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	345226	A. BUILDING _____ B. WING _____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-OUTER BANKS	**430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959**

(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 10/21/20 to 10/23/20, and 10/29/20. 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# 7U1711	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted 10/21/20-10/23/20 and 10/29/20. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Fourteen of the fourteen complaint allegations were unsubstantiated.	F 000		
F 757 SS=E	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	F 757		11/13/20

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

Electronically Signed | 11/12/2020

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F 757	Continued From page 1 consequences which indicate the dose should be reduced or discontinued; or §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, staff interview, nurse practitioner interview, and physician interview the facility treated urinary tract infections and a sinus infection with antibiotics without a clear indication for use for 1 (Resident # 2) of 3 residents reviewed for antibiotic use. Resident #2 was treated with antibiotics 10 times at the facility in 2019-2020 for urinary tract infection and a sinus infection. Findings include: Resident #2 was admitted to the facility on 11/16/17 and had cumulative diagnoses some of which included hypertension, dementia with behavioral disturbance, pseudobulbar effect, dysphagia, Vitamin D deficiency, seizure disorder, and major depressive disorder. Documentation on the quarterly minimum data set (MDS) assessment dated 8/31/20 coded Resident #2 as having memory problems, no mood, or behavior problems. Resident #2 was coded as having no ability to speak, was rarely/never understood and rarely/never understood others. Documentation on the same MDS assessment coded Resident #2 as dependent for activity of daily living care, always incontinent of bowel and bladder, on antibiotics for 5 days of the assessment period, and having urinary tract infections in the last 30 days. Documentation on the care plan revealed	F 757	Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. " Affected Resident: Resident # 2 had no adverse effect or consequences regarding the use of an antibiotic prescribed by the medical provider from October 2019- October 2020. The medication was discontinued and resident is no longer receiving and suffered no adverse effects. " Other residents having the potential: 1. Staff Development Coordinator/Infection Preventionist RN reviewed all residents who had antibiotics ordered from 10/1/2020 through 11/6/2020 which included: proper dose, duration, monitoring and whether or not the resident met McGeer□s Criteria for Infection. Medical Director was notified of any resident receiving antibiotics who did	

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F 757	Continued From page 2 Resident #2 had a focus area, last reviewed or revised on 10/23/20, for dehydration/fluid maintenance. One of the interventions under this focus area was to assess for dehydration such as fever, infection, or electrolyte imbalance. Documentation on the care plan revealed an additional focus area, last reviewed or revised on 9/11/20, for Resident #2 for bladder incontinence. The goal of the bladder incontinence focus area was to minimize risk of skin breakdown and urinary tract infections through the next review. One of the interventions under this focus area was to report signs of urinary tract infections such as acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back pain/flank pain, malaise, foul odor, concentrated urine, and/or blood in urine. A. Documentation in a nursing note for Resident #2 dated 7/24/19 stated, "Blood obtained and awaiting pickup. Labs for urinalysis arrived, [name of on-call physician] notified. [Stated] would like to wait for urine culture before treatment started. Pt (patient) is asymptomatic at this time." Documentation in a nursing note dated 7/25/19 at 3:56 AM revealed Resident #2 was difficult to awaken for medication administration. Documentation in a nursing note dated 7/25/19 at 1:04 PM indicated the RP (responsible party) of Resident #2 was notified of the urinalysis results and Macrobid (antibiotic) was started. Documentation in a progress note by NP #1 dated 7/25/19 under history of present illness	F 757	not meet McGeer Criteria for Infection for further medical evaluation and continued necessity of antibiotic. One antibiotic was discontinued. The Medical Director reviewed all and signed off on current antibiotic orders. No other residents suffered any adverse effects from the alleged deficient practice. " Measures/systemic changes: 1. The current Antibiotic Stewardship Program was reviewed by the Corporate Nurse manager on 11/03/2020 and no changes were necessary. This program had been previously reviewed and revised in December 2019. 2. Staff Development Coordinator/Infection Preventionist RN re-educated Nurse Practitioner #1 with regard to the use of antibiotics. This education included: the facility Antibiotic Stewardship program, McGeer Criteria for Infection, Antibiotic Use Protocols, and Antibiotic Summary form. This education was completed on 11/12/2020. 3. Staff Development Coordinator/Infection Preventionist RN re-educated all licensed nursing staff regarding the facility Antibiotic Stewardship Program on 11/10/2020. " Monitoring performance: 1. An audit tool was developed which included i.e.: proper dose, duration,	

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F 757	Continued From page 3 stated, "Resident seen today for follow-up. She was seen on Tuesday for a change in condition. Labs were drawn at that time. Her urinalysis did come back positive for urinary tract infection with greater than 100,000 colony-forming units of E. Coli. Susceptibility is not yet available. Past medical history reviewed. She remains [with out a fever] with stable vital signs." Documentation under the diagnosis and plan portion of the note indicated a diagnosis of a UTI and Macrobid was prescribed. Documentation in the physician orders revealed an order written by NP #1 for Resident #2 to be administered a Macrobid (antibiotic) 100 mg (milligram) tablet orally twice a day from 7/25/19 to 7/31/19. Documentation on the Medication Administration Record (MAR) revealed Resident #2 was administered the antibiotic Macrobid as ordered from 7/25/19 to 7/31/19. Documentation on an Event Report for suspected infection/antibiotic use, dated as initiated on 7/25/19, revealed Resident #2 had an altered mental status from baseline with clear urine with a positive UA (urinalysis). The documentation stated that the McGeer criteria were not met but antibiotics were initiated. (The McGeer criteria is used for infection surveillance to define infections.) B. Documentation in a progress note by NP #1 dated 8/2/20 revealed Resident #2 was seen for a follow up to a fever on 8/1/20. Documentation under the history of the present illness revealed vital signs were stable, the fever was well controlled, became more alert with administration	F 757	monitoring and the McGeer Criteria for Infection. The SDC/Infection Preventionist and/or designee to conduct audits on 100% of all antibiotics ordered. This audit will be conducted daily, Monday through Friday during clinical meeting for four weeks, twice a week for four weeks then weekly for four weeks. The results of the audits will be discussed with the Medical Director and ordering provider. The results of the audits will determine the need for further monitoring and/or additional practice changes. The process will be ongoing as part of our Antibiotic Stewardship Program. 2. The results of the audits will be brought to QAPI meetings by the Staff Development Coordinator/Infection Preventionist RN for further evaluation and recommendations.	

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of IV (intravenous) fluids, and ate breakfast with her husband. Documentation under the diagnosis portion of the note indicated that the fever was likely caused by a UTI (urinary tract infection) and Rocephin (antibiotic) was started while waiting for the urine culture results.

Documentation in a nursing progress note dated 8/4/20 at 3:36 AM revealed, "Resident is s/p (status post day 3 off Macrobid for a UTI. No adverse reactions noted. Resident had had one injection of Ceftriaxone (Rocephin) IM (intramuscularly) and continues with the injections once daily for a UTI. No adverse reactions noted during this shift."

Documentation in the physician orders revealed an order for Resident #1 to be administered Rocephin 1-gram IM once a day from 8/3/20 to 8/5/20.

Documentation on the MAR revealed Resident #2 was administered Ceftriaxone (Rocephin) on 8/4/19 and 8/5/19 as ordered.

Documentation on an Event Report for suspected infection/antibiotic use, dated as initiated on 8/2/19, revealed Resident #2 had the signs and symptoms of a fever of 101.8 degrees F (Fahrenheit) and lethargy along with a positive UA. A BMP (basic metabolic panel), CBC (complete blood count), UA C&S (urinalysis culture and sensitivity), and chest x-ray was ordered by NP #1. The documentation on the event report stated antibiotics were initiated, chest x-ray was negative, and the McGeer criteria were not met.

C. Documentation in the nursing notes for

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Resident #2 dated 4/28/20 revealed, "[NP #1] rounded on resident, and new order for UA/CS (urinalysis/culture and sensitivity) given due to resident seeming off her normal baseline. RP (responsible party) in agreement."

Documentation in the nursing notes for Resident #2 dated 4/30/20 revealed the UA and C&S was obtained through a sterile catheter with the resident tolerating the procedure well. There was no documentation of new or worsening urgency, fever, increased frequency, suprapubic pain, gross hematuria, flank pain, or shaking chills.

Documentation in the nursing notes for Resident #2 dated 5/4/20 revealed, "UA C&S resulted and noted per [NP #1]. Resident has a UTI per [NP #1] start Macrobid 100 mg (milligrams) x 7 days and probiotics x 7 days."

Documentation in physician orders for Resident #2 revealed an order for administration of Macrobid 100 mg tablet taken by mouth twice a day initiated on 5/4/20 and discontinued 5/5/20 for a urinary tract infection.

Documentation on the MAR revealed Resident #2 was administered 2 doses of Macrobid as ordered on 5/4/20 and another 2 doses on 5/5/20 as ordered.

Documentation on an Event Report dated as initiated on 5/4/20 revealed Resident #2 had altered mental status and a positive urinalysis with clear colored urine. The documentation on the event report stated antibiotics were initiated and the McGeer criteria were not met.

Documentation in the nursing notes dated 5/5/20

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at 11:29 AM for Resident #2 revealed Resident #2 had a temperature of 102.8 degrees (F). The nurse administered Tylenol, a cold cloth to the resident's head, and cold packs to the sides of the resident's arms to help lower her temperature. NP #1 ordered IM (intermuscular) Rocephin (antibiotic) for three days.

Documentation in the physician orders for Resident #2 revealed an order for administration of Ceftriaxone (Rocephin) 1 gram intravenously once a day initiated on 5/5/20 and discontinued on 5/5/20 for a urinary tract infection.

Documentation on the MAR revealed Resident #2 was administered one dose of Ceftriaxone (Rocephin) as ordered on 5/5/20.

Documentation on in a progress note by NP #1 dated 5/5/20 at 4:22 PM revealed in the plan portion of the note that the plan was discussed in detail with the RP (responsible party) to monitor closely, vital signs every shift, 1 gram of Rocephin IM (intramuscularly) for 3 days, continuation of Macrobid 100 mg twice daily, push fluids by mouth, Tylenol when necessary, and notification of physician on call if condition worsened. Documentation in the same progress note also revealed later in the afternoon the resident's overall appearance and vital signs improved.

Documentation in the nursing notes dated 5/5/20 at 8:06 PM revealed Resident #2 continued to have a high temperature and new orders were received to send the resident to the hospital.

D. Documentation in a nursing note dated 5/8/20 revealed Resident #2 returned from the hospital with a new order for Augmentin (antibiotic)

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875-125 mg tablet twice a day for 3 days for treatment of a urinary tract infection.

Documentation in a physician orders revealed an order for administration of Amoxicillin-pot Clavulanate (Augmentin) 875-125 mg tablet twice daily for a urinary tract infection 5/8/20 to 5/10/20.

Documentation on the MAR revealed Resident #2 was administered 5 doses of Amoxicillin-pot Clavulanate (Augmentin) as ordered from 5/8/20 to 5/10/20.

Documentation on an Event Report for an infection control report dated as initiated on 5/8/20 revealed Resident #2 completed antibiotic therapy and the McGeer criteria were not met.

E. Documentation in the nursing notes dated 5/25/20 revealed a CBC and a UA C&S was ordered.

Documentation in the nursing notes dated 5/26/20 revealed the UA C&S was obtained via an in and out catherization with the urine described as clear yellow, with a slight order. There was no documentation of new or worsening urgency, fever, increased frequency, suprapubic pain, gross hematuria, flank pain, or shaking chills.

Documentation in a progress note dated 5/29/20 by NP #1 revealed Resident #2 was seen for a follow up to laboratory results that were ordered on 5/25/20. The documentation in the progress note explained under history of present illness, Resident #2 had been admitted to the hospital from 5/6/20 to 5/8/20 for treatment of Klebsiella UTI/sepsis and discharged on Augmentin. The

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documentation under the plan portion of the note revealed Resident #2 was to be started on Bactrim DS (antibiotic) by mouth twice a day empirically until sensitivity reports became available.

Documentation in the physician orders revealed Resident #2 was ordered to receive Bactrim DS one tablet 800-160 mg orally twice a day from 5/29/20 to 6/1/20.

Documentation on the MAR revealed Resident #2 was administered one dose of Bactrim DS as ordered on 6/1/20.

Documentation in the nursing notes on 6/1/20 revealed Bactrim DS was discontinued for Resident #2 due to an adverse reaction of swollen lips and a red neck. Bactrim was added to the list of the resident's allergies and Rocephin 1-gram IM was to be administered every 12 hours for 10 days.

Documentation in the physician orders revealed an order for Resident #2 be administered Rocephin 1-gram injection twice a day for a urinary tract infection from 6/1/20 to 6/10/20.

Documentation on the MAR revealed Resident #2 was administered 18 doses Cefepime (Rocephin) as ordered from 6/2/20 to 6/10/20.

Documentation on an Event Report for suspected infection/antibiotic use dated 5/29/20 revealed Resident #2 had altered mental status and a positive uranalysis result. The documentation on the event report stated antibiotics were initiated and the McGeer criteria were not met.

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F. Documentation in a nursing note dated 6/13/20 revealed Resident #2 had a seizure witnessed by the nurse, the on-call physician was notified, and laboratory values were ordered, one of which included a UA C&S via a straight catherization.

Documentation in a nursing note dated 6/17/20 revealed the on-call NP was notified of a positive urine culture. The documentation in the note further revealed the on-call NP requested the facility provider address the urine culture results because the resident was asymptomatic.

Documentation in a progress note by NP #1 dated 6/22/20 revealed under the history of the present illness Resident #2 was seen for a follow up to a urinalysis. Documentation under the plan in the note revealed, "Resident asymptomatic, without fever or other overt symptom, and colony count was low, therefore we will repeat UA C&S as this could be containment."

Documentation in the nursing notes on 7/7/20 for Resident #2 revealed a verbal order was given by NP #1 for a repeat UA C&S.

Documentation in a progress note by NP #1 dated 7/10/20 revealed under the history of the present illness Resident #2 was seen for a follow-up to urinalysis, she was asymptomatic and without fever. The documentation revealed the resident was diagnosed with a urinary tract infection and started on Augmentin (antibiotic).

Documentation in the physician orders revealed Resident #2 was ordered to receive Augmentin 500-125 mg 1 tablet by mouth twice a day for a urinary tract infection starting on 7/10/20 and discontinued 7/10/20. Documentation in the

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physician orders revealed a change in the order for Augmentin to 500-125 mg 1 tablet by mouth twice a day for a urinary tract infection starting on 7/11/20 and discontinued on 7/17/20. Documentation in the physician orders changed again stating Resident #2 was ordered to receive Augmentin 875-125 mg one tablet by mouth twice a day with the instructions to give two doses to complete the antibiotic dosing for the urinary tract infection on 7/17/20 to 7/18/20.

Documentation on the MAR revealed Resident #2 was administered one dose of Augmentin 500-125 mg as ordered on 7/10/20.

Documentation on the MAR revealed Resident #2 was administered 12 doses of Augmentin 500-125 mg as ordered from 7/11/20 to 7/16/20.

Documentation on the MAR revealed Resident #2 was administered 2 doses of Augmentin 875-125 mg as ordered on 7/17/20 and 7/18/20.

Documentation in an Event Report initiated on 7/10/20 revealed Resident #2 had no signs or symptoms of a UTI. The documentation stated, "Did not meet (Mc Geer) criteria. No supporting documentation of UTI noted. (Antibiotic) ordered by NP #1."

G. Documentation in a nursing note dated 8/16/20 at 5:24 PM for Resident #2 revealed, "Resident slept [half] way through lunch and slept through dinner. Resident arouses when shaken but falls asleep fast. Did not push feeding dinner due to possibility of aspiration while resident so somnolent."

Documentation in a nursing note dated 8/17/20

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revealed a UA C&S was obtained via a straight catheter per a physician's order. There was no documentation of new or worsening urgency, fever, increased frequency, suprapubic pain, gross hematuria, flank pain, or shaking chills.

Documentation in a progress note by NP #1 dated 8/21/20 for Resident #2 revealed in the history of present illness, "UA, C&S, CBC and BMP were ordered to evaluate a subtle change from baseline. She had not consumed usual amount of dinner x 2 over the weekend. She has profound dementia that renders her unable to express basic needs. Her appetite is usually very stable with 75-100% meal consumption. Per nursing, she has remained afebrile (without fever) with stable [vital signs] and has resumed usual eating pattern, etc." Documentation in the plan portion of the note revealed the nursing staff was ordered to look for the final result of the urine C&S for the final result every shift and notify the on-call provider of results so the results could be addressed further if needed.

Documentation in a follow up progress note by NP #1 dated 8/24/20 stated Resident #2 was suspected to have a UTI. Documentation in the plan portion of the note revealed, "Husband aware threshold for aggressive [antibiotic therapy] low in this resident as she has been hospitalized for urosepsis this year."

Documentation in the physician orders for Resident #2 revealed an order for Cefepime (antibiotic) 1 gram administered intravenously twice a day for a urinary tract infection initiated on 8/24/20 and discontinued on 8/25/20.

Documentation on the MAR revealed Resident #2

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was not administered Cefepime on 8/24/20.

Documentation in the physician orders for Resident #2 revealed an order for Macrobid 100 mg capsule to be given by mouth for a urinary tract infection initiated on 8/24/20 and discontinued on 8/24/20.

Documentation in the physician orders for Resident #2 revealed an order for Macrobid 100 mg for one capsule to be given twice a day was initiated on 8/24/20 and discontinued on 8/25/20 with the special instructions to stop Macrobid and initiate Cefepime when it arrived from Medipack (pharmacy).

Documentation on the MAR revealed Resident #2 was administered 2 doses of Macrobid as ordered on 8/24/20.

Documentation in the physician orders for Resident #2 revealed an order for Cefepime 1 gram administered intravenously twice a day for a urinary tract infection initiated on 8/25/20 and discontinued on 8/25/20.

Documentation on the MAR revealed Resident #2 was administered 1 dose of Cefepime on 8/25/20 at 6:00 AM but was in the hospital for the next scheduled dose at 6:00 PM.

Documentation on an Event Report dated as initiated on 8/24/20 revealed Resident #2 had altered mental status, decreased appetite and was started on Macrobid twice a day until Cefepime IV arrived from the pharmacy. Documentation in the evaluation notes stated, "Resident had [Altered Mental Status], did not have greater than 100,000 cf/u (colony forming

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unit). Ordered by [NP #1]. No leukocytes noted. Resident had fever x 1. Resident did not meet criteria. No increased incontinence, urgency, or frequency noted." The documentation on the event report stated antibiotics were initiated and the McGeer criteria were not met.

H. Documentation in the nursing notes on 8/25/20 beginning at 12:56 PM revealed Resident #2 went to the dentist and returned lethargic with a temperature of 101.8 degrees F. Tylenol and IV (intravenous) hydration was administered. At 2:53 PM the resident's temperature was 98 degrees F. At 3:40 PM NP #1 and the responsible party for Resident #2 agreed to send Resident #2 to the emergency room for evaluation.

Documentation in a nursing note on 8/26/20 at 6:05 PM stated, "Report received from [hospital] stating that resident will be returning to the facility tonight. [Diagnosis] of UTI, mild dehydration."

Documentation in physician orders for Resident #2 revealed an order for Cefepime 1 gram to be administered intravenously with 100 ml (milliliters) normal saline over 60 minutes every 12 hours from 8/27/20 to 9/1/20 for a urinary tract infection.

Documentation on the MAR revealed Resident #2 was administered 10 doses of Cefepime as ordered from 8/27/20 to 8/31/20.

Documentation in a regulatory progress note by the Medical Director dated 9/9/20 stated that Resident #2 was sent to the emergency room on 8/25/20, treated with Cefepime and IV hydration with good results. The documentation also revealed a head CT (x-ray of the head) was performed in the hospital indicating the resident

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had a chronic sinus infection fungal in nature, a specialist consulted, and no further treatment was warranted at that time. The Medical Director stated in the plan portion of the progress note under recurrent urinary tract infections, "May consider prophylactic antibiotic regimen if increased frequency of recurrence."

I. Documentation in the nursing notes on 9/12/20 at 7:10 PM revealed Resident #2 slept through dinner, was difficult to arouse, appeared pale, had a temperature of 102 degrees F, and was transferred to the emergency room.

Documentation in the nursing notes on 9/12/20 at 10:30 PM revealed Resident #2 returned from the hospital after receiving medication for seizures.

Documentation in the nursing notes on 9/15/20 at 3:15 PM revealed Resident #2 had emesis of 100 ml (milliliters) of undigested food.

Documentation in the nursing notes on 9/15/20 at 5:24 PM revealed Resident #2 was pale, had a distorted face, and was difficult to wake up. Resident #2 was sent to the hospital.

Documentation in the nursing notes on 9/16/20 at 3:23 AM revealed Resident #2 returned from the hospital with a diagnosis of a UTI.

Documentation in the nursing notes on 9/16/20 at 12:30 PM revealed, "[RP] called with concerns about resident going out to hospital. Reviewed ER reports with him. Spoke to [Medical Director] about ER notes and tests. Informed [RP] that [Medical Director] wanted to stop Cefuroxime (antibiotic) because the results didn't show a UTI. CT showed questionable sinus infection per

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[Medical Director]. Orders received for Augmentin 875/125 mg daily x 7 days and Probiotic x 7 days. [RP] notified about treatment plan."

Documentation in the physician orders revealed an order for administration of Cefuroxime Axetil 500 mg tablet given by mouth twice a day for a urinary tract infection initiated on 9/16/20 and discontinued on 9/16/20.

Documentation on the MAR revealed Resident #2 was administered one dose of Cefuroxime Axetil 500 mg tablet on 9/16/20.

Documentation in the physician orders revealed an order for administration of Augmentin 875-125 mg tablet given once a day for acute sinusitis initiated on 9/17/20 and discontinued on 9/17/20.

Documentation on the MAR revealed Resident #2 was administered one dose of Augmentin as ordered on 9/17/20.

Documentation in a follow up progress note by NP # 1 dated 9/17/20 stated in part under history of present illness, "[Resident #2] was apparently seen at the ER again on 9/15, dx with a UTI, given Rocephin dose in ER 1G IV and returned to the facility with Ceftin orders. [Medical Director] in house yesterday and was given records - specifically UA results - to review and she discontinued that [antibiotic] as labs did not support UTI [diagnosis] at [that time] or warranted [antibiotics] [treatment] at that time. She subsequently started her on Augmentin for a possible sinus infection noted on CT during last in-patient hospitalization - Unfortunately she has been experiencing [nausea/vomiting/diarrhea] for which she is being evaluated today for."

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Documentation under the assessment portion of the progress note revealed a diagnosis of diarrhea suspected related to antibiotic therapy with the discontinuation of the drug Augmentin. Documentation under the plan portion of the progress note revealed in part, "Due to the resident's adverse [symptoms] from Augmentin most likely to include [nausea/vomiting/diarrhea], and considering sinus issue likely chronic and not likely to cause systemic issues, and appears it may actually be fungal in nature, medical director, myself and RP all in agreement to [discontinue] Augmentin at this time."

Documentation on the Event Report for antibiotic use dated as initiated on 9/16/20 revealed under the evaluation notes, "Resident (#2) sent out for paleness, difficult to arouse, resident returned back to the facility with dx (diagnosis) of UTI and CT results stated sinus infection. Resident does not meet criteria. [Medical Director] ordered [antibiotic] for sinus infection." The Event report indicated antibiotics were initiated and the

J. Documentation in a nursing note dated 10/17/20 revealed nursing was unable to keep Resident #2 awake long enough to feed her dinner. There was no documentation of a fever, new or worsening urgency, increased frequency, suprapubic pain, gross hematuria, flank pain, or shaking chills.

Documentation in a nursing note dated 10/19/20 revealed NP #1 was into see Resident #2 and a UA C&S, CBC, and BMP were ordered.

Documentation in the physician orders for Resident #2 revealed an order for administration of Ceftriaxone (antibiotic) 1-gram injection once a

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morning from 10/22/20 to 10/29/20.

Documentation on the MAR revealed Resident #2 was administered two doses Ceftriaxone as ordered on 10/22/20 and 10/23/20. The MAR reflected that the physician's order for Ceftriaxone was discontinued on 10/23/20.

Documentation on an Event Report dated as initiated on 10/22/20 revealed the resident had altered mental status, a positive UA. The Report had not been completed yet and the event was still open. The infection control preventionist (ICP) was interviewed on 10/22/20 at 4:00 PM. The ICP nurse revealed that the facility policy for infection control antibiotic stewardship was to follow the McGeer criteria for administration of antibiotics. ICP nurse stated that each time an antibiotic was prescribed for a resident the facility completed an Event Report for a suspected infection/antibiotic use. The ICP nurse explained that the Event Report for suspected infection/antibiotic use required three or more of the symptoms of the UTI (urinary tract infection) without a catheter in order to meet the criteria for antibiotic use. The ICP nurse provided the facility policy entitled, "Revised McGeer criteria for infection surveillance checklist" dated 11/28/17. The ICP nurse explained that on Table 1 of the criteria for infection the resident must have fever, leukocytosis, acute mental status change, and acute functional decline. The ICP nurse explained that on Table 2 of the McGeer criteria the urinary tract infection surveillance definitions listed the criteria for the treatment of a UTI without an indwelling catheter. The ICP nurse revealed that the facility had the expectation that NP (Nurse Practitioner) #1 and the Medical Director follow these criteria listed on the facility policy. The ICP

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nurse provided documentation of antibiotic stewardship and the McGeer criteria training provided to the NP #1 and the Medical Director on 7/28/20. The ICP nurse indicated that many elderly female residents in long term care have a positive urinalysis without any symptoms of a UTI, therefore not requiring antibiotic therapy.

Nurse #1 was interviewed on 10/22/20 at 12:26 PM. Nurse #1 stated Resident #2 had a history of UTIs. Nurse #1 stated the facility treated the urinary tract infections very aggressively with antibiotics and IV hydration because the resident declined rapidly when she had a UTI. Nurse #1 stated Resident #2 usually ate and drank 100% of what was given to her and the nurse aides would report to her if Resident #2 was not eating or drinking. Nurse #1 did not know why Resident #2 had frequent UTIs, stating that it could be her immobility or a decline in overall health.

NP #1 was interviewed on 10/23/20 at 12:46 PM. NP #1 stated that Resident #2 had been her patient for 2 years and Resident #2 had a very involved RP (responsible party). NP #1 stated that Resident #2 has subtle changes and she decompensates quickly. NP #1 stated she was able to notice these subtle changes in her condition and when she talked to the RP it was always agreed upon to do a urinalysis. NP #1 further added that Resident #2 was treated with antibiotics and she always improved. NP #1 explained that Resident #2 could not met the McGeer criteria because she was verbally unable to say she had a feeling of urgency, suprapubic pain, or increased incontinence. NP #1 explained that as a clinician she had to go by the body language and the clinical signs of a UTI, reiterating that Resident #2 always improved with

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antibiotic treatment. NP #1 stated that the use of antibiotics without the use of the McGeer criteria for Resident #2 was justified due to her dementia and nonverbal status. NP #1 stated that since Resident #2 could not vocalize how she was feeling, and if the facility waited to meet the McGeer criteria such as a fever along with not eating and lethargy, it would mean Resident #2 would be sent out to the hospital. NP #1 indicated that sending the Resident to the hospital was something both she and the RP would like to avoid. NP #1 revealed that on 10/22/20 she started Rocephin right away because the longer the length of time she waited to start the antibiotics the greater the chance Resident #2 will get a fever and be subsequently sent to the hospital. NP #1 indicated that a hospital admission was distressing for Resident #2 as a resident with dementia. NP #1 stated she would change the antibiotic once she has the culture and sensitivity results. Np #1 noted that hospitalization of Resident #2 in May 2020 with urosepsis was the first hospitalization the resident had in the two years she had been a provider at the facility.

The facility Director of Nursing (DON) was interviewed on 10/23/20 at 3:22 PM. The DON indicated that it was a fine line between to treating Resident #2 with an antibiotic and waiting for more symptoms to appear. The DON stated she understood the concerns of NP #1 and the RP in wanting to treat the UTI before the resident decompensated quickly.

The facility Administrator was interviewed on 10/23/20 at 12:04 PM. The Administrator stated that Resident #2 ate and drank everything offered to her. The Administrator stated that the

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increased sleepiness of Resident #2 could be normal aging or dementia. The Administrator stated that the facility did have an antibiotic stewardship program but that attempts were being made to appease the family of Resident #2 despite her asymptomatic UTIs.

The facility Medical Director was interviewed on 10/23/20 at 3:37 PM. The facility Medical Director stated that she had discussed the use of antibiotics to treat asymptomatic UTIs for Resident #2 with NP #1. The Medical Director stated she trusted the judgement of NP #1 and she agreed Resident #2 would have a hard time meeting the McGeer criteria for antibiotic use due to the resident's cognition. The Medical Director agreed with the use of antibiotics for Resident #2 to help prevent urosepsis and a hospitalization. The Medical Director confirmed she thought NP #1 was treating Resident #2 appropriately with antibiotics despite not meeting the McGeer criteria.