STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34399 Based on interview and record review the facility failed to implement their written policies and procedures that prohibit and prevent abuse and neglect for three (Dietary Aide N, CNA O and LVN F) of 9 employees reviewed for abuse and neglect. The facility failed to conduct criminal background checks upon hire for Dietary Aide N, CNA O and LVN F upon hire. This failure could place residents at risk for abuse and receiving care from unemployable staff. Findings included: Review of facility's policy Abuse dated 02/17/20 reflected under procedure 1. Screening: a. Pre-employment screening will be completed on all employees, to include: Criminal History Check .background check . Professional Licensure, certification or registry check as applicable .Misconduct Registry. Review of Dietary Aide N's personnel file reflected her hire date was 04/22/22. There was no criminal background check in her file. Review of CNA O's personnel file reflected her hire date was 4/11/22. There was no criminal background check in her file. Review of LVN F's personnel file reflected her hire date was 4/06/22 and there was no criminal background check in her file. Review of Dietary Aide N, CNA O and LVN F's criminal background check completed on 06/09/22 reflected all three were employable and had no bars to employment. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/22 at 12:54 PM with Administrator revealed he had to re-run all of the EMRs a criminal background checks for staff who were not new hires because the previous HR person was let go about a month ago. He stated he would search and see if he could locate the original background checks. He stated they have hired a new HR person that is supposed to start 6/16/22. He stated he knew the criminal background checks were supposed to be done upon hire. He stated in the interim they are sending the application to corporate office who will be doing the background checks. He stated not having the criminal background checks or EMRs place residents at risk for someone to work who was not eligible to work with the elderly. He stated he had to do the criminal background checks to ensure the facility staff were employable since he could not find them. Interview on 06/10/22 at 3:25 PM with Administrator revealed the criminal background checks should have been completed by previous HR upon hire. He stated HR has been gone for about a month and Corporate was running them for any new hires.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on interview and record review, the facility failed to ensure a discharge MDS was electronically completed and transmitted to the CMS System within 14 days after completion for two (Resident #3 and Resident #41) of three residents reviewed for discharge assessments. The facility failed to complete and transmit Resident #3's and Resident #41's discharge MDS assessment within 14 days of completion. This failure could place the residents at risk of having incomplete records. Findings include: Review of Resident #3's face sheet, dated 06/09/22, reflected Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 12/29/21 to home. Review of Resident #3's discharge summary, signed by physician on 01/05/22, reflected Resident #3 discharged from the facility on 12/29/21 to her home. Review of Resident #3's MDS assessments on 06/08/22 revealed Resident #3 did not have a discharge MDS assessment completed. This MDS record was identified as greater than 120 days late. Resident #3's electronic record reflected in Resident #3's MDS assessments of the Discharge MDS assessment was 147 days overdue. Review of Resident #41's face sheet dated 06/09/22 reflected Resident #41 was a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 05/13/22 to home with home health services. Review of Resident #41's discharge summary, dated 05/13/22, reflected Resident #41 discharged on [DATE] to home with home health services. Review of Resident #41's MDS assessments from April to June 2022 revealed Resident #41 did not have a discharge MDS assessment completed. Resident #41's electronic record reviewed on 06/08/22 reflected in Resident #41's MDS assessments of the Discharge MDS assessment was 12 days overdue. Interview on 06/09/22 at 2:25 PM with MDS Coordinator revealed Residents #3 and #41 should have had discharge MDS completed but they were missed. She did not realize these two residents did not have discharge MDS assessments completed. Resident #41 was not a planned discharge but MDS assessments for both residents should have been completed within 14 days of discharge and then transmitted the discharge MDS assessments. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy MDS Transmission revised 04/05/21 reflected under transmittal requirements that Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS system, including the following: . Discharge assessments .Guidelines .4. The facility MDS coordinator or Utilization Review Consultant should transmit MDS assessments to the QIES ASAP system in compliance with RAI guidelines/Transmittal Requirements as outlined above to achieve transmission within 14 days after completion of MDS assessment or 7 days after completion of tracking forms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one (Residents #19) of one resident reviewed for feeding tubes. LVN B failed to flush Resident #19's G-Tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) with 100 cc's of water after his bolus feeding and prior to medication administration and failed to flush with 100 cc of water after medication administration per physician's orders. These failures could affect residents by placing them at risk of obstruction of the G-tube and potential for dehydration because of inadequate hydration. Findings included: Resident #19's Admission MDS assessment, dated 03/28/22, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses including quadriplegia (paralysis from the neck down), post traumatic seizures, dysphagia (swallowing difficulties) and gastrostomy (the surgical formation of an opening through the abdominal wall into the stomach) status. Resident was unable to participate in the brief interview for mental status and assessed by the staff to be severely cognitively impaired. Resident #19 received 51% or more of total calories through tube feeding (G-tube - tube inserted through the abdomen that delivers nutrition directly to the stomach.). Resident #19's Care Plan, initiated on 03/28/22, reflected, . [Resident #19] has dehydration or potential fluid deficit r/t Enteral Feeding .requires tube feeding and is at risk or complications .Interventions included . Administer tube feeding and water flushes as ordered . Review of the record titled, Communication between the Dietitian and the Attending Physician, dated 03/16/22, Reflected, Recommendation: . Flush with 100 ml before and after meds and each bolus, The physician agreed and signed and dated the order on 03/31/22 Review of Resident #19's Physicians Order Report dated 06/08/22 and printed at 10:08 a.m., reflected, . feeding-bolus-Give 2 cartons of Isosource 1.5 bolus per G-tube (500 ml) and flush with 100 ml water after bolus .order date 3/23/22 .Every Shift 1. Flush with 100 ml water after bolus. 2. Flush with 100 ml before and after each medication administration .order date 3-17-22 . Review of Resident #19's MAR for June 2022 reflected, feeding-bolus-Give 2 cartons of Isosource 1.5 bolus per G-tube (500 ml) and flush with 100 ml water after bolus .start date 3/23/22 .Every Shift . 1. Flush with 100 ml water after bolus and before and after each medication administration .start date 3-17-22 . An observation on 06/08/22 at 08:10 a.m. revealed LVN B at the medication cart pulling the following medications for G-tube administration and bolus feeding for Resident #19: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elderberry Syrup (immune supplement) 1 teaspoon Flonase Suspension (steroid) 50 mcg nasal spray Lamotrigine tablet (anticonvulsant) 200 mg 2 tablets Levetiracetam Solution (anticonvulsant) 100 mg/ml- 10 ml Levocarnitine Solution (Metabolic and Endocrine, other) 1 gm/10 ml- 5 ml Sertraline (antidepressant) 50 mg 1 tablet Aspirin 81 mg 1 tablet 2 cartons of Isosource (calorie dense protein) 1.5 calorie 250 ml per carton. LVN B donned gloves and placed each of the tablets into a plastic sleeve and crushed them and placed each of the medications into an individual plastic cup. LVN B gathered 6 pill cups and 1 plastic water cup and entered the resident's room. LVN B filled the plastic water cup with water and poured approximately 10 cc's of water into each pill cup. LVN B retrieved a 60-cc piston syringe and placed it onto the end of the g-tube and drew back for residual revealing no residual. LVN B then went to the bathroom sink to expel the air that was drawn up into the piston syringe. LVN B then attached the piston syringe and administered the 2 cartons of Isosource. After completion of the feeding, she flushed the g-tube with approximately 10cc of water and began administering each of the medication, flushing with approximately 10 cc's of water between each medication. LVN B flushed the G-tube with approximately 10 cc after the last medication. In an interview with LVN B on 06/08/21 at 10:00 a.m., she stated she had misread the instructions on the water flushes after his bolus feedings and medication administration. She stated by not flushing with enough water could cause the resident to not receive adequate fluid intake and complications with his g-tube. She stated she had worked for the facility for about 3 weeks and had received onboarding training upon hire and had shadowed another nurse for 4 days. Review of LVN B employee training, revealed she had completed the new hire Education pathways on 05/30/22. She was skills checked on G-Tube administration on 06/09/22. In an interview on 06/08/21 at 2:00 p.m. the DON stated the staff were to follow the physician's orders for how water to use to flush a residents G-Tube. She stated the nurse failed to follow the orders. She stated the dietician had requested and the physician had approved the amount of water since the resident is on bolus feedings to ensure he remained adequately hydrated. She stated they should not be giving the medication and the feeding at the same time, since this will cut down on the amount of water the resident will receive. She stated she had changed the directions so that there is at least an hour in between the medication administration and the feedings. Review of the facility's policy, Standards and Guidelines: Enteral Tube Feeding, dated March 27, 2021, reflected, .Verify/obtain physician's orders for enteral feeding .Consult with Registered Dietitian as needed/ordered related to tube feeding/flush requirement .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs with inadequate monitoring for one (Resident #4) of 7 residents reviewed for medications. The facility failed to adequately monitor Resident #4's PT/INR levels at least monthly while taking Coumadin (anticoagulant medication) 4 mg daily since 03/23/22. Resident #4's last lab dated 03/22/22 reflected Pro Time (PT) was 26.5 and INR was 2.5. On 06/08/22, Surveyor notified the facility of Resident #4's PT/INR lab not being completed since 03/22/22. Facility ordered a Stat PT/INR lab to be drawn on 06/08/22. Resident #4's PT was 44.3 and INR was 4.5 (high out of therapeutic range) on 06/08/22. Resident #4's INR was 4.5 which placed her at a greater risk for bleeding while on Coumadin medication and on 06/09/22 physician ordered Resident #4's Coumadin medication to be held at least 2 days and when INR level is 3 or below. Resident #4's physician ordered PT/INR labs be drawn next 2 days. Pharmacy Consultant did not have access to residents' labs to ensure PT/INR labs were completed for residents on Coumadin medication. There was not a system in place to ensure and monitor resident's physician orders like PT/INR labs to have a specific timeframe and the immediacy is based on the need for surveyor intervention. An Immediate Jeopardy (IJ) was identified on 06/09/22. While the IJ was removed on 06/10/22, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated due to facility continuation of in-servicing and monitoring of the plan of removal. This failure placed residents on anticoagulant medications with inadequate monitoring, at risk of major or fatal bleeding, hospitalization or death. Findings included: Review of Resident #4's face sheet dated 06/09/22 reflected she was an [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of type 2 diabetes mellitus, hypothyroidism, hypertension, atherosclerotic heart disease, generalized muscle weakness, unsteadiness on feet and lack of coordination Review of Resident #4's Admission MDS assessment dated [DATE] reflected she had diagnoses of atherosclerotic heart disease, hypertension, diabetes mellitus and thyroid disorder. She had a BIMS of 10 indicating she was moderately cognitively intact. Resident #4 required supervision with ADLs of transfers, dressing, toileting, personal hygiene with one-person physical assistance. Resident #4 was on anticoagulant and diuretic medications. Review of Resident #4's Comprehensive Care Plan date initiated and last revised 05/24/22 reflected the following: (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #4 was on anticoagulant therapy (Coumadin) related to disease process of Coronary Artery Disease. Interventions initiated on 03/01/22 included the following: to monitor/document/report to MD prn s/sx (signs and symptoms) of anticoagulant complications: blood tinged or [NAME] blood in urine, black tarry stools, dark or bright red blood in stools, severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs). Revised on 06/08/22 reflected PT/INR labs monthly. Report abnormal lab results to the MD. -revised on 02/02/22 reflected Resident #4 had a fall and at risk for further falls due to unsteady gait. Resident #4 had falls on 02/01/22 and 02/02/22 with no injury. Review of Consolidated physician orders dated 06/08/22 reflected Resident #4 had the following current physician orders: - start date of 03/02/22 of Coumadin tablet 4 mg give 1 tablet by mouth of one time a day related to Atherosclerotic Heart Disease. - start date of 03/19/22 for PT/INR. There was no frequency or timeframe noted. Review of Resident #4's PT/INR lab collected on 03/22/22 at 10:53 am and received on 03/22/22 at 4:14 pm reflected Resident #4 had a PT (pro time) level of 26.5 and INR of 2.5 (therapeutic range of 2.0 to 3.0). Dated and time signed 0600 am - Nurse signed waiting for doctor's response. Then written on lab Continue with Warfarin 4 mg Recheck PT/INR with physician signature. Review of Resident #4's labs from 03/23/22 to 06/09/22 revealed there were no PT/INR levels completed since 03/22/22. Review of Resident #4's Nurse note by LVN K dated 03/23/23 reflected PT/INR reported to [Physician G]. No change in dose at this time. No bleeding episodes noted. Record Review of Nurse's MAR for March to June 2022 reflected the following for Resident #4: March 2022 - Resident #4 was administered Coumadin tablet 4 mg (Warfarin sodium) 1 tablet at 5 pm from 03/02/22 to 03/14/22, 03/16/22 to 03/31/22. 03/15/22 was blank. April 2022 - Resident #4 was administered Coumadin tablet 4 mg (Warfarin sodium) 1 tablet at 5 pm on 04/01/22, 04/05/22 to 04/26/22, 04/30/22. On 04/02/22, 04/03/22, 04/28/22 and 04/29/22 Resident #4 was out on pass. May 2022 - Resident #4 was administered Coumadin tablet 4 mg (Warfarin sodium) 1 tablet at 5 pm from 05/01/22 to 05/04/22, 05/06/22, 05/09/22 to 05/20/22, 05/22/22 to 05/31/22. On 05/07/22, 05/08/22, and 05/21/22 resident was out on pass. June 2022 - Resident #4 was administered Coumadin tablet 4 mg (Warfarin sodium) 1 tablet at 5 pm from 06/01/22 to 06/08/22. Review of Resident #4's PT/INR lab collected at 06/08/22 at 11:30 PM and received on 06/09/22 at 6:42 AM revealed PT was 44.3 and INR was 4.5. DON wrote on lab to hold x 2 days PT/INR tomorrow and next day. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of Pharmacy Consultant recommendations for April and May 2022 reflected no pharmacy recommendations for Resident #4. She was reviewed for medications. Record Review of Resident #4's Pharmacy Consultant recommendation printed 02/01/22 reflected Resident #4 was receiving warfarin 3 mg without routine lab monitoring. Due to potential bleeding problems with INR is above range, please consider a protime lab with INR to be done monthly. This pharmacy recommendation had no physician/prescriber response. Observation and Interview on 06/08/22 at 4:15 PM revealed Resident #4 was sitting in her recliner with no bruising or bleeding. Resident #4 stated she was on Coumadin and had been on coumadin for [AGE] years. She stated she did not have any bruising or bleeding. She denied any bleeding in her gums. She stated in the past she had bruises but currently had no bruising at this time. She stated she bleeds easily. She stated she was not aware the facility had not drawn her PT/INR labs to check her coumadin since March 2022. She stated her physician at previous facility checked her PT/INR lab levels every 2 weeks. She stated she would like her PT/INR labs drawn to check her levels since she took Coumadin medication. Resident #4 stated she had no recent falls. Interview on 06/08/22 at 4:08 PM with Resident # 4's physician (Physician G) revealed Resident #4 should be checked for PT/INR labs once a month since her last INR was stable (2.5) and facility should have a protocol of how often PT/INR labs should be drawn for residents on Coumadin. Resident #4's physician stated the facility should have been redrawn Resident #4's PT/INR monthly after 03/22/22. He stated coumadin medication is the drug which levels fluctuate frequently and resident's eating and other medications she took can affect it. He stated the risk of PT/INR labs not being drawn are that Coumadin levels can go up and go down and it can put you more at risk for bleeding. Interview on 06/08/22 at 4:20 PM with ADON A revealed the facility did not have a standing order or protocol for coumadin and how often PT/INR levels should be checked. She stated at minimum PT/INR levels should be checked at least monthly for Resident #4 and last time it was checked was on 03/22/22. She stated they reviewed physician orders and check physician orders daily. She stated she did not put a specific lab order timeframe for the PT/INR to be checked for Resident #4 and it was up to physician to determine how often it needed to be checked. She stated in the past we had trouble with physician asking for it to be re-checked earlier than the routine lab order so when PT/INR results are given to doctor the nurse needs to find out from doctor when next time it needs to be ran. ADON A stated she was aware that the pharmacy consultant did not review lab orders of PT/INR levels and requirements for Coumadin medication. She stated Resident #26 is the only other resident who was on Coumadin at the facility. Interview on 06/08/22 at 4:30 PM revealed DON and ADON A stated there was not anything in electronic record that would catch if a resident's physician order like the PT/INR lab did not have a specific timeframe on it. ADON A stated Resident #26's physician ordered her PT/INR checks to be done weekly. DON stated Resident #4's PT/INR labs were not being completed since 03/22/22 and should have been done monthly. DON stated they had contacted Resident #4's physician after becoming aware of PT/INR levels not being completed after surveyor intervention to have it drawn tomorrow to check Resident #4's PT/INR levels. DON stated they can contact Resident #4's physician to do the PT/INR order STAT so Resident #4's results will be available in the morning. They were not aware of any facility policy on Coumadin or lab monitoring. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Follow-up interview on 06/09/22 at 9:20 AM with Physician G revealed Resident #4's PT/INR lab was higher and his concern was the INR being at 4.5. He stated he ordered Resident #4's Coumadin 4 mg daily to be held at least for next 2 days and have labs redrawn the next 2 days. Physician G stated Resident #4's Coumadin medication will be held until INR is below 3 and will start her back on a lower dose of Coumadin once it gets below 3. He stated the nurse will contact him with the PT/INR results. He stated residents on Coumadin should have PT/INR checked at least monthly or more often depending on the results. He stated residents on coumadin should be monitored for falls and are at risk for falls, bleeding and skin tears. Physician G stated Resident #4's INR was 2.5 which was in stable range on 03/22/22 and should have been checked monthly. He stated the INR of 4.5 was high which placed Resident #4 at a greater risk of bleeding. Interview on 06/09/22 at 9:30 AM with Pharmacy Consultant revealed monthly she reviewed new physician orders on all residents, reviewed medications to ensure appropriate, checking medication allergies of residents and blood pressure and vitals required for medications. She stated she checked residents' controlled drug documentation including prn controlled drug medications. She stated she reviewed resident psychotropic meds for dosage reduction. She stated she had not checked Resident #4's labs to see if PT/INR labs were completed for resident on coumadin in April or May 2022. She stated PT/INR labs should be checked monthly at least or more often if ordered from physician. She stated PT/INR levels fluctuate could go too low and higher which places residents at risk for bleeding. She stated if she had reviewed Resident #4's clinical record for PT/INR labs and reviewed the lab orders she would have recommended to physician about a timeframe for routine lab orders for PT/INR. She stated she had not reviewed labs for PT/INR lab levels for Resident #4 or any residents on Coumadin medication. She stated she did not have access to resident's labs to review the labs. Interview on 06/09/22 at 1:48 PM revealed DON was not aware of facility's policy for Coumadin and lab order monitoring until today. She did not know the facility had a policy for Coumadin and lab order monitoring. Interview on 06/09/22 at 3:35 PM with Administrator revealed the communication between Physician G and the nurse was not very clear about when next time the PT/INR lab should be drawn for Resident #4. Administrator stated the nurse who reported Resident #4's PT/INR results on 03/23/22 was an agency nurse and should have found out when Physician G wanted the PT/INR labs to be redrawn. He further stated nurse should have put a physician order of next PT/INR lab for Resident #4. He stated he expected his staff to follow the policy on Coumadin and lab monitoring. Review of facility's policy Coumadin dated 02/17/20 reflected the facility was to monitor residents receiving anticoagulant therapy. Under procedure 1. Residents on Coumadin will be monitored for signs and symptoms of bleeding. 2. PT/INR will be checked as ordered by the physician. 3. Licensed Nurse will notify the physician of the PT/INR results and document any new orders. 4. If applicable physician orders will be followed for any diet restrictions. (continued on next page)

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	675066	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility's policy Lab Monitoring dated 03/08/20 reflected the policy was that physician ordered laboratory services will be provided and monitored. Under procedure 1. Lab monitoring requires a physician order. 2. Lab orders will be obtained for all drugs that require therapeutic monitoring. Follow these steps: a. Request an order from the physician for a baseline order b. Request ongoing (therapeutic) lab orders. c. Notify lab of new orders following center's laboratory service procedure. d. Complete a lab requisition: hard copy or enter online depending on lab used. e. Enter orders into clinical software assign and document in progress notes. f. Enter the lab on the lab tracking form at the front of the book to enter lab to be drawn, date drawn, return receipt of the results and the physician notification g. Licensed nurse will continue to document on the lab tracking form until steps of tracking are complete. 3. When physician does not choose to order labs for baseline or therapeutic levels, documentation of same will be noted in the resident's clinical software in the progress notes. 4. All lab results will be reviewed by a nurse. The nurse will date and document the time the result was reviewed or confirm results in the clinical software. 5. Lab results at are within normal limits will be reported to the physician. 6. Critical lab results will be called to the physician or on-call physician immediately. Initial, date and time the lab result. Note if new orders were received. Document same in resident's clinical software progress notes. 7. Abnormal lab results will be sent to the physician. Note any medications the resident is taking that could affect the lab value and note all treatments that have been done (i.e., UA), date and signature of nurse .The following is a list of medications for therapeutic lab tests. Warfarin (coumadin) medication required prothrombin time for frequency of every month for the purpose to monitor therapy range. Review of facility's policy Lab Orders dated 03/08/20 reflected the facility was to provide or obtain laboratory services to meet the needs of its residents. [Facility] is responsible for the timeliness of the services. [Facility] must notify the attending physician of the lab results. Procedure 1. Lab orders will be entered in the clinical software and assigned to the appropriate flow sheet. 2. The Director of Nursing/designee will be responsible to monitor lab orders to ensure that a ordered labs have been drawn as ordered by the physician. 3. Lab personnel will be responsible to report to the charge nurses all labs that have been drawn that day. Charge nurse will be responsible to initial date lab is drawn on the MAR/TAR. The Director of Nursing/designee will be responsible to notify the lab when a lab result is not received in a timely manner. 5. The attending physician will be notified promptly of lab results. 6. Laboratory results will be maintained in the resident's clinical record. Review of Coumadin - FDA prescribing information, side effects and uses from https://www.drugs.com/pro/coumadin.html#content retrieved on 06/09/22 reflected under Coumadin Dosage and Administration the following: The dosage and administration of Coumadin must be individualized for each patient according to the patient's International Normalized Ratio (INR) response to the drug. Adjust the dose based on the patient's INR and the condition being treated. Consult the latest evidence-based clinical practice guidelines regarding the duration and intensity of anticoagulation for the indicated conditions. Recommended Target INR Ranges and Durations for Individual Indications An INR of greater than 4.0 appears to provide no additional therapeutic benefit in most patients and is associated with a higher risk of bleeding. Atrial Fibrillation .In patients with non-valvular AF, anticoagulate with warfarin to target INR of 2.5 (range, 2.0-3.0). The Administrator and DON were notified of the Immediate Jeopardy on 06/09/22 at 1:49 pm due to the above failures and provided the IJ template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility's Plan of Removal for Immediate Jeopardy was accepted and RDCO was notified on 06/10/22 at 2:13 PM. The accepted Plan of Removal for the Immediate Jeopardy included the following: The Texas Department of Health and Human Services Committee (TXHHSC) entered facility for annual survey. During their investigation an IJ (Immediate Jeopardy) was cited in regard to Coumadin Management on 6/9/2022. -Resident(s) found to be affected: Resident #4 Immediate interventions: 6/8/22 1604: Provider was notified that the orders were received 1604: STAT PT/INR ordered 1625: Resident was assessed, found no bruising, bleeding or injury. 1943: DON called facility to check statis of lab draw 2127: DON called facility to check statis of lab draw 2140: DON called facility to check statis of lab draw 2150: DON called facility to check statis of lab draw 2153: Nurse returned DON's call saying the tech has not arrived 2200: CCL called about STAT Lab 2220: Nurse returned DON saying tech has not arrived 2318: Nurse returned DON saying tech has not arrived 2245: Notified Tech on the way o 2346: Phlebotomist at facility for STAT lab- sample acquired Immediate interventions: 6/9/22 0642: Lab results reported to provider with new orders obtained*INR 4.5 Physician G was called. Left a message 0659: Physician G returned the call: gave a new order to hold coumadin for 2 days, repeat PT/INR on 6/10 and 6/11. 0800: Resident assessed for petechiae along with any signs of bleeding or bruising, none noted. Vital signs, stools, urination, weights, ADL, activities are consistent with baseline. Resident is stable, thriving and happy with care. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	0915: Physician G came in to assess resident- unremarkable o 1015: Received new orders from Physician G: PT/INR daily until INR is below 3.0, then start coumadin 3mg by mouth 1 tab daily. Then PT/INR weekly o 1215: Physician completed assessment note and spoke to the survey team. Asked ADON A to contact Resident #4's cardiologist to see if it would be safe to change Coumadin to Eliquis. ADON A called Resident #4's cardiologist but spoke to his nurse. The nurse said that per cardiologist, Resident #4 has a diagnosis of Atrial Fibrillation and that is why she is on Coumadin, but she knew the doctor prefers Eliquis. 1215: RDCO emailed Consultant Pharmacy regarding the pharmacy consultant failing to note the missing PT/INR for Resident #4's Coumadin, o 1604: Cardiologist nurse called back and said he recommends discontinuing coumadin and change to Eliquis. The dosage depends on her kidney function so PCP Physician G will provide the appropriate order. 16:33 RDCO emailed Consultant Pharmacy again asking for an immediate in-service to the consultant on monitoring for labs required for medication management and safety. Then followed up with a call for expediency. A plan was set in motion for the consultant's supervisor to provide an in-service as asked and a different consultant will complete an audit of the facility's medications requiring lab monitoring. PCC log in and lab portal access was provided. Expected to be completed by 6/10/22 3PM 1723: Physician G gave orders to draw CMP for 6/10 and he will decide on the dose once he has received the results. 2030: Pharmacy Consultant received in-service from her supervisor on the requirements of monitoring therapeutic lab values as it relates to Medication management and safety. 6/10/22 Interventions completed 0930: RDCO re-educated the DON/ADON A and Medical Records tech on medication management, and the policy and procedures of Consolidation of Monthly Orders. 0930: RDCO re-educated the DON that she is ultimately responsible for the accurate completion of the Consolidation of Monthly Orders. 0930: RDCO re-educated the DON that she is ultimately responsible for ensuring the pharmacy consultant has reviewed the lab monitoring by reviewing the pharmacy consultant recommendations report. 0930: RDCO re-educated DON/ADON A on monitoring for lab documentation and follow up. -Potential residents to be affected by identified practice: o The facility has reviewed all coumadin orders and has identified one resident who is on coumadin. The resident has received coumadin management in accordance with provider orders. No further action needed at this time. Corrective action implemented so identified practice will not recur with root cause analysis: 5/27/22 a certified letter by overnight carrier notice of contract termination with Central Clinical Labs and Xray services to be complete on July 26, 22. On 6/9/22 RDCO has re-educated the DON/ADON on PT/INR procedures and lab process per the Coumadin management policy. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/9/22 RDCO has re-educated on the STAT lab requirements of 4 hours to draw and 2 hours to result. On 6/9/22 DON has educated the nurses on STAT lab requirements of 4 hours to draw lab and 2 hours to receive results. On 6/9/22 The DON/designee educated all nurses on Policy for Coumadin management. o On 6/9/22 RDCO has re-educated DON/ADON that the nurse on duty at the time of receipt of lab results and STAT lab results is responsible to notify the physician and orders resulting. Then DON/ADON will verify the next morning that those lab results have been processed properly and it will be discussed in IDT. On 6/9/22 DON educated the nurses that the nurse on duty at the time of receipt of lab results and STAT lab results is responsible to notify the physician and orders resulting. On 6/9/22 The DON created a PT/INR binder that contains the policy for reference and the log sheets and educated the nurses on the expectations of completion and follow up. DON/ADON will monitor this binder daily. On 6/9/22 Lab login is posted at the nurse's station o On 6/9/22 A PT/INR flow sheet has been developed to track labs, therapeutic range, and orders- to be managed by DON/designee and place in a binder at the nurse's station. Nurses have been educated by the DON and placed in a binder. On 6/9/22 The Regional Director of Clinical Operations (RDCO) has re-educated the Inter-Disciplinary Team (IDT) to follow-up with orders post-test results of PT/INR, system changes and processes. o Any nurse on vacation or that works PRN or new nurse or agency nurse will receive this reeducation prior to working their next schedule shift. The nurse will demonstrate competency by passing the designated quiz. This re-education will be provided either by DON/ADON and/or other additional designees. o If the staff nurse does not properly demonstrate understanding, they will receive continued education prior to working their shift. On 6/10/22 Pharmacy Regional Director of Clinical Operations has arranged for a consultant to perform a full audit of all medications requiring lab monitoring. On 6/10/22 Pharmacy Regional Director of Clinical Operations will conduct an in service to the current pharmacy consultant who failed to note a missing PT/INR and monitoring therapeutic lab values. On 6/9/22 The physician has been re-educated on carefully reviewing consolidated orders to include needed therapeutic values via phone. Will obtain official signature 6/10/22. On 6/10/22 received the history and physical from the cardiologist that includes the diagnosis of Atrial Fibrillation. He defers to the PCP (Physician G) to decide about ordering Eliquis or not. Tracking and Monitoring: (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and Interview on 06/10/22 at 12:05 PM with Corporate Pharmacy Consultant revealed he was at facility to do a full complete on residents who have medications that require therapeutic lab monitoring and especially residents on anticoagulant medications. He stated going forward the facility's assigned pharmacy consultant would be reviewing these medications which require therapeutic lab monitoring including coumadin, physician orders and the labs on their monthly visits. Record Review of In-service dated 06/08/22 and 06/09/22 Lab process, PT/INR procedure and Coumadin Management revealed MDS Coordinator, LVN B, LVN C, LVN F, LVN H, LVN I, LVN J and RN Weekend Supervisor. Interviews on 06/10/22 from 1:48 PM to 3:03 PM with 5 of 5 LVN (LVN B, LVN C, LVN F, LVN H and LVN I) including facility and agency nurses from all shifts revealed they had been in-serviced on protocol for Coumadin and lab monitoring of PT/INR for residents on Coumadin. All five LVNs were knowledgeable that any residents on Coumadin should be receiving at least monthly or more frequently if ordered by physician. They were in-serviced on when discussing resident 's PT/INR lab results with physician to find out if any changes in dosage, when next the physician wants the PT/INR ordered and to put a lab order along with physician order of PT/INR lab to next be drawn. They were knowledgeable of facility starting a system of lab monitoring including PT/INR binder at nurse's station. Interview on 06/10/22 at 2:36 PM with RN Weekend Supervisor revealed she had been in-serviced on the protocol and facility policy for residents on Coumadin and lab monitoring. She stated residents on Coumadin medication must have a PT/INR ran monthly or more frequently if physician ordered. She stated when they receive PT/INR lab results, they contact physician immediately with PT/INR lab results and put in any new medication changes' physician orders for Coumadin and the lab order for PT/INR monitoring. Record Review of In-service provided by consultant pharmacy group dated 06/09/22 reflected pharmacy consultant was in-serviced on medication monitoring guidelines including warfarin (coumadin) and on monitoring of lab results. She was in-serviced on consultant role of recommending routine labs and follow-up on results) and steps to taken when additional facility follow up needed. Interview on 06/10/22 with 02:34 PM revealed Pharmacy Consultant was in-serviced to look at residents with Coumadin to ensure PT/INR lab orders are being completed and PT/INR physician lab orders have frequency of when PT/INR should be checked. She stated she was provided access to resident labs now and if a resident is missing lab orders find them she will be contacting DON to check on labs. She knew types of medications like Lasix, Digoxin, Depakote and could go over what labs are required of each. She stated PT/INR should be checked at least monthly or more often if physician order states it. She stated when she reviews resident medication each month she will be reviewing medication orders and lab orders to ensure they are being completed. Follow-up interview on 06/10/22 at 5:57 PM revealed Pharmacist Consultant stated the pharmacy recommendations she did monthly went to DON, physician and Administrator. She could not recall the pharmacy recommendation for Resident #4 dated 02/01/22. Record Review of facility's in-services for DON and ADON A by RDCO on 06/09/22: (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-PT/INR - Coumadin process DON/ADON A will do the following: All residents on Coumadin will be entered on the Coumadin flow sheet including PT/INR, Dose and next scheduled lab. Lab PT/INR - will be drawn in accordance with doctor orders. DON/ADON A will also list each resident in the IDT meeting minutes with their drug and next lab draw. IDT will discuss and validate it on flow sheet. DON/ADON A will ensure a note is placed in the medical record when lab results are received, Doctor notified, order changes and next scheduled lab draw was discussed. Policy for Coumadin Management reviewed. - DON/ADON ensure nurses understand they are responsible for processing all lab results STAT or otherwise when they are received to include calling the lab if not received timely, notify physician, any new orders or dose changes. DON/ADON A will validate this process and discuss in IDT meeting. Interview on 06/10/22 at 03:34 PM with ADON A revealed she was in-serviced and was aware of the facility's policy on Coumadin protocol and PT/INR lab monitoring. She stated residents on coumadin medication should have PT/INR lab orders to include when to be checked and/or frequency of lab. She stated she or the DON will review PT/INR lab orders Monday through Friday daily to ensure nurse put in PT/INR order correctly as a physician order and in lab system. She stated they will review any changes to anticoagulant medications and ensure physician order was put in the system. She stated the facility has initiated a PT/INR flowsheet to be located at nurse's station for all residents on Coumadin to include date, their name, last PT/INR results, Coumadin medication order and next PT/INR lab date for order. She stated the nurse who contacts the doctor about the PT/INR results should ask the physician about next PT/INR lab draw and put ph[TRUNCATED]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44212 Based on observation, interview and record review the facility failed to store, prepare and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure sanitary practices were maintained in the kitchen as the dishwashing machine did not have a data plate nor did the food service staff know how to operate the dishwash machine. These failures could place residents who eat from the kitchen at risk for cross-contamination and food-borne illness. Findings included: Observation, interview and record review on 06/07/22 at 9:18 a.m. revealed the Dietary Aide N was running the dishwash machine. The Dietary Aide stated he completed the Dish Machine Log. The Dish Machine Log, dated June, revealed that every temperature recorded was 120 and every ppm was 200. The Dietary Aide stated he was unsure what the number 120 was or how to obtain it but copied it from the previous day's record. The Dietary Aide proceeded to run a cycle of the dishwash machine and it only reached 115 degrees Fahrenheit. The Dietary Aide checked the chlorine level of the dishwash machine, and the test strip revealed 150 ppm instead of the 200 ppm he stated it was supposed to be. The Dietary Aide stated someone told him the dishwash machine ppm was supposed to be 200 but he was not sure who, possibly the dietitian. Interview on 06/07/22 at 9:20 a.m. the Dietary Manager stated the dishwash machine had no data plate. She stated the dishwash machine company representative told them the machine was to reach 120 degrees Fahrenheit but it was only reaching 115 degrees Fahrenheit. She stated she was not sure why it is was not working and needed to have maintenance. The Dietary Manager stated the risk to the residents was bacteria as the dishwash machine was not properly sanitizing. Interview on 06/07/22 at 11:21 a.m. the Administrator stated they turned up the water heater so the dishwash machine was now reaching 120 degrees Fahrenheit. The Administrator stated he spoke to the dishwash machine company representative who stated it was a low temperature dishwash machine so it was to reach 120 degrees Fahrenheit and the chlorine was to be 50-100 ppm. He stated the kitchen was using the incorrect strips that were for quaternary ammonium, but they now had the correct strips for chlorine. The Administrator stated the dishwash machine did not have a data plate as it was a very old machine, but they did have a policy. Interview on 06/08/22 at 2:31 p.m. the Dietary Manager stated she spoke to the dishwash machine company representative who stated they would get the facility a data plate and the machine was to run at a minimum of 120 degrees Fahrenheit and 100-200 ppm chlorine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Dishwashing Machine Use policy, dated 2001, revealed Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. Review of the U.S. Public Health Service, Food Code (2017) section S4-204.113(A)(B) A WAREWASHING machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operation specifications including the: Temperatures required for washing, rinsing, and SANITIZING; Pressure required for the fresh water SANITIZING rinse unless the machine is designed to use only a pumped SANITIZING rinse. [NAME]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to 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 for one (Resident #12) of nine residents observed for infection control. LVN C failed to perform hand hygiene after completing finger stick blood sugars and before donning gloves to draw up and administer Resident's #12 insulin. LVN C failed to sanitize the glucometer after obtaining a blood sample for the fingers stick blood sugar and returning the glucometer to the medication cart. Theses failure could place residents at risk for infection and cross contamination. Findings included: Record review of Resident #12's Face Sheet dated June 2022, reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus without complications and Alzheimer's disease. An observation on 06/07/22 at 11:10 a.m. revealed LVN C at the medication cart preparing to perform Resident #12's fingers stick blood sugar. LVN C removed the glucometer from the medication cart and performed hand hygiene and donned gloves. LVN C placed a test strip in the end of the glucometer, picked up a lancet device and alcohol wipe and entered the resident's room to perform the FSBS. LVN C pricked Resident #12's finger and obtained a blood sample for FSBS. LVN C returned to the medication cart, removed the test strip, and disposed of it and the lancet and placed the glucometer back into the cart without sanitizing it. LVN C removed her gloves and without performing hand hygiene, opened the computer to reveal resident would receive 4 units insulin coverage. LVN C then donned gloves without performing hand hygiene and retrieved the resident' vial of insulin and a syringe and drew up the inulin. LVN C re-entered the resident's room and administered the insulin. LVN C then disposed of the syringe, removed her gloves, and performed hand hygiene. In an interview with LVN C on 06/07/22 at 11:20 a.m. she stated she performs hand hygiene prior to the FSBS and after she completes the Insulin if a resident needs insulin. Then she stated she should have sanitized her hands before and after donning and doffing gloves. She stated she had run out the germicidal wipes to clean the glucometer with and had not taken the time to go and get a new container of wipes. She stated she had wiped the glucometer with an alcohol wipe. She stated by placing the soiled glucometer back in the drawer she had caused potential for cross-contamination of the medication cart. She stated by not sanitizing the glucometer properly she could potentially expose residents to blood borne pathogens. Review of LVN C's personnel file reflected a hire date of 05/30/22. LVN C had completed training on safety and company process. She had not completed a training on infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/08/22 at 01:25 p.m. stated staff were to sanitize their hands any time they change their gloves and when they go from dirty to clean. She stated staff needed to make sure all equipment was cleaned with and appropriate germicidal wipe between patient use especially glucometers. She stated these failures placed residents at risk of the spread of germs and cross contamination. In an Interview with ADON A on 06/08/22 at 1:30 p.m. revealed they had not done skills checks yet on LVN C. She stated they would be in servicing her and the other staff on hand hygiene and proper cleaning of the glucometer today. ADON A stated they had to clean the glucometer with a germicidal wipe, not an alcohol wipe, becasue the alchol wipe was not an approved germicide. Review of, List D: EPA's Registered Antimicrobial Products Effective Against Human HIV-1 and Hepatitis B Virus, dated 12/02/2021, accessed on 06/13/22, at https://www.epa.gov/sites/production/files/2021-02/documents/2021.12.21.list_d.pdf, reflected that isopropyl alcohol was not listed. Record review of the facility's policy titled, Handwashing, dated March 03, 2020, reflected, .The use of glove does not replace proper hand washing .Employees must wash their hands .under the following situations . When hands are visible soiled .before and after performing any invasive procedure (e.g., finger stick blood sampling) .after removing gloves . Review of the facilities undated polity titled, Glucometer Disinfection/Quality control, reflected, .Gather appropriate supplies .Wash hands and apply gloves .Change gloves prior to cleaning machine if they are soiled with blood/body fluids .Use EPA Approved wipe .using wipes, wipe front, back and sides of glucometer .Use EPA approved wipe to thoroughly wet surface per manufacture guidelines .Place the visibly wet glucometer on clean tissue or barrier to air dry .Perform hand hygiene .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44212 Based on interview and record review, the facility failed to maintain antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 1 (Resident #154) of 24 residents reviewed for antibiotics. The facility's infection prevention and control program did not maintain a facility-wide system to monitor the use of antibiotics. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: Review of the undated face sheet for Resident #154 revealed an [AGE] year-old male with an admitted [DATE] and diagnoses to include dementia, urinary tract infection (an infection in any part of the urinary system, the kidneys, bladder, or urethra), anemia (a condition in which the blood doesn't have enough healthy red blood cells), and hypertension (a condition in which the force of the blood against the artery wall is too high). Review of the MDS for Resident #154, dated 05/31/22, revealed a BIMS score of 03 indicating severe cognitive impairment and supervision required for bed mobility, walking, and eating. Dressing, personal hygiene and toilet use required extensive assistance. The MDS also revealed Resident #154 was frequently incontinent of both bowel and bladder. Review of the Care Plan for Resident #154, dated 06/09/22, revealed Resident #154 is on Antibiotic Therapy related to infection (UTI), Takes Amoxicillin prophylaxis, and Antibiotics are non-selective and may result in the eradication of beneficial microorganisms and the emergence of undesired ones, causing secondary infections such as oral thrush, colitis, and vaginitis. Review of the Order Summary Report for Resident #154, dated 05/19/22, revealed, Amoxicillin Tablet 500 MG, give 1 tablet by mouth two times a day for prophylactic use. Review of the undated Medication Administration Record for Resident #154 revealed he received the Amoxicillin tablet 500 mg two times a day related to urinary tract infection from 05/19/22 to 06/09/22. Review of the undated Note to Attending Physician/Prescriber for Resident #154 revealed, Patient is currently receiving Amoxicillin 500 mg po BID for prophylaxis. This order may not decrease risk of infection but will increase risk of resistance. Please add a stop date for this medication. The Physician/Prescriber response had a check mark next to agree with the signature of Physician D dated 05/27/22. Review of the Progress Notes for Resident #154, dated 06/08/22, revealed Physician Assistant E was notified regarding the residents Amoxicillin order and stated to continue the medication. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Infection Surveillance Monthly Report, dated May 2022, revealed Resident #154 was not included. Interview on 06/09/22 at 02:04 p.m. the Regional Director of Clinical Operations stated the McGeer criteria (guidelines used to retrospectively assess antibiotic initiation appropriateness) was built into the facility's EMR and used for antibiotic surveillance. She stated when an antibiotic was prescribed and input in the EMR, it would trigger the McGeer criteria to be completed. Interview on 06/09/22 at 2:21 p.m. the Infection Preventionist (IP) stated this was the first time she was seeing the Antibiotic Stewardship Policy provided by the Regional Director of Clinical Operations. The IP stated the Infection Assessment was how the facility performed antibiotic surveillance. The IP stated an Infection Assessment was not completed for Resident #154 and she was not sure why. She stated when an antibiotic order was put in the EMR, it triggered the Infection Assessment for the McGeer evaluation. The IP stated ADON A put in the antibiotic order for Resident #154, and it should have triggered for her to complete the McGeer evaluation. The Infection Preventionist stated so many things need to be completed to meet the McGeer criteria such as identifying the organism. The Infection Preventionist stated, based on the assessment, Resident #154 did not meet the criteria to receive an antibiotic. Interview on 06/09/22 at 3:19 p.m. ADON A stated she never did the Infection Assessment that triggered on the EMR for any resident because the Infection Preventionist did infection control. ADON A stated she was not sure where the assessment went as she had never filled one out. Review of the facility's Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, dated 02/17/20, revealed All resident antibiotic regimens will be documented on the center-approved antibiotic surveillance tracking form. The information gathered will include: a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic (see approved surveillance list); e. Start date of antibiotic; f. Pathogen identified (see approved surveillance list); g. Site of infection; h. Date of culture; i. Stop date; j. Total days of therapy; k. Outcome; and (continued on next page)

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