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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 04/03/2023.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		

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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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(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents. Based on observation, interview, and record review the facility failed to complete an accurate Minimum Data Set (MDS) for one Resident (R)64, regarding inaccurate discharge location.

Findings included:

- Review of Resident (R)64's medical record

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F 636	Continued From page 2 revealed a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The entry "Minimum Data Set" (MDS), dated 02/06/23, documented the resident admitted from an acute hospital. The care plan, dated 02/06/23, instructed the staff the resident intended to return home following his stay at the facility. The discharge "MDS," dated 02/13/23, documented the resident discharged from the facility to an acute hospital. On 03/29/23 at 08:51 AM, Administrative Nurse E stated the resident discharged from the facility to home on 02/13/23. The discharge MDS, dated 02/13/23, was inaccurate as it documented the resident discharged to the hospital. On 03/29/23 at 10:00 AM, Administrative Nurse D stated she would expect for the staff to complete the MDS correctly. The facility used the "Resident Assessment Instrument" (RAI) for completion of the MDSs. The facility failed to complete an accurate MDS for this resident who discharged to home from the facility.	F 636		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		

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§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents with 20 selected for review including one reviewed for restorative nursing contracture management (abnormal permanent fixation of a joint). Based on observation, interview, and record review, the facility failed to provide restorative services of contracture management services for the one sampled Resident (R)31.

Findings included:

- The "Medical Diagnosis" tab for R31 included diagnosis of Parkinson's Disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one side of the body) following cerebral infarction (stroke- damage to tissues in the brain

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due to a loss of oxygen to the area), and contracture of the left hand.

The "Quarterly Minimum Data Set" (MDS) dated 09/23/22 assessed R31 with a "Brief Interview of Mental Status" (BIMS) score of 15 indicating intact cognition. She had an upper extremity range of motion impairment to one side that interfered with daily functions or placed her at risk for injury. R31 received Occupational Therapy five days and did not receive any restorative nursing services for splint or brace assistance.

The "Annual MDS" dated 12/23/22 assessed R31 with no impairment to long- and short-term memory recall, had no impairment to her upper extremity range of motion that interfered with daily functions or placed her at risk for injury. She did not require Occupational Therapy and received restorative nursing services five days for passive range of motion and two days for splint or brace assistance.

The "ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment" dated 01/16/23 for R31 revealed she required setup assist for morning and HS (hour of sleep) cares and extensive assist for dressing.

The "Care Plan" dated 02/07/23 revealed a restorative nursing program for splint assistance. The staff were to assist with donning the left-hand splint after lunch one time per day to wear for two hours as tolerated to prevent decline with flexion of digits (fingers). R31 may wear the palmar based left digit three through five finger extension orthotic for one hour at a time three times a day to prevent further contracture formation, skin

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integrity compromise, and pain.

The "Task" tab instructed the staff to assist with the splint to the left hand after lunch one time per day to wear for two hours as tolerated to prevent decline with flexion of the digits. R31 may wear the palmar based left digit three through five finger extension orthotic for one hour at a time three times a day to prevent further contracture formation, skin integrity compromise, and pain.

The "Occupational Discharge Summary" dated 02/17/23 revealed R31 had limited use/tolerance of the current hand based finger extension splint to the left hand but tolerated two hours wear of a soft washcloth roll to facilitate finger extension until air filled finger extension orthotic was received/shipped.

The "Therapy to Nursing Communication" binder included a daytime splint scheduled, undated, for R31 which was the daytime splint schedule posted in her room.

On 03/27/23 at 04:47 PM, observed R31 with contracture to the left hand and was unable to extend digits three through five. A sign was in her room instructing staff to put a splint on her left hand at night and to take it off in the morning. The resident did not have a splint to her hand at this time.

On 03/27/23 at 04:48 PM, R31 stated she was unable to open three fingers on her left hand and has a splint that she wears at night.

On 03/28/23 at 10:48 AM, observed a blue splint on R31's overbed table.

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On 03/29/23 at 09:33 AM, observed R31 sitting in her recliner in her room, no splint or orthotic in place to her left hand. R31 had a sign in her room for "Daytime Hand Splint Schedule" which included times from 09:00 AM to 11:00 AM, 01:00 PM to 03:00 PM, and optional 06:00 PM to 08:00 PM. This sign was posted next to the sign for her nighttime splint.

On 03/29/23 at 09:34 AM, R31 stated the splint for her hand at night was blue and the splint for her hand during the day was white and black and she had not seen it for two weeks. R31 stated she thought maybe it was in the drawer and pointed to the stand next to her recliner. R31 stated staff has not offered to assist to put the splint on today and did not think the staff knew how to do it. R31 stated she had therapy about two weeks ago. R31 stated she monitored the skin in her hand for breakdown and there was not any however stated if felt moist all of the time.

On 03/29/23 at 09:44 AM, Certified Nurse Aide (CNA) P was not aware R31 was to have a splint in place at intervals during the day to R31's left hand. CNA P looked in the room for the splint and found a white rolled washrag with Coban (self-adherent elastic wrap) wrapped with a black fabric strap. The staff did find a soft fabric carrot shaped device in her drawer that the resident placed in her left hand.

On 03/29/23 at 09:45 AM, R31 stated that was not the white and black splint she was referring to.

On 03/29/23 at 09:49 AM, Consultant therapy staff GG stated consultant therapy staff HH made a heat molded palm protector for R31 and it had

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F 688	Continued From page 7 been over a month since R31 received therapy services. On 03/29/23 at 09:51 AM, Consultant therapy staff HH stated R31 had too much pain with the splint when she had returned from the hospital and another splint had been ordered that had not arrived yet that has an air bladder that was expandable. R31 had been out of the splint so long at the hospital she could not tolerate the splint she had been using before. A hand roll was made for her to use when she could not tolerate the other one, around four weeks ago, and referred to the one found in the drawer of the rolled washrag with black fabric strap and Coban wrapped around it. Consultant therapy staff HH stated the nursing staff was made aware by a written communication form placed in the communication binder for therapy to nursing. On 03/29/23 at 10:09 AM, Administrative Nurse D stated she would expect the staff to assist R31 with splint placement per therapy direction. The facility policy " Contracture Documentation" dated 01/2023 revealed a resident with a limited range of motion or contracture shall receive appropriate treatment and services, based on the comprehensive assessment of the resident, to increase range of motion and/or prevent further decrease. The facility failed to ensure staff assisted R31 with the left hand splint placement during the day to prevent further contracture to digits three through five of her left hand.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents with 20 selected for review. Based on observation, interview, and record review, the facility failed to assess, monitor, and implement interventions to prevent further accidents/injuries for two residents, Resident (R)42 and R21, with bruises, and failed to ensure immediate appropriate interventions were implemented for R9 following falls to prevent further falls/injury.

Findings included:

- The "Medical Diagnosis" tab for R9 included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), repeated falls, history of falling, cognitive communication deficit, muscle weakness, dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and urge incontinence (involuntary passage of urine occurring soon after a strong sense of urgency to void).

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The "Admission Minimum Data Set" (MDS) dated 06/08/22 for R9 assessed her with a "Brief Interview of Mental Status" (BIMS) score of 13 indicating intact cognition. She required limited assistance from one staff for transfers, walking, locomotion, dressing, and toilet use. R9's balance during transitions and walking was not steady and she could only stabilize with staff assistance. She used a walker and a wheelchair for mobility. R9 was continent of bowel and occasionally incontinent of urine and was not on a toileting program for bowel or bladder. R9 had no falls since admission/entry.

The "ADL [activities of daily living] Functional/Rehabilitation Care Area Assessment" (CAA) dated 07/05/22 revealed R9 had a recent decline due to her Parkinson's Disease and required 24-hour nursing care for supervision and assistance with ADL's due to her weakness, fatigue, and confusion. R9 used a wheelchair for locomotion and was working with therapy to improve her mobility.

The "Falls CAA" dated 07/05/22 for R9 revealed she was at risk to fall due to weakness, impaired mobility, confusion, and occasional impulsivity. She had falls prior to admission but none since admitted to the facility. R9 could propel herself in the wheelchair and staff assisted her with ADL's and monitor for safety.

The "Care Plan" dated 01/06/23 included these interventions in place prior to 09/13/22: Keep needed items, water, etc. in reach, ensure she is wearing appropriate footwear when ambulating or wheeling in the wheelchair, non-skid strips to the floor in front of the recliner, and a one-way slide in her wheelchair. Additional interventions added

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from 09/13/22 forward for falls included:
1. On 09/13/22, non-skid strips to the floor in front of her toilet.
2. On 10/09/22, provided a grabber to assist her safely to reach items off the floor.
3. On 10/26/22, anti-roll bars to the wheelchair.
4. On 10/31/22, staff to lay out extra set of clothing within her reach daily if needed.
5. On 11/18/22, bright colored "call before you fall" sign in her room.
6. On 11/28/22, "call before you fall" sign in bathroom.
7. On 12/20/22, insulin changed.
8. On 12/24/22, placed Dycem (thin rubber-like non-slip material) in recliner.
9. On 01/15/23, encourage R9 to maintain items in smaller totes with lids to manage belongings safely.
10. On 01/19/23, staff to offer her toileting before and after meals as tolerated by her.
11. On 02/10/22 (for fall 02/01/23, 9 days prior), strips put down on floor in front of closet.
12. On 02/16/23, will provide small fidget devices for lap to help her satisfy her fidgeting.
13. On 02/27/23, will add to falling star program and star will be placed outside door.
14. On 03/11/23, non-skid strips in front of bed.
15. On 03/20/23, lower back of seat in wheelchair for better positioning as she is leaning forward more.

Review of the progress notes revealed R9 fell 21 times between 09/13/22 through 03/20/23, with 10 of those falls resulting in skin tears/bruising injury.

The "Progress Note" dated 09/13/22 revealed R9 was on the floor in the bathroom. The staff educated R9 to call for staff assistance when

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needing to transfer. The intervention was not appropriate due to R9's moderately impaired cognition.

The "Fall Committee IDT" (interdisciplinary team) note dated 09/14/22, the next day following the fall, revealed will add non-skid strips to the floor in front of the toilet and also reminder her to call for assistance prior to self-transferring as she can be very unsteady due to her Parkinson's Disease.

The "Progress Note" dated 10/09/23 revealed R9 was on the floor in front of her recliner. The note lacked a new intervention to prevent further falling.

The "Incident" report dated 10/09/22 for R9 lacked a new intervention to prevent further falls.

The "Fall Committee IDT" note for R9 dated 10/10/22, the next day following the fall, revealed would provide R9 a reacher (handled gripper to pick things up) to assist her safely reach for items off the floor.

The "Progress Note" dated 11/18/22 revealed R9 was laying on the floor of her room with the wheelchair located at her feet. The note lacked a new intervention to prevent further falls. There was no injury noted from the fall, however, she had developed a bruise below her left eye in the last couple of days. (R9 fell on 10/31/22 resulting in laceration to the forehead).

The "Incident" report dated 11/18/22 for R9 lacked an intervention to prevent further falls.

The "Fall Committee IDT" dated 11/21/22, three days after the fall, revealed would place a bright

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colored call before you fall sign in R9's room as a reminder.

The "Progress Note" dated 11/28/22 revealed R9 was on the floor in front of the toilet, stating she lost her balance after standing up from the toilet. R9 had a 1.5 centimeter laceration to the back of her head. The bleeding stopped and did not require a bandage. The note lacked an intervention to prevent further falls.

The "Incident" report dated 11/28/22 lacked an intervention to prevent further falls.

The "Fall Committee IDT" note dated 12/01/22, three days after the fall, revealed would place a bright colored call before you fall sign in front of her toilet in the bathroom.

The "Progress Note" dated 12/24/22 revealed a Certified Nurse Aide (CNA) alerted the nurse R9 was on the floor. When the nurse arrived in the room, R9 was sitting in her recliner and a Certified Medication Aide (CMA) was applying a wet wash cloth to R9's right hand due to a laceration. The nurse sent R9 to the emergency for the right hand laceration.

The "Progress Note" dated 12/25/22 at 01:58 AM revealed R9 returned from the emergency room at 12:35 AM. R9 returned with her right hand wrapped with gauze, the nurse cleaned the dry blood off of her hand and placed steri-strips on the skin tear. The note lacked immediate intervention to prevent further falls.

The "Fall Committee IDT" note dated 12/27/22, three days after the fall and two days after return from the emergency room revealed staff would

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provide Dycem to the seat of R9's recliner to prevent her from slipping out.

The "Progress Note" dated 01/07/23 revealed R9 stood up out of wheelchair and her feet slipped in her slippers and she slid down the wall to the floor in an upright position. The note lacked a new intervention to prevent falls.

The "Incident" report dated 01/07/23 lacked a new intervention to prevent further falls.

The "Fall Committee IDT" note dated 01/09/23, two days after the fall, revealed would add non-skid surface to base of slippers as R9 enjoyed wearing them.

The "Progress Note" dated 01/15/23 revealed R9 was sitting on the floor on left side of buttocks holding herself up with her left hand. R9 reported she was looking for a business card in a basket in the closet, she spilled the basket which had beads in it, and she slipped to the floor. R9 had a 0.5 centimeter "slit" to her left wrist by her watch. The note lacked a new intervention to prevent further falls.

The "Incident" report dated 01/15/23 included an intervention educated to use call light and would need call light attached while in the wheelchair. The intervention was not appropriate due to R9 having moderate cognitive impairment.

The "Fall Committee IDT" dated 01/16/23, the day after the fall revealed would provide small totes that would be easier for R9 to manage with lids to prevent items from falling out when she pulls them out of the closet.

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The "Progress Note" dated 01/19/23 at 06:30 PM revealed the resident was on the floor, barefoot, shirt off, pants to her ankles, and several wet areas on the floor. R9 reported she was trying to put her pants on and fell. R9 had a skin tear to her right forearm. The note included the staff reminded R9 to call for assistance with transfers and to get dressed. The intervention was not appropriate due to R9 having moderate cognitive impairment.

The "Incident" report dated 01/19/23 included the same education intervention.

The "Fall Committee IDT" note dated 01/20/23, the day after the fall, included an intervention for staff to offer toileting before and after meals as tolerated by her.

The "Progress Note" dated 02/01/23 at 06:15 PM revealed R9 was on the floor in her room by her closet with her pants around her ankles. R9 reported she was changing her pants and fell and bumped her hand on the door. R9 had a skin tear to her left hand which measured 2.5 centimeters by 2.5 centimeters and required steri-strips. The note lacked an intervention to prevent further falls.

The "Incident" report dated 02/01/23 lacked a new intervention to prevent further falls.

The "Fall Committee IDT" note dated 02/02/23, the day after the fall, revealed will place non-skid strips in front of her closet to keep from slipping when she self-transfers.

The "Progress Note" dated 02/04/23 revealed R9 was on the floor in another resident's room with

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nightgown on and socks that were not non-skid. R9's wheelchair was found in a different resident room. The note lacked a new intervention to prevent further falls.

The "Incident" report dated 02/04/23 lacked a new intervention to prevent further falls.

The "Fall Committee IDT" noted dated 02/06/23, two days after the fall, revealed would have Speech Therapy to evaluate and treat for safety awareness and impulsivity. The intervention was not an immediate intervention to prevent further falls.

The "Progress Note" dated 02/05/23 revealed R9 was sitting on the floor in front of her wheelchair. The note lacked an intervention to prevent further falls.

The "Incident" report dated 02/05/23 revealed the staff found a superficial abrasion to the right side of her back. The report lacked a new intervention to prevent further falls.

The "Fall Committee IDT" note dated 02/06/23, the day following the fall, revealed would have the family come in and unpack totes removing extra items not needed in her room and take them home with them in an effort to de-clutter the room.

The "Social Services" note dated 02/12/23 revealed R9's family gave permission to clean out the closets and put away clothing totes in her room that she has been falling sorting through. Staff packed up a tote of summer clothing. The facility failed to have an intervention in place while waiting for the totes to be gone through, which

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occurred seven days after the fall.

The "Progress Note" dated 02/16/23 revealed R9 was sitting on the floor in front of the recliner bent forward fidgeting with a quilt. R9 had a skin tear to her left elbow. The note lacked a new intervention to prevent further falls.

The "Incident" report dated 02/16/23 lacked a new intervention to prevent further falls.

The "Fall Committee IDT" note dated 02/17/23, the day after her fall revealed would provide small lap fidget devices for R9 to fidget with to keep her busy.

The "Progress Note" dated 02/27/23 revealed R9 was laying in her room on her abdomen on the floor, arms to her side, head at the foot of the bed with the wheelchair near her. R9 reported she hit her temple on the floor and her makeup bag was in her left hand and makeup was scattered on floor near her. R9 had a 3.0 centimeter skin tear to the right side of her face and a 1.5 centimeter skin tear to her right wrist. The note lacked a new intervention to prevent further falls.

The "Incident" report dated 02/27/23 lacked a new intervention to prevent further falls.

The "Fall Committee IDT" note dated 02/28/23, the day after the fall, revealed would implement the falling star program and place a star outside of the door of her room for more frequent monitoring by staff.

The "Progress Note" dated 03/01/23 revealed R9 had multiple bruises on her face, hands, arms, and torso from previous fall. R9 continued to be

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impulsive and would stand and ambulate without assistance or lean forward in the wheelchair to fidget with items on the floor. Staff would remind her repeatedly to sit back down.

The "Progress Note" dated 03/07/23 at 03:03 PM revealed R9 was on the floor in her bathroom laying on her right side and a small amount of blood was dripping from her forehead. The resident who shared a bathroom alerted the staff to R9 being on the floor. The wheelchair was not near the doorway and the recliner was not fully down. R9 had a laceration to her forehand, digits three through five on her right side, blood inside of her mouth, and bruising to the right side of her face with a hematoma near her right eyebrow. R9 was sent to the emergency room.

The "Progress Note" dated 03/07/23 at 07:57 PM revealed the staff seated R9 near the nurse's station to observe her condition. R9 was removing her steri-strips and trying to stand and ambulate without assistance of devices.

The "Fall Committee IDT" note dated 03/09/23, two days after the fall, revealed would add a motion sensor alarm in R9's room near the bed and bathroom to further alert staff of her attempts to self-transfer.

The "Progress Note" dated 03/11/23 at 11:25 PM revealed R9 was sitting on the floor on the side of the bed. R9 told the nurse she was hungry and given a snack and a soda. The note lacked if the motion sensor alarm activated. The note lacked a new intervention to prevent further falls.

The "Incident" report dated 03/11/23 lacked a new intervention to prevent further falls and revealed

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R9 told the staff she just felt like getting out of bed.

The "Fall Committee IDT" note dated 03/13/23, two days after the fall revealed would add non-skid strips next to her bed to keep from slipping.

The "Progress Note" dated 03/15/23 revealed R9 fell on 03/14/23 at 04:30 PM. R9 was laying flat on her stomach in the middle of the floor in her room with her face turned to the side, wheelchair within reach. R9 had her makeup bag and makeup sprawled out near her, fresh makeup on her face and lipstick fresh. Lipstick was "smooshed" into the floor and lid found on the other side of the room. R9's face had bruising from previous falls and no new skin injuries noted with this fall. The staff assisted R9 to her wheelchair. She was in the wheelchair for one minute before she began standing up to bend over to help the nurse clean up the floor, the nurse frightened R9, causing her to lose her balance. The nurse grabbed the gait belt and slowly lowered her to the floor and began giggling and smiling once sitting on the floor leaned back against the recliner. The nurse sat on the floor with her until she was ready to get in the wheelchair. The staff provided R9 one on one supervision due to constant standing and walking without assistive device.

The "Fall Committee IDT" note dated 03/15/23 revealed would place mats on the floor in R9's room to give her a cushioned space to sit on the floor as she chooses.

The "Progress Note" dated 03/20/23 revealed R9 was sitting on the floor in the hallway, unable to

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say what happened. The note lacked an intervention to prevent further falls.

The "Fall Committee IDT" note dated 03/23/23, three days after the fall, revealed would lower the back of the seat of R9's wheelchair for better positioning as she was always leaning forward in her wheelchair and needed frequent reminders to scoot back in the chair.

The "Progress Note" dated 03/23/23 at 11:20 PM revealed R9 continues to impulsively stand from wheelchair and lean forward in the chair to reach things on the floor. The staff reminds R9 frequently to propel self in wheelchair and sit back in her chair for safety.

The "Progress Notes" dated 03/23/23 through 03/28/23 lacked if the back of the seat of the wheelchair had been lowered, the fall intervention put into place on 03/23/23.

On 03/27/23 at 02:21 PM observed R9 in her room sitting in the recliner with her feet elevated, wheelchair out of reach. Yellow and faded black bruising present to her right cheek and right side of forehead. R9 was dozing off and on, stated she fell a couple of weeks ago and did not answer further questioning.

On 03/28/23 at 10:18 AM observed R9 sitting in the recliner in her room with her feet elevated, a touch pad style call light in place on the bed and the overbed table out of reach. Non-skid socks were in place to her feet and her shoes were on the floor in front of the closet where there were non-skid strips on the floor. R9 said the bathroom was falling in and when asked if she needed to go to the bathroom she said "no" but probably should

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and she did not want to.

On 03/28/23 at 10:19 AM CNA M stated she did not know if R9 could use a call light or not, this was her first day here since November and had been on duty for 20 minutes. CNA M moved one of the touch pad call lights to the arm of R9's recliner in reach before exiting room. CNA M asked R9 is she needed to go to the bathroom and R9 said no.

On 03/28/23 at 12:52 PM CNA N brought R9 to her room in her wheelchair, offered to toilet her several times and R9 declined. CNA M removed the foot pedals from the wheelchair, placed them in a bag on the back of the wheelchair, locked the wheelchair brakes, and assisted R9 to transfer to the recliner. R9 then stated she needed to go to the bathroom. CNA M transferred R9 back to the wheelchair and took her into the bathroom, moved the wheelchair outside of the bathroom, then washed her hands at the sink in the room. CNA M went back into the bathroom and assisted R9 with toileting needs and to get back into the recliner.

On 03/28/23 at 03:40 PM CNA O propelled R9 into her room, locked her wheelchair, turned on the TV, handed R9 the remote, moved the overbed table next to her.

On 03/28/23 at 04:00 PM observed R9 sitting in the recliner in her room, wheelchair facing the door and unlocked.

On 03/28/23 at 04:01 PM CNA O stated she did not transfer R9 to the recliner and the that the other staff on duty said they did not either. CNA O stated R9 should have help for transfers.

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On 03/28/23 at 04:03 PM observed R9 using the remote to her recliner and was raising the recliner up, alert CNA O and at that time Administrative Nurse F arrived and assisted CNA O with R9 back to the wheelchair. Did not observe a one way slide in the wheelchair. The recliner had a cloth incontinence pad in place, did not observe a Dycem in place.

On 03/29/23 at 12:03 PM Licensed Nurse (LN) I stated the charge nurse makes a new intervention after a resident falls and the IDT team meets and they put an intervention in the care plan. I do what I can after the fall and the IDT team may have a better intervention. I do not put interventions on the care plan. I talk to the CNAs to discuss what we are doing and pass it on in report to the next shift, that way they can documents if the intervention is effective, and if they think it was ineffective they will put into place what they think would be effective and let their shift know. LN I stated R9 she has never seen R9 use a reacher and if in her room she should be in the recliner or laying down.

On 03/29/23 at 03:06 PM Administrative Nurse D stated education to a resident with a "BIMS" of 12 or lower was not appropriate. The motions sensors put in R9's room were removed and we decided to try and encourage her not to be in her room. The intervention for the removing the slick shoes and nonskid surface applied to slippers were removed from the care plan when updating interventions. Administrative Nurse D stated the "hope" is that the staff puts into place an immediate intervention after a fall.

The facility policy "Fall Prevention" dated January

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2023 revealed it was the policy of the facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize the potential for injury.

The facility failed to implement immediate and appropriate interventions following falls in a timely manner and failed to follow up on the interventions for R9, who had 21 falls from 09/13/22 through 03/20/23, to prevent further falls/accidents for this resident.

- Review of Resident (R) 42's "Physician Orders," dated 03/28/23, revealed diagnoses which included, chronic respiratory failure, unsteadiness on feet, fatigue, muscle weakness, lack of coordination, neuropathy (lack of sensation in extremities), and disorder of bone density.

The "Annual Minimum Data Set" (MDS) dated 11/25/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 13, which indicated cognition was intact. The resident was without no skin issues. She required extensive assistance of staff with activities of daily living (ADLs), and limited assistance of staff with locomotion. The resident did not walk and her balance during transition was not steady, she was only able to stabilize with staff assistance. The resident had no functional limitation of her upper or lower extremities. She used a wheelchair as a mobility device. The resident did not experience falls during the look back period. She received anticoagulants (medications which thin the blood) for seven days of the look back period.

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The "Fall Care Area Assessment" (CAA), dated 12/09/22, documentation included the resident required extensive assistance of one to two staff with ADLs. She used a wheelchair for locomotion. She was at risk for due to weakness and needed staff assistance with all mobility and ADLs. The resident requested assistance with her ADLs and does not attempt them on her own.

The "Care Plan," (CP), dated 3/28/23, directed staff the resident took anticoagulant medication for atrial fibrillation (irregular heart rate). Staff should monitor closely for excessive bruising or other signs and symptoms of bleeding and notify the nurse immediately of skin breakdown which included bruises and skin discoloration.

Review of the resident's "Physician Orders," dated 03/08/23, included orders for Eliquis Tablet 5.0 milligrams (MG), give 1 tablet by mouth two times a day for blood thinner, ordered 02/26/22.

On 03/27/23 at 02:19 PM, the resident with purple bruising of her left lower arm approximately the size of a silver dollar. The resident reported she received Eliquis, a blood thinner and she bumps her arms on things. She was noted to reach between her recliner and bedside table to throw a tissue in the trash on her left side. She confirmed she bumped her arm on the bedside table positioned on her left side above her trash can. On inquiry the resident reported the facility had not offered interventions to prevent injury and did not monitor the discolored areas on a routine basis. To her knowledge nothing was done to prevent further injury when the bruising occurred.

Review of the resident's Electronic Medical Record (EMR) revealed the lack of

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documentation of the existence of the discolored area on the resident's arm, nor interventions to prevent the further injury.

On 03/28/23 at 12:31 PM, Certified Nurse Aid (CNA) Q served the resident lunch, on inquiry she confirmed the resident with discolored area on her left arm. She reported she was not aware of the cause of the bruising or of any interventions in place to prevent further injury. She stated areas should be reported to the nurse when identified and the nurse should assess and put intervention in place to prevent further injury.

On 03/29/23 at 11:55 AM, Licensed Nurse (LN) H stated the staff should report bruising of resident's bruising or discoloration. The nurse should assess the area and document findings in the progress notes. The nurse should initiate investigation to try and prevent further injury. LN H confirmed the bruised area had not been reported, had not been assessed, nor an intervention provided to prevent further injury. She confirmed facility did not track or measure bruises or discolored area routinely to determine status.

On 03/29/23 12:01 PM, Administrative Nurse F, agreed with LN H and confirmed the above.

On 03/29/2023 at 12:36PM, LN H verified the discolored area on the resident's left forearm measured 03.9centimeter (cm) by 07.2cm by no depth.

On 03/29/23 at 01:02 PM, Administrative Nurse D stated staff should report bruises, skin tears, and or discolored areas to the nurse. The nurse should assess the area to include measurements

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to determine the status. Residents that receive anticoagulants are prone to bleeding and should be checked daily. The nurse should assess, document, and follow-up with an investigation to determine the cause of trauma so we can put an intervention in place to prevent further injury and track the resolution of the area to determine the effectiveness of the intervention.

The facility policy "Care and Treatment Accident Intervention," dated 01/2023, documentation included the facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accidents. This includes systems and processes designed to identify hazards and risks, implement interventions to reduce hazards and risks, and monitor for effectiveness and modify approaches as indicated.

The facility failed to identify, assess, investigate, and provide interventions for this resident with bruising to protect and help prevent further skin issues.

- Review of resident (R)21's, "Physician Orders," dated 03/07/23, revealed diagnoses which included, chronic atrial fibrillation (irregular heart rhythm, lack of coordination, edema (swelling in extremities), cognitive communication deficit, need for assistance with personal care, fatigue, muscle weakness, hyperlipidemia, and history of malignant neoplasm of breast (breast cancer).

The "Annual Minimum Data Set" (MDS) dated 10/3/22, documented the "Brief Interview for Mental Status" (BIMS) score of 13, which

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indicated cognitively intact. The resident required limited assistance of staff with bed mobility, transfers, toilet use, personal hygiene, and walking in the room. She required extensive assistance with dressing. The resident was totally dependent on staff for bathing. Her balance during transition was not steady and she was only able to stabilize with staff assistance. The resident had no functional limitation in range of motion of her upper nor lower extremities. She used a walker and wheelchair as mobility devices. The resident had not experienced falls. She received anticoagulants (medication to thin the blood) for seven days of the look back period. Although she was at risk for skin breakdown, she had no current skin breakdown or skin treatment.

The "Quarterly MDS," dated 01/03/23 documented the following changes from the above with a BIMS score of 14, which indicated cognitively intact. She required limited assistance of staff with ADLs.

The " ADL Functional/Rehabilitation Potential, Care Area Assessment" (CAA), dated 10/17/22, documentation included the resident required limited to extensive assistance of staff with all mobility ADLs. She was able to make her needs known. Her skin monitored daily with bathing and cares. Nutritional intake was fair. She was able to make minor positional changes on her own and was up frequently throughout the day with staff.

The "Care Plan," (CP), dated 01/17/23, directed staff the resident took anticoagulant medication for atrial fibrillation (irregular heart rate). Staff should monitor closely for excessive bruising or other signs and symptoms of bleeding and notify the nurse immediately of skin breakdown which

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included bruises and skin discoloration.

On 03/27/23 at 03:16 PM, the resident acknowledged the bruise on her left hand and stated she takes a blood thinner medication, and she barely touches anything and gets a bruise. She stated she hits her hands when going through the doorways.

On 03/28/23 at 12:01 PM, the resident was sitting in her wheelchair in the dining room feeding herself. She used regular utensils and did not strike her hands when feeding herself. The discoloration to the top of her left hand persists.

Review of the resident's "Physician Orders," dated 03/07/23, included orders for Warfarin 6.0 milligrams (mg) given on alternate days from Warfarin 9.0 mg, by mouth daily for blood thinner, ordered 03/27/23.

Review of the resident's Electronic Medical Record (EMR) revealed the lack of documentation of the existence of the discolored area on the resident's arm, nor interventions to prevent the further injury.

On 03/28/23 at 10:34 AM, Certified Nurse Aid (CNA) Q on inquiry confirmed the resident with the discolored area on her left arm. She reported she was not aware of the cause of the bruising or of any interventions in place to prevent further injury. She stated areas should be reported to the nurse when identified and the nurse should assess and put intervention in place to prevent further injury.

On 03/29/23 at 11:35 AM, LN H confirmed the resident for Warfarin/Coumadin as of 03/25/23,

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for Coumadin 6.0 mg, by mouth daily on Tuesday, Thursday, Friday, and Saturday. Warfarin/Coumadin 9.0 mg on Sunday, Monday, and Wednesday started 3/25/23.

On 03/29/23 at 12:36 PM, Licensed Nurse (LN) H stated the staff should report bruising of resident's bruising or discoloration. The nurse should assess the area and document findings in the progress notes. The nurse should initiate investigation to try and prevent further injury. LN H confirmed the bruised area had not been reported, had not been assessed, nor an intervention provided to prevent further injury. She confirmed facility did not track or measure bruises or discolored area routinely to determine status.

On 03/29/2023 at 12:41PM, LN H verified the discolored area on the resident's right forearm 5.2cm x 7.0 cm purple discoloration, with no measurable depth.

On 03/29/23 at 01:02 PM, Administrative Nurse D stated staff should report bruises, skin tears, and or discolored areas to the nurse. The nurse should assess the area to include measurements to determine the status. Residents that receive anticoagulants are prone to bleeding and should be checked daily. The nurse should assess, document, and follow-up with an investigation to determine the cause of trauma so we can put an intervention in place to prevent further injury and track the resolution of the area to determine the effectiveness of the intervention.

The facility policy "Care and Treatment Accident Intervention," dated 01/2023, documentation included the facility provides an environment that

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F 689	Continued From page 29 is free from hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accidents. This includes systems and processes designed to identify hazards and risks, implement interventions to reduce hazards and risks, and monitor for effectiveness and modify approaches as indicated. The facility failed to identify, assess, investigate, and provide interventions for this resident with bruising to protect and help prevent further skin issues.	F 689		
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. (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 72 residents.	F 812		

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Based on observation, interview and record review, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility, as exhibited by the failure to store and label food in the refrigerator, maintain a clean refrigerator for the resident's foods and failure to utilize pasteurized eggs (a process which kills harmful bacteria) for resident's who request soft-cooked eggs for breakfast.

Findings included:

- During an environmental tour on 03/28/23 at 07:36 AM, the following areas of concern were noted:

1. Dietary Staff BB failed to utilize pasteurized eggs when she cooked and served six to eight soft-cooked eggs to residents.

2. The reach in refrigerator contained an open container of Ranch salad dressing which lacked an open date.

3. The reach in refrigerator contained an open container of Mayonnaise which lacked an open date.

4. The reach in refrigerator contained a large amount of food debris on the bottom shelf.

5. The inside of the microwave in the kitchen area had a large amount of splattered, dried on food substance on the insides of the microwave oven.

On 03/28/23 at 07:36 AM, Dietary Staff BB stated she cooked and served six to eight soft-cooked eggs to residents per their request. Dietary Staff

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F 812	Continued From page 31 BB stated she did not use pasteurized eggs for the soft-cooked eggs which had slightly runny yolks. On 03/28/23 at 07:36 AM, dietary Staff CC stated staff would be expected to utilize pasteurized eggs for any soft-cooked eggs which were served to the residents. Dietary staff CC stated any open food item in the reach in refrigerator should be dated with an open date and the inside of the refrigerator should be kept clean of any food debris. The inside of the microwave oven should be kept clean. The facility policy for "Food Procurement", revised 01/2023, included: If the facility uses unpasteurized eggs, the eggs must be cooked until all parts of the egg are completely firm. The facility's "PM Cooks Nightly Closing Duties", used as a guide for dietary staff, included the reach in coolers would be organized and cleaned nightly as well as the microwave oven would be cleaned inside and out at the end of each night shift. The facility failed to store, prepare, and serve food under sanitary conditions to prevent the spread of food borne illnesses to the residents of the facility as well as failed to utilize pasteurized eggs for soft-cooked eggs served to the residents.	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	F 880		

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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;
(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

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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 72 residents. Based on observation interview and record review, the facility failed to maintain an effective infection control program with the failure to change out nasal cannula tubing per physician order for Resident (R)40, failed to administer eye drops in a sanitary manner for R4, and failed to dispose of a used contaminated needle properly. These practices failed to follow infection control standards to reduce the risk of causing or spreading infections or exposure to a blood borne pathogen (infectious microorganism in human blood that can cause disease in humans).

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Findings included:

- The "Medical Diagnosis" tab for R40 included diagnoses of pneumonia (inflammation of the lungs), obstructive sleep apnea (disorder of sleep characterized by periods without respirations), and Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure).

The "Admission Minimum Data Set" (MDS) dated 06/30/22 assessed R40 with a "Brief Interview of Mental Status" (BIMS) score of five indicating severe cognitive impairment and he did not require the use of oxygen.

The "Quarterly MDS" dated 02/01/23 assessed R40 with a "BIMS" score of six indicating severed cognitive impairment and did not require the use of oxygen.

The "Care Plan" dated 02/15/23 revealed R40 had pneumonia and for the staff to assess lung sounds, monitor vital signs, monitor for signs and symptoms, and to give medications as ordered.

The "Orders" tab for R40 included orders dated 03/01/23 for oxygen, at two liters per minute, per nasal cannula, continuous, to keep oxygen saturation levels above 90 percent and to change the oxygen tubing weekly on Wednesday.

The "Medication Administration Record" for March 2023, for R40 revealed the staff changed the oxygen tubing on 03/01/23, 03/08/23, 03/15/23, and 03/22/23.

On 03/2723 at 02:28 PM, R31 was sitting in his room with oxygen in place per nasal cannula form

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the portable machine on the back of his wheelchair. The oxygen tubing had a date of "03/08" wrote on tape attached to the tubing.

On 03/28/23 at 10:52 AM, R31 was sitting up in his wheelchair with oxygen in place per nasal cannula from the portable machine, the tubing continued to be dated "03/08".

On 03/28/23 at 01:46 PM, Licensed Nurse (LN) I stated the oxygen tubing was to be changed weekly on Wednesday by the evening shift Certified Medication Aide (CMA).

On 03/28/23 at 02:24 PM, CMA R stated the staff changed the oxygen tubing on Wednesdays, including the tubing on the portable machines and portable bottles.

On 03/28/23 at 02:25 PM, CMA R stated R31' s oxygen tubing connected to the portable machine had a date of "03/08" and his tubing had been missed being changed twice.

On 03/28/23 at 10:07 AM, Administrative Nurse D stated she expected the staff to change the oxygen tubing weekly, including the tubing for the portable oxygen.

The facility policy "Oxygen Administration" dated January 2023 revealed the staff were to change the oxygen tubing weekly.

The facility failed to ensure staff changed R40's oxygen tubing weekly per physician order. This deficient practice increased the risk of R40 for developing additional respiratory infection.

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- On 03/28/23 at 11:18 AM, observed Licensed Nurse (LN) G roll up the supplies used to obtain the blood sugar level of Resident (R)25, which included the lancet use to prick the finger for the blood sample, remove his gloves around the rolled-up paper towels, and dispose of it in the trash can in R25's room.

On 03/28/23 at 11:22 AM, LN G stated he rolled up the lancet in the paper towels and gloves and placed in the trash can. LN G stated "no I don't think so" when questioned if the lancet should be disposed of in a sharps container (hard plastic container in which needles and glass cannot penetrate through reducing the likelihood of injuries from used contaminated needles.

On 03/28/23 at 01:09 PM, Administrative Nurse F stated needles should be disposed of in a sharps container rather than a trash can.

The facility policy "Infection Control - Sharps Disposal" dated January 2023, revealed contaminated sharps shall be discarded immediately or as soon as feasible into designated containers, which were closable, puncture resistant, and leak proof on the sides and the bottom.

The facility failed to maintain an effective infection control program to prevent the spread of infections when they failed to ensure sharps were disposed in the proper container to reduce the risk of exposure to a blood borne pathogen.

- During an observation on 03/27/23 at 04:28 PM, revealed Certified Medication Aide (CMA) R administer Artificial Tears (an eye lubricant liquid) to Resident (R)4. CMA R failed to apply gloves

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before administering the eye drop medication to the resident.

On 03/27/23 at 04:28 PM, CMA R stated she had not worn gloves during the administration of eye drops and she should have.

On 03/29/23 at 04:51 PM, Administrative Staff A stated the expectation would be for staff to wear gloves while administering eye drop medication to a resident.

The facility policy for "Medication Administration", revised 01/2023, included: When preparing to administer medication to the eyes, staff shall apply gloves.

The facility failed to maintain an infection control program to prevent the spread of infection when a staff member administered eye medication to this dependent resident without applying gloves first.