STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 COVID-19 Focused Survey was conducted on 09/01/20- 09/04/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID: T69W11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint survey was conducted on 09/01/20-09/04/20. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Center for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were 6 complaint allegations investigated and 3 of the 6 were substantiated and cited. Event ID# T69W11.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that	F 563		9/26/20

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

Electronically Signed | 09/25/2020

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F 563	Continued From page 1 provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, and family interview the facility failed to honor a resident's right to allow a resident's immediate family member to have end of life visitation in accordance with Center for Medicare and Medicaid Services (CMS) memo COVID-19 QSO-20-14-NH and the facility's COVID-19 plan for 1 of 1 resident reviewed for visitation (Resident #1). The findings included: Review of the facility's Visitation Protocol read in part, given the recent guidance from CMS and the American Health Care Association, we strongly discourage visitation at this time except for third party healthcare professional caring for residents. Under the following circumstances visitation must be limited or restricted: If you live in a county or adjacent county where community-based spread of Coronavirus or COVID-19 is occurring or has occur we ask that you not visit the Center. The only exceptions are those situations that involve end of life, situation where the visit is necessary to complete the	F 563	Please accept this Plan of Correction (POC) as Surry Community Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of non-compliance. The POC is being provided in pursuit to federal and state requirements which require an acceptable plan of correction as a condition of continued certification. Date of alleged compliance is September 26,2020. F563 Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) 1. On 8-14-2020 following a code blue event which resulted in resident #1 expiring, the facility failed to offer a visit to the family. 2. All residents in a compassion care situation(end of life, recently passed and other situations to be determined on an	

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F 563	Continued From page 2	F 563		

admission process and paperwork or situations where staff believe that the visit is necessary for clinical or psychosocial needs. The protocol contained no date.

Resident #1 was admitted to the facility on 07/17/20 with diagnoses that included: fracture of right femur, hypertension, dementia, Alzheimer's disease and others. Responsible Party (RP) #1 was listed at Resident #1's emergency contact and health care power of attorney.

Review of the comprehensive Minimum Data Set (MDS) dated 07/21/20 revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living.

Review of a nurses note dated 08/14/20 at 6:28 PM read in part, at 10:29 AM Resident #1 was found unresponsive by staff on the hall. No pulse palpated. Resident #1 transferred to the floor and cardiopulmonary resuscitation (CPR) initiated. RP #1 was contacted and 911 called. All rescue efforts turned over to emergency personnel. Emergency personnel correlated with the emergency room physician. Resident #1 was in asystole, no pulse palpated or auscultated. No respirations auscultated. Emergency personnel pronounced time of death. Postmortem care performed by staff.

Upon entrance to the facility on 09/02/20 at 10:00 AM on observation of the front door to the facility was made. There was a sign on the door indicating no visitation was allowed due to the COVID-19 pandemic and the door was locked. Upon entering the facility the Visitation Protocol was provided again with no date to the protocol.

individual basis) have the potential to be affected by this deficient practice. An audit was preformed of all residents within the last 30 days that have been in a compassion care situation and all residents audited were offered visits with their families.

3. An in-service was conducted by the Administrator on or before 9/26/2020 with DON, ADON, Staff Development, Unit Coordinator and Unit Manager regarding the right to receive/deny visitors along with updated guidance from DHHS received on 9/16/2020 regarding visits after end of life. The SDC, UC and UM will provide education to all current staff (as well as new staff upon hire) regarding this updated guidance.

4.Residents will be monitored in clinical start-up for any signs/symptoms of compassionate care needs/visits 5x weekly X 12 weeks. Director of Nursing will report to QAPI x3 months to evaluate the effectiveness and amend as needed.

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F 563	Continued From page 3	F 563		

An interview was conducted with RP #1 on 09/02/20 at 3:59 PM. RP #1 stated that on 08/14/20 at approximately 10:00 AM she received a call from the facility staff notifying her that Resident #1 was found unresponsive and CPR was in progress. She stated that she hung up the phone picked up another family member and began the 1-hour drive to the facility. She stated that about 20 minutes into the drive she called the facility for an update and got the Director of Nursing (DON) on the phone and inquired on the status of Resident #1. The DON stated that CPR was still in progress, but she would have to get the chart to see the events of the day. Approximately 10 minutes later the DON called RP #1 back and provided the events of the day but stated unfortunately Resident #1 had passed away. RP #1 stated she informed the DON of the funeral home to contact and stated that they were in route to the facility and when they arrived could they come in and see Resident #1. RP #1 stated the DON replied no Resident #1 "has already passed and you will have to wait for the funeral home to bring" Resident #1 out. RP #1 stated that she and the other family member arrived at the facility and the staff brought Resident #1's belongings to the front door and sat them outside and they waited approximately 45 minutes to an hour for the funeral home to arrive and bring Resident #1 outside so they could say their final goodbyes.

An interview was conducted with the DON on 09/04/20 at 11:20 AM. The DON stated following the events and death of Resident #1 on 08/14/20 they have done some research and there was no clear guidance on the end of life visitation. She stated that at the same time they had received

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F 563	Continued From page 4 notice that they had 3 positive cases of COVID-19 and their mind set was to protect the resident. The DON stated it did not cross her mind to offer RP #1 an end of life visit because they were in protection mode and just wanted to keep everyone safe. An interview was conducted with the Administrator on 09/04/20 at 1:32 PM. The Administrator stated that on 08/14/20 the facility was in "heightened protection" mode because the facility had 3 recent cases of COVID-19. She added they focused on end of life care and it never crossed her mind to offer RP #1 an end of life visit with Resident #1 because they were just trying to keep everyone safe.	F 563		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		9/26/20

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F 580	Continued From page 5 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family, and staff interviews the facility failed to immediately notify a resident's Responsible Party of a change in the resident's treatment that included the commencement of intravenous fluids for 1 of 3 residents reviewed for notification of a significant change (Resident #1). The findings included:	F 580	F580 Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) 1. On 8/11/2020 resident #1 received an order for IV fluids. Resident #1s responsible party was not notified of this order until 8/12/2020. Resident was discharged from facility on 8/14/2020.	

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F 580	Continued From page 6 Resident #1 was admitted to the facility on 07/17/20 with diagnoses that included: fracture of right femur, hypertension, dementia, Alzheimer's disease, chronic kidney disease stage 2, and recurrent urinary tract infections. Review of the comprehensive Minimum Data Set (MDS) dated 07/21/20 revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. No intravenous fluids (IV) were used during the observation period. Review of a physician order dated 08/11/20 read, Normal Saline (NS) (IV fluids) at 50 milliliters (ml) per hour for one liter. The order was placed in the electronic health record by the Unit Manager (UM) at 3:00 PM on 08/11/20. Review of the Medication Administration Record (MAR) dated 08/01/20 through 08/31/20 revealed that IV fluids were administered on 08/11/20 as ordered. Review of a nurses noted dated 08/11/20 at 5:27 PM read, 24-gauge (iv catheter) right antecube (right arm) infusing at 50 ml per hour. The note was signed by Nurse #2. Review of a nurses note dated 08/12/20 at 10:03 AM read in part, Responsible Party (RP) #1 contact and updated on resident status. Informed of past labs and results. Labs and medication reviewed with RP #1. The noted was electronically signed by the UM. An interview was conducted with RP #1 on 09/02/20 at 3:59 PM. RP #1 stated that on	F 580	2. The nurse that failed to notify the RP received 1:1 education by the Director of Nursing on 9/14/2020. All residents have the potential to be affected by this deficient practice. An audit was conducted of current residents for the last 30 days by the Director of Nursing and Administrator to ensure responsible party notifications for any changes of condition. 3. Education will be provided to Licensed Staff on or before 9/26/2020 by the Director of Nursing to ensure notification of the responsible party for changes in residents' treatment. This education will be provided to any new licensed staff during orientation. 4. The Director of Nursing and/or Assistant Director of Nursing will monitor changes in residents' treatments to ensure timely notifications. This will be completed as part of clinical startup 5x/week for 12 weeks. The Director of Nursing will report audit findings to the QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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F 580	Continued From page 7	F 580		

08/12/20 she had received a call from the Director of Nursing (DON) who stated she had just spent some time with Resident #1 and she felt like Resident #1 had "perked up" and requested a soft drink but was unable to drink it through the straw. RP #1 stated that she told the DON she wanted to video chat with Resident #1 and the DON stated she would arrange the video chat. RP #1 stated that at approximately 8:00 PM on 08/12/20 the UM assisted with that video chat. RP #1 indicated that Resident #1 was drowsy and would not converse with her. The UM offered to RP #1 that Resident #1 had been awake earlier and maybe she had waited too late in the evening to do the video chat. The UM panned out on the video chat to show RP #1 that Resident #1 had IV fluids infusing. RP #1 stated had no idea Resident #1 had been started on IV fluids and asked the UM when they were started. The UM stated to RP #1 that they had been started the day prior on 08/11/20.

An interview was conducted with Nurse #2 on 09/02/20 at 2:47 PM. Nurse #2 confirmed that she had initially started the IV fluids on 08/11/20 because there had been a physician order that came through indicating she needed IV fluids. Nurse #2 stated that generally the UM would notify the family of new orders when she signed them off and entered them into the electronic record. She stated she had not notified the family of the specific IV fluids but did speak to the family extensively during Resident #1's stay in the facility. Nurse #2 stated she was not sure who or when the family was notified of the IV fluids but stated either the UM would have done it or the DON who also spoke often to the family about Resident #1's condition.

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F 580	Continued From page 8 An interview was conducted with the UM on 09/03/20 at 4:37 PM. The UM stated that she rounded with the medical providers on their visits to the facility and when they wrote orders in the chart, she would sign them off and enter them into the electronic health record. The UM stated that prior to the COVID-19 pandemic she always called the families to make them aware of any new orders that occurred. She added it is "very tough with COVID" to make that happen. The UM stated she recalled video chatting with RP #1 on 08/12/20 and updating them on Resident #1. She does not specifically recall notifying them on 08/11/20 when the order was received but stated she did notify them on 08/12/20. An interview was conducted with the DON on 09/04/20 at 11:20 AM. The DON stated that they try to notify the families of any changes and numerous staff members step up and make those calls. She stated she would expect any changes to be communicated to the family the day the change was made. An interview was conducted with the Administrator on 09/04/20 at 1:32 PM. The Administrator stated that she expected the families to be notified of any changes within a few hours. She added that she was aware that the conversations about the IV fluids had occurred, but she could not speak to the timing of that notification.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		9/26/20

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F 583	Continued From page 9 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, text message documentation, staff, and family interview the facility failed to protect private health information by sending confidential protected health information home in a resident's suit case who was discharged from the facility for 1 of 1 resident investigated for privacy/confidentiality (Resident	F 583	F583 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) 1. On 8/14/2020 resident #1 was discharged from the facility and her personal items were packed up and the	

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F 583	Continued From page 10 #1). The findings included: Resident #1 was admitted to the facility on 07/17/20 with diagnoses that included: fracture of right femur, hypertension, dementia, Alzheimer's disease and others. Responsible Party (RP) #1 was listed at Resident #1's emergency contact and health care power of attorney. Review of the comprehensive Minimum Data Set (MDS) dated 07/21/20 revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. Resident #1 expired in the facility on 08/14/20. An interview was conducted with RP #1 on 09/01/20 at 3:59 PM. RP #1 stated that on 08/14/20 Resident #1 had passed away in the facility and she had picked up Resident #1's belongings the same day. RP #1 stated when she arrived home and went through Resident #1's suite case, she discovered a document in her suite case that was titled Care Provider Daily Schedule and dated 08/11/20. RP #1 stated that the document contained Resident #1's name along with other resident name and information. RP #1 stated she did not know how the document got placed in Resident #1's suite case but she was sure it was not supposed to be there. Text message review of the Care Provider Daily Schedule found in Resident #1's suite case was made on 09/01/20 at 4:30 PM. The document contained the name of Resident #1 and 5 other residents. The document included the residents	F 583	facility failed to protect private health information by sending protected health information home in resident #1s suitcase with her family. 2. All residents have the potential to be affected by this deficient practice. ST was counseled on Privacy and Confidentiality and Protection of residents' health information. An audit of resident rooms was conducted by the Director of Nursing and did not reveal private health information breaches. 3. An in-service was conducted by the Director of Nursing and the SDC with all staff on Privacy and Confidentiality and Protection of resident's health information. This information will be included in orientation for new hires. Therapy staff will return the patient schedule to the Director of Rehab at the end of their shift. 4.The Director of Rehab will audit this 5 x weekly x 12 weeks. The Director of Rehab will report results to the QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.	

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F 583	Continued From page 11	F 583		

room number, payor information, and any precautions the residents had. The document indicated it was the Speech Therapist (ST) daily schedule.

An interview was conducted with the ST on 09/02/20 at 2:03 PM. The ST stated she treated Resident #1 during her stay in the facility. She stated she worked at the facility on a as needed basis and when she arrived for work, she would pick up her schedule that had been printed for her and start seeing the residents listed on her daily schedule. The ST stated that she did not recall leaving her daily schedule in Resident #1's room but she stated from time to time she would realize she had lost or misplaced her schedule and would have to print another one. The ST stated that the daily schedule should not have been left in Resident #1's room and definitely not sent home with her belongings as it did contain names and other information of other residents.

An interview was conducted with Housekeeper #1 on 09/03/20 at 12:20 PM. Housekeeper #1 confirmed that she packed up Resident #1's belongings on 08/14/20 because her family was at the facility to collect her things. Housekeeper #1 stated she did not recall any paper documents that contained resident names, room number, payor source, or precautions on it and if she would have seen them, she would have turned them into the nursing staff at the facility.

An interview was conducted with the Director of Nursing (DON) on 09/04/20 at 11:20 AM. The DON stated that on 08/14/20 when Resident #1 expired her family came to the facility to pick up her belongings and so Housekeeper #1 went to Resident #1's room to pack up her belongings.

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F 583	Continued From page 12 The DON stated that Housekeeper #1 placed Resident #1's "papers" in a side pocket of her suite case without realizing what the papers where. The DON stated the ST should not have left the daily schedule that contained the names, room numbers, payor source, and precautions of residents in Resident #1's room and it certainly should not have been sent home in Resident #1's suite case. An interview was conducted with the Administrator on 09/04/20 at 1:32 PM. The Administrator stated that the confidential health information that was included on the ST daily schedule should not have been left in Resident #1's room and absolutely not sent home with her belongings.	F 583		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		9/26/20

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F 757	Continued From page 13 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, and Medical Director interviews the facility failed to ensure a resident's drug regimen was free from unnecessary drugs when a resident was administered an antibiotic for 4 days after the facility received a laboratory report that specified the resident was resistant to the antibiotic for 1 of 3 residents reviewed for unnecessary drugs (Resident #1). The findings included: Resident #1 was admitted to the facility on 07/17/20 with diagnoses that included: fracture of right femur, hypertension, dementia, Alzheimer's disease, Chronic kidney disease stage 2, and recurrent urinary tract infections. Review of the comprehensive Minimum Data Set (MDS) dated 07/21/20 revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. No antibiotic use was noted during the reference period. Review of a physician order dated 08/07/20 read, Cipro (antibiotic) 500 milligrams (mg) by mouth twice a day for 7 days for urinary tract infection. The order was entered into the electronic health record by Nurse #1. Review of the Medication Administration Record (MAR) dated 08/01/20 through 08/31/20 revealed	F 757	F575 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) 1. On 8/8/2020 Resident #1 was prescribed and administered Cipro for dx of UTI. Upon return of the Culture and Sensitivity 8/10/2020 Cipro was not sensitive to the bacteria identified. However, Cipro was not changed to an antibiotic sensitive to the bacteria identified until 8/12/2020. Resident was discharged from the facility on 8/14/2020. 2. All residents being tested for symptoms of UTIs can be affected by this deficient practice. An audit was conducted by the Director of Nursing of all residents having orders for UA/C&S for the last 30 days. 3. Education will be provided to licensed staff by the Director of Nursing and/or Infection Preventionist on or before 9/26/2020 and will be provided to new staff during orientation, regarding the facility process for review and reporting of Culture and Sensitivities to ensure follow through with appropriate medications for treatment/dx. Facility process is as follows: Cultures and sensitivities are sent to building via fax or nurse reviews in laboratory portal, report to MD/PA to review and/or receive new	

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that Resident #1 had received 5 doses of the Cipro between 08/08/20 and 08/12/20.

Review of a laboratory report dated 08/08/20 indicated this was the final report of Resident #1 urinalysis and sensitivity report. The report indicated that Resident #1's urine sample was dark orange and turbid and contained a trace of blood and a trace of protein. The report also indicated that Resident #1's urine contained greater than 100,000 colony forming units (cfu) per milliliter (ml) of lactose fermenting gram negative rods (organism) and was resistant (immune) to Cipro.

Review of the Nurse Practitioner (NP) progress note dated 08/10/20 read in part, urinalysis was reviewed which demonstrated greater than 100,000 Ecoli (organism). The plan was to add Cipro 500 mg by mouth twice a day for 7 days for urinary tract infection. The note was electronically signed by the NP.

Review of a physician order dated 08/12/20 read discontinue Cipro. Invanz (antibiotic) 1 gram (gm) intramuscularly (IM) for 7 days for urinary tract infection.

An interview was conducted with Nurse #1 on 09/02/20 at 3:18 PM. Nurse #1 stated that she did not recall Resident #1 and had no recollection of the order she entered for Resident #1 on 08/07/20. Nurse #1 stated that she may have pulled the lab results off the fax machine and called the on-call provider who gave the verbal orders, but she could not recall and could say with certainty that was what occurred.

An interview was conducted with the NP on

orders, then nurse to review orders to be appropriate as related to sensitivities.

4. The Director of Nursing and/or Assistant Director of Nursing will audit orders for culture and sensitivities in clinical startup 5 x weekly x 12 weeks. The Director of Nursing will report audit findings to the QAPI committee monthly x 3 months to evaluate the effectiveness and amend as needed.

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09/03/20 at 9:55 AM. The NP stated that she visited with Resident #1 often during her stay at the facility and upon review of her progress notes indicated that she added Cipro on 08/10/20 and then changed it to Invanz on 08/12/20 after the family reported to the staff that Resident #1 had a history of multidrug resistant organisms that in the past had required IM or intravenous (IV) antibiotics. The NP was unaware that the Cipro had been started on 08/07/20 and stated that it was possible that someone called the report to the on-call provider who initiated the Cipro. She added that when she reviewed the lab report on 08/10/20 she had not seen the culture report. The NP stated that if she had seen the culture report indicating that Resident #1 was resistant to Cipro, she would have chosen a different antibiotic to treat her infection. The NP further indicated that the Cipro was not helping with Resident #1's infection and it certainly did not help her overall health condition. She added that Resident #1 had so many other contributing factors that may have led to her overall decline including dementia and dysphagia with pocketing of food, her kidney function was getting worse and she had a urinary tract infection on top of all that.

An interview was conducted with the Medical Director (MD) on 09/03/20 at 3:02 PM. The MD stated that he had visited with Resident #1 during her stay at the facility. The MD was not certain who or why the Cipro had been initiated. He reviewed the lab reported and stated that he would not have started empiric antibiotic based off the Resident #1's urinalysis report. The MD stated that her urine was very concentrated which was due to her overall hydration status. He stated he would have given her fluids and repeated the urinalysis. The MD stated that if he would have

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seen the culture report he would have certainly changed the antibiotic to something that would have been effective because the Cipro was not benefiting Resident #1 at all. The MD stated that someone missed the culture report and he would have to try and find out how that happened and correct the issue.

An interview was conducted with the Unit Manager (UM) on 09/03/20 at 4:37 PM. The UM stated that lab reports were received via fax machine in the business office. She stated that she went periodically throughout the day and checked for any new lab reports that may have come through. The UM stated that she reviewed the lab reports and discerned which lab reports needed to be called to the provider and which ones could wait until the provider returned to the facility. If the lab report could wait until the provider returned to the facility, she would place the report in a folder at the nurse's station and the provider would review it on their next scheduled day at the facility. The UM stated that she recalled getting the Cipro changed because Resident #1 was having a hard time swallowing her medications. She added that she did not recall seeing the sensitivity report where Resident #1 was resistant to Cipro, if she had seen it, she would have called the provider to get it discontinued and get something else initiated. The UM stated she was not sure who pulled the lab sheet off the printer or who called the provider but stated someone should have caught the fact that Resident #1 was resistant to the antibiotic (Cipro) she had been prescribed.

An interview was conducted with the Director of Nursing (DON) on 09/04/20 at 11:20 AM. The DON stated that the NP signed off the final

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sensitivity on 08/10/20 and she was not certain if she read it wrong or did not see it. She further stated that at some point the resident's family reported that Resident #1 had a history of having multidrug resistant infection and she was switched to Invanz IM. The DON added she would have expected the sensitivity to have been noted sooner and the antibiotic changed sooner.

An interview was conducted with the Administrator on 09/04/20 at 1:32 PM. The Administrator indicated she had been notified of the unnecessary antibiotic and stated it should not have happened. The lab report should have been reviewed and called to the provider so the antibiotic could have been changed to something that would have helped Resident #1's urinary tract infection.