STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395483	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Markley Rehabilitation and Healthcare Center	550 East Fornance Street Norristown, PA 19401

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with resident and staff, it was determined that the facility failed to accommodate a resident's preference for morning care for one of 24 resident records reviewed (Resident R9).Findings include:Review of Resident R9's clinical record revealed that the resident was admitted on [DATE], diagnosed with Multiple Sclerosis (a chronic neurological disorder).Review of Resident R9's, annual MDS (Minimum Data Set an assessment of residents' needs) dated June 4, 2025, revealed the resident was, alert, and oriented and indicated it was very important to the resident the time he got up and ready in the morning, and the time he went to bed. Review of Resident R9's care plan revealed the resident had an ADL (Activities of Daily Living) self- care deficit due to Multiple sclerosis that assessed the resident needing the help of one assist with dressing. On August 4, 2025, at approximately 11:00 a.m. the surveyor heard in the hallway, Resident R9 hollering from the resident's room that he hadn't receive morning care from his Nurse aide (NA) Employee E10. Surveyor immediately interviewed Resident R9 that stated, I don't like to get dressed late in the day. I like to get ready between 9-9:30 a.m. never get dressed and ready when I want. It's 11:00 a.m. and I should be ready. My urinal wasn't emptied either. If there is more than 3-4 inches already in there, I spill it on myself and I am wet. Interview with Nurse aide, Employee E10 confirmed she could not get the resident ready sooner because she needed to have another NA accompany her when giving care to Resident R9 and she could not find anyone to help her. Interview with the Unit Manager, Employee E 11 confirmed the facility failed to accommodate Resident R9's preferences. 28 Pa. Code 211.12(d)(1)(2) Nursing Services

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

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to develop a baseline care plan related to antibiotics, within 48 hours of admission that includes the minimum healthcare information necessary to properly care for a resident, for one of 31 residents reviewed (Resident R53). Findings include: Review of facility policy, Care Plans - Baseline dated March 2022, revealed, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Review of Resident R53's admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 25, 2025, revealed that the resident was admitted to the facility on [DATE], with diagnoses including multi-drug resistant organism (MDRO), urinary tract infection, wound infection, enterococcus (bacterial) infection and fracture of the left lower leg. Continued review revealed that the resident received intravenous (IV) therapy (therapy that delivers liquid substances directly into a vein) for antibiotics upon admission to the facility. Review of progress notes for Resident R53 revealed a nurses note, dated July 21, 2025, which indicated that the resident was admitted to the facility for IV cefepime (antibiotic medication) for bacterial skin infection and prosthetic joint infection. The note continued that Resident is currently on contact precautions [infection control measures used to prevent the spread of infection from one person to another] for CRE [Carbapenem-resistant Enterobacteriaceae - a type of bacteria that is difficult to treat with antibiotics] Review of Resident R53's physician orders for July and August 2025 revealed that the resident received daptomycin (antibiotic medication) from July 25, 2025, through August 4, 2025; cefepime (antibiotic medication) from July 21, 2025, through July 27, 2025; and doxycycline (antibiotic medication) from July 22, 2025, and scheduled through July 27, 2026. Further review revealed that the resident was on contact precautions for CRE from July 21, 2025, through August 4, 2025. Review of Resident R53's care plan, initiated July 21, 2025, revealed that no care plan had been developed related to the resident's infection, use of antibiotics and contact precautions. Interview on August 7, 2025, at 12:12 p.m. the Director of Nursing confirmed that no care plan had been developed for Resident R53 related to the resident's infection, use of antibiotics and contact precautions. 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services

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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 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** Based on interviews and review of clinical records and facility policy it was determined that the facility did not ensure a resident's care plan was developed to meet the care and assistants needed for dental services for one of 24 resident records reviewed (Resident R11).Findings include:Review of the facility's policy for Activity of Daily Living (ADL) revised April 2025 states, Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygieneResident R11 was admitted to the facility on [DATE], diagnosed with anemia, major depression, anxiety, and abnormal gait and mobility.Review of Resident R11'a dental exam dated, December 13, 2024, notes moderate soft plaque buildup and inflamed swollen bleeding gums. Hygiene was noted fair and required staff to perform oral care twice daily for Resident R11 due to the resident needing help.Review of Resident R11's dental exam dated, January 14, 2025, instructed staff to perform oral hygiene twice daily due to the resident requiring help with the daily cleanings. Review of Resident R11 dental exam dated June 5, 2025, noted the resident with Extremely inflamed gingivae on margins and papillae. Staff to perform oral hygiene, suggested improved home care and to consult the physician for the resident benefiting in using Peridex (a prescript antiseptic mouth wash that helps with plaque and gingivitis).Further review of Resident R11's clinical records revealed a care plan was developed for dentures not for the oral health and care of the resident's natural teeth.The unit manager Employee E11 confirmed that Resident R11 had natural teeth and did not have dentures on August 6, 2025, at 12:00 p.m.28 PA. Code 211.12(d)(1) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and review of facility policy, it was determined that that facility failed to provide timely assistance with activity of daily living for one of 24 residents reviewed. (Resident R9) Findings include:Review of the facility policy titled Activity of Daily Living (ADL), Supporting revised April 2025 stated, Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) . elimination (toileting).Review of Resident R9's clinical record revealed that the resident was admitted [DATE], with the diagnoses of Multiple Sclerosis (a chronic neurological disorder).Review of Resident R9's care plan dated September 2023, revealed the resident had a ADL self- care deficit due to Multiple sclerosis that assessed the resident needing the help of one assist with activities of daily living.On August 4, 2025, at approximately 11:00 a.m. the surveyor heard in the hallway, ResidentR9 hollering from the resident's room that he hadn't receive morning care to his nurse aide (NA) Employee E10. Resident yelled, sure put them first not me as it was observed the NA was in the hallway just outside the resident's room. Surveyor interviewed Resident R9 that stated, my urinal had not been emptied since last night. They don't empty my urinal so I can't use it to pee because I spill it when I went to use the urinal, it was full, and I spilled the urine on myself. If there is 3-4 inches of urine in the urinal and I am laying down trying to use it, it spills, and I get wet. I had to wait until she did lounge duty to clean me. Interview with the NA on August 4, 2025, at 1:00 p.m. confirmed the NA could not get Resident R9 ready sooner because she had to wait until she found another NA to accompany her because the resident requires two staff members for care. The NA also indicated the NA had lounge duty (residents that are safety risk require additional supervision are watched in the lounge area) between 10:30-11:00 a.m. The NA confirmed the urinal was not emptied until she was able to provide care at 11:00 a.m. Interview with the Unit Manager Employee E 11 confirmed on August 4, 2025, the resident did not receive timely incontinence care and failed to accommodate Resident R9's preferences. 28 Pa. Code 211.12(d)(1)(2) Nursing Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of clinical records, it was determined the facility did not ensure physicians were notified of a dental recommendation for one of 24 residents reviewed (Resident R11). Findings include:Review of Resident R11's clinical record revealed the resident was admitted to the facility on [DATE], diagnosed with anemia, major depression, anxiety, and abnormal gait and mobility.Review of Resident R11's dental exam dated June 5, 2025, noted the resident with Extremely inflamed gingivae on margins and papillae. Staff to perform oral hygiene, suggested improved home care and to consult the physician for the resident benefiting in using Peridex (a prescript antiseptic mouth wash that helps with plaque and gingivitis).Further review of Resident R11's clinical records revealed no documented evidence the physician was made aware of the dental recommendation for Peridex. Interview with Unit manager, Employee E11 confirmed there was no evidence the physician was notified of the dental recommendation on August 6, 2025, at 12:00 p.m.28 Pa. Code 211.12(d)(1) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, staff interviews, and review of facility policy, it was determined that the facility failed to ensure that all drugs and biologicals used in the facility were stored in accordance with professional standards for two of two medication carts. (carts 3a and 3b+c)Findings include:Review of facility policy titled Medication Labeling and Storage revised February 2023, revealed that the facility stores all medications in locked compartments, only authorized personnel have access to the keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Multi-dose medications that have been opened are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Observation of medication pass on August 4, 2025, at 09:48 a.m., on the Third-floor nursing unit revealed Licensed nurse, Employee E8, preparing to administer ordered medication. Observation of the medication cart A at time of the medication administration revealed that all over the counter medication stored in the top drawer of med cart A revealed all bottled of over-the-counter medications (35 bottles of multi dose over the counter medications) were found unlabeled with date of opening. Further review of medication cart A revealed that multi dose eyedrops (21 total were not labeled with date of opening).Interview with Licensed nurse, Employee E7 at time of the observation confirmed that the multi-dose medications were supposed to be labeled with the date of opening and were not labeled. Employee E7 stated that is the responsibility of all nurses that work on the medication cart to label the medications. Observation of medication pass on August 4, 2025, at 10:10 a.m., on the Third-floor nursing unit revealed licensed nurse employee E8 completing medication pass on medication cart 3a+b, Observation of this cart revealed that all over the counter medication stored in the top drawer of med cart A+B (34 bottles of multi dose over the counter medications) were found unlabeled with date of opening. Further review of medication cart A+B revealed that multi dose eyedrops (10 total were not labeled with date of opening).Interview with Licensed nurse, Employee E8 at time of the above observation confirmed that the multi-use medications were not labeled. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 211. 12 (c) Nursing services28 Pa. Code 211.12 (d)(1) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on review of facility policies, clinical record review and interviews with residents and staff, it was determined that the facility failed to provide dental services to meet the needs residents for one of 31 residents reviewed (Resident R112). Findings include: Review of facility policy, Dental Consultant dated April 2007, revealed, Dental care shall be provided through the services of a Consultant Dentist. Interview on August 4, 2025, at 12:41 p.m. Resident R112 stated that his dental problems have not been addressed by the facility. Resident R112 continued that he needs to see an oral surgeon for evaluation and x-rays. Review of Resident R112's clinical record revealed a dental examination, dated April 30, 2025, which stated that the resident has numerous broken teeth and rampant decay. Referred (below) to oral surgeon for radiographic examination and extractions of any teeth with a less than favorable overall prognosis. After extractions will re-evaluate for restorative. Please refer this patient to an oral surgeon for full radiographic examination and extractions of any teeth with less than favorable overall prognosis. Continued review of Resident R112's clinical record revealed another dental examination, dated June 3, 2025, which stated that the resident not yet seen by oral surgeon. Rewrote referral (below). After extractions, will evaluate further for restorative. Please refer this patient to an oral surgeon for full radiographic examination and extractions of any teeth with less than favorable overall prognosis. Continued review of Resident R112's clinical record revealed another dental examination, dated June 24, 2025, which stated that the resident not yet seen by oral surgeon. Rewrote referral (below). Will evaluate further for restorative after extractions are completed. Please refer this patient to an oral surgeon for full radiographic examination and extractions of any teeth with less than favorable overall prognosis. Continued review of Resident R112's clinical record revealed another dental examination, dated July 18, 2025, which stated that the resident not yet seen by oral surgeon. Rewrote referral (below). After extractions, will evaluate further for possible restorative and partials. Please refer this patient to an oral surgeon for full radiographic examination and extractions of any teeth with less than favorable overall prognosis. Further review of Resident R112's clinical record revealed no evidence that the resident was examined or scheduled for an appointment to be examined by an oral surgeon. Interview on August 6, 2025, at 11:30 a.m. Employee E3, unit manager, confirmed that Resident R112 was not seen by an oral surgeon as recommended by the dentist. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(3) Nursing services

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that residents had the capacity to understand the terms of a binding arbitration agreement for three of five residents reviewed (Resident R39).Findings include: A Binding Arbitration Agreement is a legal process where parties in a dispute agree to have a neutral third party decide their case instead of a judge or jury. The arbitrator's decision is final, and the parties usually cannot appeal it. Review of facility policy, Binding Arbitration Agreements dated November 2023, revealed, Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. Continued review revealed, The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement. Further review revealed, After the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the document. A signature alone is not sufficient acknowledgement of understanding. The President or representative must verbally acknowledge understanding and the verbal acknowledgement documented by a staff member who explains this agreement. Review of Resident R39's admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), April 9, 2025, revealed that the resident was admitted to the facility April 9, 2025, and had diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). Continued review revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 00, which indicated that the resident was severely cognitively impaired. Review of resident R39's clinical record revealed a psychological evaluation dated April 12, 2025, which indicated that resident R 39 has a short attention span and disoriented to date and day with impaired memory. Further review of this evaluation revealed residents thought process to be distracted and tangential. Review of nursing notes for Resident R39 revealed a nursing note, dated April 9, 2025, which indicated that the resident was oriented to person only and place only. Review of Social Service notes dated April 10, 2025, which indicated the resident has confusion. Review of a physician note dated April 14, 2025, revealed Resident R 39 was alert and oriented x 1-2(refers to a person's awareness of only one or two of four possible spheres: person, place, time, and situation, and forgetful. Review of resident's care plan revealed the resident has cognitive function with impaired though process. With intervention to include the need for supervision and assistance with decision making dated April 10, 2025. Review of Resident R39's Binding Arbitration Agreement, dated April 23, 2025, revealed that in the space designated for the signature of the resident, it was noted that Resident R39 verbally signed the agreement. In the space designated for the signature of the facility's authorized agent, the agreement was signed by Employee E7 admission Director. Interview with admission Director, Employee E7 on August 6, 2025, at 1:20 p.m. revealed that she read the Arbitration agreement to Resident R39 and the resident verbally consented to the agreement. 28 Pa Code 201.29(a) Resident rights

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on review of clinical records and interviews with staff it was determined the facility did not ensure documented communication and collaboration with one resident's hospice agency related to the resident's condition were obtained for one of 24 resident records reviewed. (Resident R2) Findings include: Review of Resident R2's clinical record revealed that the resident was admitted to the facility and placed on hospice care June 2025. Review of the communication book from the hospice service did not reveal documentation and/or evidence of the services Resident R2 received while under their care. Interview with Licensed nurse, Employee E12 on August 6, 2025, at 1:25 p.m. stated, Normally other hospice companies we use write a note telling us what type of care they provided. Things that we need to know for an example if the resident went to the bathroom, how much they ate, if they got a bath, {Resident R2} service does not document this. 28 Pa Code 211.12(d)(1)(3) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, and staff interviews, it was determined that the facility failed to implement appropriate tracking and surveillance of infection for three of three months of infection surveillance data reviewed. ([DATE] through [DATE]) Findings include: Review of facility policy titled Surveillance for Infection dated September of 2017 revealed the infection preventionist will conduct ongoing surveillance for healthcare acquired infections and other epidemiologically significant infections that had substantial impact on potential resident outcomes that may require transmission-based precautions and other preventative interventions.For residents with infections that meet the criteria for definition of infection for surveillance, collection of the following data is appropriate:-identifying information (residents name, age, room number, unit, and attending physician)- diagnosis- admission date- date of onset of infection (may list onset of symptoms, or date of positive diagnostic test)-infection site (be specific as possible, pathogen, invasive procedure or risk factors including surgery, indwelling tubes, foley, fractured hip, malnutrition, etc.) pertinent remarks additional relevant information including temperatures other symptoms white blood cell count etcetera also recorded that the resident is admitted to admitted to the hospital or expired and treatment measures and precautions. Review of policy titled Infection Control Meeting dated February 2022, revealed that the interdisciplinary team will meet to review residents with active infections, residents with antibiotic usage, and infection prevention and control topics on a weekly basisThe interdisciplinary team will review the following areas: resident site of infection, active or resolved infection, organism, facility or community acquired, precautions, date of onset, culture results, antibiotic therapy, antibiotic stewardship efforts, root cause, and care plan interventions. Review of the document for Infection Surveillance Monthly Report date [DATE] revealed the total number of infections is twenty-eight, six community acquired, and fourteen hospitals acquired. The report is broken down further to infection category which indicates ten other, two respiratory, one skin, and nine urinary tract infections with an inaccurate total documented of twenty - eight. Actual listed of infections equal twenty-two. Continued review of the document Infection Surveillance Monthly report [DATE] revealed tracking list of infection categorized by infection type. The report exabits resident name, unit/ room, infection, signs and symptoms, status, pharmacy order and comments. There are twenty-eight infections listed on this report. No signs or symptoms, ten without identifying location(room) three antibiotic ordered with no end dates. Review of the document for Infection Surveillance Monthly Report date [DATE] revealed the total number of infections is thirty-two, thirteen community acquired, and fifteen hospital acquired. The report is broken down further to infection category which indicates six blood infections, one bone infection, thirteen other infections, three respiratory infections, two skin infections and seven urinary tract infections with an inaccurate total documented of thirty-two recorded infections. Continued review of the document Infection Surveillance Monthly report [DATE] revealed tracking list of infection categorized by infection type. The report exabits resident name, unit/ room, infection, signs and symptoms, status, pharmacy order and comments. There are thirty-two infections listed on this report. No signs or symptoms, fourteen without identifying location(room), six antibiotics ordered with no end dates. Review of the document for Infection Surveillance Monthly Report date [DATE] revealed the total number of infections is thirty-one, nine community acquired, and twenty hospital acquired. The report is broken down further to infection category which indicates four blood infections, one bone infection, one mouth and throat, one genital, seven other infections, five respiratory infections, three skin infections and nine urinary tract infections. Continued review of the document Infection Surveillance Monthly report [DATE] revealed tracking list of infections categorized by infection type. The report exabits resident name, unit/ room, infection, signs and symptoms, status, pharmacy order and comments. There are thirty-one infections listed on this report. No signs or symptoms, twelve without identifying location(room), five antibiotics ordered with no end dates. All of the above monthly infection surveillance reports failed to include pertinent information of resident diagnosis, signs and symptoms, diagnostic test results, specific infection, and any precautions. Interview with Infection Preventionist, Employee E5 on [DATE], at 1:05p.m. Employee E5 provided monthly surveillance reports and described the process of tracking the infections. When Infection Preventionist, Employee E5 was asked related the limited information provided on the report, Employee E5 stated that all the requested information can be found in the individual resident's clinical record. Employee E6 confirmed that the all the information is not currently reflected in the tracking surveillance reports. Continued interview with Infection

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395483	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Markley Rehabilitation and Healthcare Center	550 East Fornance Street Norristown, PA 19401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, review of facility documentation, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to maintain an effective antibiotic stewardship program for three of five of residents reviewed for antibiotics (Residents R53, R63, and R61).Findings include: Review of facility policy, Antibiotic Stewardship revised December 2016, revealed The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Review of facility policy, Review of Surveillance of Antibiotic Use and Outcomes revised December 2016, revealed, Antibiotic usage and outcome data will be collected and documented using facility approved antibiotic surveillance tracking form. The data will be used to guide 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 (IP). The IP will review antibiotic utilization as a part of the antibiotic stewardship program and identify specific situations that are not consistent with appropriate use of antibiotics. All resident antibiotic regimes will be documented on facility approved Antibiotic Surveillance tracking form; the information gathered will include resident name, room number, date symptoms appeared, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome, and adverse events. Review of Resident R53's admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 25, 2025, revealed that the resident was admitted to the facility on [DATE], with diagnoses including multi-drug resistant organism (MDRO), urinary tract infection, wound infection, enterococcus (bacterial) infection and fracture of the left lower leg. Continued review revealed that the resident received intravenous (IV) therapy (therapy that delivers liquid substances directly into a vein) for antibiotics upon admission to the facility. Review of Resident R53's physician orders for July and August 2025 revealed that the resident received daptomycin (antibiotic medication) from July 25, 2025, through August 4, 2025; cefepime (antibiotic medication) from July 21, 2025, through July 27, 2025; and doxycycline (antibiotic medication) from July 22, 2025, and scheduled through July 27, 2026. Further review revealed that the resident was on contact precautions for CRE from July 21, 2025, through August 4, 2025. Review of facility documentation pertaining to infection surveillance tracking logs for May, June, and July 2025, revealed that Resident R63 was prescribed an antibiotic prophylacticaly on June 4, 2025, for an indefinite amount of time. This resident was not reflected on the surveillance logs presented. Further review revealed that resident 61 also treated prophylacticaly for suspected cellulitis was not reflected on the surveillance logs. Review of Resident R63's admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool, dated May 3, 2025 revealed that resident R 63 was admitted to the facility on [DATE], with diagnoses including Diabetes (chronic metabolic disorder charactered by elevated glucose levels), Hypertension(blood pressure in the arteries are persistently elevated), and dementia (decline in cognitive functions). Review of Resident R63's physician notes dated June 4, 2025, revealed that . Daughter reports she is complaining of feeling wet with urine, abdominal discomfort and hallucinations. -Resident will not allow straight cath (catheter)/she is incontinent - will treat empirically with ABT (antibiotic) Review or Resident R63's physician orders revealed an order for Cipro oral tablet 250 milligrams (mg) (ciprofloxacin HCL), give 250 mg by mouth two times a day for prophylaxis. Start Date June 4, 2025, with end date indefinite. Review of Resident R63's medication administration record revealed that the resident received the medication Cipro the entire month of July 2025. The use of this antibiotic was not reflected in the infection surveillance report. Review of Resident R61's MDS (Minimum Data Set - a mandatory periodic resident assessment tool, dated July 20, 2025, 2025, revealed that Resident R 61 was admitted to the facility on July17, 2025, with diagnoses including Asthma (condition in which a person's airways become inflamed making it difficult to breath). Review of Resident R61's physician orders revealed an order for the antibiotic ciprofloxacin 250 mg prophylactically for suspected cellulitis, there were lab no results, no specific location no, follow up notes if the antibiotic was effective, and this infection and antibiotic was not reflected in the infection surveillance. 28 PA Code 211. 12(c)(d) Nursing services