DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor Nursing Home

DATE SURVEY COMPLETED: February 19, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Revised		
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced annual and complaint survey was conducted at this facility from February 13, 2025, through February 19, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was sixty-two (62). The survey sample totaled twenty-four (24).		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	Scope		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		
	This requirement is not met as evidenced by:		
	Cross Refer to the CMS 2567-L survey completed February 19, 2025: F600, F641, F684, F695, F802, F812, F842, F880 and		

Provider's Signature _____ Title _____ Date _____

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	F881.		

Provider's Signature _____ Title Administrator Date 3-7-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced emergency preparedness survey was conducted at this facility from February 13, 2025 through February 19, 2025. The facility census was 62 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, and complaint survey was conducted at this facility from February 13, 2025, through February 19, 2025. The deficiencies contained in this report are based on observations, interview, record review and review of other facility documents as indicated. The facility census on the first day of the survey was sixty two (62). The survey sample totaled sixteen (16) residents. This requirement is not met as evidenced by: Abbreviations/definitions used in this report are as follows: abt - antibiotic; ASE - adverse side effects; C.auris - candida auris, a type of yeast that causes severe illness; cc- cubic centimeter, measurement of fluid; CFU - colony-forming unit, a unit that measures	F 000		

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

Electronically Signed | 03/13/2025

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.

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F 000	Continued From page 1	F 000		

the number of microbial (bacteria, fungi, viruses) in a sample that are viable;
CNA- certified nursing assistant;
Coude- a type of foley catheter with a curved tip;
CPO's - carbapenemase-producing organisms, bacteria reistant to carbapenem antibiotics;
DON - Director of Nursing;
dysuria- pain or discomfort with urination;
ED - emergency department;
EMR- electronic medical record;
ESBL - extednded-spectrum beta-lactamases, enzymes produced by certain bacteria that make common antibiotics ineffective to treat the infection;
F - Fahrenheit, degrees of temperature;
foley - a medical device (catheter) used to drain urine from the bladder;
Fr- French; unit of size for foley catheters;
leukocytosis - elevated white blood cells in the blood stream that is often indicative of an infection;
LPM- Liters per minute, the rate of supplemental oxygen flow;
LPN - Licensed Practical Nurse;
MD - medical doctor
MDS- Minimum Data Set; federally mandated comprehensive, standardized, clinical assessment of all residents in Madeicare/ medicaid nursing homes that evaluates functional capabilities and health needs;
mg- milligrams;
ml - milliliters;
NHA - Nursing Home Administrator;
pan-resistant organisms - infections that are not susceptible to multiple antibiotics;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
r/t - related to;

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F 000	Continued From page 2 SPO2 - pulse oximeter, a measurement of the amount of oxygen in the blood; SW - Social Worker; UA - urine analysis; Urology - branch of medicince that deals with the urinarya nd reproductive systems; UTI - urianry tract infection; w/o - without.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other documentation as indicated, it was determined that for one (R462) out of three residents reviewed for abuse, the facility failed to ensure that R462 was free from physical abuse by R461 resulting in harm when R462 obtained a broken nose and laceration to the bridge of nose. Due to the facility's corrective measures completed on 5/28/24, the facility was notified that R462's incident was a harm past non-compliance.	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 3 Findings include: Cross refer F684 The facility's undated policy, titled, "Freedom from Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of Property, Exploitation, Injury of Unknown Origin and Crime" documented, "...Definitions: 1. Abuse - the infliction of injury...with resulting physical harm, pain or mental anguish...and includes...a. Physical abuse - the unnecessary infliction of pain or injury ... to a ... resident ... includes hitting, kicking, slapping..." Review of R462's record revealed: 3/6/24 - R462 was admitted to the facility with diagnoses including dementia. 3/15/24 - R462's admission MDS assessment revealed that R462's cognition was severely impaired with a BIM's score of 6. R462 had no mood or behavioral symptoms exhibited during the review period. Review of R461's record revealed: 5/6/24 - R461 was admitted to the facility with diagnoses including depression, insomnia and adult personality and behavior disorder. 5/6/24 - R461 had a physician's order for safety checks every 2 hours every shift. 5/7/24 - R461 was care planned for impaired thought process related to dementia with interventions including administering medications as ordered, cuing, reorienting and supervising as needed.	F 600		

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F 600	Continued From page 4 5/10/24 - R461 was care planned for verbal and physical aggressive behavior towards staff related to dementia. R461's interventions included: - R461's triggers for physical aggression are night shift hours ...R461's behaviors are de-escalated by snacks and activities like using fidget books; - analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; - assess and address for contributing sensory deficits; - assess and anticipate R461's needs for food, thirst, toileting needs, comfort level, body positioning, pain, etc. - give the resident as many choices as possible about care and activities; - modify environment such as adjusting room temperature to comfortable level, reducing noise, dimming lights, placing familiar objects in room, keeping door closed, etc. and; - assess resident's coping skills and support system. - assess R461's understanding of the situation ...allow time to express self and feelings towards the situation 5/10/24 - R461's care plan interventions for behavioral problems of paranoia and making false accusations included: - anticipate and meet the resident's needs; - assist R461 to develop more appropriate methods of coping and interacting ... encourage the resident to express feelings appropriately; - caregivers to provide opportunity for positive interaction, attention ...stop and talk with him when passing by; - explain all procedures to R461 before starting and allowing the residents a few minutes to adjust	F 600		

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F 600	Continued From page 5 to changes; - if reasonable, discuss the resident's behavior ... explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; - intervene as necessary to protect the rights and safety of others ...approach/speak in a calm manner. divert attention ...remove from situation and take to alternate location as needed. - praise any indication of the resident's progress/improvement in behavior and; - provide a program of activities that is of interest and accommodates residents' status. 5/16/24 - R461's Admission MDS revealed that R461 had a BIMS score of 6 with severe cognition impairment, was feeling down and depressed, tired and having little energy for 7-11 days. In addition, R461 displayed physical and verbal behavioral symptoms occurring 1-3 days and had significant risk of physical illness or injury interfering with his care, putting others at significant risk of physical injury and intrusion on the privacy or activity of others during the review period. 5/16/24 - R461 had a physician's order for safety checks every 30 minutes while in bed ... "If resident awakes, allow him to exit room and offer preferred activities. 5/16/24 - R461's physical aggression care plan intervention was updated to include safety checks every 30 minutes while resident is in bed ..."if [R461] wakes (sic), allow [R461] to get dressed if he desires to do so and allow [R461] to enter common area with preferred activities." 5/18/24 11:20 PM - A nurse progress note documented, " ... (Registered Nurse) called (sic)	F 600		

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F 600	Continued From page 6 to (room #) for resident [R462] altercation and noted to be seated in chair actively bleeding from face with roommate [R461] in front of him. Residents easily separated and this resident (sic) assessed. No c/o (complaints of pain) nose very swollen and bruised and lacerations noted on bridge of nose and below left eye ..." 5/19/24 3:04 AM - A facility incident report submitted to the State Agency documented that on 5/18/24 at 11:20 PM, " ...found residents in altercation ... CNA called for help and residents were separated. Both residents were sent to ED (Emergency Department) for further evaluation." 5/19/24 12:25 AM - A hospital ED (Emergency)Teaching Physician Note documented, "82 - year old white male with dementia ...now status post traumatic injury to his face by a punch from his roommate ...has an injury to the nose ...he did feel somewhat woozy (dizzy)... Impression: Laceration to the bridge of the nose/nasal fracture." 5/23/24 - A facility 5 day follow up summary submitted to the State Agency documented, " ...the alleged perpetrator [R461] was striking the alleged victim and stated, 'You were stealing my stuff' ...Upon assessment ...[R461] was actively bleeding from his face ...Lacerations noted to the bridge of the nose and under the left eye. 2/18/25 2:00 PM - In an interview, E2 (DON) stated that some information about R461's aggressive behaviors from outside facility was not relayed to them prior to R461's admission on 5/6/24. The facility failed to ensure that R462 was free	F 600		

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F 600	Continued From page 7 from physical abuse by R461 when R461 struck 462 on the face which resulted in R462's broken nose and laceration to the bridge of nose. 2/18/25 3:00 PM - During interview, FM1 (Family Member) stated, "They (facility) advertised that they have a memory care unit. We checked the place before [R461's] admission and we were told that they will have somebody sit outside of the room and leave the door open to keep an eye on him specially when [R461] gets up and goes near the roommate. I don't know what the circumstance was when the hitting happened but I guess nobody was out there to keep an eye on him when he got up and became physically aggressive to his roommate..." 2/19/25 10:00 AM - Findings were discussed with E1 (NHA) and E2 (DON). 2/19/2 3:47 PM - In an email correspondence, E1 submitted to the Surveyor documentation of the corrective action plan with correction completed 5/28/24 at 3:00 PM. Corrective Actions: 1. Education for staff began on 5/20/24 on Resident - to - Resident Mistreatment (RRM), which included risk factors of RRM, ways to de-escalate residents, documentation of behaviors, monitoring and provider notification. 2. QAPI 2nd quarter review. 3. Strengthen of the admission screening process: Evaluating each potential resident for: - History of aggression, violence and other behavioral issues. - Psychiatric diagnosis and treatments. - History of substance abuse or withdrawal	F 600		

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F 600	Continued From page 8 symptoms. - Prior incidents of resident - to - resident aggression in other facilities. Interdisciplinary Review Process: - Admission team (including DON and social services) must review hospital discharge summaries, psychiatric evaluations, and legal history before approval or the last 6 months, or if potential admission has been in their current facility for < (less) 6 months, all notes available. - History of assault, involuntary psychiatric hospitalizations require further discussion before acceptance. Enhanced Admission Documentation and Communication - Improved Handoff Communication: Require detailed behavioral history reports from referral sources before admission approval, at least 6 months of notes or all notes available if resident at current facility < 6 months. -Admission Care Plan Implementation: Within 48 hours of admission, develop an individualized care plan that includes safety interventions for at - risk residents. Monitoring and Compliance - Admission Audits: Review 100% of admission, focusing on behavioral risk assessments and compliance with the new process. No immediate action required related to facility correction and no further occurrences after the incident on 5/18/24. This was verified by interviews with staff about resident - to - resident physical abuse education, spot inspection for resident interactions and inspection of the facility abuse incident reports. 2/19/25 10:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit	F 600		

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F 600	Continued From page 9 Conference.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R22) out of sixteen residents reviewed for assessments, the facility failed to ensure that R22's 12/31/24 MDS correctly documented R22's active diagnoses. Findings include: R22's clinical record revealed: 11/4/16 - R22 was admitted to the facility. 11/5/24 3:52 AM - R22's [hospital] ED (emergency department) physician record documented that R22 was admitted to the hospital with "left-sided weakness and expressive aphasia." From 11/5/24 to 11/9/24 - R22 was admitted to the hospital for a stroke, according to the hospital records. 11/9/24 12:25 PM - R22's [hospital] discharge summary documented "acute cerebral infarction (stroke)" as R22's "reason for hospitalization." From 12/5/24 to 12/17/24- R22 was admitted to the hospital and diagnosed with a seizure disorder.	F 641	During the survey, it was determined that the MDS Coordinator failed to update the Minimum Data Set (MDS) to include a new diagnosis Arterial Fibrillation for a resident readmitted from the hospital. This omission resulted in an inaccurate resident assessment, which could impact care planning and reimbursement. Step 1: Corrective Action The resident #22□s MDS was immediately reviewed and corrected to reflect the diagnosis of Arterial Fibrillation, ensuring accuracy in the assessment. The resident #22□s care plan was updated to include appropriate interventions for stroke management. The physician and interdisciplinary team were notified to ensure all necessary follow-up care was provided. Resident #22 did not experience any adverse effect/no harm related to coding inaccuracy. Step 2: Identification of other residents The MDS coordinator audited all MDS assessments of residents readmitted or	3/7/25

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F 641	Continued From page 10 12/5/24 - R22 was admitted to the hospital after a fall with resultant right hip fracture. 12/6/24 8:41 AM - E15 (hospital Neurologist MD) documented, " ...evidence suggesting laminar necrosis and hemorrhagic conversion and right temporal lobe, both of these are high risk to have seizures, would strongly consider starting anticonvulsant." 12/31/24 - The quarterly Minimum Data Set (MDS) assessment lacked evidence of R22's active diagnoses of stroke and seizures. 2/17/25 3:06 PM - During an interview, E16 (RNAC) stated, "All diagnoses especially ones with new medications should be added to the MDS. She had a seizure and was put on anti-seizure medication about four months ago. I will look into the stroke diagnosis." 2/19/25 10:00 AM - Findings were discussed at the exit conference with E1 (NHA) and E2 (DON).	F 641	admitted in the past 30 days to ensure coding accuracy. This audit was completed on 3/5/2025 There were no additional modifications required on MDS assessments. Step 3: Systematic Changes The MDS Coordinator and interdisciplinary team members will receive education and retraining on: The importance of accurate coding of new diagnoses upon admission/readmission. Proper review of hospital discharge summaries, physician orders, and progress notes for updated diagnoses. Ensuring the MDS accurately reflects the resident□s current medical status. Training conducted by the Nursing Home Administrator (NHA) 2/22/2025 and documented in personnel files. Policy and Procedure Updates: The facility will revise policies related to: MDS completion and accuracy upon admission, readmission, and quarterly reviews. Interdisciplinary communication to ensure all new diagnoses are captured and updated in the MDS. Step 4: Monitor Effectiveness A monitoring tool was developed to monitor MDS assessments for proper coding for section I. MDS coordinator will utilize monitoring tool and will audit all readmissions and admissions weekly for four weeks then monthly X three months.	

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F 641	Continued From page 11	F 641	to ensure all diagnoses are accurately captured. The results of these audits will determine the need for further monitoring. Findings from audits will be reviewed in the quarterly QAPI meeting and additional corrective actions will be implemented as needed.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R461) out of one sampled resident, the facility failed to ensure the physician's order to administer tamsulosin HCL, aripiprazole and escitalopram oxalate. Findings include: Cross refer F600 5/6/24 - R461 had a physician's order for tamsulosin HCL give 2 capsules to equal 0.8 mg in the evening for enlarged prostrate. 5/6/24 (discontinued 5/13/24) - R461 had a physician's order for aripiprazole 5 mg give 2.5 mg (1/2 tablet) in the evening for depression. 5/7/24 - R461 had a physician's order for	F 684	Step 1: Corrective Action During a survey it was identified that the facility failed to ensure physician's orders were completed related to the ordered medications not being available from the pharmacy leading to a lapse in resident care. Resident #461 no longer resides in the facility. Step 2 Identification of other residents: All residents have the potential to be affected by the deficient practice. A thorough review of current medication orders was completed and no other residents were affected. Completed on	3/7/25

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F 684	Continued From page 12 escitalopram oxalate 10 mg 1 tablet in the morning for depression. 5/13/24 - R461 had a physisian's order for aripiprazole 5 mg 1 tablet by mouth at bedtime for depression. 2/18/25 10:00 AM - A review of R461's May 2024 Medication Administration Record revealed the following missing medication doses: 6 pm - tamsulosin HCL 0.8 mg - one out of 12 missed dose on 5/8/24; 6 pm - aippirazole 2.5 mg - four out of seven missed doses on 5/6/24-5/9/24; 8 pm - aripiprazole 5 mg - five out of six missed doses on 5/13/24 - 5/17/24; 8 am - escitalopram oxalate - two out of 11 missed doses on 5/15-17/24. 2/18/25 10:20 AM - A review of nurse progress notes from 5/6/24 through 5/19/24 revealed the following: - 5/6/24 7:39 PM - awaiting delivery from pharmacy, pharmacy notified; - 5/7/24 7:45 PM - awaiting pharmacy delivery; - 5/8/24 7:26 PM - awaiting delivery; - 5/8/24 7:29 PM - awaiting delivery; - 5/9/24 6:14 PM - awaiting delivery; - 5/13/24 7:55 PM - awaiting delivery; - 5/14/24 8:00 PM - awaiting delivery; - 5/15/24 8:57 AM - not available; - 5/15/24 10:08 PM - unavailable; - 5/16/24 8:58 AM - none available, attempted to order; - 5/16/24 6:05 PM - on order; - 5/17/24 7:35 PM - awaiting order. 2/18/25 10:47 AM - In an interview, E3 (ADON) confirmed that R461 missed all those doses on	F 684	02.28.25For any missing medications, immediately contact the pharmacy and request an expedited delivery. Step 3 Systematic Changes: Policy & Procedure Update: Policy reviewed and updated to include a clear protocol for notifying physicians promptly when medications are unavailable. Completed 02.24.25 Must document new order received If no new order, the nurse must document such The policy will be communicated to staff and available for review as needed. Staff Education & Training: Current licensed nurses will receive re-education on Missed Medication and Notification of. Completed 02.28.25 New licensed nurses will receive training during their classroom orientation. Review of new admissions Social Service Director or Designee will review current medication orders on all new admissions and readmissions to ensure the facility can supply medication as ordered prior to acceptance. Step 4: Monitor Effectiveness Audits: The Social Service Director or Designee will review all new admission charts within 24 hours of admission to ensure all medications ordered are available and available X3 months until 100% compliance is obtained X3 consecutive months.	

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F 684	Continued From page 13 the dates and times identified by the surveyor. E3 further stated that R461's son [FM1] signed a facility Pharmacy Services Agreement on 5/6/24 that R461's medications will be filled by the facility and that the facility pharmacy provider was not able to fill the medications as indicated. 2/18/25 1:18 PM - During interview, E5 (RN, SW) stated that during R461's admission to the facility, "...We were not aware that [R461's] prescriptions were to come from [Pharmacy 2], another provider with insurance issues which caused the delay in obtaining the scripts and availing the medications. I was calling [Pharmacy 2] almost everyday to follow up on [R461's] prescriptions because [Pharmacy 1], our facility pharmacy provider, could not fill due to insurance... [Pharmacy 2] finally sent the prescriptions to us by mail on 5/15/24"...When asked if the facility notified the attending physician regarding the delay in R461's medication delivery and that R461 was missing multiple doses, E5 stated, "I spoke to the NP (E9) about it for the first time on 5/8/24. I asked her to write a script for [R461's] meds to be faxed to [Pharmacy 2]. When her script was sent over, we learned from the (Pharmacy 2] that the scripts were not accepted because the meds had to be prescribed by their [Pharmacy 2] physician [Physician 1] - so it was another cause of the delay because we had to look for [Physician 1] to write the scripts." 2/19/25 10:00 AM - Findings were discussed with E1 (NHA) and E2 (DON). 2/19/25 10:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 684	The Director of Nursing will review the facility 24-hour Summary Monday-Friday to ensure that the Physician was made aware of any missed medications and to verify compliance with the updated notification procedures was followed X3 months until 90% compliance is obtained X3 consecutive months. Then weekly X3month. Quality Assurance: Results of the compliance audits will be reported to the quarterly Quality Assurance Committee.	

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F 695	Continued From page 14	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, follow-up and interview, it was determined that for one (R19) out of one resident reviewed for respiratory care, the facility failed to ensure the supplemental oxygen therapy tubing was changed per standard of practice. Findings include: The facility's Oxygen Therapy policy stated, "...Procedure: ...4. label oxygen tubing with the date... 8. Label the humidifer container with the date...". Revised 6/19/2024 Review of R19's clinical record revealed: 12/4/24 - E8 (MD) ordered in R19's electronic medical record (EMR), "Administer 3 LPM (liters per minute) supplemental O2 (oxygen) via nasal cannula. Titrate to keep SPO2 (pulse oximetry) above 92% every shift. Change oxygen tubing and [humidifier] filter every Tuesday night shift ...for cleaning." This order dictated that the oxygen tubing be changed every seven days.	F 695	Step 1: Corrective Action: The facility failed to ensure the supplemental oxygen therapy tubing was changed per standard of practice. Resident #19's oxygen tubing had a last change date of 02.05.25. According to our facility policy, oxygen tubing is replaced every 7 days. This task is scheduled in the Treatment Administration Record. A label on the tubing indicated the last change date and initials of the staff member who performed the task; however, the tubing was past its scheduled replacement date of 02.12.25. The oxygen tubing for Resident #19 was replaced immediately. Step 2: Identification of other Residents: All residents who receive oxygen or respiratory therapy have the potential to be affected by the deficient practice. A thorough review of all patients receiving oxygen therapy was conducted on 02.17.2025. No other residents were affected by the deficient practice.	3/7/25

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F 695	Continued From page 15 2/14/25 (Friday) 2:30 PM - The Surveyor observed R19's oxygen tubing was dated "2/5/2025". R19's oxygen tubing was nine days old. 2/17/25 (Monday) 12:01 PM - The Surveyor observed R19's oxygen tubing was dated "2/5/2025". R19's oxygen tubing was twelve days old. 2/17/25 1:37 PM - During an interview, E14 (LPN) with the Surveyor observed R19's oxygen tubing and confirmed that it was dated 2/5/2025 and that it was ordered to be changed every seven days on Tuesdays. 2/19/25 10:00 AM - Findings were discussed at the exit conference with E1 (NHA) and E2 (DON).	F 695	Step 3: Systematic Changes: Staff Education: Mandatory training for current nursing staff on the importance of changing oxygen tubing at least every seven days to prevent infection, airway obstruction, and other health-related issues. Education Completed 02.28.25 The staff educator or designee will educate new nursing employees during their classroom orientation. Updated Policy and Procedure: Review of the facility's policy regarding oxygen tubing replacement to ensure compliance with CMS regulations and industry best practices. Completed 02.20.25 Clearly outline the requirement for tubing to be changed at least every seven days. The policy will be communicated to nursing staff and available for review as needed. Step 4: Monitor Effectiveness: Audits: The Director of Nursing or Designee will conduct weekly oxygen tubing replacement to ensure compliance weekly X3 months until 100% compliance is achieved over three consecutive months. Any deficiencies or discrepancies will be immediately addressed by the management team. A log of audits will be maintained by the Director of Nursing Quality Assurance: Results of the compliance audits will be reported to The quarterly Quality	

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F 695	Continued From page 16	F 695	Assurance Committee.	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility records, it was determined that the facility failed to ensure that a qualified person in charge was present during hours of Kitchen operation. Findings include: 2/18/25 12:30 PM - A review of the time punches for Dietary employees revealed that on January 3, 27, 30, and February 7, a Certified Food Protection Manager (CFPM) was not present after 4:00 PM for dinner service. In addition, on January 18, 19, and February 1, 2, and 15, a CFPM was not present for breakfast food service.	F 802	1. Unable to correct for past shifts that lacked a CFPM in the kitchen. 2. All residents have potential to be affected. In the immediate future we will cover as many shifts as possible with CFPM staff while the others are in the process of becoming certified. Test date for uncertified cooks will be on 4/15/2024 due to availability of testing locally. 3. All cooks will be required to have a CFPM Certification upon hire.	4/15/25

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F 802	Continued From page 17 2/18/25 2:00 PM - Findings were reviewed with E1 (Administrator) and E? (Food Service Director). 2/19/25 10:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 802	4. Status of CFPM expiration dates will be reviewed quarterly at QA and as needed.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food/items were stored and/or prepared under sanitary conditions. Findings include: 1. During the initial tour of the kitchen on 2/13/25	F 812	F812 (Observation #1) 1. Immediately dated and labeled any items opened and not labeled. Undated resident□s food container, also lacking full name and room number was discarded. The employee's lunch bag was	3/20/25

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F 812	Continued From page 18 beginning at 9:10 AM, the following observations were made: - The standard reach in refrigerator near the entrance had a food container with a resident's last name labeled with no date, name, opened and undated bag of lettuce, block of cheese, and a bottle of grape juice and a personal lunch bag of a kitchen staff; - The dry food storage room revealed opened and undated bags of mashed potato powder, cheddar cheese mix, ranch dressing mix, turkey gravy, cake mix, dried raisins, gelatin, a box of lasagna and linguine noodles; A follow-up visit to the kitchen on 2/17/25 at 10:25 AM found: Observation of the overhead kitchen cabinet revealed the following opened and expired spice bottles confirmed onsite by E7 (FSD): - light chili powder - best by 5/2/23 - dill weed - best by 11/29/24 - lemon and pepper - best by 2/17/24 2. 2/17/25 11:15 AM - An observation on the snack/nourishment refrigerator serving the 2nd floor residents revealed two unlabeled and undated pitchers of beverages. E12 confirmed the two pitchers of ice tea and and punch were not labeled and dated. 3. 2/17/2 11:30 AM - An observation on the snack/nourishment refrigerator serving the 3rd floor residents revealed an unlabeled and undated pitcher of beverage. E13 confirmed that the pitcher contained punch and was not labeled and dated. 4. 2/18/25 12:4 PM - A review of 234 temperature logs revealed 27 meal temperatures were not	F 812	removed and the employee was instructed on proper storage of personal items. 2. All residents have potential to be affected. Identified items were labeled and dated. 3. Kitchen manager in-serviced all staff on properly labeling and dating all open food and drinks. Staff was in-serviced on labeling requirements for family provided food. 4. Kitchen manager or deisgnee will audit weekly x4 and monthly x2 until 100% compliant. Findings will be reported in QA. F812 (Observation #2) 1. Immediately removed and discarded the observed expired & past the best by dated spices. 2. All residents have potential to be affected. All spices were checked for dates and discarded as appropriate. 3. All spices will have their expiration dates recorded on a chart for review. Kitchen manager will review the chart weekly to ensure that spices get discarded before expiration date. 4. Kitchen manager or designee will check that all spices are recorded on the spice chart weekly x4, then monthly x2 until 100% compliant. Findings will be reported in QA.	

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F 812	Continued From page 19 documented between December 1, 2024, and February 16, 2025. 2/18/25 2:00 PM - Findings were reviewed with E1 (Administrator) and E? (Food Service Director). 2/19/25 10:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 812	F812 (Observation #3) 1. Pitchers on 2nd floor snack/nourishment refrigerator were immediately dated and labeled of contents by kitchen manager. 2. All residents have potential to be affected. All other pitchers were checked for proper labeling and labeled as appropriate. 3. Staff was in-serviced on the requirement to properly label the pitchers. 4. Kitchen manager or designee will audit all refrigerators and carts for proper labeling of beverage pitchers weekly x4 and monthly x2 until 100% compliant. Findings will be reported in QA. F812 (Observation #4) 1. Cannot correct for previously missed log entries. 2. All residents have potential to be affected. 3. Kitchen manager in-serviced staff on the requirement to record temps for each applicabile food category for each meal. Kitchen manager or designee will, at least weekly, review all temp logs and record them on Google Sheets. 4. Kitchen manager will audit spreadsheet for the entries for every meal weekly x4 and monthly x2 until 100% compliant. Findings will be reported in QA.	

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F 842	Continued From page 20	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		3/7/25

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F 842	Continued From page 21 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R22) out of five residents reviewed for unnecessary medications, the facility failed to have medical records that was accurately documented with R22's Eliquis having an inaccurate indication. Findings Include: According to the Eliquis drug information insert, there are "six indications for prescribing Eliquis:	F 842	Step 1 Corrective Action During the recent survey conducted, it was determined that an anticoagulant was prescribed and administered to a resident without a correct indication for use. This was found to be out of compliance with regulatory standards for medication management and resident safety.	

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F 842	Continued From page 22 reduction in the risk of stroke/ systemic embolism in NVAF (non-valvular atrial fibrillation) ...". Bristol-Meyers Squibb company, 2021 Review of R22's clinical record revealed: 11/4/16 - R22 was admitted to the facility. 11/9/24 12:25 PM - C2 (hospital neurology MD) documented in R22's discharge summary, " ...Reason for hospitalization - acute cerebral infarction (stroke) ... atrial fibrillation (A fib) ... Hospital Course - A fib- new diagnosis this admission ...will start Eliquis ...". 12/17/24 - E8 (MD) ordered in R22's EMR, "Eliquis oral tablet 5 mg (apixiban) Give one tablet by mouth two times a day for history of stroke." 2/18/25 1:47 PM - During an interview, C1 (consultant pharmacist) confirmed, " ... History of stroke is not an indication for novel anticoagulants like Eliquis. It would be more appropriate to use her [R22's] A fib diagnosis." 2/19/25 10:00 AM - Findings were discussed at the exit conference with E1 (NHA) and E2 (DON).	F 842	Resident #22□s diagnosis was immediately corrected: A clear and appropriate indication for the anticoagulant was documented. Resident #22 had no adverse effect or consequences from the deficient practice. Step 2 Identification of other residents: An audit of all residents within the facility who have an active order for Xerelto or Eliquis was conducted and completed on 02.19.25. Two additional residents were identified as having an incorrect indication of use listed. There were no adverse effects or consequences from the deficient practice. Step 3 Systematic Changes: Staff Education & Training: Current licensed nurses staff will receive re-education on Anticoagulant Prescribing Guidelines and Indications for use of. Completed on 02.28.25 New licensed staff will receive Anticoagulant Prescribing Guidelines and Indications for use of training during classroom orientation. Medical Provider Anticoagulation Ordering Physicians and providers will verify that facility staff have correctly documented indications of use prior to signing a verbal order.. Physicians and providers will document a current indication of use when inputting provider written orders.	

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F 842	Continued From page 23	F 842	Step 4: Monitor Effectiveness Audits: The night shift supervisor will complete a 24 hour order summary each night to ensure that all new anticoagulant medication orders have the correct indication of use is documented X3 months until 100% compliance is achieved over three consecutive months Quality Assurance: Results of the compliance audits will be reported to the quarterly Quality Assurance Committee. Findings and improvement plans will be reported in the quarterly QAPI meetings for continuous oversight.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		3/7/25

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F 880	Continued From page 24 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 25 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for three residents (R22, R39, R55) out of eighteen residents reviewed for infection control, the facility failed to establish an infection control program that included enhanced barrier precautions. For R39, who had a sacral wound during November 2024, review of R39's EMR revealed no order for enhanced barrier precautions. For R22, who had an indwelling foley catheter from 12/4/24 to 12/20/24, review of R22's EMR revealed no order for enhanced barrier precautions. For R55, on 1/24/25, R55 had a urine specimen noted to have escherichia coli (E.coli) ESBL, which required ongoing enhanced barrier precautions. These precautions were not implemented until 2/18/25. Findings include: The facility's Enhanced Barrier Precautions (EBP) Policy stated, " ...Policy Statement - this facility is committed to protecting residents and staff by implementing EBP for residents who meet the criteria outlined by the CDC. These precautions require the use of personal protective equipment (PPE) during high-contact resident care activities to prevent the spread of MDROs (multidrug-resistant organisms). Procedure: 1. Identifying Residents for EBP: a. Residents requiring EBP include those who: i. Have wounds, including pressure ulcers, surgical wounds, or	F 880	Step 1: Corrective Action: The facility failed to implement Enhanced Barrier Precautions (EBP) for residents requiring precautions. Upon discovery, Enhanced Barrier Precautions were immediately implemented on identified resident #55 and resident #39. Resident #22 no longer meets the criteria for Enhanced Barrier Precautions. Step 2: Identification of other residents: All residents who meet the criteria for Enhanced Barrier precautions were at risk. A thorough review of all current residents was conducted on 02.19.25. Two residents were identified as meeting the criteria for Enhanced Barrier Precautions. The two residents identified were immediately placed on Enhanced Barrier Precautions. Step 3: Systematic Changes: Staff Education: Mandatory training for staff on Enhanced Barrier Precautions including the guidelines to implement Enhanced Barrier Precautions. Education completed 02.28.25.	

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F 880	Continued From page 26 chronic skin breakdown, regardless of multidrug-resistant organism status. ii. Have an indwelling medical device (e.g. central venous catheter, urinary catheter, feeding tube, tracheostomy), regardless of multidrug-resistant organism status. Iii. Have been identified as colonized or infected with an MDRO per facility infection control risk assessment ...". Revised 6/19/2024 1. Review of R22's clinical record revealed: 11/4/26 - R22 was admitted to the facility. From 12/5/24 to 12/17/24, R22 was hospitalized and had an indwelling foley catheter placed. 12/17/24 1:42 PM - R22's [hospital] discharge summary documented, " ... narrative Summary of hospital course: She [R22] was seen by urology given history of urinary retention with difficult placement of foley catheter. A coude catheter was placed without difficulty by urology ... The patient did attempt a voiding trial but had to have the foley replaced. The patient will have to follow-up with urology as an outpatient for voiding trial ...". 12/17/24 - E8 (MD) ordered in R22's EMR, "14 Fr (French) foley catheter with 10 cc balloon for dysuria. Monitor output every shift." 12/30/24 - E8 (MD) discontinued the foley catheter order. Review of R22's EMR orders lacked evidence of an order for Enhanced Barrier Precautions from 12/17/24 to 12/30/24, the period of time that R22 had an indwelling foley catheter.	F 880	The staff educator or designee will educate new employees during their classroom orientation. Policy and Procedure Review & Updates: Facility infection control policies were reviewed and updated to reflect recommendations on EBP, emphasizing early identification. Update completed on 02.20.25. The policy will be communicated to staff and available for review as needed. New Admission Screening: All new admissions will be reviewed by the Social Service Director for the following and the facility will place new admission on EBP upon admission. Residents with chronic wounds or indwelling medical devices regardless of their multidrug-resistant organism status. Residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO Step 4: Monitor Effectiveness Audits: The Infection Control preventionist or The Director of Nursing will audit all residents with chronic wounds or indwelling medical devices to ensure EBP are maintained, weekly X3 months until 100% compliance is achieved over three consecutive months. The Infection Control preventionist or The Director of Nursing will audit all residents with a history of or actual infection of CDC-targeted or other epidemiologically important MDRO weekly X3 months until 100% compliance is achieved over three consecutive months.	

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F 880	Continued From page 27 2. Review of R39's clinical record revealed: 8/1/24 - R39 was admitted to the facility. From 10/17/24 to 12/6/24, E8 (MD) ordered left heel wound care in R22's EMR, This left heel wound was documented as open and being treated with medihoney on 11/21/24 at 2:24 PM by E2 (DON) in R39's EMR progress notes. From 10/21/24 to 12/6/24, E8 (MD) ordered sacral wound care in R22's EMR. This sacral wound was documented as having serous drainage and being treated with medihoney and calcium alginate on 11/21/24 at 2:24 PM by E2 (DON) in R39's EMR progress notes. 2/10/25 - E8 (MD) ordered left heel wound care in R22's EMR. 2/18/25 - E8 (MD) ordered Enhanced Barrier Precautions for R39. Review of R39's EMR orders lacked evidence of an order for Enhanced Barrier Precautions during the period of time that R39 had active wound care orders (10/17/24 to 12/6/24 and 2/10/25 to 2/18/25). 3. Review of R55's clinical record revealed: 3/8/24- R55 was admitted to the facility. 1/22/25 - R55's urine specimen was reported to contain Escherchia coli ESBL. Review of R55's EMR orders lacked evidence of an order for Enhanced Barrier Precautions	F 880	Quality Assurance: Results of the compliance audits will be reported to the quarterly Quality Assurance Committee.	

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F 880	Continued From page 28 starting on 1/22/25 after notification that R55 was infected with an MDRO organism. 2/4/25 1:48 PM - E5 (RN/IP) emailed DHSS Division of Public Health asking, " ...If we have a resident with a resistant microorganism, in this case ESBL UTI, do they need to be on enhanced barrier precautions indefinitely while they are a long term resident?...". 2/4/25 2:30 PM - C3 (DHSS Office of Infectious Disease Epidemiology) replied, " ...So if the ESBL is epidemiologically important, then we recommend placing the patients on Enhanced Barrier Precautions. In other words, if ESBL infections are rare in your facility, we would recommend EBP, since that can limit the spread of the organism. But it is not strongly recommended, like we would for C. auris, CPOs, or pan-resistant organisms." 2/13/25 11:35 AM - The Surveyor observed and spent time in R55 's room during intial screening. R55 was in a private room but lacked evidence of Enhanced Barrier Preacutions and personal protective equipment (PPE). 2/18/25 11:55 AM The Surveyor observed that R55's living area lacked evidence of Enhanced Barrier Precautions and PPE. 2/18/25 - E8 (MD) ordered Enhanced Barrier Precautions for R55. The facility lacked evidence of Enhanced Barrier precautions for R55 from 1/22/25 to 2/18/25. 2/18/25 10:35 AM - During an interview, E2 (DON) stated, "We haven't had anyone on	F 880		

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F 880	Continued From page 29 enhanced barrier precautions in the last 6 months. " 2/19/25 10:00 AM - Findings were discussed at the exit conference with E1 (NHA) and E2 (DON).	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R10 and R54) out of eighteen residents reviewed for infection control, the facility failed to have an antibiotic stewardship program that monitored antibiotic usage. For R10, who was treated with seven days of keflex, the facility lacked documentation of required McGeer's criteria symptoms in R10's EMR. For R54, who was treated with five days of augmentin, the facility lacked documentation of the urine specimen results and required McGeer's criteria symptoms. Findings include: The facility's Measure of Antibiotic Use and Antibiotic Stewardship Activities policy stated, " ...The facility will routinely monitor the impact of its antibiotic stewardship activities within the quality assurance/performance improvement program (QA/PI) ...	F 881	Step 1; Corrective Action The facility treated 2 residents with use of antibiotics without supporting documentation of symptoms to meet the criteria according to The McGeer's Criteria for Antibiotic Use. Resident #10 did have a positive urine specimen result and had no adverse effect or consequences regarding the use of an antibiotic prescribed by the medical provider. Resident #54 did have a positive urine specimen result and had no adverse effect or consequences regarding the use of an antibiotic prescribed by the medical provider. Step 2 Identification of other residents:	3/7/25

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F 881	Continued From page 30 Procedure - ... 2. Data to be considered as an assessment of the antibiotic stewardship program may include: a. Completeness of clinical assessment documentation at the time an antimicrobial is ordered. - Assessment and documentation of assessment, - Physical examination, - Laboratory findings, if applicable, - Rationale for antimicrobial use ...". Revised 6/19/2024 McGeer's Criteria for Infection Surveillance: Syndrome - UTI (urinary tract infection) without indwelling catheter Criteria - must fulfill both 1 and 2 1. At least one of the following sign or symptom: - Acute dysuria (pain on urination) or pain, swelling or tenderness of testes, epididymis or prostate - Fever or leukocytosis (elevated white blood cell count), and greater than 1 of the following: -- acute costovertebral angle pain or tenderness -- suprapubic pain -- gross hematuria -- new or marked increase in incontinence -- new or marked increase in urgency --new or marked increase in frequency - If no fever or leukocytosis, then greater than 2 of the following: -- suprapubic pain -- gross hematuria -- new or marked increased in incontinence -- new or marked increase in urgency --new or marked increase in frequency 2. At least one of the following microbiologic criteria - greater than 10 to the fifth CFU/ml of no more than 2 species of organisms in a voided urine sample - greater than 10 to the second CFU/ml of any	F 881	A retrospective audit of infection-related documentation over the past three months was conducted to identify cases where infections were not documented according to McGeer□s Criteria. No residents were identified as being improperly diagnosed with an infection or treated inappropriately despite missing supporting documentation. Step 3 Systematic Changes: Policy & Procedure Update: The Infection Prevention & Control Policy was revised to align with McGeer□s Criteria for infection surveillance. Update complete 02.21.25 The policy will be communicated to staff and available for review as needed. Staff Education & Training: Current licensed nurses, infection preventionists, and other relevant staff will receive re-education on McGeer□s Criteria and documentation. Completed on 02.28.25 New hires will receive infection control training during classroom orientation. Medical Provider Antibiotic Ordering Physicians and providers will verify that facility staff have documented symptoms according to McGeer□s Criteria prior to ordering antibiotics. Physicians and providers will document accordingly Enhanced Infection Surveillance: The Infection Preventionist (IP) will review the facility's 24-hour summary Monday-Thursday to ensure adherence to McGeer□s Criteria is being met for those	

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F 881	Continued From page 31 organism(s) in a specimen collected by an in-an-out catheter. 1. Review of R10's clinical record revealed: 8/6/19 - R10 was admitted to the facility. Review of R10's EMR progress notes from 1/19/25 to 1/24/25 lacked evidence of R10 with complaints of any of the signs or symptoms in the McGeer's criteria for UTI without an indwelling catheter. 1/24/25 - E8 (MD) ordered in R10's EMR, "Alert chart - Monitor for adverse reactions r/t (related to) abt (antibiotic) for UTI every shift for abt use for 3 days ...". 1/24/25 - E17 (RN) documented a health status note in R10's EMR, " ... UA (urine analysis) result came in. MD made aware. New MD order obtained. Macrobid oral capsule 100 mg (Nitrofurantoin) give 1 capsule by mouth two times a day for UTI for 7 days. Family made aware." Between 1/25/25 9:49 PM and 1/26/25 9:30 PM, there were four health status notes documented that lacked evidence of any of the McGeer's criteria for signs/symptoms of UTI. 1/26/25 - R10's urine culture obtained on 1/24/25 was reported as having grown proteus mirabilis organism. 1/26/25 - E8 (MD) ordered in R10's EMR, "Keflex oral capsule 500 mg (Cephalexin) Give 1 capsule by mouth two times a day for UTI (urinary tract infection) for 7 days."	F 881	with expected infections. Step 4: Monitor Effectiveness Audits: The Director of Nursing (DON) and Infection Preventionist will conduct random chart audits on 2-3 charts per week X 3 months until 100% compliance is achieved over three consecutive months to ensure infections are documented according to McGeer□s Criteria. Quality Assurance: Results of the compliance audits will be reported to the quarterly Quality Assurance Committee. The facility□s Medical Director will oversee adherence to infection control practices and provide additional guidance as needed.	

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F 881	Continued From page 32 1/27/25 2:44 AM - E18 (RN) documented in R10's EMR, "T (temperature) 97.7. Keflex for UTI w/o (without) ASE (adverse side effects). Denies Dysuria and is inc (incontinent) of bladder ...". Between 1/28/25 2:31 AM and 2/3/25 3:00 AM, there were six health status notes documented that lacked evidence of any of the McGeer's criteria for signs/symptoms of UTI. Review of R10's orders lacked evidence of an order for a urine analysis, urine culture or blood lab work, specifically a CBC (complete blood count) which would include a WBC (white blood cell count), on or around the date of 1/24/25. The facility lacked evidence that met McGeer's criteria for treating R10's UTI with antibiotics. 2. Review of R54's clinical record revealed: 1/31/24 - R54 admitted to the facility. Review of R54's EMR documented temperatures between 12/31/24 to 1/13/25 revealed normal temperatures, ranging from 97.1 F (Fahrenheit). 1/3/25 - E8 (MD) ordered in R54's EMR, "Augmentin oral tablet 500-125 mg (Amoxicillin & Potassium Clavulanate) Give 1 tablet by mouth three times a day for **DO NOT START ABX UNTIL SPECIMEN OBTAINED for 5 days." 1/4/25 12:05 PM - E17 (RN) documented in R54's EMR, "Urine specimen was picked up by a [laboratory] lab tech." Between 1/3/25 9:35 PM and 1/5/25 1:36 AM,	F 881		

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F 881	Continued From page 33 there were six health status notes documented in R54's EMR that lacked evidence of any of McGeer's criteria for signs/symptoms of UTI. 1/6/25 1:44 PM - E4 (RN) documented in R54's EMR, "Results for urine analysis and culture received, indicative of mixed culture greater than three organisms. MD made aware, no new orders for repeat urine at this time. Per MD, continue Augmentin as ordered." Between 1/7/25 9:50 PM and 1/8/25 00:58 AM, there were three health status notes documented in R54's EMR that lacked evidence of any of McGeer's criteria for signs/symptoms of UTI. The facility lacked evidence that met McGeer's criteria for treating R54 with antibiotics. 2/17/25 2:22 PM - During an interview, E5 (RN/IP) stated, "We use McGeer's criteria for infection antibiotic stewardship." 2/19/25 10:00 AM - Findings were discussed at the exit conference with E1 (NHA) and E2 (DON).	F 881		