STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455390	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab-San Antonio	5027 Pecan Grove San Antonio, TX 78222

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 7 (Resident #1) residents reviewed for quality of care. 1. The facility failed to schedule an ENT appointment for Resident #1 per a physician's order. 2. The facility failed to schedule a Vascular appointment for Resident #1 per a physician order. This failure could affect resident who were referred for services with outside providers and could result in a decline in physical condition. The findings were: Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction (a disruption in the brain's blood flow), Hemiplegia (paralysis of one side of the body) and Depression. Record review of Resident #1's quarterly MDS assessment, dated 08/17/2024, revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment. The MDS assessment revealed Resident #1 used a wheelchair for mobility and was dependent on staff for transfers to and from the wheelchair. Section K-Swallowing/Nutritional Status, revealed Resident #1 did not have signs or symptoms of difficulty with swallowing and did not have weight loss. Record review of Resident #1's November 2024 physician orders revealed the following physician orders refer to ENT for dysphagia, dated 04/16/2024, refer to [hospital name] ENT Clinic, dated 09/13/2024, and referral to vascular for eval on abdominal aortic aneurysm, dated 10/07/2024. Record review of Resident #1 progress notes revealed a nursing note, dated 05/17/2024 at 11:26 a.m., by the ADON that stated attempts had been made for the past two weeks to schedule an ENT appointment for the resident, but the appointment had not been made due to a payor source. Record review of Resident #1 progress notes revealed a nursing note, dated 05/17/2024 at 11:42 a.m., by the ADON that stated the ADON contact [hospital name} ENT and sent over the referral for review and was told it may take 5-10 days. ADON stated she would follow up with [hospital name] at that time to get the appointment scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a physician progress note, dated 07/27/2024, revealed documentation by the physician that stated Resident #1 was inquiring about his referral to ENT specialist and said Resident #1 had a pending referral to [hospital name] for ongoing dysphagia. The physician stated Resident #1 had been receiving speech therapy and Resident #1's speech was more understandable. Record review of a nursing progress note dated 08/29/2024 at 11:52 a.m., by the ADON stated the ADON called ENT at [hospital name] and received a recording that they were experiencing a system wide outage. Record review of a nursing progress note dated 08/30/2024 at 1:58 p.m., by the ADON revealed the ADON called ENT at [hospital name] and spoke with a representative who told the ADON the referral was received and an order for a swallow study was received but never uploaded to the system. The ADON told the representative the information would be refaxed. Record review of a nursing progress note, dated 09/13/2024 at 2:37 p.m., by LVN D revealed that LVN D contacted [hospital] ENT clinic to attempt to reschedule Resident #1's appointment and was informed that a new referral with diagnosis codes, face sheet and swallow study would have to be faxed to the clinic and the nurse could call back in 5 business days to check on the status of the referral. Record review of a nursing progress note dated 09/20/2024 at 11:55 a.m., by LVN D revealed LVN D called [hospital name] ENT clinic to follow up on the referral and faxed last week and was informed the referral was never received and was asked to re fax the referral to a different fax number. Record review of a nursing progress note dated 09/27/2024 at 11:36 a.m., revealed LVN D called [hospital name] ENT clinic and was informed the referral was pending. LVN D stated he was transferred to the referral department and notified that [hospital name] was no longer taking new patients. Record review of a physician progress note dated 10/11/2024, revealed Resident #1 had been in the ER for viral gastroenteritis (an intestinal infection involving diarrhea, cramps, nausea, vomiting, and fever), and a vascular aneurysm (abnormal bulge or ballooning in the wall of a blood vessel) was discovered. The physician documented prerenal vascular aneurysm-incidentally seen on abdominal studies- refer to vascular specialist asap. Record review of a progress note by NP B, dated 10/15/2024, revealed NP B met with Resident #1 and stated Resident #1 was upset and told NP B it should not take that long to schedule an appointment and Resident #1 was worried about the condition of the aneurysm and wanted it evaluated soon. NP B stated nursing reported they had not called any offices to schedule the appointment even though the order was provided last week. Record review of a progress note by NP A, dated 11/05/2024, revealed NP A reminded the ADON about the pending ENT referral and stated orders were in place for a vascular referral, patient was anxious to hear updates and NP A discussed this with the ADON. Record review of a psychological services progress note, dated 11/05/2024, revealed Resident #1 spoke at length about lack of follow through on scheduling offsite appointments and hearing issues will be addressed yet seeing little evidence of change. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #1 on 11/15/2024 at 10:50 a.m., Resident #1 stated he received an ENT referral from his physician in April 2024 and still did not have an appointment scheduled. Resident #1 stated he also had a referral to a vascular surgeon from his physician at the beginning of October and said that appointment had also not been scheduled yet. Resident #1 expressed frustration stating he believed an ENT physician would have been able to help his dysphagia to improve. Resident #1 stated his communication and swallowing had improved significantly since arriving at the facility and working with Speech Therapy, but he strongly believed, if he would have been able to see an ENT specialist, he could have had the potential to show more improvement. Resident #1 stated in April he understood there was an issue with his insurance but said it had now been 7 months and no one has scheduled his ENT appointment. Resident #1 said he asked staff about it often and would get different responses as to why it had not been done. During an interview with LVN B on 11/15/2024 at 11:56 a.m., LVN B stated he was PRN and was the Charge Nurse assigned to that shift for Resident #1. LVN B was asked if he was aware of any outside specialist referrals or appointments that needed to be made for Resident #1 and he said no. During an interview with LVN A on 11/18/2024 at 10:30 a.m., LVN A stated she was PRN and was the Charge Nurse assigned to that shift for Resident #1. LVN A stated she was not aware Resident #1 had an ENT referral and a vascular referral order that needed to be scheduled. LVN A said that information should be communicated on the 24-hour report from shift to shift and LVN A said she was not notified of any appointments that needed to be scheduled. LVN B said she thought the charge nurses were responsible for scheduling appointments for residents. During an interview with the ADON on 11/18/2024 at 11:27 a.m., the ADON stated the charge nurses were responsible for scheduling appointments. The ADON stated she was not sure why Resident #1 did not have an ENT appointment scheduled yet but stated she thought Resident #1 had an insurance coverage issue at the beginning and then said we had a big turn over in staff and I don't know what happened to all of the papers. We had someone that was helping look into that appointment, but he (LVN D) quit, and I don't know where the file is and I don't know anything about the status of Resident #1's appointment. The ADON stated she was not aware of the vascular referral and did not know why Resident #1 needed to see the ENT or the vascular physician. During an interview with the Admissions Director on 11/18/2024 at 11:53 a.m., the Admissions Director stated scheduling specialty appointments was a team effort. The Admissions Director said she was not familiar with Resident #1's vascular referral but was familiar with the ENT referral. The Admissions Director said she called about 10-15 ENT offices in April and called a few in May and the clinics she called did not accept his insurance. The Admissions Director said she notified NP B and NP B told her to contact [hospital name] ENT clinic. The Admissions Director stated LVN D started working on that and then was told they were not taking new patients at time. The Admissions Director stated there were other things that could have been done like call other ENT offices, call back to [hospital name] to check if they were taking new patients again, look for other resources for Resident #1. The Admissions Director stated she was not aware of any additional efforts to schedule any appointments for Resident #1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with NP B on 11/18/2024 at 12:15 p.m., NP B expressed frustration that Resident #1's ENT appointment had not been scheduled since April 2024 and the vascular appointment had not been scheduled. NP B stated Resident #1 had requested the ENT appointment in April due to his past stroke and dysphagia and the physician agreed and ordered the referral. NP B stated the facility had given so many excuses as to why it had not been done. NP B stated she mentioned the referral each time she visited the facility and said Resident #1 mentioned it to her as well. NP B said the facility had not had a reliable source to schedule appointments. NP B mentioned the pending vascular appointment to a charge nurse and was told that nurse didn't have time and NP B said, they all say it is someone else's roll to do it. NP B stated I know Resident #1 is frustrated and I am frustrated for him. He is able to make these requests and I feel like they just disregard them. NP B stated Resident #1 was getting better and had been improving with ST but stated Resident #1 still had room for improvement and would benefit from an ENT. During this interview, NP B stated she received a text from the facility ADON asking if NP B had a vascular physician preference regarding the referral order from 10/07/2024. During an interview with Resident #1's Physician on 11/18/2024 at 1:06 p.m., the Physician stated she gave the order for the ENT referral for Resident #1 in April at Resident #1's request related to his dysphagia. The Physician stated she asked about the referral every time she went to the facility and did not get an answer. Regarding the vascular referral the Physician stated, I am concerned, the patient is concerned, and it needs to get done and I am not sure why it is not getting done. During an interview with the DON on 11/18/2024 at 1:44 p.m., the DON stated she was unaware of why Resident #1's ENT appointment had not been scheduled since April 2024 and said she understood several people had been working on it, but she did not know the details. The DON stated she was hired at the facility in August 2024 as the ADON and was promoted to the DON in October 2024. The DON stated she was not aware of the vascular referral until today and stated, going forward, I am going to ask the physicians to give the referrals to myself, the ADON or the new Social Worker and the three of us with start working these referrals. The DON stated the importance of scheduling resident referrals timely was we don't want anything bad to happen to their health, it could be detrimental to their health. Record review of facility policy titled, Appointments (Nursing Policy and Procedure Manual 2003), the policy stated, the facility will assist with outside facility resident appointments to ensure the resident attends any scheduled appointments.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assured accurate administering of all drugs to meet the needs of residents for 1 of 3 residents (Resident #1) reviewed for medication regimen. 1. LVN B did not administer Resident #1's Hydrocortisone gel to his face within the parameters of the scheduled administration time on 11/15/2024. 2. MA A documented that MA A administered medications to Resident #1 on 11/15/2024 that had not been administered. 3. MA A prepared Resident #1's medications, placed the medications in unlabeled cups and stored the medications in the top drawer of MA A's medication cart on 11/15/2024. 4. MA A was administering Lidocaine 4% patches for Resident #1 instead of Lidocaine gel as ordered. 5. LVN A did not administer Resident #1's Hydrocortisone gel to his face within the parameters of the scheduled administration time on 11/18/2024. These failures could place residents who receive medications administered by the facility at risk of not receiving the intended therapeutic benefit of their medication. The findings were: Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction (a disruption in the brain's blood flow), Hemiplegia (paralysis of one side of the body), Hypertension (high blood pressure) and Depression. Record review of Resident #1's quarterly MDS assessment, dated 08/17/2024, revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment. Record review of Resident #1's undated comprehensive care plan revealed Resident #1 had a care plan for hypertension, date initiated 1/31/2024 and revised 02/16/2024. The care plan interventions included to give hypertensive medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate. Resident had a care plan for potential for uncontrolled pain, date initialed 01/31/2024 and revised 02/16/2024, and interventions included to administer analgesia medications as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's November 2024 MAR, 11/15/2024 at 11:01 a.m., revealed an order for Hydrocortisone external gel 1% -apply to face topically two times a day for dry skin for ten days was scheduled for 9 a.m. on 11/15/2024. The order start date was 11/08/2024 and end date was 11/19/2024. The order was not initialed or checked on 11/15/2024 to indicate the medication had been administered. Record review of Resident #1's November 2024 MAR, 11/15/2024 at 11:01 a.m., revealed the following orders scheduled for AM on 11/15/2024 ,were initialed and had a check mark indicating the medications had been administered by CMA A: Lactulose oral solution 10gm/15ml- give 30ml by mouth one time a day for constipation, Lidocaine external gel 4%- apply to bilat shoulders topically one time a day related to pain, Lisinopril oral tablet 20mg-give 1 tablet by mouth one time a day for HTN hold for SBP<110 and DBP<60, Miralax oral packet 17 gm- give 17 gram by mouth one time a day related to unspecified protein calorie malnutrition, Pepcid oral tablet 20mg- give 1 tablet by mouth one time a day for GERD, Vitamin D3 Tablet 5000unit- give 1 tablet by mouth one time a day for vit D deficiency, Artificial tears ophthalmic solution .2-.2-1%- one drop to both eyes twice daily, Senna oral tablet 8.6mg- give 2 tablet by mouth two times a day for constipation give two tabs to equal 17.2mg BID. Record review of Resident #1's November 2024 MAR, 11/18/2024 at 10:35 a.m., revealed an order for Hydrocortisone external gel 1% -apply to face topically two times a day for dry skin for ten days was scheduled for 9 a.m. on 11/18/2024. The order was initialed and checked on 11/18/2024 to indicate the medication had been administered by LVN A. During an interview with Resident #1 on 11/15/2024 at 10:50 a.m., Resident #1 stated he was supposed to have a face cream administered twice a day and said he was not getting it in the morning. Resident #1 stated he had spoken to the DON about it and had continued to have an issue and expressed frustration over not receiving the medication. During the interview, Resident #1 stated he had not received any of his morning medications and stated he usually would have had them by that time of day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation with MA A on 11/15/2024 at 11:43 a.m., MA A stated she was responsible for administering medications to Resident #1. MA A stated the time code AM on the MAR meant sometime between when she gets to work in the morning and noon. MA A stated she had obtained Resident #1's blood pressure around 10 a.m. and then he took off on me and I haven't given the meds to him yet. MA A stated she initialed and checked the MAR for Resident #1's 11/15/2024 AM medications indicating that she had already administered the medication but stated she had not administered the medications. MA A stated she should not have signed the MAR until the medications had been administered. MA A stated she had received training about documentation during medication administration and stated medications should only be signed off as administered after the medications have been administered. MA A stated, but I have all the medications ready for [Resident #1] in my top drawer and proceeded to unlock her cart and pull out a medicine cup containing 6 pills. MA A stated the pills were 2 Senna, 1 Vitamin D, 1 Pepcid, 1 Lisinopril, 1 Multi Vitamin. MA A also pulled a cup of liquid out of the top drawer and stated it was Resident #1's Lactulose and Miralax mixed together in the same cup. MA A stated she could not find the Lidocaine on the cart and needed to go to central supply. She returned to the cart with a box of Lidocaine 4% pain relief patches that contained 5 patches in the box. MA A stated Resident #1 received Lidocaine patches to his bilateral shoulders and MA A stated she always administered lidocaine patches. When asked further about the order, MA A looked at the order and said well, I don't know why it says Lidocaine gel, I always just do the patches. MA A stated she had received training to not prefill resident medication and store in the cart and stated the medications could have spilled in the cart or could have been administered to the wrong resident. MA A stated she had received training on the rights of medication administration that included verification of the right medication and right dose during medication administration. During an interview with LVN B on 11/15/2024 at 11:56 a.m., LVN B stated he was aware Resident #1 had an order for Hydrocortisone external gel 1% -apply to face topically two times a day for dry skin for ten days scheduled for 9 a.m. LVN B stated he had not administered the medication during the administration scheduled time parameters. LVN B stated he had received training on administering medications when scheduled and stated the importance of administering medications when scheduled was so we can reach the unified goal of healing. During an interview and observation with LVN A on 11/18/2024 at 10:30 a.m., LVN A stated she was aware Resident #1 had an order for Hydrocortisone external gel 1% -apply to face topically two times a day for dry skin for ten days scheduled for 9 a.m. LVN A stated she had not administered the medication to Resident #1 but did initial and check it off on the MAR as being administered for 11/18/2024. LVN A stated medications could be administered up to one hour prior and one hour after the medication was scheduled to be administered. LVN A stated she had prefilled the medication and it was in her cart ready to administer to Resident #1. LVN A stated she should not have documented that she administered a medication prior to administering the medication and said yes, I have been a nurse for years and I know I should not do that. LVN A unlocked her medication cart and was unable to locate the prefilled medication cup she had stated she made for Resident #1 and stated, maybe it got thrown in the trash. LVN A stated she had received training regarding not prefilling resident medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 11/18/2024 at 1:44 p.m., the DON stated staff should not save documentation to a resident's MAR, indicating medications were administered until after the medications were administered to the resident. The DON stated the importance of documenting after medication administration was to indicate that the medication was administered. The DON stated documenting a resident received a medication that the resident had not received could have an adverse effect on the resident because the resident is on the medication for a reason. A diabetic could go into a diabetic coma, and we would not know what happened if the documentation was saying they got the medication. The DON stated the expectation was medications were administered up to one more before or one hour after the scheduled time for administration and stated AM meant the morning shift. The DON stated staff should never prefill medications or store the medications in the cart because the medications could have been administered to the wrong resident. The DON stated the charge nurses were responsible for inputting physician orders into the electronic medical record when an order was received from the physician. The DON stated the nurse and medication aides should have followed the medication administration rights that included verifying they were administering the right medication and the right dose by comparing the medication to the orders prior to administration. During an interview with Resident #1's Physician on 11/18/2024 at 1:06 p.m., the Physician stated Resident #1 would not of experienced an adverse outcome related to the MA administering Lidocaine 4% patches in place of the order for Lidocaine 4% gel. Record review of a document titled Medication Aide Proficiency Audit, dated 05/08/2024 for MA A, reflected the following columns labeled: skills, S/N (satisfactory or needs improvement), observer and date. Under the following columns, MA A had an S score dated 05/08/2024: 38. Check medication 3 times, 41. Observe 6 rights -Right patient- Right time - Right medication - Right does - Right route- Right documentation, 42. Use correct technique-dermal patches, 46. Properly store drugs, 49. Checks MAR for accuracy. The document was signed by MA A and the ADON on 05/08/2024. Record review of facility policy titled, Medication Administration Procedures (Pharmacy Policy and Procedure Manual 2003 Revised 10/25/17), stated the following: 3. Open the unit dose package only when you are administering medication directly to the resident. Removing medication from its unit dose packaging in advance lessens the ability to positively identify the medication and increases the chance of drug administration errors and contamination. 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if the policy permits, medications may be charted immediately before administration. 14. A specific order must be obtained from the Physician to change the dosage form of a resident's medication (e.g., tablet to liquid form). 20. The 10 rights of medication should always be adhered to: 1. Right patient 2. Right medication 3. Rights dose 4. Right route 5. Right time 6. Right patient education 7. Right documentation 8. Rights to refuse 9. Right assessment 10. Right evaluation. Record review of a facility document titled, Job Description Charge Nurse (Human Resources Manual 2014), reflected, properly administer resident medication and timely and accurate documentation of resident chart's were components of the required Charge Nurse knowledge base. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility document titled, Job Description Certified Medication Aide (Human Resources Manual 2014), reflected, responsible for appropriately administering resident's prescribed PO, topical (unbroken skin) and rectal medication according to the physician's orders and medication administration policies and records all medication administration according to company policy were components of the required Certified Medication Aide knowledge base. Record review of a document titled, Inservice Training Attendance Roster, listed the training topic as Medication Administration and stated Verifying the 7 rights of medication administration- right patient, right drug, right dose, right time, right route, right reason, and right documentation. All medications need a change of direction sticker when medication orders are changed in PCC to ensure both PCC and medication/blister pack match. The date conducted is 06/20/2024-06/21/2024. The roster contained 23 employee signatures that included MA A and MA B.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 3 (Resident #3) residents reviewed for medication administration. MA B failed to perform hand hygiene after administering medications to Resident #2 and before administering medications to Resident #3. This failure could place residents receiving medication at risk for cross contamination and/or spread of infection. The findings were: Record review of Resident #2's undated face sheet revealed Resident #2 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Dementia (a general term for impaired ability to remember, think, or make decisions), Anxiety and Asymptomatic Human Immunodeficiency Virus Infection (a virus that attacks the body's immune system). Record review of Resident #2's admission MDS assessment, dated 09/25/2024, revealed Resident #2 had a BIMS score of 0, indicating severe cognitive impairment. Section I- Active Diagnoses of the MDS assessment listed diagnoses that included Dementia and Asymptomatic Human Immunodeficiency Virus Infection. Record review of Resident #2's comprehensive care plan revealed Resident #2 had a care plan, date initiated 09/14/2024 and revised 09/25/2024, for impaired immunity related to a diagnosis of asymptomatic human immunodeficiency virus infection. The goal of the care plan was Resident #2 was to remain free from infection. Interventions included the resident is at risk for contracting infections due to impaired immune status. Keep environment clean and people with infection away. Record review of Resident #3's undated face sheet revealed Resident #3 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Dementia (a general term for impaired ability to remember, think, or make decisions), Viral Hepatitis C (a viral infection that causes liver inflammation), Schizoaffective Disorder (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as delusions and hallucinations) and Anxiety. Record review of Resident #3's admission MDS assessment, dated 09/04/2024, revealed a BIMS score of 2, indicating severe cognitive impairment. Section I-Active Diagnoses of the MDS assessment listed diagnoses that included Dementia, Schizophrenia and Viral Hepatitis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455390	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab-San Antonio	5027 Pecan Grove San Antonio, TX 78222

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation on, 11/15/2024 at 9:26 a.m., MA B was observed administering the following medications to Resident #2: Donepezil HCl oral tablet 5mg, Evotaz oral tablet 300-150mg, Folic Acid oral tablet 1mg and Tivicay oral tablet 50mg. MA B administered the oral medications to Resident #2 in the doorway to his room by handing him a medication cup with the 4 medications in the cup and a glass of water. Resident #2 swallowed the medications, drank the water and handed the cups back to MA B. MA B returned to her medication cart and disposed of the cups in the trash can attached to her medication cart. MA B then stated she needed to obtain a blood pressure for Resident #3 and MA B picked up the blood pressure cuff that was on top of her medication cart and entered Resident #3's room. Resident #3 was observed lying in his bed. MA B explained to Resident #3 that MA B was going to check his blood pressure and proceeded to place the cuff on Resident #3's right wrist. After checking Resident #3's blood pressure, MA B returned to the medication cart, placed the blood pressure cuff on top of the cart and then pulled the following medications from the cart for Resident #3: Lorazepam oral tablet 1mg, Buspirone HCl oral tablet 7.5mg and Amlodipine Desylate oral tablet 10mg. MA B entered Resident #3's room and handed Resident #3 the medication cup and a cup of water. Resident #3 swallowed the medication, drank the water and handed both cups back to MA B. MA B returned to the medication cart and threw the cups in the trash can attached to the medication cart. During an interview with MA B on 11/15/2024 at 9:40 a.m., MA B stated she should have performed hand hygiene after administering medications to Resident #2 and before administering medications to Resident #3. MA B stated she had received training on proper hand hygiene during medication administration and stated the importance of hand hygiene during medication administration was to prevent contamination. During an interview with the DON on 11/18/2024 at 1:44 p.m., the DON stated staff had received training regarding hand hygiene during medication administration and stated the importance of hand hygiene during medication administration was to prevent cross contamination and prevent infections. Record review of a document titled Medication Aide Proficiency Audit, dated 06/04/2024 for CMA B, reflected the following columns labeled: skills, S/N (satisfactory or needs improvement), observer and date. Under the column for infection control and proper handwashing, CMA B received an S on 06/04/2024. Record review of facility policy titled, Fundamentals of Infection Control Precautions (Infection Control Policy and Procedure Manual 2019 and updated 3.2024), stated hand hygiene continues to be the primary means of preventing the transmission of infection. Record review of a document titled, Job Description Certified Medication Aide, reflected responsible for observing infection control policies for medication administration was listed as a criteria that related to the job of a certified medication aide.