STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehabilitation Hospital	2381 Lawrenceville Road Lawrenceville, NJ 08648

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37547 Based on record review and review of other pertinent facility documentation, it was determined that the facility failed to ensure that the administration of a resident's enteral tube feeding (allows liquid food to enter the stomach or intestine through a tube) was consistently documented to indicate if it were administered or held on the Medication Administration Record. This deficient practice was identified for 1 of 1 resident, (Resident #27) reviewed for tube feedings. This deficient practice was evidenced by the following: During the initial tour of the facility on 09/03/24 at 8:38 AM, the surveyor observed Resident #27 lying awake in bed. The resident stated that their tube was clogged four to five weeks ago. A review of Resident #27's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but was not limited to: other pneumonia (lung infection), and dysphagia, pharyngeal phase (problems in the throat during swallowing). A review of Resident #27's Admission Minimum Data Set (MDS), an assessment tool, revealed that the resident had Brief Interview for Mental Status Score (BIMS) of 15 out of 15, which indicated that the resident was fully cognitively intact. Further review of the MDS indicated that the resident had a swallowing disorder with coughing or choking during meals or when swallowing medications and complaints of difficulty or pain with swallowing. The MDS specified that the resident experienced no significant weight loss and had a feeding tube (PEG, percutaneous endoscopic gastrostomy, a feeding tube inserted through the skin and the stomach wall for people who can not obtain nutrion by mouth). A review of Resident #27's Care Plan revealed an entry dated 07/09/24, that had a Focus of: I have a nutritional problem or potential nutritional problem, risk for malnutrition r/t (related to) abnormal nutrition-related labs, EN (enteral nutrition) via PEG, dysphagia, MASD (moisture associated skin damage) at sacrum (a triangular bone in the lower back) partial thickness, add MVI (multivitamin), 1) Possible unintentional weight loss 2) Enteral nutrition support. Goals included but were not limited to: I will tolerate TF (tube feeding) 100% by next review date, .I will be free from s/sx (signs and symptoms) of dehydration through next review date .My skin integrity will be improved or maintained by next review date and My abnormal nutrition-related labs will show improvement by next review date. Interventions included but were not limited to: Provide and served diet as ordered: NPO (nothing permitted orally): Jevity 1.2 at GR (rate) of 75 ml/hr x 20 hr, TV (total volume) to provide 1800 kcal (calories), 83 gm (grams) pr (protein),1215 ml free water .via peg to meet 100% ENN (enteral nutritional needs) fluid needs, monitor and record intake at meals . (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #27's Order Summary Report revealed an order dated 08/13/24 for NPO diet. A second order dated 09/03/24, for Enteral Feed Order in the afternoon Enteral: Jevity 1.2 .liquid feeding tube every shift, feeding pump set at 75 ml/hr for 20 hours, total volume 1,500 ml A review of Resident #27's August 2024 Medication Administration Record (MAR) revealed an entry for an Enteral Feed Order in the afternoon Enteral: Jevity 1.2 Cal liquid via feeding tube every shift, feeding pump set at 75 ml/hr for 20 hours, total volume 1500 ml, 100 ml flush after medication start date 08/11/24. Further review of the entry revealed that on 08/25/24, 08/27/24, 08/28/24, and 08/29/24 at 1400 (2:00 PM) the order was not signed out to indicate whether the tube feeding was admininistered or held and the fields that were allotted for charting were left blank. A review of Resident #27's Progress Notes within the electronic health record (EHR) from 08/25/24 through 08/29/24, did not indicate that the resident left the facility or experienced difficulties with tube feeding administration. On 09/05/23 at 10:09 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that the resident went out to the hospital on 08/12/24, and the entry for tube feeding administration on the MAR was left blank but there was documentation on the MAR on 08/13/24, that the entry was signed out as held on that date. The LPN/UM stated that the entry should have been charted as not administered if the resident were not here. The LPN/UM reviewed the August MAR and stated that on 08/27/24, 08/28/24, and 08/29/24, the patient was in the building and the nurse did not properly document. The LPN/UM stated there was no excuse why she was not documenting. The LPN/UM further stated that even on 08/25/24, 08/27/24, 08/28/24, and 08/29/24 blanks were noted on the MAR. The LPN/UM stated that she did not know why it was not signed out, but the patient was in the building and I think it was missed. The LPN/UM stated that there were no orders in place to indicate that the tube feeding was held for any reason. On 09/05/24 at 11:44 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she would not expect to see blanks on the MAR. The DON stated that a lack of documentation was a problem. The DON stated that sometimes care was given and provided, but they just did not sign. The DON further stated, In nursing, if you did not document, you did not do it. A review of the facility policy, Enteral Tube Feeding via Continuous Pump (Revised November 2018) revealed the following: .Documentation: The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. .9. The signature and title of the person recording the data. A review of an undated facility policy, Administering Medications revealed the following: .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-29.2(d), 27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40041 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to handle potentially hazardous food to prevent food borne illness. This deficient practice was evidenced by the following: On 09/03/24 at 8:46 AM, during the initial tour of the kitchen, the surveyor observed the following in the walk-in meat freezer in the presence of two (2) Food Service Directors (FSD #1 and FSD #2). 1. An opened slab of roast beef on the top shelf was not labeled or dated. 2. An opened bag containing six (6) salisbury patties was not labeled or dated. At that time, during an interview with the surveyor, FSD #1 stated, everything that is in the freezer should have dates. Once it is opened, it should be dated. FSD #2 discarded the roast beef and salisbury patties. On 09/05/24 at 1:15 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator stated, when food packages are opened, it should be labeled and dated with the use by date. A review of the facility policy titled Food Receiving and Storage (revised November 2022) revealed, Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). NJAC 8:39-17.2 (g)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 43308 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that their Quality Assurance and Performance Improvement Program's (QAPI) sources of quantitative data was being analyzed to evaluate program effectiveness and implement new processes. This deficient practice was identified during the standard survey and was evidenced by the following: Refer to S1410 On 09/03/24 at 08:32 AM, during the entrance conference the surveyor requested the facility's QAPI book. On 09/06/24 at 08:45 AM, the Licensed Nursing Home Administrator (LNHA) provided the QAPI book. A review of the QAPI book revealed that the facility started a QAPI in January of 2024 on the two-step tuberculosis (TB) skin test (a procedure that helps determine if a person has a recent TB infection or a boosted reaction to an old infection) for employee health and that the Infection Preventionist (IP) and Human Resources (HR) were responsible to audit the active employee files which was ongoing. Further review of the QAPI book revealed that in April 2024 the two-step TB skin test QAPI was still ongoing. On 09/06/24 at 09:37 AM, the LNHA provided an audit that was completed only for the newly hired employees for January 2024. There was no documented evidence that an audit was completed for active employees from January 2024 to August 2024. During an interview with the surveyor on 09/06/24 at 09:52 AM, the LNHA stated, in the presence of the survey team, that QAPI was the process to monitor the improvement of the identified concerns. She further stated that if there was no improvement, then the QAPI committee reviewed why it was not improving and what interventions could be put into place. When asked about the provided audit, the LNHA stated that the January audit that was provided for the employee health two-step TB skin test was completed for the newly hired employees and not the active employees. She further stated that the expectation would be to audit all of the active employees as indicated by the QAPI plan. The LNHA confirmed that the audits from February to August 2024 were not completed. The LNHA acknowledged that since there was a QAPI on it, there should have been audits completed from January to August 2024 on the active employees and the information should have been presented at the QAPI meetings. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 09/06/24 at 10:22 AM, the infection Preventionist (IP) stated in the presence of the survey team, that she started the QAPI on employee health two-step TB skin tests for active employees because she was trying to put a system in place to have the files in order. The IP further stated that she started with the newly hired employees in January because it would be easier. When asked about the ongoing audits, the IP stated it fell by the way side. The IP emphasized the plan was to review all the active employees, but they started with the newly hired employees first. The IP confirmed there were no other audits completed for the active employees related to the employee health two-step TB skin test. She further stated that the expectation was that all active employees should have been reviewed since it was brought to QAPI. A review of the facility's undated Quality Assurance and Performance Improvement (QAPI) Program policy, included, 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include a. tracking and measuring performance. 3. The committee meets at least quarterly (or more often as necessary) to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. NJAC 8:39-33.1(a)(e); 33.2 (a)(b)(c)(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37547 Based on interview and review of other pertinent facility documentation, it was determined that the facility who had been in an active COVID-19 (potentially, deadly virus) outbreak since 08/21/24, failed to conduct complete and thorough contact tracing (method used to identify COVID-19 exposure and prevent transmission) upon the identification of a single new case of COVID-19 in a resident or staff member in accordance with the facility policy, Centers for Disease Control (CDC), Local Health Department, State Health Department and all current guidance related to infection control. This deficient practice was identified for 1 of 1 resident, (Resident #21) reviewed for COVID-19. This deficient practice was evidenced by the following: On 09/03/24 at 7:26 AM, the surveyor entered the facility and was informed by the Registered Nurse Night Supervisor (RNNS) that the facility was in an active outbreak and the last positive resident (Resident #21) was expected to complete isolation precautions that day. There was signage posted on the front door of the facility and at the receptionist desk that informed visitors that the facility was in outbreak and mask usage was required. On 09/03/24 at 8:48 AM, the surveyor observed Licensed Practical Nurse (LPN) # 1 outside of Resident #21's room during the medication pass. The surveyor observed that there was no signage or PPE (personal protective equipment, equipment worn to protect the body from injury or disease) to indicate that the resident was on isolation precautions for COVID-19. When interviewed, LPN #1 stated that Resident #21 was assigned to her and she did not have any residents who had COVID-19 on her assignment. On 09/03/24 at 9:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #21 was cleared of COVID-19 and isolation precautions were discontinued. A review of Resident #21's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: interstitial pulmonary disease (lung disease), and cognitive communication deficiency. The Diagnosis section of the form was later updated on 08/24/24, to include a diagnosis of COVID-19. A review of Resident #21's Admission Minimum Data Set (MDS), an assessment tool, revealed that the resident had a Brief Interview for Mental Status score of 15 out of 15 which indicated that the resident was fully cognitively intact. A review of Resident #21's Care Plan revealed an entry dated 08/25/24, with a Focus of: I have COVID-19 (resolved 09/03/24). Interventions included but were not limited to: COVID-19 testing per the Federal, State, and local recommendations/regulations . A review of Resident #21's Health Status Note in the Electronic Health Record (EHR) revealed an entry dated 08/26/24 at 10:14 AM that was documented by the DON, revealed: The patient tested with COVID positive (+). The resident is on isolation precaution for positive COVID, he/she is in a single room by his/herself, all services provided in the room. The patient is made comfortable. Will continue plan of care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/04/24 at 9:38 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that the first resident who tested positive for COVID-19 on 8/11/24, resided on the second floor in a private room. The IP stated that she checked to see if the resident had visitors or who the resident had contact with. The IP stated that she confirmed that the resident had visitors often. When the surveyor asked the IP if she completed contact tracing, the IP stated that she documented notes on the comment section of the line listing (describes an outbreak in terms of person, place and time and allows for quick identification of trends, missing information and errors). The IP stated she normally used the CDC Checklist and completed contact tracing, but I have not done it for this outbreak yet. The IP stated she had to put it together, as her contact tracing is in the comment section of the line listing. The IP stated, we are not out of outbreak, so I have not put it together yet. I just document on my line listing. At that time, the IP stated that on 08/16/24, a resident on the second floor tested positive. The IP stated the resident had frequent visitors from the outside and had since been discharged to home. The IP stated on 08/17/24, she was texted at home over the weekend by a nurse and was informed that there were three residents who tested positive for COVID-19. The IP stated that Transmission Based Precautions TBP (isolation), and droplet precuations (necessary when a patient infected with a pathogen, is within three to six feet and a mask or respirator is required to be worn) and contact precautions (precautions intended to prevent transmission of infectious agents spread by direct or indirect contact with the patient or the patient's environment) were instituted. The IP stated that an N 95 mask (filters out 95% of particles), face shield, goggles, gloves and gown were required to be worn into the affected resident's room. The IP further stated that she notified the local health department official on either Sunday or Monday of the positive cases. The IP stated the official was not available, and someone else responded in her absence. They informed her of a need to start a line list. The IP stated that she usually did contact tracing and symptoms but the outbreak stayed in one hallway. She stated, it may have been from that, it was hard. No one else was sick except for the three residents. The IP stated that a fourth resident who was a room mate of a positive resident, then tested positive four days later. The IP stated in all, she had eight positive residents and one staff member (a house keeper who did not work on either of teh sub-acute units located on the second or fifth floor). The IP stated there was another staff member, who does not come to the clinical units and was placed under the other tab on the line listing. At that time, the IP stated that a Certified Nursing Assistant (CNA) who worked on the second floor tested positive on 08/12/24. The IP stated when interviewed, the CNA stated that she took care of someone who was ill at home, but did not report that their loved one had COVID. The IP stated that the CNA came into work early and stated that she felt like she was getting a cold and requested to be tested and was sent home early before her shift. The IP stated the CNA's last day worked was on 8/10/24. When the surveyor asked if any staff or residents were tested in response to the positive CNA the IP stated that she would have to look and see what assignment the CNA had. The IP stated the nurses would notify her if any residents displayed signs and symptoms of COVID-19 and nobody was symptomatic at that time. When asked when do you test residents and staff? The IP stated, I only test if symptomatic. The IP further stated I ask who they were with. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At that time, the IP stated, We talk, but it is not documented. It is me yelling at them, where were you, who at home is sick? No testing is done, only residents who were symptomatic were tested and no mass testing was done. The IP stated, the previous outbreak (ended on 07/16/24), we tested everybody, because it was out of control. The IP stated the only contact tracing performed was on the line list and has not been transferred onto my notes yet. The IP stated rapid tests were done and the results were documented on the resident's charts in the progress notes. The IP stated right now there are no active cases. The IP stated the last case was Resident #21, who tested positive on 08/24/24, and was removed from isolation on 09/03/24, on day 11. The IP explained that residents were maintained on isolation for 10 (ten) days. The IP stated that she had not spoken with Resident #21 about it to determine possible exposure. At that time, the surveyor asked the IP if she completed staff or resident education in response to the outbreak? The IP stated no education that pertained specifically to COVID-19 was completed for this outbreak. On 09/04/24 at 11:09 AM, the surveyor interviewed the Executive [NAME] President (EVP) who stated that if signs and symptoms of COVID-19 were exhibited, testing was completed and and the IP reached out to the Local Health Department (LHD), Outbreak Coordinator, who directed for Contact Tracing. The EVP stated that her expectation was for the IP to pull the staff schedules and review for possible exposure. The EVP stated that she was not IP certified and relied on the IP to work out the details with the LHD. The EVP stated that contact tracing may be documented on the line list. On 09/04/24 at 12:40 PM, the surveyor reviewed the facility line listing provided by the IP in her presence, which included eight (8) residents and one (1) staff member (from acute care). The CNA who the IP stated worked on the second floor and tested positive for COVID-19 on 08/12/24, was not included on the line list. Two (2) of the resident's comment sections which the IP stated was where she documented contact tracing were blank with no documented evidence that contact tracing was completed. When the surveyor asked the IP why there were blanks on the line listing she stated, It should have been done. The IP further stated that the comment section was intentionally not filled in because a common denominator of exposure was not found. The surveyor noted that Resident #21 was not included on the line list provided. The IP stated that was because the resident had a lot of visitors, and was placed under the other tab. At that time, the IP stated that on Monday 08/19/24, she sent the line list to the LHD. When the surveyor asked why she waited until 08/19/24 to inform the LHD, the IP stated, It took three residents to form an outbreak. The IP further stated, The definition of an outbreak was: two or more staff or residents with similar symptoms. At that time, the surveyor reviewed an email correspondence between the IP and the Health Department dated 08/21/24 at 9:39 AM, which included the following guidance for the IP to institute: .Conduct contact tracing on all resident and staff cases, Conduct testing of close contacts (someone who is within six feet of a COVID-19 case for a cumulative total of 15 minutes or more over a 24-hour period during the COVID-19 case's infectious period) as appropriate (on days 1, 3, and 5), If the facility is unable to perform contact tracing, broad based testing of the unit/wing/facility can be conducted (every 3-7 days until no new cases are found for 14 days), Be sure to follow all applicable federal and state directives. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Outbreak Documentation: .Template: COVID-19 Facility Line List Template Include only residents and staff associated with this current outbreak. Be sure to add non-facility onset cases to the other cases tab on the line list after consulting with the LHD. At that time, the surveyor asked the IP to define close contact, she stated, Anyone who spent more than five minutes with a resident with care within a three to five feet distance. There was no documented evidence reflected on the line listing in the comment section to indicate that the IP interviewed both staff and residents who tested positive for COVID-19 or, visited or rendered care to the affected individuals to determine any close contacts who may have been exposed to the positive individuals to prevent the further spread of COVID-19. On 09/04/24 at 1:05 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the IP's documentation of contact tracing that was noted on the comment section of the line list. The LNHA stated, I would expect more information to have been provided. The LNHA stated that she would have included: known or potential exposures, additional test results, contact tracing and findings, activities, underlying conditions etc. The LNHA stated that the IP can document contact tracing on the line list, but it has to be more comprehensive. The LNHA stated, If proper contact tracing was not done, there could be spread of COVID-19. On 09/04/24 at 11:22 AM, the surveyor interviewed the DON who stated, I expect the line list to be comprehensive and include all residents with COVID. The DON stated that if the IP did contact tracing and did not document it, that was an issue. On 09/04/24 at 3:49 PM, the LNHA provided the surveyor with a copy of the line listing via e-mail. The surveyor reviewed the line listing and noted that Resident #21 was added to the line listing after surveyor inquiry. The surveyor reviewed Resident #21's comment section of the line listing which revealed the following: possible exposure from an unsampled resident, (who was also on the line listing as positive for COVID-19), residents observed conversing prior days. A review of the facility policy, Contact Tracing-Residents (Updated 07/2023) revealed the following: Contact tracing is a method of identifying those who may have been exposed to COVID-19, to help track and prevent the transmission of COVID-19. Close contact (exposure) is defined by the CDC as being within 6 (six) feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period. Procedure: Identify the infectious period for the resident. An infectious period begins 2 (two) days prior to symptom onset, if symptomatic. If asymptomatic, the infectious period is calculated as 2 (two) days prior to the COVID-19 specimen collection date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Add 10 (ten) days from the start of the identified infectious period, to determine the end date of the infectious period. For each day of the infectious period, identify all locations the resident visited within the facility (e.g., resident room, dining room, activity room) or if the resident was hospitalized or in another facility (e.g., hospital and unit, dialysis facility). For each location, make notes about each person that could have been in contact with the resident including visitors, other residents, staff, and volunteers. Identify contacts at each location for each day during the infectious period. For each person exposed, investigate the interaction between the case-person and the exposed contact. Was the resident wearing a mask?, Was the resident able to wear the mask consistently? , Was the resident coughing?, What was the nature of the interaction?, How close were the case-person and the exposed person?, For any of the interactions, was the exposed person wearing a mask or other appropriate PPE? Determine if exposed persons meet the definition of a close contact. A person in close contact with the case-patient during the symptomatic period would be considered exposed. Notify all exposed persons of their exposure and the required monitoring and quarantine restrictions. A COVID-19 Resident Contact Tracing Tool and Contact Tracing Location Tracker were attached to the policy. Also attached to the policy was a COVID-19 Resident Contact Tracing Tool which was not utilized by the IP to determine potential exposures that may have occurred at the facility. A review of the facility policy, CDC Guidance-New Infection in Healthcare Personnel or Resident (Revised 09/24/22) revealed the following: The facility will review and implement recommendations by the CDC. Regulatory guidance and/or directives provided by the State and or CMS (Centers for Medicare and Medicaid Services) may supersede the CDC recommendations. A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad based approach; however, a broad-based (e.g., unit, floor, or other specific areas of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (one) (where day of exposure is day 0), day 3 (three) and day 5 (five). NJAC 8:39-19.4 (a)(d)(f)(g)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 37547 Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to ensure full implementation of the antibiotic stewardship program, including ongoing monitoring and use of a nationally recognized surveillance criteria prior to consulting the prescriber. This deficient practice was identified for 1 of 1 resident reviewed for antibiotic stewardship, (Resident #27). This deficient practice was evidenced by the following: On 09/04/24 at 9:38 AM, the surveyor interviewed the Infection Preventionist (IP) regarding the facility Antibiotic Stewardship Program (efforts to ensure that antibiotics are used only when necessary and appropriate). The IP stated that she had worked at the facility for nearly one year and had worked as an IP since 2019. When the surveyor asked the IP to describe how the Antibiotic Stewardship Program worked she stated, With a prayer. The IP stated that she monitored residents on antibiotics. When the surveyor requested to view the Antibiotic Stewardship documentation, the IP stated that she would need to run a report in order to do so. When the surveyor asked the IP to run the report, the IP stated that she would have to get back to the surveyor at a later time with that information. The IP stated that she reviewed the Antibiotic Stewardship Program recently with both the Medical Director and Administrator at a Quality Assurance Performance Improvement. (QAPI) meeting. At that time, the IP stated that she used the McGeer Criteria [used for retrospectively counting true infections, with more diagnostic information (positive laboratory testing often used to meet the criteria for definitive infection)]. The IP stated that there was a tool in the computer system, but the nurses did not always complete it. The IP stated that if she had time, she went into the computer and completed the tool. When the surveyor asked the IP to demonstrate use of the tool within the computer that was on her desk in front of her, she stated that the report would need to be ran from the electronic health record. The surveyor asked the IP to identify a resident who was currently being monitored for the antibiotic stewardship and the IP stated, I cannot tell you right now. The IP stated that she ensured the appropriate usage of a prescribed antibiotic was met with the McGeer Criteria Assessment. The IP stated that if the McGeer Criteria was not met, she reached out to the doctor and asked if changes could be made. When the surveyor asked the IP to provide a list of residents who currently received antibiotics at the facility, or an example of the McGeer Criteria Assessment template in her computer or elsewhere, the IP was unable to provide the surveyor with documented evidence of completion of any component of an Antibiotic Stewardship Program. On 09/04/24 at 1:05 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that Antibiotic Stewardship was reviewed during QAPI meetings. The LNHA stated that the IP should have been able to provide evidence of the facility Antibiotic Stewardship Program when requested. The LNHA stated that she would look within the QAPI Binder. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/05/24 at 9:29 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that when a resident demonstrated signs and symptoms of an infection she first evaluated the signs and symptoms of the infection and then notified the doctor. LPN #1 stated that if the resident had a cough or wheeze, the doctor may order a chest x-ray or a COVID test, or if the resident were confused the doctor may order a urine culture. LPN #1 stated if an antibiotic was ordered, she started it as soon as possible and informed both the resident and the resident's family. LPN #1 stated that no additional documentation or notification were required when a new antibiotic treatment was ordered. On 09/05/24 at 11:22 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the facility reviewed resident antibiotic usage at QAPI Meetings and clinical meetings. The DON stated that when an antibiotic was ordered, the nurse should document, review signs and symptoms, see why the antibiotic was ordered, and then update the resident's care plan. The DON stated that the IP did the McGeer Criteria and there must be two symptoms present. The DON stated that she was unsure if the nurses were required to complete the McGeer Criteria. The DON stated that she would have expected that the IP would have shown the surveyor her Antibiotic Stewardship when requested and should have known of at least one resident who received an antibiotic when asked. The DON stated the IP should have had a binder with the information requested in her office. The DON further stated that she was not an IP, but she knew who the residents were who received antibiotics. On 09/05/24 at 12:06 PM, the LNHA stated that she was ultimately responsible for oversight of the IP's work, and agreed to furnish the surveyor with a binder used for Antibiotic Stewardship. On 09/05/24 at 1:17 PM, in a later interview with the LNHA, she provided the surveyor with a binder used for Antibiotic Stewardship and stated that the information was used during QAPI meetings. When the surveyor asked why the binder only contained laboratory data and reports that were obtained from the electronic health record (EHR) that pertained to antibiotic usage and failed to contain documented evidence of McGeer Criteria Assessments, the LNHA stated that there was more education that needed to be done with the IP. On 09/06/24 at 10:01 AM, in the presence of the survey team, the DON stated that after an antibiotic was started, the nurse filled out the infection screening evaluation. The DON explained that the Medical Doctor provided an order for antibiotics, and the Infectious Disease (ID) Doctor did the screening and confirmed that the antibiotic was appropriate and there was no resistance to the antibiotic. The DON stated that the IP was responsible for reviewing the Antibiotic Stewardship and she should have been documenting in the EHR and also should have been tracking antibiotic usage. The DON stated that the monthly tracking that was provided within the binder was completed by the laboratory. On 09/06/24 at 10:07 AM, the LNHA stated that the facility reviewed antibiotic usage both daily and monthly. When asked how the facility ensured appropriate antibiotic usage, the LNHA stated that labs and symptoms were reviewed. The LNHA stated that documentation of daily tracking was not maintained and only monthly tracking provided by the lab was kept. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/06/24 at 10:13 AM, the IP stated that she was tracking antibiotic usage in the EHR that were prescribed both from the hospital and in house. The IP stated that she spoke with the nurses to track changes if any changes were identified during the daily meeting. The IP stated the staff nurse would complete the assessment form and determine if the McGeer criteria was met within three days of a resident starting an antibiotic. The IP stated that if the antibiotic criteria was not met, then the doctor was notified and the the antibiotic was discontinued. When the surveyor asked if antibiotic stewardship should have been reviewed prior and what the process was to determine if an antibiotic were appropriate prior to administration, the IP stated that she reviewed Antibiotic Stewardship in daily clinical meetings. The IP stated that she reviewed the information prior to presenting. When the surveyor asked the IP how she could have explained resident information fully if there was missing documentation on the assessment forms that were provided to the survey team, the IP stated, I will go off memory to try and fill out the information that was missing. The IP further stated that she did not document daily when the daily meetings were held, as they just discussed it. At that time, the IP stated the importance of Antibiotic Stewardship was to identify infections and how we can discuss whether the antibiotics that were used were effective or not. On 09/06/24 at 4:42 PM, the LNHA provided the surveyor with a list of residents who received antibiotics in-house for the past three months. The surveyor reviewed the list and noted that Resident #27 was included on the list. The surveyor reviewed the Medication Administration Record (MAR) within the resident's EHR which revealed that on 08/04/24 at 9:00 AM, the resident was ordered and received Amoxicillin-Pot Clavulanate Tablet 875-125 mg (milligrams) Give 1 (one) tablet via PEG (percutaneous endoscopic gastrostomy, feeding tube inserted through the skin and the stomach wall, directly into the stomach) Tube every 12 hours for bacterial infection for 2 (two) days. On 08/04/24 at 1644 (4:44 PM), the order was discontinued and revised for the same dosage and the indication of Pneumonia was replaced the indication of bacterial infection which was omitted. The order had a start date of 08/04/24 at 2100 (9:00 PM) and an end date of 08/06/24 at 23:59 (11:59 PM). A review of the MAR indicated that the resident received a dosage of the medication at 9:00 PM as ordered and on 08/05/24 at 9:00 AM. Further review of the MAR revealed that there were blanks on the MAR on 08/05/24 at 9:00 PM , and there were also blanks for the medication administration times that pertained to 08/06/24 at both 9:00 AM and 9:00 PM, with no documentation provided into the allotted spaces to indicate the status of antibiotic administration through the end date of 08/06/24 at 23:59 (11:59 PM). A review of Resident #27's Physician Progress Note dated 08/04/24 at 1517 (3:17 PM) revealed a First Docs Readmission Note, which indicated .the resident was readmitted to the facility after he/she was sent out to acute care on 7/30/24 for worsening shortness of breath .IV (intravenous Rocephin (antibiotic) administered for penumonia [sic] . Further review of the Progress Notes (PN) failed to contain a notation that referred to an order for Amoxicillin-Pot Clavulanate Tablet 875-125 mg (milligrams) Give 1 (one) tablet via PEG (percutaneous endoscopic gastrostomy, feeding tube inserted through the skin and the stomach wall, directly into the stomach) Tube every 12 hours for bacterial infection for 2 (two) days. A review of a PN dated 08/05/24 at 1458 (2:58 PM) resident was sent to the hospital. On 08/05/24 a 22:54 (10:54 PM), a Discharge Summary note revealed that .was told by ER Nurse patient admitted with Heart Failure .Further review of the EHR revealed that on 08/08/24 at 23:56 (11:56 PM), an Admission Summary note revealed that the resident arrived back to the facility from the hospital via stretcher . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, Antibiotic Stewardship (Revised 12/2016) revealed the following: Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. .When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. Discharge or transfer medical records must include all of the above drug and dosing elements . .As soon as clinically appropriate, the prescriber will be asked to review converting parenteral (administered elsewhere in the body other than the mouth) antibiotics to an oral formulation. Review of the facility policy, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes (Revised 12/2016) revealed the following: Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide the decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection Preventionist, or designee. The IP, or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. a. Therapy may require further review and possible changes if: the organism is not susceptible to antibiotic chosen; the organism is susceptible to narrower spectrum antibiotic; therapy was ordered for prolonged surgical prophylaxis; or Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics . All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form . (continued on next page)

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