STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155342	A. BUILDING 00 B. WING	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MOUNT VERNON NURSING AND REHABILITATION	1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 30, 31, August 1, 2, 5, 6, 2024 Facility number: 000234 Provider number: 155342 AIM number: 100273490 Census Bed Type: SNF/NF: 61 Total: 61 Census Payor Type: Medicare: 4 Medicaid: 31 Other: 26 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 14, 2024.	F 0000	This plan of correction serves as the facilty Credible Allegation of Compliance. The facility requests to submit written documentation to substantiate compliance in place of an onsite visit.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on interview and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 2 of 6 days during the annual survey period. (8/1/24, 8/2/24) Finding includes: On 8/1/24 at 8:05 A.M., a posted staffing sheet	F 0732	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. The resident census information is posted each day by the scheduler and is accurate. 2. How will you identify other	09/12/2024

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

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	was observed sitting on the receptionist desk. The sheet included, but was not limited to: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Aide). Total number of RN, LPN, and CNA for each shift. Total hours of RN, LPN, and CNA for each shift. The form indicated that 4.5 CNAs worked the evening shift (2:00 P.M. to 10:00 P.M.) but did not specify which half of the shift worked. On 8/2/24 at 8:10 A.M., a posted staffing sheet was observed sitting on the receptionist desk. The sheet included but was not limited to: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Aide). Total number of RN, LPN, and CNA for each shift. Total hours of RN, LPN, and CNA for each shift. The form indicated that 5.5 CNAs worked the evening shift (2:00 P.M. to 10:00 P.M.) but did not specify which half of the shift the CNA worked. During an interview on 8/02/24 at 9:19 A.M., the scheduler indicated she was not aware 1/2 shift coverage hours should have been listed on the posted staffing forms. On 8/2/24 at 11:45 A.M., the Administrator provided a current Posted Nurse Staffing Data policy, dated 7/2019 that indicated "...the purpose was to allow public access to posted nursing staffing data per federal regulations...the total hours should be broken by total hours worked by RN, LPN, and CNA...the Posted Nurse Staffing form should also reflect staff absences on each shift due to call-offs and the Total Hours adjusted accordingly..."		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Scheduler will be in-serviced by DNS/designee on the accurancy of the posted nursing staff information. Daily staffing hours are reviewed and will be updated as needed by DNS/designee. 3. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? Daily observational rounds will be completed by ED/designee to ensure posted staffing information is updated and accurate. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The ED/designee will completed posted staffing QA tool weekly x4 weeks, monthly x6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for 4 of 4 medication carts observed and 2 of 2 treatment carts.(Plaza Cart 101-113, Plaza cart 114-140, Cottage Short Hall, Cottage Long Hall, Plaza Treatment Cart, Cottage Treatment Cart) Findings include: On 7/30/24 at 10:03 A.M., the following was observed in the Plaza medication cart (for rooms 101-113): 3 jars of CBD (Cannabidiol) with Resident 26's name handwritten on it with no other label 1 package of donuts and a drink with no labels. At that time, QMA (Qualified Medicine Aide) 23 indicated they belonged to him. On 7/30/24 at 10:15 A.M., the following loose pill was observed in the Plaza medication cart (for rooms 114-140): 1 white oblong pill with marking "ML8" On 7/30/24 at 10:30 A.M., the following loose pills were observed in the Cottage Short Hall medication cart: 1/2 round orange pill 1 white oblong pill with marking "ATV 20" On 7/30/24 at 10:40 A.M., the following was observed in the Cottage Long Hall medication cart: 2 daily medication containers with several loose pills that had no name, labels, or identifiers. At that time, QMA 7 indicated the containers belonged to Resident 29 and staff administered	F 0761	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #26 and Resident #29 medications are being stored appropriately. The CBD was destroyed and the donuts and drink were removed from the cart. Loose pills were destroyed. Medications for resident #29 which had inappropriate labeling were destroyed. The following meds from the cottage were destroyed: antifungal cream, skin therapy tube, deodorant, and a tube of lotion. From the plaza the following medications were destroyed: antifungal powder and traimcinolone cream. 2. How will you identify other residents having the potiential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potiential to be affected by the alleged deficient practice. Medication and treatment carts were audited by DNS/designee to ensure all medications are stored and labeled with open dates per policy. Nurses and QMAs will be in-serviced by the CEN/designee on medication storage and labeling.	09/12/2024

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	medications to the resident from the containers. On 7/31/23 at 7:40 A.M., the treatment cart for Cottage Unit was observed to have the following: 1 tube of antifungal with no label 1 opened tube of Skin Therapy with no label 3 cans of opened deodorant with no labels 1 tube of (name of lotion) with no label On 7/31/24 at 7:58 A.M., the treatment cart on the Plaza Unit was observed to have the following: 1 tube of Triamcinolone cream (Steroid Cream) with no label 1 bottle of antifungal powder with no label During an interview on 7/30/24 at 10:08 A.M., QMA 24 indicated there should be no loose pills or food in the medication carts. During an interview on 7/30/24 at 10:42 A.M., QMA 7 indicated they were unaware that the containers for Resident 29 were not labeled. During an interview on 7/31/24 at 7:45 A.M., LPN (Licensed Practical Nurse) 15 indicated resident names should be on the bottles in the treatment cart, and shaving cream and deodorant should not be in the treatment cart. During an interview on 7/30/24 at 11:10 A.M., the DON (Director of Nursing) indicated Resident 29 was on VA (Veteran Affairs) Respite and would be reimbursed by the VA for medications. She indicated Resident 29's son brought the medications in the containers and did not leave the bottles but that staff had compared the bottles with the orders. At that time, she indicated there should have been a label on the containers. 3.1-25(b)(4)		3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Daily audit to be completed of medication and treatment carts to ensure appropriate storage and open dates are being used. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The DNS/designee will complete medication storage QA tool weekly x4 weeks, monthly x6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action.	

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F 0880 SS=E Bldg. 00	3.1-25(j) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Resident use equipment was not cleaned for 2 of 2 random observations of vitals during medication administration, staff did not change gloves during resident care for 3 of 5 residents observed for care, and failed to track all infections for 10 of 10 residents reviewed for infections. (Resident 49, Resident 33, Resident 22, Resident 18, Resident 53, Resident 42, Resident 25, Resident 161, Resident 15, Resident 36, Resident 12, Resident 53, Resident 5, Resident 51, Resident 2, Resident 7)) Findings include: 1. On 7/30/24 at 10:30 A.M. during a medication pass, QMA (Qualified Medication Aide) 23 was observed to take Resident 49's blood pressure, then take Resident 33's blood pressure with the same cuff. The blood pressure cuff was not sanitized prior to or after either resident. 2. On 8/2/24 at 10:04 A.M., CNA (Certified Nurse Aide) 6 and CNA 14 were observed performing incontinence care for Resident 22. Neither CNA washed their hands prior to putting on gloves to start the care. CNA 16 removed the resident's visibly soiled shirt, placed it in the dirty linen, placed a clean shirt on the resident, then assisted the resident into a sit to stand sling without changing gloves. The CNAs raised the lift, and removed the soiled brief. Both CNAs removed	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #49, #33, #22, #18, #53, #42, #25, #161, #15, #36, #12, #53, #5, #51, #2, and #7 were assessed with no ill effects noted related to alleged deficient practice. C.N.A. #6, #9, #14, #16, and QMA #23 will be educated on infection control practices including hand hygiene and shared equipment cleaning policies. Residents with infections are being tracked, logged and placed on facility map appropriately per policy including resident #25 UTI, resident #161 UTI, resident #15 UTI, resident #36 pneumonia, resident #12 upper respiratory infection, resident #53 pneumonia, resident #5 UTI, resident #2 cellulitis/rash, resident #7 infected wound on toe. Blood pressure cuff is now sanitized between each use. The sit-to-stand lift is now sanitized after each use. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	09/12/2024

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	their gloves and put on clean gloves without hand hygiene in between, and a clean brief was placed on the resident. Resident 22 was then transferred to a wheelchair, and both CNAs removed their gloves. The sit to stand lift was not cleaned after use. CNA 14 then washed hands for 30 seconds with soap and water, and CNA 16 washed hands for 9 seconds with soap and water. 3. On 8/5/24 at 9:12 A.M., CNA (Certified Nurse Aide) 16 and CNA 9 entered Resident 53's room and CNA 16 shut the door. CNA 9 used hand sanitizer and rubbed her hands together for three seconds, and CNA 16 got hand sanitizer and rubbed her hands together for six seconds. CNA 9 pulled the privacy curtain, put gloves on, used the bed remote to lay the resident in a flat position; CNA 16 put gloves on, pulled the resident's blankets back and moved the pillows at the head of bed while CNA 9 began to remove the resident's brief. CNA 16 began wiping the front of the resident with wipes, then rolled the resident on her right side facing CNA 9. CNA 16 then removed the soiled brief out from under the resident and used wipes to clean the resident's bowel movement. CNA 16 put a new brief under the resident, removed her gloves and used hand sanitizer for five seconds and put on new gloves. CNA 9 handed CNA 16 barrier cream and CNA 16 put barrier cream on the resident's bottom. CNA 9 assisted the resident in rolling back to her back and fastened her brief. CNA 16 removed her gloves and rubbed hand sanitizer on her hands for four seconds. CNA 16 and CNA 9 grabbed the residents bedsheets and pulled the resident up in bed. CNA 9 removed her gloves and rubbed hand sanitizer on her hands for five seconds.4. On 8/2/24 at 10:29 A.M., Certified Nurse Aide (CNA) 14 and CNA 16 were observed performing peri care for Resident 18. CNA 14 put on gloves, hooked Resident 18's lift pad onto the lift, raised		All residents have the potential to be affected by the alleged deficient practice. Nursing staff will be educated by Infection Preventionist (IP)/designee on infection control practices regarding hand hygiene and shared equipment cleaning. IP will be educated by DNS/designee on policy for tracking infections and placing on facility map. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Daily rounding observaitons will be completed regarding hand hygience practices and shared equipment cleaning. DNS/designee will complete daily audit of infection control events and ensure these are moved to tracking log and map per facility policy. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The DNS/designee will complete infection control QA tool weekly x4 weeks, monthly x6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary	

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	up the bed, moved Resident 18 to the bed using the lift, unhooked the pad, pulled down Resident 18's pants, and undid the resident's brief. Without changing gloves, CNA 14 wiped Resident 18's front pubic area by wiping front to back three times using the same wipe. The resident was rolled onto her side and CNA 14 wiped bowel movement off Resident 18's buttocks using 3 wipes. The brief was bundled up and thrown away. Without changing gloves, CNA 14 put a new brief under Resident 18. CNA 14 changed gloves, fastened the new brief, and pulled up Resident 18's pants. At that time, the open wipes contained fell on the floor with a clean wipe sticking out of the container and touching the floor. CNA 14 picked up the wipes and put the exposed wipe that had been touching the floor back into the container and closed the lid. CNA 14 removed her gloves. CNA 14 indicated she needed to go get a new battery for the lift. CNA 14 left the room and went to the closet where the list batteries were stored. CNA 14 was not observed to perform hand hygiene. During an interview on 7/31/24 at 8:05 A.M., the Infection Preventionist indicated the equipment should be cleaned in between residents and as needed. During an interview on 8/5/24 at 9:23 A.M. CNA 9 indicated she would use hand sanitizer instead of washing her hands unless a resident was on transmission based precautions. CNA 16 indicated while performing care she should change gloves between clean and dirty tasks. During an interview on 8/2/24 at 10:32 A.M., IP indicated staff were expected to wash their hands for at least 30 seconds. Hands were supposed to be sanitized/washed when going from dirty to		action.	

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	clean tasks. The IP also indicated any wipes that were exposed to the floor should be disposed of. 5. On 8/6/24 at 11:00 A.M., the infection control program's resident infection tracking was reviewed for the months of May 2024, June 2024, and July 2024. At that time, the Infection Preventionist (IP) indicated tracking of infections was completed by reviewing the infection events from the resident's clinical records, and then placed on a map for that month with colors that indicated what type of infection the resident had. The infection event forms as well as the tracking map were completed by month. Review of all infections included, but was not limited to, the following: May 2024 Resident 42's infection event indicated a Urinary Tract Infection (UTI) on 5/10/24. This was not tracked on the facility tracking map. Resident 25's infection event indicated a UTI on 5/6/24. This was not tracked on the facility tracking map. June 2024 Resident 161's infection event indicated a UTI on 6/12/24. This was not tracked on the facility tracking map. Resident 15's infection event indicated a UTI on 6/16/24. This was not tracked on the facility tracking map. Resident 15's infection event indicated cellulitis on 6/2/24. This was not tracked on the facility tracking map. July 2024 Resident 36's infection event indicated pneumonia on 7/31/24. This was not tracked on the facility			

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	tracking map. Resident 12's infection event indicated an upper respiratory infection on 7/17/24. This was not tracked on the facility tracking map. Resident 53's infection event indicated pneumonia on 7/31/24. This was not tracked on the facility tracking map. Resident 5's infection event indicated a UTI on 7/13/24. This was not tracked on the facility tracking map. Resident 51's infection event indicated a UTI on 7/23/24. This was not tracked on the facility tracking map. Resident 2's infection event indicated cellulitis/rash that was treated with an antibiotic on 7/30/24. This was not tracked on the facility tracking map. Resident 7's infection event indicated an infection wound on the toe on 7/18/24. This was not tracked on the facility tracking map. During an interview on 8/1/24 at 1:11 P.M., the IP indicated infections were only tracked on the facility tracking map if McGeer's criteria was met. All others were placed on a monthly facility infection surveillance summary report. The McGeer's criteria is a set of surveillance definitions used to identity healthcare-associated infections (HAIs) in long-term care facilities. The criteria are specific to the nursing home population and can be useful for assessing whether antibiotic therapy is appropriate. However, more diagnostic information, such as			

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	positive laboratory tests, is often required to meet the criteria for a definitive infection. On 8/6/24 at 10:59 A.M., the Director of Nursing (DON) indicated infections were tracked by reviewing the printed report of infection events, as well as the facility tracking map. At that time, she could not indicate which infection events were active infections, and which were not based on the information printed on the forms. She indicated only those infection events that met McGeer's criteria were listed on the tracking maps, regardless if it was an active infection or not, and not all active infections were indicated on them. On 7/30/24 at 10:00 A.M., the Administrator provided a current Infection Prevention System for Surveillance policy, revised 5/2023 that indicated "...the facility shall have a system of surveillance to identify possible communicable diseases or infections before they can spread...monitoring is provided as ongoing tracking to rule out an infection, the development of new/recurrent infections and / or the spread of infections by surveillance log and facility map..." On 8/1/24 at 10:30 A.M., the DON (Director of Nursing) provided a current Standard and Transmission- Based Precautions (Isolation) policy, revised 4/24/24 that indicated "...always assume that every resident is potentially infected or colonized with an organism that could be transmitted in the healthcare setting...shared equipment should be cleaned and disinfected in-between each resident use" On 8/1/24 at 10:30 A.M., the DON provided a current Hand Hygiene policy, revised 12/2021 that indicated "...healthcare personnel should use an alcohol-based hand rub or wash with soap and			

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	water for the following clinical indications: Immediately before touching a resident...Before moving from work on a soiled body site to a clean body on the same resident, After touching a resident or the resident's immediate environment, After contact with blood, body fluids, or contaminated surfaces, immediately after glove or PPE (Personal Protection Equipment)..." 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(l)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program Based on interview and record review, the facility failed to ensure residents who required an antibiotic were prescribed the appropriate antibiotic for 2 of 3 residents reviewed for UTI (urinary tract infection). (Resident 43, Resident 30) Findings include: 1. On 7/30/24 at 12:21 P.M., Resident 43's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/23/24, indicated no cognitive impairment, occasional incontinence of the bladder, and no UTIs in the last 30 days. Physician orders included, but were not limited to: ceftriaxone (an antibiotic) injection, 1 gram, ordered on 7/17/24. Resident 43's MAR (Medication Administration Record) for July 2024 indicated ceftriaxone 1 gram was given on 7/17/24 at 8:00 P.M.	F 0881	It is the policy of this facility to establish an infection prevention and control program, including using protocols for antibiotic stewardship to ensure that residents do not receive antibiotics without indications. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #43 and #30 were assessed for any ill effects related to alleged deficient practice with no concerns noted. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents being treated with antibiotics have potential to be affected by the alleged deficient practice.	09/12/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MOUNT VERNON NURSING AND REHABILITATION	1415 COUNTRY CLUB RD MOUNT VERNON, IN 47620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A progress note, dated 7/17/24 at 3:01 P.M., indicated "Resident report burning upon urination. New orders from MD, UA [urinalysis], CBC [complete blood count], BMP [basic metabolic panel], Rocephin [ceftriaxone] 1 gm [gram] x1 dose IM [intramuscular] ..." The clinical record lacked an Infection Event for the UTI. On 8/2/24 at 12:40 P.M., the Director of Nursing (DON) indicated Resident 43 did have a UTI on 7/17/24, and the physician treated the resident without the lab results based on a symptom of burning with urination. 2. On 8/1/24 at 11:11 A.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, chronic kidney disease stage 3, and polyneuropathy. The most current Annual Minimum Data Set (MDS) Assessment, dated 6/7/24, indicated Resident 30 had severe cognitive impairment, required substantial assistance from staff (staff does more than half) for toileting, did not receive antibiotics during the 7-day lookback period, and did not have a UTI (urinary tract infection). Physician orders included, but were not limited to: ceftriaxone (generic form of Rocephin) 1 g - Give 1 g IM x 2 doses every 24 Hours, dated 7/14/24 and completed on 7/15/24. An Infection/Antibiotics Surveillance report, dated 7/12/24, indicated Resident 30 had a UTI confirmed by a culture and sensitivity test that revealed Escherichia Coli (a bacteria) was in the urine. Rocephin (an antibiotic) 1 gram (g) intramuscularly (IM) every 24 hours for 2 days		IP will be educated by the DNS/designee regarding antibiotic stewardship policy, reviewing cultures to ensure appropriate antibiotic use and communicating with providers to ensure antibiotics are used appropriately. IP/designee will educate nurses on completion of infection events at first sign of infection. 3. What measures will be put into place to ensure this practice does not recur? DNS/designee will review new infection events, facility action report for signs and symptoms of infection and new antibiotic orders daily to ensure appropriate documentation is completed, cultures are reviewed and appropriate communication is given to providers when ordering antibiotics. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? IP/designee will bring completed infection control and antibiotic stewardship committee minutes to QAPI meetings to be reviewed by the committee. The committee overseen by the ED will verify expected and necessary processes have occurred. These will be presented at each QAPI meeting. If threshold of 100% compliance is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action.	

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	was ordered. A lab report, dated 7/14/24 and signed by the Nurse Practitioner (NP), indicated Resident 30 had E. coli in her urine. The lab report indicated E. coli was resistant to ceftriaxone. On 8/2/24 at 11:00 A.M., the Director of Nursing (DON) indicated the lab report dated 7/14/24 indicated E. coli was resistant to ceftriaxone. She indicated antibiotic use was reviewed monthly during QAPI (quality assurance and performance improvement) meetings and the Infection Preventionist (IP) reviewed newly prescribed antibiotics daily. On 8/2/24 at 11:03 A.M., the IP indicated that she reviewed culture and sensitivity reports daily, and the prescribing physician reviewed them as well. She indicated she would call the physician if the infection did not meet McGeer's criteria or if the antibiotic was found to be resistant to the organism. At that time, she indicated ceftriaxone was resistant to E. coli and she should have called the doctor. On 7/30/24 at 2:00 P.M., the Administrator provided a current Antibiotic Stewardship Program policy, dated 11/2017, that indicated "The facility shall establish key elements for antibiotic prescribing and a system to monitor and manage antibiotic use. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients"			