STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235669	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Rehab Center of Novi Inc	31215 Novi Road Novi, MI 48377

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46865 Based on observation, interview, and record review, the facility failed to provide a privacy cover over an indwelling catheter bag for one Resident (R2) of two residents reviewed for catheters. Findings include: On 4/22/24 at 9:31 AM, R2 was observed resting in bed. An observation that was made on R2's catheter bag revealed no dignity privacy bag covering the catheter bag. On 4/23/24 at 8:43 AM, R2 was observed watching TV in bed. R2's catheter bag revealed no dignity privacy bag covering the catheter bag. On 4/24/24 at 1:09 PM, the DON was interviewed regarding the lack of a dignity privacy bag for R2. The DON said that R2 should have had a dignity privacy bag for his catheter bag. The DON it was explained that the nursing staff are to check that residents with catheter bags have dignity privacy bags in place. A review of R2's Electronic Medical Record (EMR) revealed R2 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. R2 had the following medical diagnoses: Neuromuscular Dysfunction of the Bladder, Multiple Sclerosis, and Paraplegia. A review of R2 's Quarterly Minimum Data Set (MDS) dated [DATE] revealed R2 had a Brief Interview of Mental Status score of 13/15 (cognitively intact). According to the MDS, R2 required maximal assistance with bed mobility, toileting hygiene, and transfers. The MDS included that R2 had an external catheter. A review of the facility policy titled, Promoting/Maintaining Resident Dignity, with a revised date of 11/2023, revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity .Maintain resident privacy.

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** 32568 Based on interview and record review, the facility failed to ensure three (R46, R48, and R108) of four residents reviewed for advance directives had their code status/treatment preferences clearly documented in their clinical record. Findings include: R46 A review of R46's clinical record revealed R46 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: spinal stenosis, anemia, hypertension, and diabetes. A review of R46's Minimum Data Set (MDS) assessment dated [DATE] revealed R46 had intact cognition. On [DATE] at 1:55 PM, a review of R46's full electronic medical record (EMR) was conducted. A review of a form titled, (Facility Name) Advance Directives revealed R46's wife signed the form and indicated R46 did not want Cardio-Pulmonary Resuscitation (CPR) in the event where my heart stops beating, or my respirations cease. The form was signed on [DATE]. A review of a progress note for R46 dated [DATE], revealed, .Resident would like to be DNR (Do-Not-Resuscitate) . On [DATE] at 10:41 AM, an interview was conducted with the Director of Nursing (DON). When queried about where the nurses looked to confirm a resident's code status, the DON reported it would be flagged on the home page in the EMR whether the resident was DNR or Full Code. When queried about why R46 had a progress note that noted he wanted to be a DNR and a signed Advance Directives form that indicated DNR, but there was nothing flagged in the EMR to notify nursing of R46's wishes, the DON reported she would look into it. On [DATE] at 2:06 PM, the DON followed up and reported there was a new Advance Directives form put into R46's EMR that was found in a hard chart that was kept on the unit. The DON reported nurses could access the hard chart or EMR to confirm a resident's code status, but that both charts should match. The DON reported the Social Worker had to ensure everything was in place prior to the code status being flagged in the EMR. On [DATE] at 2:55 PM, an interview was conducted with the Social Worker. When queried about the facility's process for obtaining residents' advance directives and ensuring their treatment wishes were readily available for staff to review in the case of an emergency, the Social Worker reported the nurse reviewed advance directives with the residents upon admission, the social services reviews them during the Social Services Assessment. Residents' preferred code status was reported to the nurse or the DON and was placed into the physician's mailbox for a signature. The Social Worker further reported there was a binder on the units that included the residents' advance directives forms in addition to being flagged in the EMR. According to the Social Worker, nursing was responsible for ensuring residents' code status was updated in the EMR. When queried about R46 and why there was no code status flagged in the EMR, a DNR form in the EMR, and a full code form in the binder, the Social Worker reported it was also documented in her assessment. The Social Worker reported R46 changed his code status to full code upon readmission to the facility on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Social Services assessment dated [DATE] revealed R46's Advance Directive was Do Not Resuscitate (DNR) and the request was In MD (physician's) box for signature. A review of a Social Services assessment dated [DATE] revealed R46's Advance Directive was full code (all life saving measures should be attempted in the event the resident stops breathing, including CPR). It should be noted that the signed Advance Directive in the EMR on [DATE] was for DNR and did not match what was in the binder on the unit, which was Full Code as of [DATE]. R48 On [DATE] at 12:17 PM, a review of R48's clinical record revealed no code status flagged in the EMR and no advance directive form was found in the EMR. Further review of R48's clinical record revealed R48 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: cerebral infarction, hypertension, and hemiplegia. A review of a MDS assessment dated [DATE] revealed R48 had severely impaired cognition. A review of R48's progress notes revealed a Social Services note dated [DATE] that noted, .Advanced directive completed with nursing and son, SW (social work) reviewed with patient . A review of R48's Social Services assessment dated [DATE] revealed R48's advance directive was a Full Code. There was no indication in R48's EMR that she was a full code. On [DATE], the facility uploaded an Advance Directives form that indicated R48 wanted CPR, tube feeding, hospitalization , and intravenous (IV) fluids. The form was signed on [DATE]. On [DATE] at 2:06 PM, the DON reported the form was in the binder on the unit, but not in the EMR prior to questioning. R108 On [DATE] at 2:15 PM, a review of R108's clinical record revealed no code status flagged in the EMR and no advance directives form to indicate R108's treatment wishes. Further review of R108's clinical record revealed R108 was admitted into the facility on [DATE] with diagnoses that included: atrial fibrillation, diabetes, and urinary tract infection. On [DATE] at 10:46 AM, R108's code status and advance directives were requested from the DON. On [DATE] at approximately 2:06 AM, it was discovered that the facility uploaded an Advance Directives form for R108 into the EMR that indicated she wished to be a full code, but did not want to donate organs. The form was signed on [DATE]. The DON reported the form was in the binder on the unit, but not in the EMR. A review of R108's Social Services assessment dated [DATE] revealed R108's advance directive was full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, revised , d+[DATE], revealed, in part, the following, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive .Upon admission, the resident or an appropriate legal representative will be asked to complete and sign an advance directive for the facility .Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care .

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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** 46865 Based on interview and record review, the facility failed to develop and implement a care plan for hearing loss for one Resident (R19) hearing loss or one resident reviewed for hearing loss/communication. Findings include: A review of R19's Electronic Medical Record (EMR) revealed R19 was admitted to the facility on [DATE] with the pertinent medical diagnosis of hearing loss of the right ear. A review of R19's annual Minimum Data Set (MDS) dated [DATE] revealed R19 had a Brief Interview for Mental Status score of 3/15 (severely cognitively impaired). According to the MDS, R19 had hearing aids. A review of R19's comprehensive care plan, with no date, revealed R19 did not have a care plan regarding hearing concerns and the use of hearing aids. On 4/14/24 at 1:41 PM the MDS Coordinator F was interviewed regarding a hearing care plan. MDS Coordinator F said the care plan for R19's hearing concerns was missed. MDS Coordinator F said the hearing care plan was placed in the EMR the night of 4/23/24 because it was overheard that R19 did not have a care plan for hearing aids. On 4/24/24 at 1:14 PM the Director of Nursing (DON) was interviewed regarding the lack of a hearing care plan in the EMR. The DON said R19 should have had a hearing care plan related to the hearing aids. The DON said it is expected that it is the duty of the MDS Coordinator to make care plans for the residents.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to thoroughly assess and document a pressure ulcer for one (R30) of two residents reviewed for pressure ulcers. Findings include: On 4/22/24 at 9:50 AM, R30 was observed seated in a wheelchair with a splint applied to his right arm. When asked questions, R30 replied, Okay to each question. A review of R30's clinical record revealed R30 was admitted into the facility on [DATE] with diagnoses that included: traumatic brain injury. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R30 had severely impaired cognition and was dependent on staff assistance for all activities of daily living, bed mobility, and transfers. A review of R30's Physician's Orders revealed an active order with a start date of 1/18/24 for Venelex ([NAME]-[NAME] oil) ointment applied to the coccyx and covered with an ABD (abdominal) pad every day shift and night shift and as needed. A review of an Entrance Conference Worksheet Electronic Health Record (EHR) Information form completed by the facility revealed documentation regarding pressure ulcers was located in the EHR under Wound Care Progress Note/Flowsheet. A review of the Wound Care Progress Note/Flowsheet documentation for R30 revealed no documentation since 2020. A review of R30's Medication Administration Records (MAR) from February 2024 through April 2024 revealed orders for Skin Assessment/Shower Schedule .Write Progress Notes: Must do skin assessment after each shower or if resident declined shower . The following was documented: 2/16/24 - redness on coccyx 2/20/24 - old redness on coccyx 2/27/24 - open skin on coccyx 3/5/24 - old open skin on coccyx 3/12/24 - old open skin on coccyx 3/22/24 - old open skin on coccyx 3/26/24 - open skin on coccyx 4/1/24 - old open skin on coccyx 4/9/24 - old open skin on coccyx (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/16/24 - open skin on buttocks A review of the Certified Nursing Assistant (CNA) documentation to indicate any skin problem for the resident (R30) revealed open area was documented on the following dates: 4/8/24, 4/10/24, 4/13/24, 4/16/24, 4/17/24, 4/19/24, 4/21/24, 4/22/24, Further review of R30's clinical record revealed no documentation of the measurements and characteristics of the open skin on R30's coccyx and buttocks as documented on the MAR. On 4/24/24 at 9:24 AM, an interview was conducted with the wound care coordinator, Licensed Practical Nurse (LPN) 'C'. When queried about where weekly skin assessments were documented, LPN 'C' reported they were completed on shower days and results were documented on the MAR. When queried about any wounds that R30 had currently, LPN 'C' reported he did not have any wounds and all treatment was being done as a preventative intervention. LPN 'C' explained Physician 'EE' evaluated all wounds and documented his evaluations in the clinical record (progress notes). LPN 'C' further explained that Physician 'EE' was not currently following R30 because he did not have any pressure ulcers. At that time, LPN 'C' was asked if there was any documentation of R30's skin as a result of the CNA and nurse documentation that mentioned open area to the coccyx. LPN 'C' reported she did not see anything in the record and would look into it. LPN 'C' further reported that she was notified last week that R30 had an open area to his coccyx, but it had not yet been assessed. On 4/24/24 at 9:47 AM, an interview with the Director of Nursing (DON) was conducted. The DON explained that weekly skin assessments were documented on the MAR and if a resident had a wound, Physician 'EE' evaluated the resident and documented in a progress note. At that time, the DON was asked where any assessment of R30's open areas to the coccyx were documented. The DON reviewed the EHR and confirmed there was no documented assessment of R30's wound. The DON reported she did not know if R30 had any open areas. On 4/24/24 at 9:58 AM, an observation of R30's skin was conducted with LPN 'C'. When R30's brief was removed, no treatment was observed on R30's coccyx, bloody drainage was observed in the brief and a large area of scar tissue with scattered areas of what appeared to be moisture damaged skin and partial thickness skin loss. On 4/24/24 at 11:30 AM, the Administrator and Nurse Practitioner (NP) 'D' followed up regarding R30 and reported that NP 'D' had been evaluating R30's wounds. NP 'D' reported she started working at the facility in October 2023 and R30 had always had issues with the skin on his coccyx. NP 'D' reported she never saw the coccyx open up completely. When queried about where were evaluation/assessment of R30's coccyx would be documented, NP 'D' reported it would be in the progress notes. A review of R30's Physician progress notes revealed the following documentation written by NP 'D': On 1/5/24, 1/19/24, 1/23/24, 2/6/24, NP 'D' documented, .Stage IV (full thickness skin and tissue loss) sacral and ischial ulcer with ulceration and minor bleeding of surrounding area .Plan: Continue with Venelex ointment and cover with ABD pad . The next time NP 'D' evaluated R30 was on 3/15/24 and the following was documented, .Stage IV sacral and ischial ulcer with ulceration and minor bleeding of surrounding area .Plan: Continue with Venelex ointment and cover with ABD pad . The same thing was documented on 3/19/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24, NP 'D' documented, .Stage IV sacral and ischial ulcer .Hx (history) of Stage IV sacral and ischial ulcer. Resolved but high risk for breakdown . The same was documented by NP 'D' on 4/16/24. There was no documentation to describe the measurements and characteristics of R30's coccyx. It was documented by NP 'D' that the wound was resolved. However, based on the observation made on 4/24/24, there was open areas and bloody drainage. A review of a facility policy titled, Skin Assessment, revised 1/2024, revealed, in part, the following: . Documentation of skin assessment: .Document type of wound .Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46865 Based on interview and record review, the facility failed to document urinary output consistently for one Resident (R2) of two residents reviewed for catheters. Findings include: A review of R2's Electronic Medical Record (EMR) revealed R2 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. R2 had the following medical diagnoses: Neuromuscular Dysfunction of the Bladder, Multiple Sclerosis, and Paraplegia. A review of R2 's quarterly Minimum Data Set (MDS) dated [DATE] revealed R2 had a Brief Interview for Mental Status score of 13/15 (cognitively intact). According to the MDS, R2 required maximal assistance with bed mobility, toileting hygiene, and transfers. The MDS included that R2 had an external catheter. A review of R2's catheter care plan dated 4/22/24 revealed Monitor/document (urine) odor, color, amount, and sediment Q (every) shift. A review of the Treatment Administration Record (TAR) for the month of January 2024 revealed the following undocumented outputs for the day shift: 1/14, 1/15, 1/18, and 1/23. A review of the Treatment Administration Record (TAR) for the month of January 2024 revealed the following undocumented outputs for the night shift: 1/12, 1/13, 1/14, 1/15, and 1/16 A review of the Treatment Administration Record (TAR) for the month of February 2024 revealed the following undocumented outputs for the day shift: 2/5, 2/8, 2/9, 2/10, 2/11, 2/13, 2/14, 2/15, 2/16, 2/20, 2/22, 2/25, and 2/26 A review of the Treatment Administration Record (TAR) for the month of February 2024 revealed the following undocumented outputs for the night shift: 2/4, 2/6, 2/7, 2/8, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14, 2/15, 2/17, 2/18, 2/19, 2/20, 2/25, and 2/29 A review of the Treatment Administration Record (TAR) for the month of March 2024 revealed the following undocumented outputs for the day shift: 3/5, 3/7, 3/8, and 3/19 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 1:13 PM the Director of Nursing (DON) was interviewed regarding the undocumented urinary outputs. The DON said the nursing staff have to record the output when the foley catheter has been emptied. Upon departure from the facility there was no facility policy given that addressed the documentation of urinary catheter output.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interviews, and record reviews the facility failed to ensure consistent dialysis communication documentation and assessments were maintained in the clinical record for one (R40) of one resident reviewed for dialysis. Findings include: On 4/22/24 at 1:41 PM, R40 was observed in bed. When asked, R40 stated they receive dialysis care five days a week for two and a half hours each day. R40 explained the dialysis entity comes to the facility and provide their dialysis treatment at the bedside. Review of the medical record revealed R40 was readmitted to the facility on [DATE], with a diagnosis that included end stage renal disease. Review of the medical record on 4/22/24, revealed the last dialysis communication/assessment documentation in the medical record was dated 5/8/23. On 4/23/24 at 10:36 AM, the Director of Nursing (DON) was interviewed and asked where the documentation for R40's dialysis treatments/communication/assessments are kept, and the DON stated the entity emails them to the facility. The DON was then asked why the communication/assessments had not been uploaded to the R40's medical record since May 2023 and the DON stated they would look into it further and follow back up. At 1:59 PM, the DON stated they had gotten in touch with the dialysis center and received all of the communication/assessments from dialysis since May 2023 to current and it's now uploaded in the resident's record. No further explanation or documentation was provided by the end of the survey.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41415 Based on interview and record review the facility failed to implement an effective antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for two (R's 159& 160), this deficient practice had the ability to affect multiple residents who were prescribed antibiotics during their inpatient care at the facility. Findings include: According to the Center for Disease Control's (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 2015: .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 . Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year . studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic- resistant organisms .Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections .Identify clinical situations which may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use . The Core Elements of Antibiotic Stewardship for Nursing Homes (cdc.gov) Review of the facility's Infection Surveillance program from June 2023 through April 2024 documented multiple N/A documentation under criteria met for McGeer's for residents admitted from the hospital on an antibiotic. R159 Review of the facility's Infection Control Form for January 2024, documented the following in part, . (R159's name) Date of onset 01/08/2024 . Type of Infection- COVID-19 . Symptoms- productive cough . Amoxicillin 875-125 MG (milligram) BID (twice a day) x 7 days . McGeer criteria- Y (Yes) . [R159's name] Date of onset 01/08/2024 . Type of Infection- COVID-19 . Symptoms- productive cough . Doxycycline 100 MG BID X7Days . McGeer criteria- Y (Yes) . Review of R159's progress notes documented the following: On 1/4/24 at 7:30 AM, a nurse's note documented in part . alert, verbal able to communicate needs, received awake in bed . no resp. (respiratory) distress noted. No c/o (complaints of) pain, scheduled medications given . swabbed for covid last night, tested positive . ordered to quarantine patient . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235669	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Rehab Center of Novi Inc	31215 Novi Road Novi, MI 48377

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 - Few	On 1/8/24 at 10:12 PM, a nurse's note documented in part . Resident in bed . able to make needs known verbally . BP (blood pressure) 136/81, PR (pulse rate) 61, RR (respiration rate) 18, temp (temperature) 97.5 . 02 sat (oxygen saturation) 93% on RA (room air). Denied SOB (shortness of breath) or respiratory distress. No chest pain, nausea and vomiting . new order given for oral antibiotics . Further review of the medical record revealed no additional signs or symptoms documented or justification for the prescribed antibiotics. Review of January 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented the administration of the doxycycline hyclate 100 mg and amoxicillin-pot clavulanate 875-125 mg medications administered twice a day from 1/8/24 until 1/15/24. R160 Review of the facility's Infection Control Form for February 2024, documented the following in part, . (R160's name) . Type of Infection- UTI (urinary tract infection) . Symptoms- nausea, vomiting, poor appetite, abdominal pain, + dipstick, leukocyte . Cultures 1/29- no growth . Cipro 250 MG BID x3 days . McGeer criteria Y (yes) . Review of a physician note dated 1/29/24 at 5:05 PM, documented in part . she had some nausea/vomiting earlier today-she says it is more gagging rather than vomiting, but still poor appetite . no chills, no runny nose, no sore throat, no body aches, no dysuria (pain with urination), UA (urinalysis) dip stick done today is positive for LE (leukocyte esterase), will give cipro 250 mg bid x 3 days-urine sent for UA/culture, she is awake and alert and visiting with family members. She apparently was having this nausea at the hospital . Review of the UA culture collected 1/29/24, documented the following results in part . Mixed genital flora isolated. These superficial bacteria are not indicative of a urinary tract infection. No further organism identification is warranted on this specimen . This did not meet the criteria of an UTI infection. On 4/23/24 at 3:23 PM, an interview was conducted with the facility's Infection Control Preventionist (ICP) B. ICP B confirmed the facility utilized McGeers criteria and was asked about the review of residents who admit to the facility from the hospital prescribed an antibiotic and why they were all documented as N/A in on the surveillance record, ICP B explained they don't review the resident prescribed antibiotics at the hospital because they usually come to the facility and finish the antibiotic in a few days and that is why N/A is documented. On 4/24/24 at 10:24 AM, a second interview was conducted with ICP B, and they were asked why R159 was prescribed Amoxicillin-pot clavulanate 875-125 mg (milligram) and Doxycycline 100 mg on January 8th, 2024, until 1/15/24? And why R160 was started on Cipro 250 mg, twice a day for three days for a urinary tract infection prophylactically when neither resident met criteria and the ICP B stated they would follow up on it. At 2:47 PM, the ICP B returned and stated they could not provide and explanation or documentation for R159's antibiotic administration, however provided the physician's note from 1/29/24, UA and culture results for R160. No further explanation or documentation was provided before the end of the survey.