STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008270	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF ELMWOOD PARK	7733 WEST GRAND AVENUE ELMWOOD PARK, IL 60707

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2395515/IL161672 2396212/IL162509 2394344/IL160243 2393905/IL159701 Facility Reported Incidents Investigations FRI of 8/11/2023/IL163715	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3) 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued From page 2	S9999		

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met evidenced by:

Based on interviews and record reviews, the facility failed to provide appropriate and sufficient supervision to prevent avoidable accidents for two residents (R2 and R19) out of three residents reviewed for falls in a sample of 34. This failure resulted in R19 sustaining a right pelvic fracture.

Findings include:

1. On 9/5/23 at 4:15 pm, V11 (Nurse) stated that V11 recalls R19's fall incident, but does not recall the date it occurred. V11 stated that the CNA (Certified Nurse Aide) found R19 on the floor in R19's room. V11 stated that R19 is alert with confusion. V11 stated that V11 performed a head to toe assessment and assessed R19's range of motion. V11 stated that V11 did not note any injuries. V11 stated that R19 was sent to the hospital for evaluation because it was an unwitnessed fall.

On 9/6/23 at 12:25 pm, V39 (Restorative Aide) stated that R19's fall precaution intervention is

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S9999	Continued From page 3	S9999		

bed in lowest position. V39 stated that R19 is non-ambulatory. V39 stated that V39 has not seen R19 try to walk on own. V39 stated that the restorative nurse informed the aides what interventions needed to be put in place after a resident falls. V39 stated that the restorative nurse's last day was 9/1/23 and at this time, there isn't a restorative nurse.

On 9/6/23 at 12:40 pm, V4 (Restorative Aide) stated that R19 is non-ambulatory. V4 stated that staff pivot R19 from bed to wheelchair. V4 stated that R19 does not attempt to self propel wheelchair or attempt to ambulate on own.

R19's medical record notes R19 with diagnoses including, but not limited to, dementia, generalized muscle weakness, unsteadiness on feet, and falls.

R19's medical record notes on 8/11/23, V11 RN noted R19 found on the floor by CNA as she was doing her rounds, unwitnessed, and V11 was notified. V11 went immediately to R19's room and saw R19 on the floor on her bottom by her bed. No injuries noted, vital signs taken, within normal limits, and range of motion within baseline. R19 stable, no complaints of pain, not in any distress. R19 transferred back onto bed, made clean and comfortable. Nurse practitioner made aware and ordered to send R19 to the hospital for evaluation.

R19's fall care plan, dated 5/9/23, notes R19 is at high risk for falls related to poor safety awareness.

R19's MDS (Minimum Data Set), dated 8/2/23, notes R19's cognition is moderately impaired for daily decision making. R19 requires extensive

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S9999	Continued From page 4	S9999		

assistance with bed mobility. R19 is totally dependent on two staff members for all transfers. R19 is totally dependent on one staff member for toileting/incontinence care.

This facility's investigation of R19's fall incident notes R19 is alert and oriented x 1 with confusion. R19 has poor safety awareness and impulsivity due to dementia. The agency CNA assigned to provide care for R19 on 8/11/23 was interviewed by facility staff at the time of the incident. Per the CNA's interview, R19's bed was in the lowest position, call light was within reach, and R19's bedside table was by R19's bed where R19 could easily reach her stuff.

There is no documentation found in R19's medical record or care plan noting R19 has a behavior of being impulsive.

R19's behavior charting, dated 8/6/2023 at 12:23 pm noted R19 in the common room area where lunch is being served where she is closely supervised. R19 is seen sliding off her wheelchair onto the floor. Actions taken by staff: Reposition R19. R19 was placed on a 1:1 for feeding. Where she continued to attempt to slide off her wheelchair. The nurse re-positioned R19 x2. After lunch R19 was then placed back to her bed. Continuously rounding by staff and fall precautions in place. Where R19 was noted to be calm and resting. Any new treatment or interventions initiated: Monitor R19 closely. Continuously rounding by staff. Continue with fall precautions in place.

R19's behavior charting, dated 8/10/23 at 2:42 pm, noted R19 in the common room area where she is closely supervised. R19 is seen sliding off her wheelchair onto the floor. Actions taken by

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	IL6008270	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 5	S9999		

staff: Reposition R19. R19 was placed on a 1:1 for feeding. Where she continued to attempt to slide off her wheelchair. The nurse re-positioned R19 x 2. After lunch R19 was then placed back to her bed. Continuously rounding done by staff and fall precautions in place. Where R19 was noted to be calm and resting. Any new treatment or interventions initiated: No.

2. On 9/6/23 at 10:50 am, V36 CNA stated that R2 requires two person assist for all care. V36 stated that all residents that are totally dependent for care should have two CNAs present during care. V36 stated that when R2 coughs, his legs will move towards the sides of bed. V36 stated that staff should use pillows and wedges to prevent R2 from falling out of bed.

On 9/6/23 at 3:00 pm, V28 (Wound Care Nurse) stated that R2 has a history of moving legs to the sides of bed. V28 stated that these are not purposeful movements. V28 stated that when R2 coughs, R2's legs will sometimes move.

Review of R2's medical record notes R2 with diagnoses including chronic respiratory failure with hypoxia (lack of oxygen), gastrostomy, anoxic brain damage, and tracheostomy-ventilator dependent.

R2's MDS, dated 5/10/23 notes R2 with severely impaired cognition . R2 is totally dependent on two staff members for bed mobility, transfers, and toileting. R2 has impairment in range of motion to all extremities.

Review of R2's medical record, dated 9/1/23 at 8:10 pm, notes the CNA reported that during resident care, the CNA turned R2 to the left side

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S9999	Continued From page 6	S9999		

to clean R2. R2 started to move leg and fell on floor. R2 sustained a small scratch on right eyebrow and was transported to the hospital for evaluation. R2 returned from hospital by ambulance via stretcher. R2 came back with no new orders and discharge papers. R2 has a laceration to the right eyebrow with a bandage over eyebrow.

R2's fall care plan notes R2 is at risk for falling related to dependent with ADLs (activity of daily living) and transfers. R2 requires staff anticipation with ADLs.

This facility's fall prevention and management policy, dated 09/2022, notes a fall risk evaluation will be completed on admission, re-admission, quarterly, significant change, and after each fall. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.
(B)

Statement of Licensure Violations (2 of 3)

300.610a)
300.1210a)
300.1210b)
300.1210c)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy

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S9999	Continued From page 7 Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 8 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These Requirements were not met evidenced by: Based on interview and record review, the facility failed to adequately monitor a gastrostomy stoma site for placement and signs/symptoms of infection. This affected one of three residents (R14) reviewed for Gastrostomy tube care. This failure resulted in R14's gastrostomy tube dislodging requiring hospitalization, requiring abdominal surgery. Findings include: On 9/5/23 at 2:45 pm, V5 (Nurse) stated that V5 was the one that documented first about R14's abdomen feeling hard on palpation, G-tube (gastrostomy tube) area warm to touch. V5 denied any redness to abdomen. V5 stated that when she attempted to flush R14's G-tube, it was a little tighter (difficult to flush) and R14 appeared to be in pain. V5 stated that she notified V52 NP (Nurse Practitioner), R14's enteral feeding held, an urgent abdominal x-ray was ordered, and intravenous fluids started. V5 stated that when she checked the G-tube for any residual, she did not get any. V5 stated that it was difficult to pull back on syringe. V5 stated that R14's G-tube looked like what appeared to be curdled milk.	S9999		

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S9999	Continued From page 9	S9999		

On 9/7/23 at 12:25 pm, V25 (Nurse) stated that V25 endorsed to oncoming nurse that R14's abdomen was distended, abdominal x-ray ordered. V25 stated that R14's feedings held while waiting for x-ray to be done. V25 stated that V25 did not hold R14's medications or water flushes via gastrostomy tube because only the enteral feedings were held. V25 stated that V25 did not clarify order with nurse practitioner. V25 stated that R14's abdomen was reddened and firm. V25 stated that there was resistance with instilling water and medications via gastrostomy tube. V25 stated that abdominal ultrasound results were obtained on 7/5/23 and the nurse practitioner was notified. Order received to resume G-tube feedings.

On 9/13/23 at 9:45 am V2 DON (Director of Nursing) stated that when staff receive order for an urgent x-ray, the nurse is expected to call the outside diagnostic imaging company, and then staff wait for technician to come to facility to complete the testing. V2 stated that depending on the situation, may have to send resident to the hospital if testing cannot be done within 24 hours. V2 stated that if the order is for an urgent abdominal x-ray and the resident is a diabetic, do not want resident to be without feeding for 24 hours, so would send resident to hospital for testing to be done. V2 stated that typically routine testing should be completed within 24 hours, urgent orders should be completed much sooner and the same day. V2 was informed that V52 NP ordered to hold R14's feedings until results known, staff continued to use G-tube (gastrostomy tube) for water flushes and administration of medications. V2 acknowledged that staff should have clarified order with physician/NP regarding water flushes and medications as well as delay in x-ray being done.

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S9999	Continued From page 10	S9999		

V2 stated that there is a lack of communication between nurses, between physician/NP and nurses due to the use of a lot of agency nurses. V2 was informed that on 7/7/23, R14 was sent to the hospital due to abnormal vital signs and had a CT (computerized tomography) scan of abdomen that showed R14's G-tube was dislodged and there was fluid collection in the abdominal subcutaneous tissue requiring surgical incision and drainage and debridement. V2 is unsure why abdominal x-ray was changed to abdominal ultrasound as there is no order for an ultrasound.

On 9/13/23 at 11:00 am V58 (attending physician) stated that if R14 would have had an abscess, the abdominal ultrasound should have shown fluid collection or abscess. V58 stated that at the time of the ultrasound, there may not have been enough fluid collecting in R14's abdomen to show up. V58 stated that the physician can only order testing based on the information the nurse provides. If the nurse does not let the physician know of any difficulty with flushing G-tube, he will not know. If he had known that, he would have ordered a abdominal x-ray with gastrografin to check G-tube placement. V58 stated that based on the information provided, abdomen hard, reddened, V58 would suspect skin infection. V58 stated that there was a lack of communication between the nurse and V52 NP regarding what was going on with R14.

R14's hospital medical record, dated 7/7/23 at 2:12pm, notes R14 presented to the hospital with fever, low blood pressure, and diaphoresis (sweating). The physician's physical assessment noted dry mucus membranes in mouth, rapid heart rate - 148 beats per minute, coarse breath sounds, G-tube with surrounding redness, tenderness, and cellulitis (inflammation), and skin

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S9999	Continued From page 11	S9999		

hot. R14's G-tube was flushed with water and the water was coming out of G-tube site. Physician notified. WBC (white blood cell) count 16.2 (normal range is 3.5-10.5). CT (computerized tomography) scan of R14's abdomen noted gastrostomy tube dislodged with the distal tip now positioned in the subcutaneous (under the skin) tissues; large amount of abdominal wall subcutaneous emphysema (air in the tissues under the skin); and diffuse abdominal wall inflammatory fat stranding (thickened fat tissue indicating inflammation or infection in the surrounding tissues) suggesting abscess or instillation of feeding material. R14 was transferred to another hospital due to need for a bed in an intensive care unit. R14 diagnosed with G-tube infection from dislodged G-tube. R14's G-tube was removed and abdomen surgically debrided. R14's abdomen with large subcutaneous fluid collection and displacement of G-tube into the subcutaneous tissue.

Review of R14's medical record notes:
On 7/3, V5 (nurse) noted g-tube area site is hard to palpate and with abscess. V52 NP notified with order to hold feeding and do urgent abdominal x-ray.
On 7/4 at 2:12pm, V25 (nurse) noted abdominal x-ray not done yet, informed V52, ordered to start intravenous fluids and discontinue once abdominal ultrasound result is in, orders carried out.
On 7/5 at 6:44 am, V53 (nurse) noted V53 called the outside diagnostic imaging company and spoke with representative in regards to R14's abdominal x-ray. Representative stated someone will be in facility when they have someone available. Endorsed to oncoming shift nurse.
On 7/5 at 2:32pm, V25 noted x-ray not done yet, followed up outside company, V25 was informed

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S9999	Continued From page 12	S9999		

that somebody will come and do it this afternoon, endorsed accordingly.
On 7/6, V52 NP made rounds, informed about redness and tenderness at R14's abdominal wall, V52 noted abdominal ultrasound negative for abscess, but showed some abdominal wall edematous changes. Site is red and painful. area superior and right of g-tube with erythema, edema, warmth, and tenderness.
On 7/7, V32 (nurse) noted at 7:40 am noted by respiratory therapist on duty that R14's heart rate is 140 beats/minute. Vital sign checked and blood pressure 100/56, respirations 23 breaths per minute, temperature 97.7, oxygen saturation level 93%. V52 NP notified with order to send R14 to the hospital. All due medication given. R14 left facility at 11:00 am by private ambulance.
On 7/7, R14 admitted with diagnosis sepsis. R14 was to be transferred to another hospital for a higher level of care.
On 8/29/23, R14 was re-admitted status post surgery for infected G-tube site.

This facility's tube feeding policy, dated 09/2022, notes to check for G-tube placement using auscultation prior to flushing
(A)

Statement of Licensure Violations (3 of 3)

300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)5)

Section 300.610 Resident Care Policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008270	A. BUILDING: _____ B. WING _____	C 09/21/2023

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S9999	Continued From page 13 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999		

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S9999	Continued From page 14	S9999		

practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Requirements were not met evidenced by:

Based on interview and record review the facility failed to follow their antibiotic stewardship policy to ensure one resident was receiving the correct treatment for a urinary tract infection and wound infection, and failed to track the duration of antibiotic therapy, in order to monitor the effectiveness of antibiotic therapy. This affected

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S9999	Continued From page 15	S9999		

two of three residents (R9, R12) reviewed for antibiotic therapies. This failure resulted in R9 being hospitalized with a white blood count of 79.1(normal range 3.5-10.5) and diagnosed with septic shock related to sacrococcygeal osteomyelitis and urinary tract infection/cystitis.

Findings include:

1. R9 was admitted to the facility on 4/11/22 with a diagnosis including hemiplegia affecting right side, unspecified dementia with behavioral disturbance, urinary tract infection, vitamin D deficiency, transient ischemic attack and cerebral infarction, hypertension, chronic obstructive pulmonary disease, osteoarthritis right knee, pain in right foot and rhabdomyolysis.

R9's wound evaluation and management summary dated 6/28/23 documents: skin tear left buttocks 16 x 19 x 2.0cm, heavy purulent exudate. Wound progress: deteriorated due to infection, patient non complaint with wound care, generalized decline of patient. Deep undermining cavity with purulence expressed. Culture taken and sent by MD for rapid culture and sensitivity. Nurse practitioner started doxycycline on 6/27/23. Will adjust based on sensitivity.

On 9/6/23 at 11:04 AM, V37 (Wound MD) said R9's wounds had declined, resulting in the right and left wounds on buttocks merging into one wound. V37 said he ordered a rapid culture for R9's buttocks wound due to purulent drainage and possible abscess. V37 said R9 was being treated with doxycycline and was awaiting culture results. V37 said he received the results but said it was on him for the delay in relaying culture result and changing the antibiotics due to the holiday. V37 said the culture results showed that

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S9999	Continued From page 16	S9999		

doxycycline was resistant to wound pathogens identified in R9's wound.

R9's wound culture report collection date 6/28/23 and reported date of 6/30/23 documents pathogens detected: peptostreptococcus 76%, Escherichia coli 7.6%, prevoteela 7.6%, staphylococcus aureus enterotoxins A/B 7.6%, peptoniphilusharei ivorii 0.76%, Acinetobacter baumannii 0.076%, enterococcus faecalis 0.076%, kiebsiellá 0.076%, pseudomonas aeruginosa 0.076%, serratia marcescens 0.076%. Under resistance genes detected and potential medication class affected: methicillin, Bactrim, tetracycline, and quinolones. The bacteria identified in this patient carries same gene that confers potential resistance to methicillin. Due to the potential seriousness of methicillin resistance, this infection should be treated aggressively and with close and vigilant monitoring of treatment effectiveness.

R9's wound evaluation and management summary dated 7/5/23 documents: skin tear left buttocks size 17 x 20 x 2.0 cm. under additional wound details: culture grew multiple organism with resistance . Will switch antibiotics. Under recommendations: discontinue doxycycline. Start Augmentin and Bactrim.

R9's physician order sheet dated 7/6/23 documents new orders for Bactrim and Augmentin.

R9's urine culture collected date 5/19/23, specimen received 5/23/23, specimen reported 5/25/23 documents positive for kiebsiella greater than 100,000. Documents resistance to cipro.

R9's physician order sheet dated 5/22/23

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S9999	Continued From page 17 documents new orders Cipro. R9's progress notes dated 5/23/23 documents: relayed urinalysis results to Nurse Practitioner and ordered to continue Cipro. On 9/7/23 at 4:55 PM, V2 (DON) said the nurses are responsible for informing the doctor or nurse practitioner of culture results to ensure residents are treated with the correct medication. V2 said they are unable to provide any documentation of antibiotic stewardship prior to end of June. R9's hospital record dated 7/5/23 documents: admitted with acute hypoxic respiratory failure, acute encephalopathy, hypotension, possible sepsis, severe leukocytosis and thrombocytosis. Labs white blood count of 79.1 (normal 3.5-10.5. CT scan under impression documents: multifocal pneumonia in left lung, collection of gas and fluid in left hip joint and areas of osseous erosion. Findings consistent with osteomyelitis and septic arthritis; prominent decubitus ulcer in sacrococcygeal region with erosion of the coccygeal segments consistent with osteomyelitis's, thickening of bladder wall possibility of cystitis. Facility antibiotic stewardship revised 9/2022 documents: It is the policy of facility to maintain an antibiotic stewardship program with mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse event associated with antibiotic use. Tracking we will monitor antibiotic use and outcome from antibiotic use. Reporting we will provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff	S9999		

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S9999	Continued From page 18	S9999		

2. R12's lab results dated 3/21/23, 4/10/23 and 6/15/23 documents: Positive C-difficile Toxin.

On 9/1/23 at 10:30 AM, V31 (Pharmacy Personnel) said, it appears that R12's original dose of vancomycin in March was not effective which is why it was restarted in April at a higher dose.

On 9/7/23 at 3:03 pm, V51 (Nurse Practitioner) refused to answer any questions.

On 9/7/23 at 4:55 PM, V2 (DON) said, R12 was not followed by an infectious diseases doctor. It was not customary to have R12 on vancomycin for four months. I wasn't aware until now. V2 said, they are unable to provide any documentation of antibiotic stewardship prior to end of June.

On 9/12/23 at 11:00 AM, V41 (IP Nurse) said, he did not have any other tracking information for R12's antibiotic use.

Facility antibiotic tracking log documents: R12; 6/20/23; C-Diff, KPC; Vancomycin; 6/30 -7/20.

Pharmacy dispense record documents: Vancomycin was dispensed on 3/21/23, In April, on 5/22/23, on 6/20/23, a three day supply was sent 6/23 and 6/26 with a request for the facility to check the stop date. This order was cancelled by the facility on 7/5 and they sent the following update on 7/5 (which is in line with the previous taper dose from 6/20) and on 7/18 until 7/20 (still in line with the original taper dose).

On 3/21/23 - Vancomycin oral capsules 125 milligram (mg) - one capsule every six hours

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S9999	Continued From page 19 times (x) ten (10) days In April, Vancomycin oral caps restarted at higher dose and tapered down - 4/12-4/22/23: 250mg by mouth four times a day. - Starting 4/23: 250mg by mouth three times a day x 10 days - Starting 5/3: 250mg by mouth twice a day x 10 days - Starting 5/13: 250mg by mouth every day x 10 days (end of therapy 5/22/23). Nursing note dated 4/15/23 documents: no loose stools, (4/18/23)-no loose stools two bowel movements semi-formed, (4/22/23, 4/24/23, 5/8/23) - no loose stool. On 5/22/23, Vancomycin was restarted: 250 mg by mouth twice a day x 10 days, then 250mg by mouth every day x 10 days. Nurse Practitioner note dated 5/22/23 documents: Pt was to complete treatment for C-difficile today, however, continues to have soft stools with mucus. (6/15/23)- CNA stating patient (R12) with diarrhea, loose stools again today, recently completed long vancomycin taper for c-difficile. Nursing note dated 6/7/23 documents no loose stools. (6/14/23)- per nurse practitioner resident can come off isolation, no foul smell, diarrhea or other symptoms, (6/15/23) - R12 was observed by nurse and CNA to have loose stool, stool collected to rule out c-difficile, (6/16/23) - normal bowel movement, (6/20/23) - R12's stool results were positive for c-difficile and (6/26/23) R12 has a small formed stool. On 6/20/23, oral vancomycin solution 25mg/ml	S9999		

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S9999	Continued From page 20 was ordered: - Sent stat 6/21/23 - 10ml (250mg) PO QID (stop date 6/30/23) - 7/1 - 10ml (250mg) by mouth three times a day x 10 days - 7/11 - 10ml (250mg) by mouth twice a day x 10 days - 7/21 - 10ml (250mg) by mouth every day x 10 days On 6/23 we received an updated order (label change) stating to take 10ml (250mg) QID with no stop date. A three day supply was sent 6/23 and 6/26 with a request for the facility to check the stop date. (Nursing note dated 6/26/23 documents: R12 had a small formed stool.) This order was cancelled by the facility on 7/5 and they sent the following update on 7/5 (which is in line with the previous taper dose from 6/20): - 7/5 - 7/10: 10ml (250mg) by mouth three times a day - 7/11 - 7/20: 10ml (250mg) by mouth twice a day - 7/21 - 7/29: 10ml (250mg) by mouth every day On 7/18 - received new order for Vancomycin oral solution 25mg/1ml - give 10ml (250mg) PO BID until 7/20 (still in line with the original taper.) Physician order sheet dated 3/22/23- 7/21/23 documents: R12 had vancomycin ordered. Medication administration record dated 4/11/23 - 5/11/23, 5/12/23 - 6/11/23, 6/12/23 -7/11/23 documents: R12 was given vancomycin. Facility antibiotic stewardship revised 9/2022 documents: It is the policy of facility to maintain an antibiotic stewardship program with mission of	S9999		

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S9999	Continued From page 21 promoting the appropriate use of antibiotics to treat infections and reduce possible adverse event associated with antibiotic use. Tracking we will monitor antibiotic use and outcome from antibiotic use. Reporting we will provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff. (A)	S9999		