16 were observed performing peri care for Resident 18. CNA 14 put on gloves, hooked Resident 18's lift pad onto the lift, raised up the bed, moved Resident 18 to the bed using the lift, unhooked the pad, pulled down Resident 18's pants, and undid the resident's brief. Without changing gloves, CNA 14 wiped Resident 18's front pubic area by wiping front to back three times using the same wipe. The resident was rolled onto her side and CNA 14 wiped bowel movement off Resident 18's buttocks using 3 wipes. The brief was bundled up and thrown away. Without changing gloves, CNA 14 put a new brief under Resident 18. CNA 14 changed gloves, fastened the new brief, and pulled up Resident 18's pants. At that time, the open wipes contained fell on the floor with a clean wipe sticking out of the container and touching the floor. CNA 14 picked up the wipes and put the exposed wipe that had been touching the floor back into the container and closed the lid. CNA 14 removed her gloves. CNA 14 indicated she needed to go get a new battery for the lift. CNA 14 left the room and went to the closet where the list batteries were stored. CNA 14 was not observed to perform hand hygiene.</p> <p>During an interview on 7/31/24 at 8:05 A.M., the Infection Preventionist indicated the equipment should be cleaned in between residents and as needed.</p> <p>During an interview on 8/5/24 at 9:23 A.M. CNA 9 indicated she would use hand sanitizer instead of washing her hands unless a resident was on transmission based precautions. CNA 16 indicated while performing care she should change gloves between clean and dirty tasks.</p> <p>During an interview on 8/2/24 at 10:32 A.M., IP indicated staff were expected to wash their hands for at least 30 seconds. Hands were supposed to be sanitized/washed when going from dirty to clean tasks. The IP also indicated any wipes that were exposed to the floor should be disposed of.</p> <p>38770</p> <p>5. On 8/6/24 at 11:00 A.M., the infection control program's resident infection tracking was reviewed for the months of May 2024, June 2024, and July 2024. At that time, the Infection Preventionist (IP) indicated tracking of infections was completed by reviewing the infection events from the resident's clinical records, and then placed on a map for that month with colors that indicated what type of infection the resident had. The infection event forms as well as the tracking map were completed by month. Review of all infections included, but was not limited to, the following:</p> <p>May 2024</p> <p>Resident 42's infection event indicated a Urinary Tract Infection (UTI) on 5/10/24. This was not tracked on the facility tracking map.</p> <p>Resident 25's infection event indicated a UTI on 5/6/24. This was not tracked on the facility tracking map.</p> <p>June 2024</p> <p>Resident 161's infection event indicated a UTI on 6/12/24. This was not tracked on the facility tracking map.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 15's infection event indicated a UTI on 6/16/24. This was not tracked on the facility tracking map.</p> <p>Resident 15's infection event indicated cellulitis on 6/2/24. This was not tracked on the facility tracking map.</p> <p>July 2024</p> <p>Resident 36's infection event indicated pneumonia on 7/31/24. This was not tracked on the facility tracking map.</p> <p>Resident 12's infection event indicated an upper respiratory infection on 7/17/24. This was not tracked on the facility tracking map.</p> <p>Resident 53's infection event indicated pneumonia on 7/31/24. This was not tracked on the facility tracking map.</p> <p>Resident 5's infection event indicated a UTI on 7/13/24. This was not tracked on the facility tracking map.</p> <p>Resident 51's infection event indicated a UTI on 7/23/24. This was not tracked on the facility tracking map.</p> <p>Resident 2's infection event indicated cellulitis/rash that was treated with an antibiotic on 7/30/24. This was not tracked on the facility tracking map.</p> <p>Resident 7's infection event indicated an infection wound on the toe on 7/18/24. This was not tracked on the facility tracking map.</p> <p>During an interview on 8/1/24 at 1:11 P.M., the IP indicated infections were only tracked on the facility tracking map if McGeer's criteria was met. All others were placed on a monthly facility infection surveillance summary report.</p> <p>The McGeer's criteria is a set of surveillance definitions used to identify healthcare-associated infections (HAIs) in long-term care facilities. The criteria are specific to the nursing home population and can be useful for assessing whether antibiotic therapy is appropriate. However, more diagnostic information, such as positive laboratory tests, is often required to meet the criteria for a definitive infection.</p> <p>On 8/6/24 at 10:59 A.M., the Director of Nursing (DON) indicated infections were tracked by reviewing the printed report of infection events, as well as the facility tracking map. At that time, she could not indicate which infection events were active infections, and which were not based on the information printed on the forms. She indicated only those infection events that met McGeer's criteria were listed on the tracking maps, regardless if it was an active infection or not, and not all active infections were indicated on them.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/30/24 at 10:00 A.M., the Administrator provided a current Infection Prevention System for Surveillance policy, revised 5/2023 that indicated .the facility shall have a system of surveillance to identify possible communicable diseases or infections before they can spread .monitoring is provided as ongoing tracking to rule out an infection, the development of new/recurrent infections and / or the spread of infections by surveillance log and facility map .</p> <p>On 8/1/24 at 10:30 A.M., the DON (Director of Nursing) provided a current Standard and Transmission-Based Precautions (Isolation) policy, revised 4/24/24 that indicated .always assume that every resident is potentially infected or colonized with an organism that could be transmitted in the healthcare setting .shared equipment should be cleaned and disinfected in-between each resident use</p> <p>On 8/1/24 at 10:30 A.M., the DON provided a current Hand Hygiene policy, revised 12/2021 that indicated . healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a resident .Before moving from work on a soiled body site to a clean body on the same resident, After touching a resident or the resident's immediate environment, After contact with blood, body fluids, or contaminated surfaces, immediately after glove or PPE (Personal Protection Equipment) .</p> <p>3.1-18(b)(1)</p> <p>3.1-18(b)(2)</p> <p>3.1-18(l)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>38770</p> <p>Based on interview and record review, the facility failed to ensure residents who required an antibiotic were prescribed the appropriate antibiotic for 2 of 3 residents reviewed for UTI (urinary tract infection). (Resident 43, Resident 30)</p> <p>Findings include:</p> <p>1. On 7/30/24 at 12:21 P.M., Resident 43's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/23/24, indicated no cognitive impairment, occasional incontinence of the bladder, and no UTIs in the last 30 days.</p> <p>Physician orders included, but were not limited to:</p> <p>ceftriaxone (an antibiotic) injection, 1 gram, ordered on 7/17/24.</p> <p>Resident 43's MAR (Medication Administration Record) for July 2024 indicated ceftriaxone 1 gram was given on 7/17/24 at 8:00 P.M.</p> <p>A progress note, dated 7/17/24 at 3:01 P.M., indicated Resident report burning upon urination. New orders from MD, UA [urinalysis], CBC [complete blood count], BMP [basic metabolic panel], Rocephin [ceftriaxone] 1 gm [gram] x1 dose IM [intramuscular] .</p> <p>The clinical record lacked an Infection Event for the UTI.</p> <p>On 8/2/24 at 12:40 P.M., the Director of Nursing (DON) indicated Resident 43 did have a UTI on 7/17/24, and the physician treated the resident without the lab results based on a symptom of burning with urination.</p> <p>48147</p> <p>2. On 8/1/24 at 11:11 A.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, chronic kidney disease stage 3, and polyneuropathy.</p> <p>The most current Annual Minimum Data Set (MDS) Assessment, dated 6/7/24, indicated Resident 30 had severe cognitive impairment, required substantial assistance from staff (staff does more than half) for toileting, did not receive antibiotics during the 7-day lookback period, and did not have a UTI (urinary tract infection).</p> <p>Physician orders included, but were not limited to:</p> <p>ceftriaxone (generic form of Rocephin) 1 g - Give 1 g IM x 2 doses every 24 Hours, dated 7/14/24 and completed on 7/15/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2024
NAME OF PROVIDER OR SUPPLIER  Mount Vernon Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 Country Club Rd Mount Vernon, IN 47620	

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)
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Infection/Antibiotics Surveillance report, dated 7/12/24, indicated Resident 30 had a UTI confirmed by a culture and sensitivity test that revealed Escherichia Coli (a bacteria) was in the urine. Rocephin (an antibiotic) 1 gram (g) intramuscularly (IM) every 24 hours for 2 days was ordered.</p> <p>A lab report, dated 7/14/24 and signed by the Nurse Practitioner (NP), indicated Resident 30 had E. coli in her urine. The lab report indicated E. coli was resistant to ceftriaxone.</p> <p>On 8/2/24 at 11:00 A.M., the Director of Nursing (DON) indicated the lab report dated 7/14/24 indicated E. coli was resistant to ceftriaxone. She indicated antibiotic use was reviewed monthly during QAPI (quality assurance and performance improvement) meetings and the Infection Preventionist (IP) reviewed newly prescribed antibiotics daily.</p> <p>On 8/2/24 at 11:03 A.M., the IP indicated that she reviewed culture and sensitivity reports daily, and the prescribing physician reviewed them as well. She indicated she would call the physician if the infection did not meet McGeer's criteria or if the antibiotic was found to be resistant to the organism. At that time, she indicated ceftriaxone was resistant to E. coli and she should have called the doctor.</p> <p>On 7/30/24 at 2:00 P.M., the Administrator provided a current Antibiotic Stewardship Program policy, dated 11/2017, that indicated The facility shall establish key elements for antibiotic prescribing and a system to monitor and manage antibiotic use. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients</p>