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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Health and Rehabilitation Center	287 N Eleventh Street Williamsburg, KY 40769

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917 42440 Based on interview, record review, and facility policy review, the facility failed to provide written notification of a facility-initiated transfer to the resident and responsible party (RP) and failed to provide documentation of ombudsman notification for three of three residents (Resident (R) 22, R27, and R68) reviewed for hospitalization out of 25 sample residents. The failure had the potential to affect the residents and/or their representatives' notification related to transfers. Findings include: Review of the facility's undated policy, What to do when a resident transfers out to the hospital, revealed If during business hours- at the time of the transfer-the office designee will talk with the resident if applicable or attempt to reach the responsible party regarding the transfer and bed hold status and mail them a copy of the notice. The facility must document multiple attempts to reach the resident representative in cases where the facility was unable to notify the representative. Always mail a copy of the notice. If the transfer happens after the office is closed- the office designee will attempt to reach the next business day and mail a copy of the notice. 1. Review of R22's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/24 and located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE] and a reentry from the hospital on 01/26/24. A Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, indicating the resident's cognition was intact. Review of R22's Census tab of the EMR revealed R22 discharged to the hospital on 01/20/24 and returned 01/26/24. R22 was also at the hospital from 04/04/24 to 04/05/24. Review of R22's Health Status Note, dated 01/20/24 at 5:06 PM and located in the EMR under the Progress Note tab, revealed Resident complains of severe pain starting in right knee going to foot no swelling or redness noted pedal pulses palpable denies injury to right leg . request to go to ER [emergency room] md [medical doctor] made aware new orders noted [RP] made aware. (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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R22's Patient Transfer Form, dated 01/20/24 and located in the EMR under the Documents tab, revealed the facility transferred R22 to the hospital for right knee pain going down to her feet. The form stated family was notified. It did not show that the resident and/or representative were provided with a written notice of transfer. Review of R22's Health Status Note, dated 04/04/24 at 4:41 PM and located in the EMR under the Progress Note tab, revealed .Writer asked resident at this time if she wanted to be sent to the hospital for evaluation and tx [treatment]. Resident stated no, she did not want to go. [Name], RP, notified. Review of R22's Health Status Note, dated 04/04/24 at 5:40 PM and located in the EMR under the Progress Note tab, revealed Resident states that she wanted to go to the hospital at this time .family notified. Review of R22's Patient Transfer Form, dated 04/04/24 and located in the EMR under the Documents tab, revealed the facility transferred R22 to the hospital for lethargy and hypoxia. It did not reveal that the resident and/or representative were provided with a written notice of transfer. Review of R22's Bed Hold Notifications, dated 01/20/24 and 04/04/24, provided by the facility, revealed no documented reason for transfer and no name/signature of who the facility notified. During an interview on 10/24/24 at 1:20 PM, R22 stated she did not remember her or her family receiving any paperwork about the reason for transfer to the hospital. 2. Review of R27's quarterly MDS with an ARD of 08/16/24 and located in the MDS tab of the EMR, revealed an admitted [DATE] and a reentry from the hospital on 01/25/24. The BIMS showed a score of 15 out of 15, indicating the resident's cognition was intact. Review of R27's Census tab of the EMR revealed R27 discharged to the hospital on 01/23/24 and returned 01/25/24. Review of R27's Health Status Note, dated 01/23/24 at 1:36 PM and located in the EMR under the Progress Note tab, revealed [RP] approached writer and said that resident agreed to go to ER. Writer spoke with resident and she stated that she would go to the ER . Review of R27's Patient Transfer Form, dated 01/23/24 and located in the EMR under the Documents tab, revealed the facility transferred R27 to the hospital for the inability to eat or drink anything for several days. It did not reveal that the resident and/or representative were provided with a written notice of transfer. Review of R27's Bed Hold Notification, dated 01/23/24, provided by the facility, revealed no documented reason for transfer and no name/signature of who the facility notified. During an interview on 10/21/24 at 1:24 PM, R27 stated she had not received any paperwork from the facility when she went out to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 10:30 AM, Licensed Practical Nurse Unit Supervisor (LPNUN) stated she believed either social services or the business office sent out bed hold/transfer notifications. She stated nursing did not send out any papers to the residents or families. She stated nursing verbally notified families that residents were sent to the hospital. During an interview on 10/24/24 at 10:53 AM, the Business Office Manager (BOM) stated she assumed the nurses' notified families of residents when they went out to the hospital. The BOM said there was not a written form provided to residents or families regarding the reason for transfer to the hospital. During an interview on 10/24/24 at 11:44 AM, the Administrator stated she sent out encrypted emails to the ombudsman monthly, if there was a discharge. She listed the residents discharged in the email. She could not retrieve the emails. During an interview on 10/24/24 at 3:40 PM, the Director of Nursing (DON) stated a copy of the transfer form, found under the Documents tab of the EMR, went with the resident to the hospital with the reason for transfer. During an interview on 10/24/24 at 3:45 PM, the Administrator stated it was expected that both the resident and representative were notified of the reason for the transfer to the hospital verbally. She stated she had not been able to provide any evidence of her notifications of discharges to the ombudsman. 3. Review of R68's EMR undated Admission Record under the Profile: tab, revealed an admitted [DATE] with diagnoses which included closed fracture of left femur with routine healing, lack of coordination, muscle weakness, and unsteadiness on feet. Review of R68's EMR Nursing Progress Note under the Progress Notes tab and dated 06/17/24, indicated R68 was discharged to the hospital related to a fall with left hip pain. During an interview on 10/24/24 at 11:13 AM, R68, she said she could not remember receiving a notice for discharge to the hospital or a bed hold notification. During an interview on 10/24/24 at 12:06 PM the BOM stated she did not send a transfer notification to R68 or to the family but only gave them a verbal notification. During an interview on 10/24/24 at 3:36 PM, the Administrator stated she could not find evidence that she notified the ombudsman regarding the hospital transfer for R68.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917 Based on record review, interviews and facility policy review, the facility failed to provide written notification regarding the facility policy for bed hold, which included the duration of the bed-hold and payment, if any, during which the resident was permitted to return and resume residence in the nursing facility for three of three residents (Resident (R) 68, R22, and R27) reviewed for hospitalization of 25 sample residents The failure had the potential to affect the residents and/or their representatives notification related to bed holds. Findings include: Review of the facility's undated policy titled, What to do when a resident transfers out to the hospital, revealed If during business hours- at the time of the transfer-the office designee will talk with the resident if applicable or attempt to reach the responsible party regarding the transfer and bed hold status and mail them a copy of the notice. Always mail a copy of the notice. If the transfer happens after the office is closed- the office designee will attempt to reach the next business day and mail a copy of the notice . the 1st notice of the bed hold policy should be at admission. This information should be in your admission packets. The 2nd notice comes into play when the resident is transferred. If the resident is Medicare A . Medicare nor the Replacement policy pays for Bed Hold. The Resident and or Resident Representative are then given the choice to hold the bed privately for $210.00 per day. If they to [sic] decline to hold the bed- they will be discharged . Review of the facility's policy titled, Bed Hold, dated 05/24 and provided by the facility, revealed There are no bed hold days paid for residents whose bill is being paid by Medicare. The resident and/or resident representative may choose to hold the bed by paying privately or may choose to not hold the bed and take the first available semi-private room when discharged from the hospital . If resident is having their bill paid by any private insurance, the facility cannot bill Medicaid for bed hold. If the resident is having their bill paid by . or other third party insurances, they may choose to pay privately to hold the bed or give the bed up and the resident readmitted to the first available semi-private room after hospital discharge . 1. Review of R68's undated Admission Record located under the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE] with diagnoses which included closed fracture of left femur with routine healing, lack of coordination, muscle weakness, and unsteadiness on feet. Review of R68's EMR quarterly MDS, dated [DATE], indicated her BIMS score was 15 out of 15, which indicated cognition was intact. Review of R68 s EMR Nursing Progress Note under the Progress Notes tab and dated 06/17/24, indicated R68 was discharged to the hospital on 06/17/24 related to a fall with left hip pain. A nursing progress note, dated 06/22/24, indicated R68 returned to the facility on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 11:13 AM, R68 stated she could not remember receiving a bed hold notification. During an interview on 10/24/24 at 12:06 PM, the Business Office Manager (BOM) stated she usually mailed a bed-hold notification to the resident representative but could not provide evidence that the notification was mailed to R68 or her representative. During an interview on 10/24/24 at 3:36 PM, the Administrator stated the bed hold policy was included in the resident admission packet, and she expected an additional bed hold notification be sent to every resident and/or representative when the resident was discharged to the hospital. 2. Review of R22's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/24 and located in the MDS tab of the EMR revealed an admitted [DATE] and a reentry from the hospital on 01/26/24. The Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, indicating the resident's cognition was intact. Review of R22's Census tab of the EMR revealed R22 discharged to the hospital on 01/20/24, while her stay was paid for by Medicaid, and returned 01/26/24. R22 was also out to the hospital 04/04/24, while Medicare A was the primary payer, and returned on 04/05/24. Review of R22's Health Status Note, dated 01/20/24 at 5:06 PM and located in the EMR under the Progress Note tab, revealed Resident complains of severe pain starting in right knee going to foot no swelling or redness noted pedal pulses palpable denies injury to right leg . request to go to ER [emergency room] md [medical doctor] made aware new orders noted [RP] made aware. Review of R22's Patient Transfer Form, dated 01/20/24 and located in the EMR under the Documents tab, revealed the facility transferred R22 to the hospital for right knee pain going down to her feet. Review of R22's Health Status Note, dated 04/04/24 at 4:41 PM and located in the EMR under the Progress Note tab, revealed .writer asked resident at this time if she wanted to be sent to the hospital for evaluation and tx [treatment]. Resident stated no, she did not want to go. [Name], RP, notified. Review of R22's Health Status Note, dated 04/04/24 at 5:40 PM and located in the EMR under the Progress Note tab, revealed resident states that she wanted to go to the hospital at this time .family notified. Review of R22's Patient Transfer Form, dated 04/04/24 and located in the EMR under the Documents tab, revealed the facility transferred R22 to the hospital for lethargy and hypoxia. Review of R22's Bed Hold Notification, dated 01/20/24, and provided by the facility, revealed R22's bed would be held for 30 days since she was covered by Medicaid. It did not state the cost to hold the bed after 30 days. Review of R22's Bed Hold Notification, dated 04/04/24, and provided by the facility, revealed The resident's bed will be held for up to 30 days therefore the resident will need to return to (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Facility Name] on or before 5/3/24. The resident's bed will be held for ___ days per your request. The notification did not state the cost of the bed hold. It listed the payment status of R22 as private. During an interview on 10/24/24 at 1:20 PM, R22 stated she did not remember if she or her family received the bed hold policy. She did not know how long the facility would hold her bed or the cost, but she had returned to the same room following her hospitalization . 3. Review of R27's quarterly MDS with an ARD of 08/16/24 and located in the MDS tab of the EMR, revealed an admitted [DATE] and a reentry from the hospital on 01/25/24. The BIMS showed a score of 15 out of 15, indicating the resident's cognition was intact. Review of R27's Census tab of the EMR revealed R27 discharged to the hospital 01/23/24, while her primary payer was Medicare A, and returned 01/25/24, Review of R27's Health Status Note, dated 01/23/24 at 1:36 PM and located in the EMR under the Progress Note tab, revealed [RP] approached writer and said that resident agreed to go to ER. Writer spoke with resident and she stated that she would go to the ER . Review of R27's Patient Transfer Form, dated 01/23/24 and located in the EMR under the Documents tab, revealed the facility transferred R27 to the hospital for the inability to eat or drink anything for several days. Review of R27's Bed Hold Notification, dated 01/23/24, provided by the facility, revealed The resident's bed will be held for up to 0 [zero] days . Since Medicare was the primary payer on discharge of the resident, we are not permitted by Medicare to hold the bed. You may pay privately to hold the bed. The notification did not state the cost to hold the bed. During an interview on 10/21/24 at 1:24 PM, R27 stated she had not received any papers from the facility about holding her bed when she went out to the hospital. During an interview on 10/24/24 at 10:53 AM, the BOM stated she checked the EMR dashboard daily for transfers to the hospital and sent out bed hold letters to the family, or residents if cognitively intact, and kept a copy. During an interview on 10/24/24 at 11:30 AM, the BOM provided copies of the Bed Hold Notifications and reported she did not record on the form who it was sent to. During an interview on 10/24/24 at 12:46 PM, the BOM stated the facility did not send the bed hold policy with the notifications. She stated the bed hold policy was reviewed on admission with the admission records. During an interview on 10/24/24 at 3:00 PM, the BOM reported she mailed out the Bed Hold Notification to the resident's responsible party. She stated she called the responsible party if the resident was covered by Medicare A insurance and notified them the insurance would not pay for a bed hold and marked no bed hold. She stated for the three residents reviewed, the responsible parties received the bed hold, not the residents. She stated the facility reviewed the cost per day on admission, and notices were sent out at least 30 days in advance of any room cost changes. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 3:45 PM, the Administrator stated that the Bed Hold Policy would be reviewed with the resident/representative on the day of admission or the next business day, to include the room cost. She stated the Bed Hold Notification was expected to be provided to the residents and/or representative upon discharge to the hospital. Upon review, the cost per day was not explicitly written on the Bed Hold Notification. She stated the BOM would call and notify them of the daily room charges. She stated the charges were relayed on admission and with any changes, with 30-day notice. 42440

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, facility policy review, and review of Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, the facility failed to ensure an Admission Minimum Data Set (MDS) assessment was completed within 14 days of admission for one of 25 sampled residents (Resident (R) 200). This failure placed the resident at risk for unmet care needs due to the lack of a timely comprehensive assessment. Findings include: Review of the facility's policy titled, MDS [Minimum Data Set], revised July 2024, revealed .2. The MDS will be completed: a) By the 14th day after the date of admission . Review of Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, dated October 2023, revealed .01. Admission Assessment (A0310A = 01). The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 . Review of R200's undated Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R200's MDS tab of the EMR revealed no documented evidence of a completed admission MDS which should have been completed by 10/14/24. During an interview on 10/24/24 at 4:30 PM, the MDS Coordinator (MDSC) stated an admission MDS should have been completed within 14 days of R200's admission and this did not occur. During an interview on 10/24/24 at 4:52 PM, the Director of Nursing (DON) stated it was her expectation that R200's admission MDS would have been completed according to the MDS guidelines which was within 14 days of R200's admission. The DON stated it was important the MDS would have been completed timely to ensure a comprehensive care plan was formulated. During an interview on 10/24/24 at 4:53 PM, the Administrator stated it was her expectation that R200's admission MDS would have been completed according to the RAI Manual which was 14 days from the resident's admitted .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on observation, record review, interview, and facility policy review, the facility failed to develop a person-centered care plan related to smoking for one of one resident (Resident (R) 29) reviewed for smoking out of 25 sampled residents. This failure placed the resident at an increased risk for smoking accident hazards. Findings include: Review of the facility's policy titled, Care Plan Policy & Protocol, revised September 2024, revealed .2. The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychological needs .6. The comprehensive care plan (in HER [electronic health record]) shall be periodically reviewed and revised by the interdisciplinary team after each assessment and on an as needed basis . Review of R29's undated Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Observation on 10/24/24 at 10:36 AM revealed R29 was in the vented smoking room with a staff member who was within arm's reach supervising R29 smoking. R29 was utilizing a smoking apron. Review of R29's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/24 revealed the facility assessed the resident to not have used tobacco during the assessment lookback period. Review of the R29's quarterly MDSs revealed the question related to smoking was asked during a comprehensive assessment (Admission, Annual, and Significant Change in Status). Review of R29's nursing Progress Note, dated 02/21/24 and located in the resident's EMR under the Progress Notes tab, revealed an order administration note of Nicotine Step 1 Transdermal Patch 24 hour 21 MG [microgram]/24HR [hours] .Remove Patch and D/C [discontinue] if PT [patient] Decides to Smoke . Resident refused patch at this time. Review of R29's Smoking/Vaping/Tobacco Safety Evaluation, dated 05/29/24 and located in the resident's EMR under the Assessments tab, revealed during the assessment the resident used cigarettes, required supervision, and no safety concerns were identified. The Smoking/ Vaping/ Tobacco Safety Evaluation, documented 1b. If resident smokes cigarettes continued with evaluation .proceed to care plan. Review of R29's current Comprehensive Care Plan, initiated on 02/29/24 and located in the resident's EMR under the Care Plan tab, revealed no documented evidence a care plan related to smoking had been developed when the resident decided to smoke. During an interview on 10/24/24 at 4:35 PM, the MDS Coordinator (MDSC) stated she completed R29's smoking assessment, dated 05/29/24. The MDSC stated prior to 05/29/24, R29 had not smoked cigarettes. The MDSC also stated R29's care plan should have reflected his choice of smoking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 4:55 PM, the Director or Nursing (DON) confirmed R29's Comprehensive Care Plan did not include a care plan related to smoking. The DON stated it was her expectation that a care plan for smoking would have been developed when R29 began smoking. The DON stated the MDS Coordinator (MDSC) would have been responsible for developing a smoking care plan for R29. The DON stated it was important that R29's care plan would have included smoking to ensure his safety and reflect his personal choice of smoking. During an interview on 10/24/24 at 4:58 PM, the Administrator stated it was her expectation R29 would have been care planned for safety and person-centered care to reflect his choice of smoking.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure Personal Protective Equipment (PPE) was discarded appropriately after care was provided to a resident who was on Transmission Based Precautions (TBP) for one of one resident (Resident (R) 59) reviewed for TBP of 25 sample residents. This failure had the potential to cause the spread of infection to other residents who resided on the hall. Findings include: Review of the facility's policy titled, Transmission Based Precautions, revised 12/20 revealed, Transmission Based Precautions will be used in addition to Standard Precautions when the routes(s) of transmission is (are) not complete interrupted using Standard Precautions .Contact Precautions. 1. Contact Precautions are intended to prevent the transmission of infectious agents which are spread by director indirect contact with the patient or the patient's environment .6. Donning PPE before entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination . Review of R59's undated Admission Record, provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R59's nursing Progress Note, dated 09/23/24 and located in the resident's electronic medical record (EMR) under the Progress Notes tab, revealed Nurse Practitioner (NP) 1 reviewed R59's laboratory results, ordered a new antibiotic, and the resident was placed on contact precautions. Review of R59's Laboratory Discharge Summary Report, dated 09/23/24 and provided by the facility, revealed the urine analysis was collected on 09/18/23. The Laboratory Discharge Summary Report, documented the two organisms of Enterobacter Cloacae and Enterococcus Faecium. Observation on 10/22/24 at 10:33 AM revealed Certified Nurse Aide (CNA) 1 and CNA2 donned PPE and entered R59's room to assist her with a transfer from her wheelchair to her bed. There was a trash can with a lid outside the resident's room in the hall. Observation on 10/22/24 at 10:36 AM revealed CNA1 and CNA2 doffed their soiled PPE at the threshold of the doorway and placed the soiled PPE in the trash can outside the resident's room. Observation on 10/22/24 at 10:39 AM of R59's door revealed a PPE station hung on the door and a sign indicating the room was under contact precautions. During an interview on 10/22/24 at 2:50 PM, CNA1 confirmed R59 was on contact TBP. The CNA confirmed she doffed her PPE at the threshold of the R59's door and disposed of the PPE in the trash can outside the resident's room in the hall. The CNA stated that was how she was instructed to dispose of the PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Williamsburg Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 287 N Eleventh Street Williamsburg, KY 40769	

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 2:52 PM, Registered Nurse (RN) 1 stated R59 was on contact precautions due to having an organism in her urine. When asked about the trash can being out in the hallway for staff to dispose of soiled PPE, RN1 stated it was her understanding that was where it should be. During an interview on 10/22/24 at 3:20 PM, the Infection Preventionist (IP) stated it was her expectation that the CNAs would have doffed their PPE and disposed of it inside the resident's room. The IP also stated the trash can should have been inside the room. During an interview on 10/24/24 at 4:43 PM, the Director of Nursing (DON) stated it was her expectation that the trash can would be inside R59's room and the CNAs would have discarded their worn PPE in the room and disposed of the PPE in the room. The DON also stated the trash can should have been in the resident's room and not the hallway to prevent outside the room from being contaminated. During an interview on 10/24/24 at 4:47 PM, the Administrator stated it was her expectation that the trash can for the soiled PPE would have been inside the isolation room.

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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 - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on record review, interview, and facility policy review, the facility failed to maintain an antibiotic stewardship program which included a system to effectively monitor antibiotic usage for one of three residents (Resident (R) 59) reviewed for Urinary Tract Infections (UTIs) out of 25 sampled residents. This failure placed the residents at risk for potential complications related to the use of an antibiotic not effectively treating an infection. Findings include: Review of the facility's undated policy titled, Infection Prevention & Control Program, revealed The facility shall maintain an Infection Prevention & Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection . Monitoring & Investigating Causes of Infection .2. When a resident exhibits signs and symptoms of infection, the McGeer Surveillance Criteria shall be utilized for possible infection. a) Urinary Tract-Fever, dysuria, chills, frequency . Review of the facility's undated policy titled, Antibiotic Stewardship Program, revealed Refers to a set of commitments designed to 'optimize' the treatment of infections while reducing the adverse events associated with antibiotic use .4. Actions to Improve Use .Our facility will implement prescribing policies and change to improve prescribing/use of antibiotics including: .Development and implementation of specific algorithm of assessing residents (McGeer Surveillance Criteria) . Review of R59's undated Admission Record provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R59's Physician Order, dated 09/19/24 and located in the resident's electronic medical record (EMR) under the Orders tab, revealed Cefdinir Oral Capsule (an antibiotic in the cephalosporin antibiotics class) 300 MG [milligram] .take 1 capsule by mouth every morning and bedtime for UTI [Urinary Tract Infection] for 10 days. The medication was ordered by Nurse Practitioner (NP) 1. Review of R59's Laboratory Discharge Summary Report, dated 09/23/24 and provided by the facility, revealed the urine analysis was collected on 09/18/23. The Laboratory Discharge Summary Report, documented the two organisms of Enterobacter Cloacae and Enterococcus Faecium. Continued review of the report revealed the antibiotic Cefdinir was resistant to the organism in the resident's urine. The report also revealed the antibiotic Levaquin was susceptible to the organism. Review of R59's nursing Progress Note, dated 09/23/24 and located in the resident's EMR under the Progress Notes tab, revealed the resident's laboratory results were received and NP1 was notified, and a new order was placed. Review of R59's Physician Order, dated 09/23/24, located in the resident's EMR under the Orders tab, revealed Levaquin Oral Tablet (an antibiotic) 250 MG .take 1 tablet by mouth every evening for UTI for 5 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 3:20 PM, the Infection Preventionist (IP) stated when NP1 prescribed the antibiotic of Cefdinir, the resident did not meet the signs and symptoms criteria for an antibiotic to be prescribed before the urinalysis culture came back. During an interview on 10/24/24 at 3:02 PM, when asked when an antibiotic should be prescribed to a resident before the culture and sensitivity report came back, NP1 stated it depended on the resident. NP1 stated if she knew the resident and the urinalysis indicated an UTI, she would go ahead and start the resident on an antibiotic because of the population who resided at the facility, and she would not want them to become septic. The NP stated she was aware of the antibiotic stewardship requirement and confirmed the initial antibiotic she ordered for R59 was resistive to the organism. The NP stated a possible negative outcome from prescribing an antibiotic resistant to an organism was gastrointestinal distress from killing off good bacteria in the gut. During an interview on 10/24/24 at 4:48 PM, the Director of Nursing (DON) stated she understood the McGreer's criteria being a surveillance tool; however, it should not trump a provider's order. During an interview on 10/24/24 at 4:49 PM, the Administrator stated it was her expectation staff follow provider's orders. The Administrator also stated it was her expectation that providers were educated on the antibiotic stewardship standards and make recommendations based on their education and knowledge.