

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Asbury Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Bower Hill Road Pittsburgh, PA 15243	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343</p> <p>Based on review of facility policy, clinical records, and resident and staff interviews, it was determined that the facility failed to make certain that showers were consistently provided for four of eight residents (Resident R7, R91, R110 and R111).</p> <p>Findings include:</p> <p>Review of the facility policy Activities of Daily Living (ADLs) dated 4/1/24, indicated that residents will be provided with care and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL) abilities are maintained. Activities of daily living include hygiene care and will be recorded in the medical record, and the residents response to the interventions will be monitored, evaluated and revised as appropriate.</p> <p>During the Resident Council meeting held on 7/15/24, at 10:00 a.m., Resident R 91 stated that he had not had a shower because occupational therapy had stopped giving him them. Resident R91 stated that he got them daily, then all of a sudden no one was helping him. He liked showers daily at home, he was there for therapy.</p> <p>Review of the clinical record record indicated that Resident R91 was admitted to the facility on [DATE], with diagnoses that included kidney failure, heart failure and placement of a pacemaker.</p> <p>Review of Resident R91's kardex dated July 2024, identified as tasks in the electronic record indicated Resident R91 had not had a shower documented since 7/4/24, eleven days ago.</p> <p>Review of the clinical record indicated Resident R7 was admitted on [DATE], with diagnoses which included traumatic brain injury without loss of consciousness, convulsions and abnormal posture.</p> <p>Review of Resident R7's kardex dated July 2024, indicated he had a shower last on 7/4/24, eleven days ago.</p> <p>Review of he clinical record indicated that Resident R110 was admitted [DATE], with diagnoses which included right shoulder and left foot fractures from a fall.</p> <p>Review of Resident R110's kardex dated July 2024, indicated Resident R110 had not had any showers since admission or documented refusals of showers.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of he clinical record indicated that Resident R111 was admitted to the facility on [DATE], with diagnoses that included a fractured right lower extremity from a fall.</p> <p>Review of Resident R111's kardex dated July 2024, did not include documentation of a shower being provided since 7/4/24, eleven days ago.</p> <p>During an interview on 7/16/24, at 12:25 p.m., Registered Nurse Unit Manager Employee E22 stated that she attempted to find shower information on the residents identified and could not provide any additional information regarding why residents were not provided showers and confirmed that the facility failed to make certain that showers were consistently provided for four of eight residents (Resident R7, R91, R110 and R111).</p> <p>28 Pa. Code: 211.11(d) Resident care plan.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26071</p> <p>Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose) and failed to follow physician orders for 3 of 6 residents receiving insulin (Residents R93, R7, and R58).</p> <p>Findings include:</p> <p>The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it 's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds.</p> <p>Review of facility policy Nursing Care of the Older Adult with Diabetes Mellitus dated 4/1/24, indicated the provider will order the frequency of glucose monitoring and establish appropriate glycemic targets for individual residents.</p> <p>Review of facility policy Change in Resident ' s Condition or Status dated 4/1/24, indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. The nurse will record in the resident ' s medical record information relative to the changes in resident's medical/mental condition or status.</p> <p>Review of facility policy Documentation of Medication Administration dated 4/1/24, indicated a nurse shall document all medications administered to each resident on the resident ' s medication administration record (MAR).</p> <p>A review of facility policy Physician Services dated 4/1/24, indicated orders for the care of residents are provided by the physician and physician extenders, and are maintained in accordance with federal regulations and facility policy.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy Charting and Documentation dated 4/1/24, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition shall be documented in the resident ' s medical record. The following information is to be documented in the resident medical record: objective observations; medications administered; treatments or services performed; changes in resident ' s condition; events, incidents or accidents involving the resident; and progress toward or changes in the care plan and objectives.</p> <p>Review of the clinical record revealed Resident R93 was admitted to the facility on [DATE], with diagnoses that included diabetes.</p> <p>Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 6/4/24, indicated the diagnoses remain current.</p> <p>Review of a physician order dated 6/25/24, revealed Fiasp Flex Touch 100 unit/ML (milliliter) solution pen injector (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours), inject per sliding scale (according to blood sugar levels), subcutaneously (under the skin) in the morning.</p> <p>Review of the clinical record Medication Administration Record (MAR) revealed that Resident R93 did not receive the above medication as ordered on 7/3, 7/4, and 7/10/24. There was no further documentation in the clinical record.</p> <p>During an interview on 7/16/24 at 9:31 a.m., the Nursing Home Administrator (NHA) conformed the above findings and that the facility failed to follow a physician order for medication administration of insulin for Resident R93.</p> <p>Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE], with diagnoses which included a traumatic brain injury, muscle wasting and diabetes.</p> <p>Review of a Physician order dated 2/13/24, indicated Humalog Injection Solution 100 unit/ml (insulin Lispro) inject as per sliding scale if 70-140=0, 141-180=1, 181-220=2, 221-260=3, 261-300=4, 301-340=5, >340=6 units and call MD, <70 initiate Hypoglycemic protocol, four times a day for Diabetes Mellitus.</p> <p>Review of the clinical record MAR revealed that Resident R7 did not have blood glucose checks completed as ordered on 6/13/24 at 2100 and on 7/5/24 at 1700.</p> <p>During an interview on 7/15/24, at 1:24 p.m., the Director of Nursing confirmed that the facility failed to follow a physician order for Resident R7 blood sugar checks.</p> <p>Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE], with diagnoses that included diabetes, depression, and anxiety.</p> <p>Review of the MDS dated [DATE], revealed the diagnoses remain current.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a physician order dated 4/29/24, indicated Humalog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) per sliding scale and for BS (blood sugar) 331 and greater, cover with 7 units and call MD (doctor) for further orders.</p> <p>Review of Resident R58's MAR revealed that the resident's CBG's were as follows:</p> <p>On 5/1/24, at 7:41 a.m. the CBG was noted to be 377.</p> <p>On 5/6/24, at 7:26 a.m. the CBG was noted to be 351.</p> <p>On 5/7/24, at 8:34 a.m. the CBG was noted to be 337.</p> <p>On 5/7/24, at 11:51 a.m. the CBG was noted to be 349.</p> <p>On 5/8/24, at 8:34 a.m. the CBG was noted to be 341.</p> <p>On 5/8/24, at 8:22 p.m. the CBG was noted to be 335.</p> <p>On 5/14/24, at 8:49 p.m. the CBG was noted to be 358.</p> <p>On 5/15/24, at 8:12 a.m. the CBG was noted to be 362.</p> <p>On 5/20/24, at 8:35 p.m. the CBG was noted to be 331.</p> <p>On 5/23/24, at 8:49 a.m. the CBG was noted to be 444.</p> <p>On 5/29/24, at 8:14 a.m. the CBG was noted to be 353.</p> <p>On 6/4/24, at 7:50 a.m. the CBG was noted to be 333.</p> <p>On 6/5/24, at 11:37 a.m. the CBG was noted to be 333.</p> <p>On 6/6/24, at 8:28 a.m. the CBG was noted to be 350.</p> <p>On 6/7/24, at 8:54 p.m. the CBG was noted to be 331.</p> <p>On 6/13/24, at 8:48 a.m. the CBG was noted to be 335.</p> <p>On 6/16/24, at 9:08 a.m. the CBG was noted to be 374.</p> <p>On 6/24/24, at 8:02 a.m. the CBG was noted to be 343.</p> <p>On 7/4/24, at 7:35 a.m. the CBG was noted to be 334.</p> <p>On 7/5/24, at 8:45 p.m. the CBG was noted to be 332.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident R58's care plan dated 5/2/24, indicated diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report as needed compliance with diet and document any problems.</p> <p>Review of Resident R58's MAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results as ordered.</p> <p>During an interview on 7/16/24, at 11:55 a.m. Registered Nurse (RN) Employee E4 stated for diabetic residents with blood glucose less than 70, they would give orange juice with sugar or glucose gel, review the resident chart, and call the doctor. For blood sugar greater than 180 and not on medication they would call the doctor. They would document in the medical record under the Vitals tab and in the progress notes.</p> <p>During an interview on 7/16/24, at 12:00 p.m. Licensed Practical Nurse (LPN) Employee E5 stated they would be concerned if the blood glucose was less than 70 or greater than 350. For less than 70, they would provide the resident with a snack or juice. For greater than 350, they would get the resident to drink water, monitor for signs and symptoms, and call the doctor. They would document in the progress notes.</p> <p>During an interview on 7/16/24, at 12:05 p.m. LPN Employee E6 stated they would be concerned with blood glucose levels less than 70 or greater than 150. If less than 70, they would give a snack, call the doctor, and recheck the blood glucose in 15-30 minutes. If greater than 150, they would call the doctor. They would document in the progress notes.</p> <p>During an interview on 7/16/24, at 12:10 p.m. RN Employee E7 stated they would be concerned with blood glucose levels less than 70 or greater than 400. If less than 70, they would give the resident a snack and call the doctor. If greater than 400, they would check the resident's orders and call the doctor. They would document in the progress notes.</p> <p>During an interview on 7/16/24, at 12:20 p.m. LPN Employee E8 stated they would be concerned with blood glucose levels less than 70 or greater than 300. If less than 70, they would give the resident juice and recheck the blood glucose in 15 minutes. If greater than 300, they would check the resident's orders and call the doctor. They would document in the progress notes and the MAR.</p> <p>During an interview on 7/16/24, at 12:25 p.m. LPN Employee E9 stated they would be concerned with blood glucose levels less than 70 or greater than 340. If less than 70, they would give the resident juice with added sugar and crackers and recheck the blood glucose in 15 minutes. If greater than 340, they would check the resident's orders, assess for signs and symptoms, and call the doctor. They would document in the progress notes and the MAR.</p> <p>During an interview on 7/16/24, at 1:20 p.m. the Director of Nursing confirmed the facility failed to document in the medical record information related to resident's change in condition, and failed to notify the doctor of a change in condition related to blood glucose for Resident R58.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 201.29(d) Resident rights</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>31343</p> <p>Based on observations and staff interview it was determined that the facility failed to maintain an environment free of potential accident hazards on the secured Dementia nursing unit (Willow).</p> <p>Findings include:</p> <p>Review of the facility policy Accidents and Incidents- Investigating and Reporting: last reviewed 4/1/24, with a previous review date of 3/15/23, indicated that the facility is in compliance with current rules and regulations governing accidents and/or incidents.</p> <p>Review of the facility policy Safety and Supervision of Residents last reviewed 4/1/24, with a previous review date of 3/15/24, indicated the facility strives to make he environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility- wide priorities.</p> <p>During an observation on 7/15/24, from 9:05 a.m., through 9:30 a.m. the following was observed:</p> <p>The residents rooms throughout the nursing unit had personal care items such as body creams, hair and body cleansers, mouth wash and soaps on their sinks in their rooms.</p> <p>The resident lounge/dining room had a bottle of hand soap by the sink, the unlocked cabinet near the sink had a bottle of skin cream, another cabinet had Clorox wipes, under the sink was a soiled gown, a cup, and a brown substance spilled. A drawer had a bag of hand sanitizer.</p> <p>During an interview on 7/15/24, at 9:30 a.m., Registered Nurse Employee E2 confirmed the facility failed to maintain an environment free of potential accident hazards on the secured Dementia nursing unit (Willow).</p> <p>During a second observation with the Director of Nursing (DON) on 7/15/24, at 9:53 a.m., personal care items were also identified in the drawers of the residents sink areas and in the bathrooms.</p> <p>During an interview on 7/15/24, at 9:53 a.m., the DON confirmed that the facility failed to maintain an environment free of potential accident hazards on the secured Dementia nursing unit (Willow).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (e)(1) Management.</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343</p> <p>Based on review of facility policy and clinical record, and staff interview, it was determined that the facility failed to make certain significant medications are administered as ordered by the physician for one of three residents (Resident R155).</p> <p>Findings include:</p> <p>Review of the facility policy Administration Procedures for all Medications, last reviewed on 4/1/24, with a previous review date of 3/15/23, indicated that medications are administrated in a safe manner.</p> <p>Review of the facility policy Medication and Treatment Orders medications shall be given upon written order from the person duly licensed and authorized to prescribe such medications. All medications orders will be consistent with principles of safe and effective order writing.</p> <p>Review of the clinical record indicated that Resident R155 was admitted to the facility on [DATE], with diagnoses that included Atrial Fibrillation (A fib- abnormal heart rhythm), history of venous thrombosis (blood clots) and embolism (blockage of an artery) of her right lower leg requiring surgery and history of having a heart stent due to a heart attack.</p> <p>A review of a physician order dated 7/9/24, indicated Rivaroxaban (Xarelto) 20mg give one tablet in the evening for Afib.</p> <p>A review of the Medication Administration Record (MAR) log dated 7/1/24 through 7/31/24, indicated the Rivaroxaban was not provided to Resident R155 for the dates 7/9/24, 7/10/24 and 7/11/24.</p> <p>Review of a progress note dated 7/11/24, indicated that the physician was notified regarding the medication not being provided.</p> <p>During an interview on 7/15/24, at 1:24 p.m., the Director of Nursing confirmed that the facility failed to make certain significant medications are administered as ordered by the physician.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28Pa. Code:211.9(e)(f)(g)(h) Pharmacy services.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>31343</p> <p>Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to properly secure one of four medications carts reviewed (Hickory Nursing Units back hall medication cart).</p> <p>Findings include:</p> <p>Review of the facility policy Security of Medication Cart, last reviewed 4/1/24, with previous review date of 3/15/24, indicated the medication cart shall be secured at all times when out of nurses view.</p> <p>During an observation on 7/14/24, at 9:10 a.m., the Hickory back hall medication cart was observed unlocked and unattended near the nurses station.</p> <p>During an interview on 7/14/24, at 9:16 a.m., Licensed Practical Nurse (LPN) Employee E3 confirmed that the medication cart was unattended and unlocked and that the facility failed to properly secure one of four medications carts reviewed (Hickory Nursing Units back hall medication cart).</p> <p>28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services.</p> <p>28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43725</p> <p>Based on review of facility policies, facility infection control documentation, observations, and staff interviews, it was determined that the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility for 11 of 11 months. (September 2023 through July 2024).</p> <p>Findings include:</p> <p>A review of the facility's IC Policy and Procedure reviewed 4/1/24, indicated the facility will identify, and reduce the risk of acquiring and transmitting infections among residents, employees, physicians, and other licensed independent practitioners, contract service workers, volunteers, students, and visitors.</p> <p>Review of infection control information from September 2023 through July 2024, failed to reveal an infection prevention tracking infections inside the facility and failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. There was no evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner.</p> <p>During an interview on 7/17/24, at 9:30 a.m. the Director of Nursing confirmed the facility failed to continue an infection control program for tracking infections inside the facility from September 2023 through July 2024.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee.</p> <p>28 pa code 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa code 201.20(c) Staff development.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Asbury Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Bower Hill Road Pittsburgh, PA 15243	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>43725</p> <p>Based on a review of the facility's antibiotic stewardship policy, infection control documentation and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program to include a system to monitor antibiotic use and conduct ongoing review of the treatment of infections (September 2023 through July 2024).</p> <p>Findings include:</p> <p>Review of the facility policy Antibiotic Stewardship reviewed 3/15/23 and 4/1/24, indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose is to monitor the use of antibiotics.</p> <p>The facility's infection control program had no documentation of antibiotic use for September 2023 through July 2024.</p> <p>The facility's antibiotic use tracking system failed to provide feedback reports on specific antibiotic use in the absence of criteria being met for active infection, recommended length of time prescribed, appropriateness, and antibiotic resistance patterns.</p> <p>The facility's antibiotic stewardship program failed to include necessary documentation and components or evidence that the program was in use within the facility at the time of the survey.</p> <p>During an interview on 7/17/24, at 9:25 a.m., the Director of Nursing confirmed the facility was unable to locate the antibiotic stewardship information from September 2023 through July 2024.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa Code 201.14(a) Responsibility of licensee.</p>		