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PARSONS PRESBYTERIAN MANOR	3501 DIRR AVENUE PARSONS, KS 67357

(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
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #144928. The 2567 was electronically sent to the facility on 09/05/19.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		

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

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.

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§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents with 26 reviewed who had physician orders for narcotics. Based on observation, interview, and record review, the facility failed to maintain a system to appropriately receive and account for 60 pills of hydrocodone/acetaminophen 5/325 mg. (milligrams), (narcotic pain medication), delivered from the pharmacy for one of the 26 residents reviewed, Resident (R) 24.

Findings included:

- Review of the pharmacy invoice, dated 08/19/19, revealed at 06:39 PM, pharmacy staff delivered 60 tablets of hydrocodone/acetaminophen 5/325 mg. (milligrams), to the facility for Resident (R) 24. Documentation on the invoice revealed the pills received by Certified Medication Aide (CMA) S.

The "Narcotic Count Sheet," dated 08/24/19 at 07:55 AM, evidenced the scheduled medication hydrocodone/acetaminophen 5/325, was not available for administration for R24.

The "Interdisciplinary Team Notes" (IDT), dated 08/25/18 at 08:49 AM, evidenced R24 brought up concerns to the charge nurse that staff failed to administer her scheduled medication hydrocodone/acetaminophen 5/325. The charge nurse notified Administrative Nurse D via e-mail.

On 08/26/19 at 12:07 PM, Administrative Staff D stated she contacted CMA S for discussion

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F 755	Continued From page 2 regarding the delivery of these narcotic medications on 08/19/19 at 06:36 PM. CMA S confirmed that she signed the delivery sheet from the pharmacy on this date but that she had laid all medication on the counter in the medication room to be put up later as she was administering evening medications to the residents at that time. On 08/27/19 at 04:55 PM, CMA S stated when she received the medication from the pharmacy on 08/19/19, she signed the invoice from the pharmacy then placed the medications on the counter in the medication room to count later. This included the 60 tablets of the hydrocodone/acetaminophen 5/325 for R24. She further stated she failed to count the medications and because they were narcotics, she should have locked the medications in the cabinet in the medication room. On 08/27/19 at 01:23 PM, Administrative Nurse D stated the expectation when staff receive medication from the pharmacy was to match the medication to the invoice and then sign the invoice after all medications are accounted for. The policy for "Medication Storage of Controlled Medication," dated 06/10/19, instructed the nurse on duty to account for all scheduled medications when receiving narcotics from the pharmacy. The facility failed to maintain a systems in place to ensure the accurate receipt and reconcilliation of controlled medications to prevent the diversion (loss) of controlled medications for this resident.	F 755		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		

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F 757	Continued From page 3 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §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: The facility reported a census of 34 residents. The 16 sampled residents included 5 reviewed for unnecessary medications and 2 sampled for constipation. Based on interview and record review, the facility failed to monitor blood pressures with antihypertensive medications for 2 of the 5 residents reviewed, including Resident (R) 6 and R33 related to monitoring blood pressures with medication that had physician ordered parameters. The facility failed to monitor the effectiveness of pain medications for the 2 of the 5 residents reviewed including R17 and R33. Furthermore, the facility failed to monitor bowel movements for the 2 of residents reviewed for constipation including R86 and R5, to ensure the	F 757		

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residents received the needed medications without adverse reactions.

Findings included:

- Review of the "Physician Orders" (PO), dated 08/06/19 for R6, documented the diagnoses of paroxysmal atrial fibrillation (a rapid, erratic heart rate begins suddenly and then stops on its own within 7 days.) and essential (primary) hypertension (abnormally high blood pressure).

The quarterly "Minimum Data Set"(MDS), dated 05/25/19, documented the resident as moderately cognitively impaired with a "Brief Interview for Mental Status" (BIMS) score of 11.

The "Activities of Daily Living Function Care Area Assessment" (CAA), dated 11/30/18, documented the resident had the diagnoses of hypertension and atrial fibrillation and required limited assistance from staff for her daily activities of daily living.

The care plan, dated 06/05/19, documented the resident had an alteration in cardiopulmonary function related to hypertension and atrial fibrillation. The staff were to monitor the resident's blood pressure daily.

The PO, dated 08/06/19, documented orders for doxazosin (an antihypertensive), 4 milligrams (mg), give one tablet by mouth twice daily for essential (primary) hypertension, ordered on 05/23/19 and clonidine, 0.1 mg, give 1 tablet by mouth every 4 to 6 hours as needed for essential (primary) hypertension. Give for blood pressure 170/80 and above, ordered on 5/23/19.

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Review of the July, 2019 "Medication Administration Record" (MAR) revealed lack of blood pressure monitoring for the resident.

Interview, on 08/28/19 at 05:43 PM, with Licensed Nurse I, stated the blood pressures should be monitored to stay within physician ordered parameters with clonidine. They should be monitored daily according to the care plan.

Interview, on 08/28/19 at 05:56 PM, with Administrative Nurse D, stated it would be her expectation that blood pressures be monitored and documented on the MAR if there were physician ordered parameters.

The facility lacked a policy for monitoring blood pressures with physician ordered parameters.

The facility failed to monitor R6's blood pressures with antihypertensive medications with physician ordered parameters, to ensure no unnecessary medication usage.

- The "Physician Orders" (PO), dated 08/06/19, documented R17 with the diagnoses of osteoarthritis and cerebral infarction.

The quarterly "Minimum Data Set" (MDS), dated 06/28/19, documented the resident with a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. The resident reported no pain and received an opioid daily during the seven day lookback period.

The admission MDS, dated 10/3/18, documented the resident with a BIMS score of 13, which indicated intact cognition. The resident received

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scheduled and as needed (PRN) medications for pain and received an opioid daily during the seven day lookback period.

The "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment " (CAA), dated 10/09/18, documented the resident with the diagnosis of osteoarthritis and required extensive assistance from staff for activities of daily living.

The "Pain CAA", dated 10/09/18, documented the resident reported frequent pain to her left foot and leg.

The care plan, dated 07/05/19, documented the resident took medication for back, shoulder, and leg pain. She received hydrocodone, a narcotic, for pain relief.

A "Physician Order" (PO), dated 08/06/19, documented an order for Norco 5 mg-325 mg, give one tablet by mouth PRN at bedtime for pain, ordered on 06/03/19.

Review of the August, 2019 MAR, revealed lack of monitoring for the effectiveness of Norco 5 mg-325 mg administered on August 4, 9, 12, 13, 14, 19, 20, 23, and 26.

Review of the July, 2019 MAR, revealed lack of monitoring for the effectiveness of Norco 5 mg-325 mg administered on July 1, 2, 3, 6, 7, 13, 15, 16, 17, 20, and 21.

Review of the June, 2019 MAR, revealed lack of monitoring for the effectiveness of Norco 5 mg-325 mg administered on June 3, 4, 6, 8, 9, 10, 14, 17, 22, 23, and 28.

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Interview, on 08/28/19 at 05:03 PM, with LN I, stated the resident took Norco every night. Staff documented pain effectiveness on the MAR. Pain should be assessed within 45 minutes to an hour after the administration of the medication. The time and effectiveness should be documented with the pain medication on the MAR.

Interview, on 08/28/19 at 05:56 PM, with Administrative Nurse D, stated it would be her expectation that staff follow-up the effectiveness of pain medication in a reasonable amount of time and document that effectiveness in the MAR.

The facility policy for "Pain Management", revised June 10, 2019, documented, " . . . Residents experiencing pain will . . . monitored to effectively treat the pain. Procedure . . . 4. The effectiveness of the pain management intervention(s) should be documented in Matrix Care."

The facility failed to monitor the effectiveness of R17's pain medication, to ensure no unnecessary medication usage.

- The "Physician Orders" PO, dated 07/15/19 for R33, documented the diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people.), pain, tremors, trigeminal neuralgia (a chronic pain condition that affects the trigeminal nerve, which carries sensation from your face to your brain), and candida stomatitis (a condition in which the fungus candida albicans accumulates on the

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lining of the mouth.).

The quarterly "Minimum Data Set" (MDS), dated 08/10/19, documented the resident with moderately impaired cognitive skills for daily decision making. She received scheduled and PRN pain medications and an opioid daily during the seven day lookback period.

The "Activities of Daily Living Function Care Area Assessment" (CAA), dated 05/17/19, documented the resident with the diagnoses of Parkinson's disease, tremors, and pain. She had a self care deficit due to debilitated health status and was receiving hospice care.

The "Pain CAA", dated 05/17/19, documented the resident received pain medication for trigeminal neuralgia and candida stomatitis.

The care plan, dated 08/15/19, documented the resident with chronic pain due to terminal condition, trigeminal neuralgia, and candida stomatitis. She received morphine sulfate, a narcotic, for pain and medication for Parkinson's disease.

The "Physician Orders" (PO), dated 07/15/19, documented an order for morphine sulfate, 20 milligrams/milliliter (ml), administer 0.5 ml by mouth every 2 hours as needed (PRN) for breakthrough pain, ordered on 5/17/19.

Review of the August, 2019 MAR, revealed lack of monitoring for the effectiveness of morphine sulfate 20 mg/ml administered on August 2, 4, 7, 15, 21, 22, 24, and 25.

Review of the July, 2019 MAR, revealed lack of

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monitoring for the effectiveness of morphine sulfate 20 mg/ml administered on July 1, 2, 9, 24, and 29.

Review of the June, 2019 MAR, revealed lack of monitoring for the effectiveness of morphine sulfate 20 mg/ml administered on June 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 14, 19, and 28.

Furthermore, the physician orders, dated 07/15/19, documented an order for propranolol 40 mg, give one tablet by mouth three times daily for tremors. Hold the medication if the systolic blood pressure was below 90, ordered on 05/07/19.

Review of the June, July, and August, 2019 MARs, revealed lack of blood pressure monitoring for this medication within the physician parameters.

Interview, on 08/28/19 at 05:26 PM, with LN I, stated the resident received morphine routinely as well as when needed. Staff documented pain effectiveness on the MAR. Pain should be assessed within 45 minutes to an hour after the administration of the medication. The time and effectiveness should be documented with the pain medication on the MAR. Blood pressures should be monitored with propranolol due to physician ordered parameters

Interview, on 08/28/19 at 05:56 PM, with Administrative Nurse D, stated it would be her expectation that staff follow-up the effectiveness of pain medication in a reasonable amount of time and document that effectiveness in the MAR. It would also be her expectation that staff monitor blood pressure with an antihypertensive medication with a physician ordered parameter

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and document the results in the MAR.

The facility policy for "Pain Management", revised June 10, 2019, documented . . . Residents experiencing pain will . . . monitored to effectively treat the pain. Procedure . . . 4. The effectiveness of the pain management intervention(s) should be documented in Matrix Care.

The facility lacked a policy for monitoring blood pressures for medications with physician ordered parameters.

The facility failed to monitor the effectiveness of R33's pain medication and to monitor blood pressures for antihypertensive medication with physician ordered parameters, to ensure no unnecessary medication usage.

- The "Physician Orders" (PO), dated 01/01/19, documented R86 with the diagnosis of constipation.

The admission "Minimum Data Set" (MDS), dated 12/01/18, documented the resident with moderately impaired cognitive skills for daily decision making. The resident was always continent of bowel and required limited assistance from staff with toileting.

The "Activities of Daily Living Function Care Area Assessment" (CAA), dated 12/06/18, documented the resident admitted from assisted living due to a progressive decline in her self care abilities. She had increased weakness and cognitive decline. She received extensive assistance from staff for toileting.

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The care plan, dated 12/23/18, documented the resident with functional incontinence related to physical and mental impairment and impaired mobility.

The "Physician Orders" (PO), dated 01/01/19, revealed the following medications for the diagnosis of constipation:

Senna, 8.6 mg, give 1 tablet by mouth daily for constipation, ordered on 11/23/18.

Senna, 8.6 mg, give 1 tablet by mouth at bedtime PRN for constipation, ordered on 11/23/18.

Lactulose, 10 gram (gm)/15 ml, give 15 ml by mouth twice daily for constipation, ordered on 11/23/18.

Review of the "Daily Charting for Bowel Movements", for December, 2018, revealed from 12/01/18 through 12/04/18 and 12/07/18 through 12/10/18, the resident had no bowel movements. The resident went without a bowel movement for 4 days each time period.

Review of the December, 2018 MAR, revealed no PRN medications administered during those 4 day periods.

Interview, on 08/28/19 at 04:56 PM, with Licensed Nurse (LN) I, revealed the dayshift nurse runs a "No BM Report" daily. Residents who have not had a bowel movement in 3 days should be on the report. Interventions should be implemented for a resident who does not have a bowel movement for 4 days. Her bowel movements should have been addressed by staff.

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Interview, on 08/28/19 at 06:24 PM, with Administrative Nurse D, stated staff should have administered PRN medications when the resident did not have a bowel movement during those times.

The facility's policy for "Bowel Elimination", revised May 2, 2019, documented to establish guidelines for monitoring individual bowel function, to promote regularity of bowel functions and avoid possible complications such as constipation . . . by utilizing a multidisciplinary approach . . . 3. If the resident has had no bowel movement recorded in 3 days or 9 consecutive shifts or has positive signs and symptoms of constipation/impaction/bowel obstruction, the licensed nurse will perform an evaluation to include auscultation and palpation. The physician will be notified of bowel status and assessment findings.

The facility failed to monitor this resident at risk for constipation, for bowel movements, and provide interventions to ensure the resident received the needed medications without adverse reactions.

- The signed "Physician Orders" (PO), dated 08/06/19, for Resident (R) 5, admitted 10/29/18, with the diagnoses of chronic pain, constipation (difficulty passing stool), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and major depressive disorder (major mood disorder).

The quarterly "Minimum Data Set" (MDS), dated 03/02/19, recorded the resident with a Brief

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Interview for Mental Status (BIMS) score of 1, indicating severely impaired cognition, her inattention comes and goes, and her disorganized thinking was continuous. Physical behaviors directed at others occurred one to three days, verbal behaviors directed at others occurred four to six days. The resident was unable to answer any pain assessments. She was on an opioid (opium like pain relief) medication for three of the seven days of the lookback period.

The "Cognition Care Area Assessment" (CAA), dated 06/01/19, recorded the resident with a BIMS of 2, indicating severely impaired cognition. She would have irrelevant conversations and switch from subject to subject. She had difficulty expressing her thoughts at times.

The "Pain CAA," dated 06/01/19, recorded the resident stated during the pain assessment she did have pain. Due to her poor cognition she was unable to determine the frequency of her pain, the intensity, or the effect from pain on her functioning. She had an order for a Fentanyl patch of 12 microgram every 72 hours. Licensed nursing will continue to assess the resident.

The annual "MDS," dated 06/01/19, recorded the resident with a BIMS of 2, indicating severely impaired cognition. Disorganized thinking was continuous. The resident was unable to answer if she had any pain, and staff observation of pain indicators such as facial grimacing, indicated possible pain occurred one to two days, and she received prn opioid medication twice during the lookback period

The Care Plan, dated 06/01/19, recorded there

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was no pattern of pain at that time and to monitor the resident for adverse reactions from pain medication such as constipation. The resident started Miralax on 06/05/19 to help with the constipation.

The PO's, dated 08/06/19, recorded the resident was on the following medications :

05/09/16 Miralax 17 gm (grams), daily for constipation.

10/14/18 Ducolax suppository 10 mg as needed (PRN) for constipation.

11/1/18 Fentanyl 12 mcg (microgram) per hour, one every 72 hours for chronic pain.

12/17/18 Senna plus 8.6/50 twice daily for constipation.

01/07/19 Tylenol extra strength 500 mg (milligram), two tablets daily for chronic pain.

Review of the "Daily Charting for Bowel Movements," revealed there was no documentation for a bowel movement from 08/04/19 through 08/10/19, for a total of seven days.

The August, 2019 Medication Administration Record lacked documentation facility staff administered the PRN Ducolax Suppository during the time frame of 08/04/19 thru 08/10/19.

Observation, on 08/22/19 at 01:04 PM, R5 was sitting at the dining room table in her wheelchair for noon meal and was able to feed herself.

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F 757	Continued From page 15 On 08/28/19 at 03:11 PM, Licensed Nurse H confirmed there was no documented bowel movement from 08/04/19 through 08/10/19, and no PRN Ducolax suppository documented for constipation was given. On 08/28/19 at 05:43 PM, Administrative Nurse D stated she expected bowel monitoring to be done daily and if a resident had not had a bowel movement in nine shifts, the nurse was to assess the resident and follow protocol for administering as needed medications. The policy for "Bowel Elimination," dated 05/02/19, instructed staff that if a resident has had no bowel movement for three days or nine consecutive shifts, the licensed nurse will perform an evaluation to include auscultation and palpation. The physician will be notified of the lack of bowel movement for three consecutive days. The facility failed to monitor bowel movements for R5, at risk for constipation, to ensure the resident received the medication without adverse reactions.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents. Based on observation and interview, the facility failed to store and prepare food under sanitary conditions for the residents of the facility.

Findings Included:

- Observation, on 08/28/19 at 10:57 AM, revealed in the main kitchen, the cabinets over a food preparation area, had laminate peeling and also lacked laminate on two of five doors. One four inches by one inch and the other two inches by one half inch.

Observation, on 08/28/19 at 12:03 PM, in the kitchenette on the second floor, revealed 11 out of 16 cabinet which were severely marred and peeling, above a food preparation area, which created uncleanable surfaces.

Interview, on 08/21/19 at 01:46 PM, Administrative Dietary Staff BB confirmed these areas stating she was aware of the need for repair of these areas.

The facility lacked a policy for cabinet maintenance.

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F 812	Continued From page 17 The facility failed to prepare foods in a sanitary manner with the failure to maintain the cabinets, above a food preparation area, for the residents of the facility.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 18 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents with 16 selected for review. Based on observation and interview, the facility failed to perform adequate hand hygiene, including cleansing of	F 880		

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hands and glove change for 2 residents reviewed, including during a dressing change and eye drop administration for Resident (R) 14 and during performance of perineal hygiene for R13.

Findings included:

- Observation, on 08/26/19 at 10:29 AM, Licensed Nurse G completed a dressing change for Resident (R) 14 to a gastric tube, cleansing with normal saline, applying antibiotic ointment, and a new dressing. She changed her gloves and put Refresh Tears in R14's eyes, failing to do hand hygiene when moving from the gastric tube to the eyes.

On 08/26/19 at 10:36 AM, Licensed Nurse G confirmed there should have been hand hygiene before donning new gloves to dispense the eye drops.

On 08/28/19 at 05:43 PM, Administrative Nurse D stated she expected the staff to do hand hygiene after removing the gloves when doing the dressing change to the gastric tube and before donning new gloves to dispense eye drops.

The facility policy for "Hand Hygiene" revealed indications for hand washing was when hands were visibly soiled or contaminated, wash hands with soap and water. The policy also instructed staff to use an alcohol based hand rub in all situations except when their hands were visibly soiled or contaminated.

The facility failed to follow a clean technique by not completing proper hand hygiene when moving from a gastric tube dressing change to instilling eye drops for this resident.

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- Observation, on 08/27/19 at 10:52 AM, revealed Certified Medication Aide (CMA) R donned gloves and provided perineal care for R13. After appropriate peri-care, CMA R failed to remove her gloves, wash her hands, and don new gloves before touching the resident's clean brief and nightgown.

Interview, on 08/27/19 at 11:05 AM, CMA R stated she should have washed her hands and changed gloves before touching the resident's brief and nightgown.

The facility policy for "Hand Hygiene" revealed indications for hand washing was when hands were visibly soiled or contaminated, wash hands with soap and water. The policy also instructed staff to use an alcohol based hand rub in all situations except when their hands were visibly soiled or contaminated.

The facility failed to ensure adequate handwashing and changing of gloves to prevent the spread of infection while providing direct care for this resident.