STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676079	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK VIEW NURSING CARE CENTER	1100 W AVE J MULESHOE, TX 79347

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by C[CONDITION] for 10 of 16 residents (Resident #1, Resident #4, Resident #5, Resident #13, Resident #15, Resident #17, Resident #27, Resident #28, Resident #29 and Resident #31) reviewed for MDS accuracy. The facility failed to accurately code the use of side rails in Resident #1's MDS. The facility failed to accurately code the use of side rails in Resident #4's MDS. The facility failed to accurately code the use of side rails in Resident #5's MDS. The facility failed to accurately code the use of side rails in Resident #13's MDS. The facility failed to accurately code the use of side rails in Resident #15's MDS. The facility failed to accurately code the use of side rails in Resident #17's MDS. The facility failed to accurately code the use of side rails in Resident #27's MDS. The facility failed to accurately code the use of side rails in Resident #28's MDS. The facility failed to accurately code the use of side rails in Resident #29's MDS. The facility failed to accurately code the use of side rails in Resident #31's MDS. This deficient practice has the potential to affect residents by placing them at an increased risk of poor self-esteem and self-worth, poor quality of life, falls, entrapment, bruising, lacerations, fractures, traumatic head injury and hanging. Findings include: Resident #1 Record review of Resident #1's current face sheet revealed a [AGE] year-old female with an admission date of [DATE]. Resident #1's [DIAGNOSES REDACTED]. Resident #1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 4, indicating severe cognitive impairment on 2/15/20. The MDS assessment, last updated on 2/15/20, revealed she required extensive 1 person assistance for bed mobility, transfers, dressing, toileting and bathing; required set up assistance for all other ADLs; had bilateral upper and lower extremity impairment; used a walker and wheelchair for mobility; was frequently incontinent of bladder and bowel; had occasional pain that required medication; and was at risk for pressure sores. Section P of MDS revealed that bed rails were not being used. Record Review of Resident #1's Care Plan, last updated 1/23/20, revealed: Date Initiated: 11/01/2019: I use side rails to aid in bed mobility and self-positioning. Record Review of Resident #1's current Physician order [REDACTED]. Resident utilizes bed rail for turning and sitting up. Record Review of Resident #1's Bed Rail/Assist Bar Evaluation revealed: 2/11/2020: BED RAIL/ASSIST BAR EVALUATION-Quarterly 9/4/2019: BED RAIL/ASSIST BAR EVALUATION-Admission 6/4/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly 8/17/2018: BED RAIL/ASSIST BAR EVALUATION-Quarterly 5/16/2018: BED RAIL/ASSIST BAR EVALUATION-Quarterly During an observation on initial tour on 3/3/20 at 10:19 AM, Resident #1's side rails were in the up-position. During an observation on 3/04/20 at 10:30 AM, Resident #1's side rails were in the up-position. Resident #4 Record review of Resident #4's clinical record revealed an [AGE] year-old female with a current readmission date of [DATE]. Resident #4's [DIAGNOSES REDACTED]. Record review of Resident #4's MDS, dated [DATE], revealed a BI[CONDITION] score of 10 out of 15 indicating moderate cognitive impairment. The MDS revealed that Resident #4 required extensive assistance from staff with bed mobility, dressing, toilet use, and personal hygiene. Section P of MDS revealed that bed rails were not being used. Record review of Resident #4's clinical records revealed a bedrail consent that was signed and dated on 10/23/2019 by Resident #4's POA. Record review of Resident #4's current MD Orders revealed: 10/12/15: May use bedside rails for positioning. During an observation on 3/4/20 at 9:20 AM, Resident #4 was sleeping in bed, and her side rails were in the up-position. Resident #5 Record review of Resident #5's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #5's [DIAGNOSES REDACTED]. Resident #5 had a Brief Interview for Mental Status (BI[CONDITION]) score of 4, indicating severe cognitive impairment on 12/7/19. The MDS assessment, last updated on 12/7/19, revealed he required extensive 1 person assistance for bed mobility, transfers, dressing, toileting and bathing; required limited 1 person assistance for hygiene and all other ADLs; had bilateral upper and lower extremity impairment; used a wheelchair for mobility; was frequently incontinent of bladder and bowel; had occasional pain that required medication; and was at risk for pressure sores. Section P of MDS revealed that bed rails were not being used. Record Review of Resident #5's Care Plan, last updated 12/22/19, revealed: I use side rails to aid in bed mobility and self-positioning. Date Initiated: 11/01/2019 Record Review of Resident #5's current Physician order [REDACTED]. Resident utilizes bed rail for turning and sitting up. Record Review of Resident #5's Consent for Bedrails revealed the consent was completed 11/[DATE]9. Record Review of Resident #5's BED RAIL/ASSIST BAR EVALUATION revealed: 2/10/2020: BED RAIL/ASSIST BAR EVALUATION-Quarterly 10/21/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly 6/4/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly 9/5/2018: BED RAIL/ASSIST BAR EVALUATION-Admission 6/5/2018: BED RAIL/ASSIST BAR EVALUATION-Comprehensive 3/6/2018: BED RAIL/ASSIST BAR EVALUATION-Quarterly During an observation on initial tour on 3/3/20 at 10:22 AM, Resident #5's side rails were in the up-position. During an observation and concurrent interview on 3/4/20 at 9:55 AM, Resident #5's side rails were in the up-position. Resident #13 Record review of Resident #13's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #13's [DIAGNOSES REDACTED]. Resident #13 had a Brief Interview for Mental Status (BI[CONDITION]) score of 99 on 12/2[DATE]9. The MDS assessment, last updated on 12/2[DATE]9, revealed he required extensive 2 person assistance for bed mobility, transfers, dressing, and toileting; required extensive 1 person assistance for hygiene, bathing and all other ADLs; had bilateral upper and lower extremity impairment; used a wheelchair for mobility; was always incontinent of bladder and bowel; had occasional pain that required medication; and was at risk for pressure sores. Section P of MDS revealed that bed rails were not being used. Record Review of Resident #13's Care Plan, last updated 11/1/19, revealed: I use side rails to aid in bed mobility and self-positioning. Date Initiated: 11/01/2019. Record Review of Resident #13's current Physician order [REDACTED]. Record Review of Resident #13's Consent for Bedrails revealed the consent was completed 11/20/2019. Record Review of Resident #5's BED RAIL/ASSIST BAR EVALUATION revealed: 2/10/2020: BED RAIL/ASSIST BAR EVALUATION 10/21/2019: BED RAIL/ASSIST BAR EVALUATION During an observation on initial tour on 3/3/20 at 2:21 PM, Resident #13's side rails were in the up-position. During an observation on 3/4/20 at 10:19 AM, Resident #13's side rails were in the up-position. Resident #15 Record review of Resident #15's clinical record reveals an [AGE] year-old male with a current admission date of [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's MDS dated [DATE] revealed a BI[CONDITION] score of 6 out of 15 indicating severe cognitive impairment. The MDS revealed that he required extensive assistance from staff with bed mobility, dressing, and toilet use; and requires supervision with personal hygiene. Section P of MDS revealed that bed rails were not being used. Record review of Resident #15's current MD Orders revealed: May use bedside rails for positioning. Record review of Resident #15's Bed Rail Consent revealed the consent was signed and dated on 2/11/20 by Resident #15's POA. During observation of Resident #15 on 3/3/20 at 10:52 AM, Resident #15's side rails were in the up-position. Resident #17 Record review of Resident #17's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #17's [DIAGNOSES REDACTED]. Resident #17 had a Brief Interview for Mental Status (BI[CONDITION]) score of 10, indicating moderate

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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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) cognitive impairment on 1/15/20. The MDS assessment, last updated on 1/15/20, revealed he required extensive 1 person assistance for bed mobility, transfers, dressing, toileting and bathing; required limited 1 person assistance for hygiene and all other ADLs. Record Review of Resident #17's Care Plan, last updated 1/16/20, revealed: I use side rails to aid in bed mobility and self-positioning. Date Initiated: 11/01/2019 Record Review of Resident #17's current Physician order [REDACTED]. Resident utilizes bed rail for turning and sitting up. Record Review of Resident #17's BED RAIL/ASSIST BAR EVALUATION revealed: 2/10/2020: BED RAIL/ASSIST BAR EVALUATION-Quarterly 10/21/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly 6/4/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly During an observation on initial tour on 3/3/20 at 11:28 AM, Resident #17's side rails were in the up-position. During an observation on 3/4/20 at 3:19 PM, Resident #17's side rails were in the up-position. Resident #27 Record review of Resident #27's clinical record revealed an [AGE] year-old female with a current admission date of [DATE]. Resident #27's [DIAGNOSES REDACTED]. Record review of Resident #27's MDS, dated [DATE], revealed a BI[CONDITION] score of 15 out of 15 indicating no cognitive impairment. The MDS revealed that she required extensive assistance from staff with bed mobility, dressing, and toilet use; and requires supervision with personal hygiene. Section P of MDS revealed that bed rails were not being used. Record review of Resident #27's Consent for Bed Rails revealed Resident #27 signed and dated the consent on 10/22/2019. Record review of Resident #27's current MD Orders revealed: May use bedside rails for positioning. During an observation on 3/4/20 at 9:45 AM, Resident #27 was lying in bed with side rails in the up-position. Resident #28 Resident #28 is an [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #28's Quarterly MDS, dated [DATE], revealed a BI[CONDITION] score of 9 out of 15 which indicates cognition is moderately impaired. MDS revealed that bed rails were not being used. Record Review of Resident #28's Care Plan, dated 2/17/20, revealed Resident #21 is able to perform ADLs independently, has impaired cognitive functioning and uses half side rails for bed mobility and repositioning. Record Review of Resident #28's Consent for Bedrails revealed the consent was dated 10/23/19. Record Review of Resident #28's Bed Rail Assessments revealed one bed rail assessment dated [DATE]. Record Review of Resident #28's current MD orders revealed: 12/2[DATE]9: Side rails x's 2 for bed mobility. During an observation on 3/4/20 at 11:29 AM, Resident #28's side rails in the up-position. Resident #29 Resident #29 is an [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #29's Quarterly MDS dated [DATE] documents a BI[CONDITION] score of 4 out of 15 which indicates cognition is severely impaired. Section P of Resident #29's MDS indicated that bed rails were not being used. Record Review of Resident #29's Care Plan, dated 3/3/20, revealed Resident #29 is able to turn and reposition independently, is at risk for falls, is incontinent of bladder and uses half rails for bed mobility and repositioning. Record Review of Resident #29's Consent for Bedrails revealed Resident #29's Responsible Party signed the consent on 11/20/19. Physician orders [REDACTED]. Record Review of Resident #29's Bed Rail Assessments revealed no bed rail assessments were completed. During an observation on 3/4/20 at 11:29 AM, Resident #29 was asleep in bed with side rails in the up-position. Resident #31 Record Review of Resident #31 current face sheet revealed an [AGE] year-old female admitted on [DATE]. Resident #31 had the [DIAGNOSES REDACTED]. Record Review of Resident #31's Significant Change MDS revealed she had a Brief Interview for Mental Status (BI[CONDITION]) score of 15, indicating no cognitive impairment on 2/13/20. Section P of Resident #31's MDS indicated that bed rails were not being used. Record Review of Resident #31's Care plan, dated 2/18/20, documents Resident #31 requires 2 staff to assist with repositioning and turning in bed, requires assistance to transfer, requires the use of a lift for transfers, incontinent of bladder, has sleep apnea, and uses half rails for bed mobility and repositioning. Record Review of Resident #31's current Physician orders [REDACTED]. Record Review of Resident #31's Consent for Bedrails revealed the Consent was completed on 10/22/19. During an observation on 3/3/20 at 10:37 AM, Resident #31 was in bed with side rails in the up-positon. During an interview on 3/5/20 at 1:45 PM, when asked whether the use of side rails should be coded in section P, MDS stated, I do not code the bed rails if the resident is able to turn and reposition themselves. It is not a restraint then. We do care plan the bedrails, so it is documented. Record review of the facility provided policy for Resident Assessment Instrument, dated 9/2010, it revealed: 7. All persons who have completed any portion of the MDS Resident Assessment form MUST sign such document attesting to the accuracy of such information. Record review of the MDS guidance from C[CONDITION], located at https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf, it revealed: Section P Coding Tips and Special Populations -In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use. It is possible that a manual method or physical or mechanical device, material or equipment may improve a resident's mobility but also have the effect of physically restraining him or her. -Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A. Remove easily means that the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over .
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet residents' medical, nursing, and mental and psychosocial needs for 2 of 16 residents (Resident #10 and Resident #17) reviewed for Care Plans. - Resident #10's Comprehensive Care Plan failed to address her Stage 2 Pressure Sore to the coccyx that required moisture barrier twice daily and as needed since 2/27/20, did not address dehydration risks related to diuretic use, did not address daily weights ordered 2/19/20, and did not address the wound care consult ordered on [DATE]. - Resident #17's Comprehensive Care Plan failed to address Resident #17's [MEDICAL CONDITION]. This failure could place residents at risk of receiving care that is substandard, unable to meet their needs, or inadequate to prevent complications. Findings include: Resident #10 Record review of Resident #10's current face sheet revealed a [AGE] year-old female with an admission date of [DATE]. Resident #10's [DIAGNOSES REDACTED]. Resident #10 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment on [DATE]. The MDS assessment, last updated on [DATE], revealed she required extensive 1 person assistance for transfers, dressing, and toileting; and required limited 1 person assistance for all other ADLs; had bilateral upper and lower extremity impairment; used a walker and wheelchair for mobility; was frequently incontinent of bladder and bowel; had occasional pain that required medication; and was at risk for pressure sores. Record Review of Resident #10's Progress Notes revealed: 2/18/20: Wound Care consult ordered. Record Review of Resident #10's current Physician order [REDACTED]. Record Review of Resident #10's Care Plan, last updated [DATE], revealed she is at risk for pressure sores, but fails to address the Stage 2 Pressure Sore that requires daily wound care. Resident #10's Comprehensive Care Plan failed to address dehydration risks related to diuretic use, failed to address daily weights ordered 2/19/20, and failed to address the wound care consult ordered on [DATE]. Resident #17 Record review of Resident #17's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #17's [DIAGNOSES REDACTED]. Resident #17 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment on 1/15/20. The MDS assessment, last updated on 1/15/20, revealed he required extensive 1 person assistance for bed mobility, transfers, dressing, toileting and bathing; required limited 1 person assistance for hygiene and all other ADLs; had bilateral lower extremity impairment and unilateral upper extremity impairment; used a wheelchair for mobility; was always incontinent of bladder and frequently incontinent of bowel; and was at risk for pressure sores. Record Review of Resident #17's Care Plan, last updated 1/16/20, revealed no care, treatment and goals related to [MEDICAL CONDITION]. During an interview on 3/5/20 at 1:50 PM, when asked what types of issues should be on the comprehensive care plan, DON stated, Anything that is done specifically for that resident. Anything related to their care. When asked would this include issues including, but not limited to: daily weights, wound care, therapeutic diets, risks of diuretics, etc., DON stated, I think it should. Record Review of the facility provided policy for Goals and Objectives, Care Plans, dated 4/2009, revealed: Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Record Review of the RAI guidelines at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf, revealed: 4.6 .it facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 4 of 16 residents (Resident #1, Resident #5, Resident #13 and Resident #31) reviewed for Respiratory Care. The facility failed to follow MD orders for changing breathing treatment supplies for Resident #1. The facility failed to follow MD orders for changing oxygen supplies for Resident #5. The facility failed to provide care consistent with professional standards for changing oxygen and breathing treatment supplies for Resident #13. The facility failed to follow MD orders for changing breathing treatment supplies for Resident #31. This deficient practice has the potential to affect residents by placing them at an increased risk of respiratory compromise, infections, pneumonia, respiratory distress [MEDICAL CONDITION]. Findings include: Resident #1 Record review of Resident #1's current face sheet revealed a [AGE] year-old female with an admission date of [DATE]. Resident #1's [DIAGNOSES REDACTED]. Record Review of Resident #1's Care Plan, last updated [DATE], revealed: Change nebulizer tubing every week. Date Initiated: [DATE]. Record Review of Resident #1's current Physician Orders revealed: [DATE]: Change HHN pipe and tubing weekly on Saturday. One time a day every Saturday. During an observation during initial tour on [DATE] at 10:19 AM, Resident #1's respiratory therapy tubing was dated [DATE]. During an observation on [DATE] at 2:18 PM, Resident #1's respiratory therapy tubing was dated [DATE]. Resident #5 Record review of Resident #5's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #5's [DIAGNOSES REDACTED]. Record Review of Resident #5's current Physician Orders revealed: [DATE]: Change O2 tubing, cannula/mask &humidifier weekly on Saturday at bedtime every Saturday. During an observation during initial tour on [DATE] at 10:22 AM, Resident #5's oxygen tubing was in a plastic bag. Neither the oxygen tubing, oxygen humidification bottle or plastic bag were dated. During an observation on [DATE] at 2:14 PM, Resident #5's oxygen tubing was in a plastic bag. Neither the oxygen tubing, oxygen humidification bottle or plastic bag were dated. Resident #13 Record review of Resident #13's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #13's [DIAGNOSES REDACTED]. Record Review of Resident #13's current Physician Orders revealed: [DATE]: Oxygen @ ,[DATE] LPM via nasal cannula to keep saturation greater than 90% every shift. During an observation during initial tour on [DATE] at 10:32 AM, Resident #13's oxygen humidifier, oxygen tubing and nasal cannula were not dated. No respiratory equipment storage bag was present. Nasal cannula draped with nasal prongs touching the inside of the nightstand drawer. During an observation on [DATE] at 2:21 PM, Resident #13's oxygen humidifier, oxygen tubing and nasal cannula were not dated. No respiratory equipment storage bag was present. Nasal cannula draped with nasal prongs touching the inside of the nightstand drawer. During an observation on [DATE] at 10:19 AM, Resident #13's oxygen humidifier, oxygen tubing and nasal cannula were dated [DATE]. Resident #31 Record Review of Resident #31 current face sheet revealed an [AGE] year old female admitted on [DATE]. Resident #31 had the [DIAGNOSES REDACTED]. Record Review of Resident #31's current Physician orders revealed: [DATE]Change oxygen tubing, cannula and humidifier weekly on Saturday. During an observation on [DATE] at 10:37 AM, Resident #31's oxygen humidifier, oxygen tubing and nasal cannula were not dated. During an observation on [DATE] at 2:38 PM, Resident #31's oxygen humidifier, oxygen tubing and nasal cannula were not dated. During an interview on [DATE] at 3:19 PM, when asked how the staff knows hand-held nebulizers and oxygen tubing and oxygen delivery equipment are not expired, RN B stated, They are dated. When asked when hand-held nebulizers and oxygen tubing and oxygen delivery equipment are to be changed, RN B stated, The night nurse on Saturdays does that. When informed that numerous oxygen tubing, humidifiers and hand-held nebulizers were undated on initial tour, RN B stated, I don't know. I know they are supposed to be changed on Saturday. When asked what the risks of using expired oxygen tubing, humidifiers and hand-held nebulizers were, RN B stated, Infections. During an interview with on [DATE] at 1:50 PM, when asked how staff knows oxygen respiratory therapy supplies are expired, DON stated, The tubing and supplies are changed every Saturday and dated with the date the equipment was changed. DON confirmed the oxygen tubing, humidification bottle, nasal canula and/or hand-held nebulizers should be dated, and there should be no longer than 7 days for dates on respiratory supplies. When asked what the risks of failing to change respiratory supplies every 7 days were, DON stated, Infection. When informed numerous oxygen and HHN setups were not dated and asked whether this meets her expectations as DON, she stated, No. Record review of the facility provided policy for Administering Medications through a Small Volume (Handheld) Nebulizer, dated ,[DATE], it revealed: 29. When equipment is completely, dry, store in a plastic bag with the resident's name and date on it. 30. Change equipment and tubing every 7 days, or according to facility protocol. Record review of the facility provided policy for Oxygen Administration, dated ,[DATE], it revealed: 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Although requested, no policies related to: When to Change Respiratory Equipment (Nasal Cannula) were provided.

F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the resident for risk of entrapment from bed rails prior to installation and failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 9 of 16 residents (Resident #1, Resident #13, Resident #15, Resident #17, Resident #21, Resident #27, Resident #28, Resident #29 and Resident #31) reviewed for Bed Rails. The facility failed to obtain informed consent before the implementation of the side rails and perform quarterly bed rail entrapment assessments for Resident #1. The facility failed to obtain informed consent before the implementation of of side rails and perform quarterly bed rail entrapment assessments for Resident #13. The facility failed to obtain informed consent before the implementation of the side rails and perform a bed rail entrapment assessment for Resident #15. The facility failed to obtain informed consent before the implementation of the side rails and perform quarterly bed rail entrapment assessments for Resident #17. The facility failed to obtain informed consent before the implementation of the side rails and perform a bed rail entrapment assessment for Resident #21. The facility failed to perform a bed rail entrapment assessment prior to the implementation of the bed rails for Resident #27. The facility failed to obtain informed consent before the implementation of the side rails and perform quarterly bed rail entrapment assessments for Resident #28. The facility failed to perform a bed rail entrapment assessment before the implementation of the side rails for Resident #29. The facility failed to perform a bed rail entrapment assessment before the implementation of the side rails for Resident #31. This deficient practice has the potential to affect residents by placing them at an increased risk of poor self-esteem and self-worth, poor quality of life, falls, entrapment, bruising, lacerations, fractures, traumatic head injury and hanging. Findings include: Resident #1 Record review of Resident #1's current face sheet revealed a [AGE] year-old female with an admission date of [DATE]. Resident #1's [DIAGNOSES REDACTED]. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment on 2/15/20. Record Review of Resident #1's Care Plan, last updated 1/23/20, revealed: Date Initiated: 11/01/2019: I use side rails to aid in bed mobility and self-positioning. Record Review of Resident #1's current Physician order [REDACTED]. Resident utilizes bed rail for turning and sitting up. Record review of Resident #1's clinical record revealed that no bed rail informed consent form had been completed. Record Review of Resident #1's Quarterly Bed Rail/Assist Bar Evaluation revealed: 2/11/2020: BED RAIL/ASSIST BAR EVALUATION-Quarterly 9/4/2019: BED RAIL/ASSIST BAR EVALUATION-Admission 6/4/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly During an observation on initial tour on 3/3/20 at 10:19 AM, Resident #1's side rails were in the up-position. During an observation on 3/04/20 at 10:30 AM, Resident #1's side rails were in the up-position. Resident #13 Record review of Resident #13's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #13's [DIAGNOSES REDACTED]. Resident #13 had a Brief Interview for Mental Status

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK VIEW NURSING CARE CENTER	1100 W AVE J MULESHOE, TX 79347

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

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) (BIMS) score of 99 on 12/24/19 indicating cognitive impairment. Record Review of Resident #13's Care Plan, last updated 11/1/19, revealed: I use side rails to aid in bed mobility and self-positioning. Date Initiated: 11/01/2019. Record Review of Resident #13's current Physician order [REDACTED]. Record Review of Resident #13's Consent for Bedrails revealed the consent was completed 11/20/2019. Record Review of Resident #5's QUARTERLY BED RAIL/ASSIST BAR EVALUATION revealed: 2/10/2020: BED RAIL/ASSIST BAR EVALUATION 10/21/2019: BED RAIL/ASSIST BAR EVALUATION During an observation on initial tour on 3/3/20 at 2:21 PM, Resident #13's side rails were in the up-position. During an observation on 3/4/20 at 10:19 AM, Resident #13's side rails were in the up-position. Resident #15 Record review of Resident #15's clinical record reveals an [AGE] year-old male with a current admission date of [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's MDS dated [DATE] revealed a BIMS score of 6 out of 15 indicating severe cognitive impairment. The MDS revealed that he required extensive assistance from staff with bed mobility, dressing, and toilet use; and requires supervision with personal hygiene. Record review of Resident #15's current MD Orders revealed: May use bedside rails for positioning. Record review of Resident #15's Bed Rail Consent revealed the consent was signed and dated on 2/11/20 by Resident #15's POA. During observation of Resident #15 on 3/3/20 at 10:52 AM, Resident #15's side rails were in the up-position. Resident #17 Record review of Resident #17's current face sheet revealed a [AGE] year-old male with an admission date of [DATE]. Resident #17's [DIAGNOSES REDACTED]. Resident #17 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment on 1/15/20. Record Review of Resident #17's Care Plan, last updated 1/16/20, revealed: I use side rails to aid in bed mobility and self-positioning. Date Initiated: 11/01/2019 Record Review of Resident #17's current Physician order [REDACTED]. Resident utilizes bed rail for turning and sitting up. Record Review of Resident #17's Consent for Bedrails revealed the consent was signed and dated on 10/31/19. Record Review of Resident #17's QUARTERLY BED RAIL/ASSIST BAR EVALUATION revealed: 2/10/2020: BED RAIL/ASSIST BAR EVALUATION-Quarterly 10/21/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly 6/4/2019: BED RAIL/ASSIST BAR EVALUATION-Quarterly During an observation on initial tour on 3/3/20 at 11:28 AM, Resident #17's side rails were in the up-position. During an observation on 3/4/20 at 3:19 PM, Resident #17's side rails were in the up-position. Resident #21 Resident #21 is an [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #21's Annual MDS, dated [DATE], revealed a BIMS score of 8 out of 15 which indicates cognition is moderately impaired. Record Review of Resident #21's Care Plan dated, 1/31/20, revealed Resident #21 requires limited assistance with ADLs, is at risk for falls, has behaviors and uses half rails for bed mobility and repositioning. Record Review of Resident #21's current MD orders revealed: 9/10/18: May use bed rails to reposition self in bed. Record Review of Resident #21's Consent for Bedrails revealed Resident #21's Responsible Part signed the consent on 3/3/20. Record Review of Resident #21's Bed Rail Assessments revealed: One bed rail assessment dated [DATE]. Resident #27 Record review of Resident #27's clinical record revealed an [AGE] year-old female with a current admission date of [DATE]. Resident #27's [DIAGNOSES REDACTED]. Record review of Resident #27's MDS, dated [DATE], revealed a BIMS score of 15 out of 15 indicating no cognitive impairment. The MDS revealed that she required extensive assistance from staff with bed mobility, dressing, and toilet use; and requires supervision with personal hygiene. Section P of MDS revealed that bed rails were not being used. Record review of Resident #27's Consent for Bed Rails revealed Resident #27 signed and dated the consent on 10/22/2019. Record review of Resident #27's current MD Orders revealed: May use bedside rails for positioning. During an observation on 3/4/20 at 9:45 AM, Resident #27 was lying in bed with side rails in the up-position. Resident #28 Resident #28 is an [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #28's Quarterly MDS, dated [DATE], revealed a BIMS score of 9 out of 15 which indicates cognition is moderately impaired. MDS revealed that bed rails and oxygen were not being used. Record Review of Resident #28's Care Plan, dated 2/17/20, revealed Resident #21 is able to perform ADLs independently, has impaired cognitive functioning and uses half side rails for bed mobility and repositioning. Record Review of Resident #28's Consent for Bedrails revealed the consent was dated 10/23/19. Record Review of Resident #28's Bed Rail Assessments revealed one bed rail assessment dated [DATE]. Record Review of Resident #28's current MD orders revealed: 12/24/19: Side rails x's 2 for bed mobility. During an observation on 3/4/20 at 11:29 AM, Resident #28's side rails in the up-position. Resident #29 Resident #29 is an [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #29's Quarterly MDS dated [DATE] documents a BIMS score of 4 out of 15 which indicates cognition is severely impaired. Section P of Resident #29's MDS indicated that bed rails were not being used. Record Review of Resident #29's Care Plan, dated 3/3/20, revealed Resident #29 is able to turn and reposition independently, is at risk for falls, is incontinent of bladder and uses half rails for bed mobility and repositioning. Record Review of Resident #29's Consent for Bedrails revealed Resident #29's Responsible Party signed the consent on 11/20/19. Physician orders [REDACTED]. Record Review of Resident #29's Bed Rail Assessments revealed no bed rail assessments were completed. During an observation on 3/4/20 at 11:29 AM, Resident #29 was asleep in bed with side rails in the up-position. Resident #31 Record Review of Resident #31 current face sheet revealed an [AGE] year-old female admitted on [DATE]. Resident #31 had the [DIAGNOSES REDACTED]. Record Review of Resident #31's Significant Change MDS revealed she had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment on 2/13/20. Section P of Resident #31's MDS indicated that bed rails were not being used. Record Review of Resident #31's Care plan, dated 2/18/20, documents Resident #31 requires 2 staff to assist with repositioning and turning in bed, requires assistance to transfer, requires the use of a lift for transfers, incontinent of bladder, has sleep apnea, and uses half rails for bed mobility and repositioning. Record Review of Resident #31's current Physician orders [REDACTED]. Record Review of Resident #31's Consent for Bedrails revealed the Consent was completed on 10/22/19. During an observation on 3/3/20 at 10:37 AM, Resident #31 was in bed with side rails in the up-position x's 2. Resident #31 was unable to lower the bed rails. During an interview on 3/5/20 at 9:50 AM, when asked to produce the missing Bed Rail Assessments and Consent for Bed Rails, ADM stated, My previous DON was not doing the bed rail assessments. We identified the issue in the QAPI. The current DON started work here January 6th. She started doing the bed rail assessments in February. There are no bed rail assessments before February. During an interview on 3/5/20 at 10:15 AM, when asked to produce the missing Bed Rail Assessments and Consent for Bed Rails, DON stated, She had not looked at the consents before yesterday when she was asked for the consents. DON stated she has tried to catch them all up. DON confirmed some residents may not have current consents and some of the bed rail assessments mat not have been completed on time. During an interview on 3/5/20 at 1:45 PM, when asked whether the use of side rails should be coded in section P, MDS stated, I do not code the bed rails if the resident is able to turn and reposition themselves. It is not a restraint then. We do care plan the bedrails, so it is documented. Although requested, no policy for side rails was provided by the facility.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review; it was determined the facility failed to ensure that its medication error rates are not 5 percent or greater. Out of 28 total number of opportunities, MA D committed 5 medication errors for a medication error rate of 17% The facility's failure to ensure that its medication error rates are not 5 percent or greater places residents at risk for accidental or intention overdose on medication, gastrointestinal upset and [DIAGNOSES REDACTED]. Findings include: During an observation of medication pass on 3/3/20 at 12:14 PM, MA D administered Vitamin D3 1000 Units 1 tab by mouth to Resident #21. When asked how many tabs of Vitamin D3 she was administering to Resident #21, MA D pointed to the Vitamin D3 and multivitamin and stated, One of each of those to make 2000 units. During a simultaneous observation of the multivitamin, review of the ingredients revealed it did not contain an additional 1000 units of Vitamin D to make 2000 total units of Vitamin D3. During an observation of medication pass on 3/3/20 at 12:22 PM, MA D administered Vitamin D3 1000 Units 1 tab by mouth to Resident #27. During the simultaneous review of the ingredients in the multivitamin, it revealed it did not contain an additional 1000 units of Vitamin D to make 2000 total units of Vitamin D3. MA D administered [MEDICATION NAME] 20mg by mouth to Resident #27 but failed to document the administration. MA D failed to administer Resident #27's [MEDICATION NAME] 10mg by mouth. During an observation on 3/3/20 at 12:37 PM, MA D poured Resident #29's [MEDICATION NAME] 100mg/5ml liquid to halfway between 5 and 7.5 ml lines. When asked how much [MEDICATION NAME] she was giving, MA D stated, 5m, but I can't see those lines all that well. During an interview on 3/5/20 at 1:50 PM, when asked how the facility ensures no medication errors, DON stated, I have come and watched several medication passes. I have had several trainings. I have been working closely with the CMA since I got here. When informed of the medication error rate, DON stated, I have been working a lot with her. Record review of the facility provided policy or Administering Medications, dated 12/2012, it revealed: Medications shall be administered in a safe and timely manner, and as prescribed. 20. As required or indicated for a medication, the individual administering the medication will record in

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) the medical record: a. The date and time the medication was administered; b. the dosage; c. the route of administration; g. the signature and the title of the person administering the drug. 22.Staff will follow established facility infection control procedures (e.g handwashing, aseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review; it was determined the facility failed to ensure residents were free of any significant medication errors for 1 of 16 residents reviewed for medication administration (Resident #15) Resident #15 received the incorrect dose of [MEDICATION NAME] Sodium twice a day for 7 days for a total of 13 doses. The facility's failure to administer medications correctly could affect all residents resulting in exacerbation of their condition resulting in complications from deterioration in health, hospitalization s. Findings include: Record review of Resident #15's clinical record reveals an [AGE] year-old male with a current admission date of [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's Order Summary Report, dated with active orders as of 01-03-2020 revealed the following order: [MEDICATION NAME] Sodium ([MEDICATION NAME] Capsule Delayed Release Sprinkle 125MG) Give 1 capsule by mouth two times a day related to Unspecified Dementia with Behavioral Disturbance. Record review of Resident #15's progress notes revealed documentation of a medication error that occurred with the medication [MEDICATION NAME]. [MEDICATION NAME] 125mg sprinkles were ordered for resident to be given twice a day. According to a progress note written on 2-11-20 it stated the Pharmacy had called facility and let them know that they had dispensed the wrong medication. They had dispensed [MEDICATION NAME] tabs 250MG. According to progress note, the resident had been given the wrong dose of medication for the last 13 doses. During an interview with DON on 3-4-20 at 10:50 AM when asked about the medication error of Resident #15, she stated that Resident #15 was not getting the right dose of medication. DON states that the doctor was notified, and that Resident #15 had not had any adverse reactions. When questioned who caught the error DON stated she was not sure but that it was caught on 2-11-20. DON stated that Resident #15 received 13 doses of the wrong medication. DON stated she was not sure if labs were drawn on Resident #15. When questioned on why she thinks this error occurred for so long and not noticed by staff giving the medication DON stated that they were not following the five rights of medication administration. DON stated she has done education and in service on employees that give out medication. DON stated she has checked the medication carts and verified that the correct medications were in the carts when compared to the orders. During an interview with DON on 3-4-20 at 2:04 PM, DON clarified that the pharmacy is the one that found the error in the [MEDICATION NAME] for Resident #15, and that no lab work had been drawn on resident per doctor's orders. Record review of facility provided policy titled Administering Medications with a revised date of December 2012, reflects in part: 3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review the facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen when they failed to: Ensure general cleanliness was maintained when preparing food. This deficient practice has the potential to affect all Residents by causing food-borne illnesses, weight loss, and a diminished meal experience. Findings include: During an observation of DA C on 03-03-20 at 11:25 AM to puree lunch, DA C washed hands and donned gloves. DA C moved the food processor closer to her with her gloved hand, then scooped meat into food processor with gloved hand, poured cheese into food processor from a plastic cup, then proceeded to retrieve tortillas from a plastic baggie with her gloved hands and warm them on the grill. DA C then tore the tortilla into small pieces into the food processor with the meat and cheese. During an observation on 03-03-20 at 11:53 AM, DA C checked temperatures on lunch on the steam table. DA C washed her hands, applied gloves then removed lids off foods on the steam table with her gloved hands. DA C checked temperatures on all the warm foods on the steam table. DA C removed gloves and applied new pair of gloves. DA C retrieved a plate with gloved hand and started serving the lunch meal. After touching the scoop with gloved hand to serve the beans and rice she retrieved a taco shell with her gloved hand to make the tacos for lunch. She proceeded with the same process until all lunch plates were served. During an interview with DA C on 03-03-20 at 12:36 PM when asked about touching kitchen utensils with her gloved hands and proceeding to touch food, she stated, I didn't even pay attention to what I was doing. States she was busy talking to the survey team she did not think about it. During an interview with DM on 3-4-20 at 11:54 AM regarding the touching of food items after touching kitchen equipment, DM verifies that staff should change gloves before handling food if they are going to touch kitchen equipment, or to use utensils to handle the food. During record review of facility's policy titled Food and Nutrition Services Staff with a revised date of October 2017, reflected in part: Food Service/Distribution 6. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 for 6 of 16 residents (Resident #1, Resident #5, Resident #10, Resident #13, Resident #27 and Resident #31) reviewed for Infection Control. The facility failed to follow MD orders for changing breathing treatment supplies for Resident #1. The facility failed to follow MD orders for changing oxygen supplies for Resident #5. The facility failed to provide care consistent with professional standards for changing oxygen supplies for Resident #10. The facility failed to provide care consistent with professional standards for changing oxygen and breathing treatment supplies for Resident #13. The facility failed to follow MD orders for changing breathing treatment supplies for Resident #31. MA D administered Resident #27's nasal spray. MA D failed to perform hand hygiene prior to taking a sharpie out of the medication cart, dating the nasal spray, and placing the nasal spray back in the medication cart drawer. LVN A failed to wash hands between glove changes after removing dirty dressing while performing wound care on Resident #27. This deficient practice has the potential to affect residents by placing them at an increased risk of poor wound healing, respiratory and wound infections, pneumonia, respiratory distress [MEDICAL CONDITION]. Findings include: Resident #1 Record Review of Resident #1's Care Plan, last updated [DATE], revealed: Give [MEDICATION NAME] twice daily and [MEDICATION NAME] as needed as ordered. Monitor/document any side effects and effectiveness. Change nebulizer tubing every week. Date Initiated: [DATE]. Record Review of Resident #1's current Physician Orders revealed: [DATE]: Change HHN pipe and tubing weekly on Saturday. One time a day every Saturday. During an observation during initial tour on [DATE] at 10:19 AM, Resident #1's respiratory therapy tubing was dated [DATE]. During an observation on [DATE] at 2:18 PM, Resident #1's respiratory therapy tubing was dated [DATE]. Resident #5 Record Review of Resident #5's Care Plan, last updated [DATE], revealed: Check 02 sat BID, if less than 90% on room air, apply oxygen ,[DATE]L per nasal cannula. Date Initiated: [DATE] Record Review of Resident #5's current Physician Orders revealed: [DATE]: Change O2 tubing, cannula/mask &humidifier weekly on Saturday at bedtime every Saturday. During an observation during initial tour on [DATE] at 10:22 AM, Resident #5's oxygen tubing was in a plastic bag. Neither the oxygen tubing, oxygen humidification bottle or plastic bag were dated (See photographs). During an observation on [DATE] at 2:14 PM, Resident #5's oxygen tubing was in a plastic bag. Neither the oxygen tubing, oxygen humidification bottle or plastic bag were dated. Resident #10 Record Review of Resident #10's Care Plan, last updated [DATE], revealed: I have Oxygen Therapy as needed. My O2 saturation runs above 90% but I chose to wear O2 throughout the day. Date Initiated: [DATE] Record Review of Resident #10's current Physician Orders revealed: [DATE]: O2 continuously @ ,[DATE] LPM via NC to keep O2 saturation greater than 90% every shift. During an observation during initial tour on [DATE] at 10:37 AM, Resident #10's oxygen tubing and oxygen humidification bottle were not dated. Resident #13 Record Review of Resident #13's Care Plan, last updated [DATE], revealed: I require Oxygen therapy: 02 ,[DATE]L per nasal cannula as needed to keep saturation >90%.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) Date Initiated: [DATE]; and Obtain 02 saturation every shift and document. Date Initiated: [DATE]. Record Review of Resident #13's current Physician Orders revealed: [DATE]: Oxygen @ ,[DATE] LPM via nasal cannula to keep saturation greater than 90% every shift. During an observation during initial tour on [DATE] at 10:32 AM, Resident #13's oxygen humidifier, oxygen tubing and nasal cannula were not dated. No respiratory equipment storage bag was present. Nasal cannula draped with nasal prongs touching the inside of the nightstand drawer. During an observation on [DATE] at 2:21 PM, Resident #13's oxygen humidifier, oxygen tubing and nasal cannula were not dated. No respiratory equipment storage bag was present. Nasal cannula draped with nasal prongs touching the inside of the nightstand drawer. Resident #31 Record Review of Resident #31 current face sheet revealed an [AGE] year-old female admitted on [DATE]. Resident #31 had the [DIAGNOSES REDACTED]. Record Review of Resident #31's current Physician orders revealed: [DATE] Change oxygen tubing, cannula and humidifier weekly on Saturday. During an observation on [DATE] at 10:37 AM, Resident #31's oxygen humidifier, oxygen tubing and nasal cannula were not dated. During an observation on [DATE] at 2:38 PM, Resident #31's oxygen humidifier, oxygen tubing and nasal cannula were not dated. During an interview on [DATE] at 3:19 PM, when asked how the staff knows hand-held nebulizers and oxygen tubing and oxygen delivery equipment are not expired, RN B stated, They are dated. When asked when hand-held nebulizers and oxygen tubing and oxygen delivery equipment are to be changed, RN B stated, The night nurse on Saturdays does that. When informed that numerous oxygen tubing, humidifiers and hand-held nebulizers were undated on initial tour, RN B stated, I don't know. I know they are supposed to be changed on Saturday. When asked what the risks of using expired oxygen tubing, humidifiers and hand-held nebulizers were, RN B stated, Infections. During an interview with on [DATE] at 1:50 PM, when asked how staff knows oxygen respiratory therapy supplies are expired, DON stated, The tubing and supplies are changed every Saturday and dated with the date the equipment was changed. DON confirmed the oxygen tubing, humidification bottle, nasal canula and/or hand-held nebulizers should be dated, and there should be no longer than 7 days for dates on respiratory supplies. When asked what the risks of failing to change respiratory supplies every 7 days were, DON stated, Infection. When informed numerous oxygen and HHN setups were not dated and asked whether this meets her expectations as DON, she stated, No. Resident #27 During an observation of medication pass on [DATE] at 12:30 PM, MA D administered Resident #27's nasal spray. MA D failed to perform hand hygiene prior to taking a sharpie out of the medication cart, dating the nasal spray, and placing the nasal spray back in the medication cart drawer. During an observation of wound care on [DATE] at 9:45 AM, LVN A performed wound care on Resident #27. Supplies were gathered, hands washed, and gloves donned. A soiled dressing was removed from the wound to Resident #27's right buttocks. LVN A disposed of the soiled dressing, removed her dirty gloves and donned new gloves without washing or sanitizing her hands. LVN A cleaned the wound and redressed the wound according to orders. During an interview on [DATE] at 10:00 AM, when asked when hand hygiene should have been performed during Resident #27's wound care, LVN A stated, after removing a dirty dressing you should remove your dirty gloves, wash or sanitize hands before applying the new gloves. That is why I had the sanitizer with my stuff, but I didn't use it did I? During an interview on [DATE] at 10:55 AM, when asked when hand hygiene should be performed during wound care, DON stated she expects staff to wash or sanitize hands between glove changes when changing from dirty to clean. While reviewing the facility provided policy for Administering Medications through a Small Volume (Handheld) Nebulizer, dated ,[DATE], it revealed: 29. When equipment is completely, dry, store in a plastic bag with the resident's name and date on it. 30. Change equipment and tubing every 7 days, or according to facility protocol. While reviewing the facility provided policy for Oxygen Administration, dated ,[DATE], it revealed: 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Although requested, no policies related to: When to Change Respiratory Equipment (Nasal Cannula) were provided. While reviewing the facility provided policy or Administering Medications, dated ,[DATE], it revealed: Medications shall be administered in a safe and timely manner, and as prescribed. 22.Staff will follow established facility infection control procedures (e.g handwashing, aseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Record review of facility provided policy titled Wound Care with a revised date of [DATE], reflected in part: 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Record review of facility provided policy titled Handwashing/Hand Hygiene with a revised date of (NAME)2015, reflected in part: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or. Alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: k. After handling used dressings, contaminated equipment, etc.