STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425139	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Health & Rehabilitation Center	140 Tokeena Rd Seneca, SC 29678

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on record review, interview, and facility policy review, the facility failed to notify the resident and the resident's responsible party of a transfer or discharge in writing for one of one resident (Resident (R) 64) reviewed for hospitalization . This created potential for the resident or their representative to have incomplete information and misunderstand the reason and process for transfer or discharge and the discharge appeal process. Findings include: Review of the facility's policy titled, Transfer and Discharge (including AMA [against medical advice]) dated 2025 revealed, Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. Policy Explanation and Compliance Guidelines: .2. Once admitted the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility . 3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests .10. Emergency Transfers to Acute Care: e. Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand. Further review of the policy revealed that it failed to address providing written information to the resident and/or the resident representative regarding the need for transferring the resident. Review of R64's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R64 was admitted to the facility on [DATE]. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Progress Notes located under the Progress Notes tab, revealed a progress note, dated 11/01/24, . [R64] reports having pain all over, staff reports that she has some nausea and vomiting . [R64] states that she has a history of IBS (irritable bowel syndrome) and is used to having nausea vomiting diarrhea frequently as well as abdominal pain frequently . will send to ED [emergency department] for further eval and treatment as indicated. Further review of the record revealed no documentation that written notification containing information as to the reason for the hospital transfer was provided to the resident and the resident's representative. During an interview on 02/12/25 at 12:00 PM, the Director of Nursing (DON) stated, we only notify the family verbally when residents are sent out of the facility, we don't give them anything in writing.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on record review, interview, and facility policy review, the facility failed to ensure one of one resident (Resident (R) 64) reviewed for hospital transfers was given a written copy of a bed hold notice prior to or within 24-hours of emergency transfer to the hospital. This failure created the potential for residents or resident representative not to have the information needed to safeguard their return to the facility. Findings include: Review of the facility's policy titled, Bed Hold Notice Upon Transfer, dated 03/11/24, revealed Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer: 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility. The resident requires the services which the facility provides; The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfer of a resident, the facility will provide within 1 (sic) (one) business day written notice of the facility's bed-hold policies, as stipulated in the State's plan .5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file. Review of R64's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R64 was admitted to the facility on [DATE]. Review of the EMR Progress Notes located under the Progress Notes tab, revealed a progress note, dated 11/01/24, . [R64] reports having pain all over, staff reports that she has some nausea and vomiting . [R64] states that she has a history of IBS (irritable bowel syndrome) and is used to having nausea vomiting diarrhea frequently as well as abdominal pain frequently . will send to ED [emergency department] for further eval and treatment as indicated. Further review of the resident EMR failed to reveal documentation of the resident or resident's representative was given written notice that specified the duration of the facility's bed hold policy. During an interview on 02/12/25 at 12:50 PM, the Director of Nursing (DON) stated, we do not have any documentation indicating that we gave the resident or resident representative written notice of transfer or of our bed hold notice.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that the oxygen tubing was changed and dated, and that the oxygen concentrator was cleaned for three residents (Resident (R) 27, R89, and R64) out of 27 sampled residents. This failure had the potential to impact the residents' treatment and interventions. Findings include: Review of the facility's undated policy titled Oxygen Administration revealed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences . Change oxygen tubing and mask/canula weekly and as needed if it becomes soiled or contaminated. Review of the facility's undated policy titled Oxygen Concentrator revealed, The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators .Change oxygen tubing and mask/canula weekly and as needed if it becomes soiled or contaminated .The main body cabinet should be dusted when needed and can be wiped clean with a damp cloth and mild household cleaner if necessary. 1. Review of the Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed R27 was admitted to the facility on [DATE] with diagnosis of acute respiratory failure. Review of R27's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/24, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Observation on 02/11/25 at 9:29 AM, R27 was lying in bed with oxygen via nasal canula (NC). The oxygen tubing was not dated. The concentrator had dust covering it and dried debris on it. The filter on the concentrator was covered in white dust. During a concurrent observation and interview on 02/13/25 at 9:53 AM, the Director of Nursing (DON) confirmed R27's filter and concentrator was dusty. 2. Review of R89's undated Face Sheet, located in R89's EMR under the Profile tab revealed R89 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis which included chronic diastolic (congestive) heart failure. Review of R89's Physician Order, dated 11/04/24, located in the resident's EMR under the Orders tab revealed oxygen at 3 lpm [liters per minute] via NC every shift to maintain O2 (oxygen) saturation of 90%. Observation on 02/11/24 at 11:31 AM revealed R83's concentrator to have a dirty air intake filter and undated tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 02/13/25 at 9:46 AM, the DON confirmed R89's oxygen tubing had dried food on it and was undated. The DON also confirmed the filter and concentrator was dusty. 3. Review of R64's undated Admission Record located in the EMR under the Profile tab, revealed R64 was admitted to the facility on [DATE] with diagnoses which included pneumonia, and heart disease. Review of R64's Physician Order, dated 11/18/24, located in the resident's EMR under the Orders tab revealed, oxygen at 2 lpm via NC continuous every shift. Check and clean concentrator filter every month and PRN [as needed] every night shift starting on the last day of the month every month. Review of R64's Admission MDS with an ARD of 11/24/24 and located in the resident's EMR under the MDS tab with a BIMS score of 13 out of 15 which indicated R64 was cognitively intact. The MDS documented R64 was receiving oxygen therapy. Observation on 02/12/25 at 12:15 PM, revealed R64's oxygen concentrator was located next to her bed had a dirty air intake filter and the tubing was undated. During a concurrent observation and interview on 02/13/25 at 9:43 AM, the DON confirmed R64's filter and concentrator was dusty, and the oxygen tubing was undated. Interview on 02/13/25 at 9:55 AM, the DON stated that the night nurse on Sundays was responsible for the changing and dating of the tubing and cleaning the concentrator.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 12273 Based on observation, interview, and document review, the facility failed to ensure the preplanned menus were followed. The facility's failure to follow the menus altered the nutritional content of the meals, reduced the calories and increased the risk of weight loss for all residents receiving meals prepared by the dietary department. Findings include: On 02/11/25 between 8:05 AM and 8:35 AM, Cook1 was observed portioning hot cereal into a bowl using a three ounce scoop. Review of the menu extension (a document that identifies the intended menu items for each diet) indicated the portion serving size for the regular diet was to be a six-ounce portion of hot cereal. On 02/12/25, between 11:50 AM and 1:20 PM, Cook2 used a three-ounce scoop to serve the creamed corn served. However, review of the preplanned menu indicated a four-ounce portion of the scalloped corn should be served. In addition, the steam table contained two pans of mashed potatoes, plates prepared for residents included either rice or mashed potatoes, with the beef tips and a dish of creamed corn. Cook2 was asked who received mashed potatoes. She indicated the mechanical soft diets and puree diets were served mashed potatoes. Cook2 used a three ounce ladle to serve the creamed corn. However, the menu indicated a four ounce portion was to be served. Review of the menu extension (which identified what foods would be served to what diets) showed mechanical soft diets and puree should have been served rice which had been altered to meet the requirements of the diet. In addition, the residents were served creamed corn and the menu identified scalloped corn would be served. Dietary Director (DD)1 verified that scalloped corn was the dish identified on the menu. DD1 then provided the recipe, which included cornbread mix, sour cream, cheese, and whole sweet corn, and stated the recipe was not prepared. Cook2 stated that the altered texture diets could not be served the item, and they used cream corn. . On 02/13/25 at 8:00 AM, Cook2 was observed serving hot cereal using a three ounce size scoop. When asked what portion size was to be served to regular diets, Cook2 stated it was a three-ounce portion. However, the menu for regular diet indicated the portion of cereal was six ounces. On 2/13/25 at 9:45 AM, during a meeting with DD1, DD2, and the Administrator when asked why the mashed potatoes instead of rice was served to residents who were on an altered texture diets, she stated she did not know. DD1 stated, The menu was not followed for portion serving sizes, for the altered texture diets, and the omission of the scalloped corn showed the preplanned menus were not followed.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 Based on observation, interview and record review, the facility failed to ensure that residents who refused the meals served were offered an alternate meal for two residents (Resident (R)26 and R21) of 27 sampled residents. Failure to ensure the two residents were offered an alternate meal placed them at risk for weight loss. Findings include: 1. Review of R26's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R26 was admitted to the facility on [DATE] with diagnoses of diabetes, heart failure and hypertension. Review of R26's quarterly Minimum Data Set (MDS) located under the MDS tab in the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 12/03/24, showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R26 was cognitively intact. During an interview on 02/11/25 at 10:56 AM, R26 stated that the facility did not honor her preferences and that she could not ask for an alternate meal. On 02/12/15 at 1:30 PM, R26 was observed in bed with her meal tray on the overbed table. When asked about the meal served, R26 stated, I don't want to eat that and explained she did eat a bowl of tomato soup that was on the tray. Although the tray card stated she should be served a ham and cheese sandwich, no sandwich arrived on the tray. When asked if she was aware that an alternative to the meal could be requested, R26 stated she did not know that an alternate was available. 2. Review of R21's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed R21 was admitted to the facility on [DATE]. Review of the R21's significant change MDS with an ARD of 12/19/24 located under the MDS tab of the EMR indicated a BIMS score of 15 out of 15 indicating R27 was cognitively intact. During an observation of meal service on 02/11/25 at 12:35 PM, Certified Nursing Assistant (CNA)2 served R21's his meal tray in his room and immediately brought the tray back out of the room. During an interview on 02/11/25 at 12:40 PM, CNA2 stated R21 did not like what was on the lunch tray and refused it. CNA2 was asked if an alternative meal was offered, and she stated that she did not offer an alternative meal and that the kitchen refuses to bring an alternate meal after trays are served. During an interview on 02/11/25 at 12:45 PM, Licensed Practical Nurse (LPN)1 stated, If the kitchen doesn't know in advance, they don't provide an alternate meal. Residents have to come ask what is being served at mealtime or come and see the menu posted on the wall. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/11/25 at 1:45 PM, the Director of Nursing (DON) stated, residents are always provided with an alternate meal if they request it and that sandwiches are also available on each unit. 39857

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 12273 Based on observation, interview and record review the facility failed to ensure that foods were stored, prepared, and distributed under sanitary conditions. Specifically, meat was observed thawing in a pan with another meat; two can opener blades were sticky to the touch and not cleaned and free of food debris when not in use; the outside of the reach-in refrigerator, the two food processors, the warmer and the steamer had dried food debris on the outside of the equipment, boxes of health shakes were thawing in the refrigeration without documentation as to when the thawing process began; two of three sanitizer buckets did not have sufficient sanitizer solution; and the cook served scrambled eggs that had not been reheated to the appropriate temperature before serving on a resident's tray. This failure could result in a risk to all residents who received food from dietary to experience a food borne illness. Findings include: Review of the facility's policy titled, Hazard Analysis Critical Control Points (HACCP) indicated foods needed to be reheated to 165 degrees Fahrenheit (F), could be held for service at a temperature of at least 145 F. On 02/11/25, between 8:05 and 8:30 AM, the following observations of the kitchen were noted. Observation of the walk-in refrigerator revealed ground beef and pork cubes thawing on sheet pans with blood pooled in the pan. One of the pans had a cooked ham stored on it with the raw meat, which can contaminate the cooked ham with beef drippings. Two can openers attached to the countertops revealed the blades of both can openers had black, sticky food matter adhered to the blades. Two commercial food processors had dried food splashes on the base, and or buttons used to operate the device. In the reach in refrigerator were undated box of health shakes, which are delivered frozen and can be served according to the manufacturers recommendations for 14 days after thawing. The box was undated when placed in the refrigerator to thaw, leaving staff without a way to track the 14 day use or discard date. The refrigerator unit had spills and splash on the doors, inside and the handles to open it were sticky. On 02/11/25 at 8:28 AM, the Dietary Director (DD)1 stated that the health shakes were undated as to when the thawing process began. The DD1 stated that staff were trained to date the box when removed from the freezer to track the 14-day expiration date. When DD1 was asked about the meat storage pans observed in the walk-in refrigerator, the DD1 stated the meat was not stored properly. On 02/12/25 at 9:20 AM, during follow-up observations, the food processors and reach in refrigerator were observed in the same condition. The warmer located near the stream table was soiled inside and out, the door handle had food matter on the handle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/12/25 at 9:45 AM, Dietary Aide (DA) was asked how often the sanitizer was refreshed. DA stated the buckets were prepared in the morning and changed before lunch. DD1 then corrected the DA and explained they needed to be changed more often depending on use and suggested every 2 hours. The DD1 obtained test strips to check the strength of the sanitizing solution (an ammonia based chemical). Two of the three buckets containing the sanitizer were no longer the right strength to sanitize surfaces if used. The buckets were dispersed throughout the kitchen preparation areas, one was located in the dish room. On 02/12/25 between 11:54 AM and 1:30 PM during observation of the noon meal service, the top shelf of the warmer had a sheet pan with bowls with soup and/or other items prepared to meet the residents' requests. At 12:03 PM, after temperatures for the hot foods on tray line were checked and recorded, [NAME] 2 began plating foods to be served to residents. At 12:25 PM, Cook2 opened the warming oven, obtained a bowl that held scrambled eggs, and set it on a tray to be served to a resident. Cook2 verified the temperature of the scrambled eggs to be 119 degrees F. When asked what temperature the eggs should be, Cook2 responded 135 degrees F. DD1 overheard the response and corrected Cook2 and stated if reheating a food item, it needed to reach 165 degrees F. The bowl was taken to the microwave, and the scrambled eggs were reheated. After testing the temperature, the eggs were now 170 degrees F. After asking about the other items in bowls being held in the warmer, DD1 asked a staff member to reheat the items to ensure they reach an appropriate temperature.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 43050 Based on observation, interview, review of facility policy, and review of Centers for Disease Control (CDC) guidance, the facility failed to establish and maintain an infection prevention and control program (IPCP) for recording incidents of infections identified under the facility's IPCP, surveillance, tracking and trending, and the corrective actions taken by the facility. This deficient practice has the potential to affect all residents in the facility. In addition, the facility staff failed to perform hand hygiene prior to and after removing gloves or touching a contaminated item and prior to touching a resident (R)35). Findings include: Review of a document titled, Centers for Disease Control (CDC) . National Healthcare Safety Network (NHSN) . Long Term Care Facility Component Tracking Infections in Long-Term Care Facilities ., dated 01/20, indicated, . Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff, and visitors. Information collected during surveillance activities can be used to develop and track prevention priorities for the facility. When conducting surveillance, facilities should use clearly defined surveillance definitions that are collected in a consistent way. This method ensures accurate and comparable data regardless of who is performing surveillance . Review of the undated facility policy titled, Infection Prevention and Control Program, indicated, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards .The Infection Preventionist (IP) serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/13/25 at 12:32 PM, the Director of Nursing (DON), who was also the Infection Preventionist (IP) stated, I enter data after I learn in morning meeting that a resident was started on an antibiotic and a urinalysis with culture was ordered. McGeer's Criteria is not used by nursing when they call the physician. When the culture comes back, I refer to the criteria and enter the information into the infection control book. If it does not meet criteria, I will occasionally talk to the physician about Antibiotic Stewardship, but I have no documentation of these conversations. I have no documentation of data collections for each type of infections; trending of infections over months; based on the data, inservices that were provided to the nursing staff to attempt to decrease infections or documentation that this information was shared during the Quality Assurance and Performance Improvement (QAPI) meeting. I never ask the Hospice nurses about why a Hospice resident was started on an antibiotic with no urinalysis or culture. Tracking and Trending is in my head. I do not have graphs or a map to show infections. When asked if facility's physicians or nurse practitioners order antibiotics without a urinalysis or culture, the DON stated, Yes they do. Interview with the Nurse Practitioner (NP) on 02/13/25 at 2:34 PM, the NP stated, The DON has talked to me about antibiotic stewardship, but I am going to do what is best for my resident especially if they are high risk. 2. The facility failed to monitor, evaluate antibiotic use, and track measures of antibiotic usage. (Refer to F881). 3. Observation on 02/11/25 at 10:36AM, Certified Nurse Aide (CNA)1, placed a cup with a lid and straw, on the handrail outside the room, which dropped to the floor. After picking up the cup and placing it back on the handrail, CNA1 entered R35's room and adjusted R35's nasal canula, without completing hand hygiene or applying gloves. CNA1 exited the room without completing hand hygiene. Interview on 02/11/25 at 12:46 PM, CNA1 acknowledged that she should have done hand hygiene and donned gloves prior to assisting R35's nasal canula. Observation on 02/12/25 at 10:33 AM, in the 200 hall, Housekeeper (HK)1 was observed to exit a resident's room wearing gloves. HK1 then pushed the cleaning cart to another resident's room. The HK1 donned clean gloves. When asked if she was trained to complete hand hygiene after removing the soiled gloves, HK1 said she did not recall. Observation on 02/12/25 at 11:24 AM, HK2 exited room [ROOM NUMBER] wearing gloves, the cleaning cart was to R75's room and HK2 began cleaning activities. Interview on 02/12/25 at 11:35 AM, HK2 acknowledged that she should have removed the gloves after exiting the room, performed hand hygiene before entering another resident's room and donning clean gloves. Interview on 02/12/25 at 10:37 AM, Registered Nurse (RN)1 stated that staff should complete hand hygiene after discarding soiled gloves and before donning clean gloves.

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	425139	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Health & Rehabilitation Center	140 Tokeena Rd Seneca, SC 29678

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050 Based on interview, record review, Center for Disease Control (CDC) guidance and policy review, the facility failed to monitor, evaluate antibiotic use, and track measures of antibiotic usage for three of five residents (Resident (R) 26, R29, and R5) reviewed for antibiotic usage out of 27 sample residents. In addition, the Antibiotic Stewardship Program lacked documentation of the tracking or trending of antibiotic usage or where infections occurred in the facility. This failure had the potential to affect all residents in the facility safety related to antibiotic usage. Findings include: Review of an undated, untitled CDC document located at http://uprevent.[NAME]. com/2855wp/wp-content/uploads/2018/01/nh-hac_mcgreercriteriarevcomp_2012-1.pdf; revealed, The Core Elements of Antibiotic Stewardship for Nursing Homes indicated .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority .Antibiotic stewardship refers to a set of commitments and actions designed to 'optimize the treatment of infections while reducing the adverse events associated with antibiotic use' .CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use .Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Below are examples of antibiotic use and outcome measures .Process measures: Tracking how and why antibiotics are prescribed .Antibiotic use measures . Tracking how often and how many antibiotics are prescribed .Antibiotic outcome measures .Tracking the adverse outcomes . Review of an undated facility's policy titled, Antibiotic Stewardship Program revealed, .Infection Preventionist utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms .Nursing staff shall assess residents who are suspected to have an infection and notify the physician; laboratory testing shall be in accordance with current standards of practice; the facility uses the McGeer criteria to define infections .Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made; antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness; antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness; random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure); antibiotics shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy); .Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to: Action plans and/or work plans associated with the program; Assessment forms; Antibiotic use protocols/algorithms; Data collection forms for antibiotic use, process, and outcome measures; .Records related to education of physicians, staff, residents, and families . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Review of R5's Admission Record located under the Profile tab of the electronic medical record (EMR) revealed R5 was admitted to the facility on [DATE] diagnoses that included diabetes, epilepsy, and schizoaffective disorder. Review of R5's Progress Notes located under the Progress Notes tab of the EMR, revealed on 02/10/25 the Hospice nurse requested a straight catheter urinalysis with culture and sensitivity (UA C&S) for confusion. On 02/10/25, Bactrim DS (antibiotic medication) was started for suspected bacterial infection with increased confusion. On 02/11/25, U/A C&S was obtained via in/out catheter. 2. Review of R29's Admission Record located under the Profile tab of the EMR revealed R5 was admitted to the facility on [DATE] diagnoses that included Lupus, diabetes, neuromuscular dysfunction of bladder, suprapubic catheter, and colostomy. Review of R29's Progress Notes located under the Progress Notes tab of the EMR, revealed on 11/20/24, Nitrofurantoin Macrocrystal (antibiotic medication)100 milligram (MG) was ordered for Urinary Tract Infection (UTI) prevention by Hospice. On 12/04/24, R29's U/A C&S was obtained, which was approximately 14 days after the start of the antibiotic on the resident. 3. Review of R26's Admission Record located under the Profile tab of the EMR revealed R5 was admitted to the facility on ,d+[DATE] diagnoses that included infection due to internal orthopedic prosthetic devices, acute respiratory failure, diabetes, dementia, and neuropathic bladder. Review of R26's Progress Notes located under the Progress Notes tab of the EMR, revealed on 06/17/24 a C&S was ordered due to a culture not completed on prior specimen. On 07/09/24, a U/A C&S was ordered for urinary burning. On 08/04/24, a U/A C&S was ordered for freezing all over. The Nurse Practitioner (NP) started Azithromycin for five days on 08/04/24. On 09/02/24, U/A C&S was ordered and on 09/05/24, R26 had ESBL plus UC (Urinary tract infection caused by extended-spectrum beta-lactamase producing bacteria. ESBL producing bacteria are resistant to many common antibiotics, making infections difficult to treat.) During an interview on 02/13/25 at 12:32 PM with the Director of Nursing (DON), who is also the Infection Preventionist (IP) stated, I do not question why antibiotics are used for Hospice residents. I do not look to see if McGeer's Criteria was met or not. I found out about orders for antibiotics in the morning meetings when the U/A C&S results have been processed. I will then review the chart and see if criteria has been met. When asked if practitioners start antibiotics on residents before the laboratory results are received, the IP stated Yes they do. I will discuss this with them, but I have no documentation to back that up. R5 who is on Hospice started on an antibiotic and then the U/A was completed a couple of days later. I do not argue my point of not meeting criteria to practitioners. I track and trend in my head. I do not have anything on paper to show where infections are located throughout the facility or education of practitioners regarding antibiotic usage. Interview on 02/13/25 at 2:34 PM, the Nurse Practitioner (NP) stated, I order antibiotics for residents before a U/A C&S if they are high risk. I do not want a resident to be septic (a life-threatening condition that occurs when the body's immune system mounts an overwhelming response to an infection.) The NP stated that the IP has talked about meeting McGeer's criteria, but I know my residents.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050 Based on interview, document review and policy review, the facility failed to ensure the Infection Preventionist (IP), had sufficient time to assess, develop, implement, monitor, and manage the facility's Infection Prevention and Control Program (IPCP). The failure placed all residents in the facility at risk. Findings include: Review of the facility's job description titled, Infection Preventionist, undated, revealed,. The infection preventionist is responsible for developing and implementing an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable environment .Establishes facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors . Develops and implements written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control; Oversees the facilities antibiotic stewardship program; Oversees resident care activities that increase risk of infection (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, point-of-care blood testing, and medication injections; Leads the facility's Infection and Prevention Control Committee. Develops action plans to address opportunities for improvement; Participates on the facility's QAA Committee; .Provides education related to infection prevention and control principles, policies and procedures to staff, residents, and families; . Maintains documentation of infection prevention and control program activities. Review of the undated facility policy titled, Infection Prevention and Control Program, indicated, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards .The Infection Preventionist (IP) serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. During the Entrance Conference Meeting on 02/11/25 at 8:23 AM, the Administrator and Director of Nursing (DON) stated, I am the facility's IP. We just hired a new IP, and she is in the process of finishing her IP certification. Review of the Infection Preventionist Infection Control Book revealed that for 2023, 2024, and January and February 2025, the DON had completed all of the documentation. (refer to F881 regarding the facility's failure to establish and maintain an infection prevention and control program (IPCP) for recording incidents of infections identified under the facility's IPCP, surveillance, tracking and trending, and the corrective actions taken by the facility.) (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility assessment dated ,d+[DATE] revealed that the facility will have one IP, and the hours were not listed for that position. Interview on 02/13/25 at 12:32 PM, the Administrator stated, We have hired IPs, and they did not work out. The DON has the proper credentials and fills the gap until someone is hired.