STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255104	A. BUILDING _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA LIVING CENTER	1950 GRANDVIEW DRIVE GRENADA, MS 38901

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/2/23 through 10/5/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F583, F699 and F880. The census at the time of the survey was 77 and the facility is licensed for 90 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		11/1/23

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

Electronically Signed | 10/23/2023

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide privacy during one (1) of seven (7) treatment observations during the survey. Resident #6 Findings include: A review of the facility policy titled, "Residents Rights", with a revision date of 11/17 revealed, "All residents in a long-term care facility have rights guaranteed to them under Federal and State law. Residents residing at this facility will be guaranteed a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. These rights include:.. # 5 Privacy and confidentiality ... #26 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment, written and telephone communications. personal care, visits, and meeting of family and resident groups, but this does not require the facility to provide a private room for each resident..." An observation on 10/03/23 at 2:42 PM, of	F 583	* On 10/6/23, the Director of Nursing assessed resident #6 with no negative findings noted. On 10/3/23, the Director of Nursing completed one-on-one education with the Treatment Nurse on policy titled "Resident Rights" with revision date 11/17, that included providing privacy during treatments. * Thirty-Six of seventy five residents have treatments and have the potential to be affected by the deficient practice. * Beginning 10/05/23, Director of Nursing and Staff Development Nurse immediately initiated in-services with Registered Nurses and Licensed Practical Nurses on policy titled " Residents Rights" with a revision date of 11/17, that included providing privacy during treatments. In-services will be ongoing until all Registered Nurses and Licensed Practical Nurses have been in-serviced. The facility Quality Assurance Committee meeting was held 10/13/23, with the committee consisting of the Administrator, Director of Nursing, Medical Director, Social Service, Maintenance Supervisor and Infection Preventionist with policy titled " Resident	

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F 583	Continued From page 2 Resident #6 receiving a treatment to left heel revealed that the Treatment Nurse entered room to perform the treatment and did not provide privacy for Resident #6. The Treatment Nurse did not close the door to resident's room, pull the privacy curtain, and did not close blinds in the resident's room leading to the outside of the facility that faces the parking lot. Resident #6's roommate was in the room during treatment care. An interview on 10/04/23 at 12:34 PM, with the Treatment Nurse confirmed that she did not provide privacy before starting the treatment or during the treatment to the resident's left heel. The Treatment Nurse confirmed Resident #6's roommate was in the room and that privacy should have been provided to keep others from seeing Resident #6 receiving treatment. An interview on 10/04/23 at 12:42 PM, with the Director of Nursing (DON) confirmed that the Treatment Nurse should have closed the door, pulled the privacy curtain, and closed the blinds to Resident #6's room while providing care for the resident. A review of the facility Face Sheet for Resident #6 revealed the resident admitted to the facility on 11-16-22 with diagnoses of Peripheral Vascular Disease, Hypertension and Gastro-esophageal Reflux Disease. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08-16-23 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #6 was cognitively intact.	F 583	Rights" with revision date of 11/17, with no changes made. * Beginning 10/09/23, The Director of Nursing and/or Staff Development Nurse will monitor by observation on form titled "Privacy with treatments" to ensure privacy provided during treatments on five residents weekly for four weeks then monthly for three months. The Quality Assurance Committee will address concerns identified from the review monthly for four month and make recommendations or changes as needed. The Quality Assurance committee will meet 10/27/23, and then monthly thereafter for four months to review monitoring of procedures and policies to ensure compliance achieved until resolved.	
F 699 SS=D	Trauma Informed Care	F 699		11/1/23

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F 699	Continued From page 3 CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma- informed approaches for one (1) of four (4) residents reviewed for trauma-informed care. Resident #15. Findings include: A record review of the facility policy, titled "Documentation-Social History", with a revision date of 10/23, revealed, "Purpose, to record observations, outcomes, and responses in relation to social services as well as interventions, including trauma informed care, as identified in the comprehensive care plan, and the delivery of direct social services..." A record review of Resident #15's Face Sheet revealed she was admitted to the facility on 12/21/2018 with a diagnosis of Post-traumatic Stress Disorder (PTSD). A record review of Resident #15's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/11/23	F 699	* On 10/04/23, the Director of Nursing assessed resident #15 with no negative findings noted. Social services submitted a significant change in status form for Level II to the appropriate agency on 10/04/23, and there was no Level II warranted from change submitted. Minimum Data Set Nurse updated resident #15 care plan on 10/4/23 to include trauma informed care with interventions for the post traumatic stress disorder. * One resident of seventy-five residents with a diagnosis of post traumatic stress disorder has the potential to be affected by the deficient practice. * Beginning 10/04/23, the Director of Nursing and Staff Development Nurse immediately initiated in-services with Social Service, Activities, Registered Nurses and Licensed Practical Nurses on policy titled "Social Documentation Progress Notes" with a revision date of 10/23, that included trauma informed care	

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F 699	Continued From page 4 revealed a diagnosis of PTSD. The Brief Interview for Mental Status (BIMS) score was 15, indicating her cognition was intact. A record review of Resident #15's care plan revealed resident was not care planned for individualized approaches related to her history of trauma. A record review of a Social Assessment, dated 8/11/23, for Resident #15 revealed that the resident had not experienced a traumatic event, had no trauma related symptoms, and no impact to the daily routine. During an observation and interview conducted with Resident #15 on 10/2/2023 at 10:30 AM, the resident was sitting in her wheelchair with no behavioral symptoms noted. Resident #15 stated she was doing fine, and she did not have concerns related to staff caring for her. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 10/3/2023 at 11:30 AM, she indicated that she was unaware that Resident #15 had a diagnosis of PTSD and there were no specific interventions or approaches to care. During an interview with the Minimum Data Set (MDS) nurse on 10/3/2023 at 1:15 PM, she verified that Resident #15 had a diagnosis of PTSD but did not have a care plan in place regarding PTSD. She stated that the facility should have a care plan with individualized interventions in place related to Resident #15's history of trauma. During an interview with the Social Worker (SW)	F 699	plan with interventions related to post traumatic stress disorder. In-services will be ongoing until all Social Services, Activities, Registered Nurses and Licensed Practical Nurse have been in-serviced. The facility Quality Assurance committee meeting was held on 10/13/23, with the committee consisting of Administrator, Director of Nursing, Medical Director,Social Service Director, Maintenance Supervisor, Activity Director and Infection Preventionist and Social Services, with policies titled "Social Documentation Progress notes" with revision date 10/23 with no changes made to the policy. * Beginning 10/9/23, the Director of Nursing and/or Staff Development Nurse will monitor by review on form titled "trauma informed care plan with interventions" five residents care plans for implementation of trauma informed care plan with interventions related to post traumatic stress disorder weekly for four weeks then monthly for three months. The Quality Assurance committee will address concerns identified from the reviews monthly for four months and make recommendations or changes as needed. The Quality Assurance committee will meet 10/27/23, and then monthly thereafter for four months to review monitoring procedures and policies to ensure compliance achieved until resolved.	

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F 699	Continued From page 5 #1 on 10/3/2023 at 1:20 PM, she stated that she completed the Social Assessment for Resident #15 and was not aware that the resident had a diagnosis of PTSD. She verified that Resident #15's care plan included no individualized approaches to care for Resident #15 in relation to her diagnosis of PTSD. SW #1 acknowledged that a care plan should be completed for the residents at the facility who have been identified as having PTSD. An interview was conducted with the Director of Nursing (DON) on 10/3/2023 at 2:00 PM, she confirmed her expectation was for a care plan to be developed that included individualized approaches to care for residents who had a diagnosis of PTSD. .	F 699		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		11/1/23

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 7 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by not performing hand hygiene during wound care and medication administration (Residents #6, #36, and #39), failure to use a clean barrier during medication pass (Resident #78) and failure to properly sanitize a glucometer after use (Resident #36) for two (2) of four (4) days of survey. Findings Include: Review of the facility policy titled, "General Infection Prevention and Control Nursing Policies" with an origination date of 06/14 and a review date of 08/21 revealed "It is the policy of this facility that all nursing activities will be performed in a manner to minimize the potential for infection in residents, staff, and visitors. Some of the specific guidelines include: All items used for resident care will be cleaned and disinfected between uses or will be designated for that resident's use only...other common-use items will be cleansed and disinfected according to the manufacturer's recommendations". Review of the facility policy titled, "Hand Hygiene"	F 880	* On 10/06/23, the Director of Nursing assessed resident #6 with no negative findings, resident # 39 was a hospice resident that was actively dying and expired on 10/04/23. On 10/03/23, The Director of Nursing completed one-on-one education with the Treatment Nurse on policy titled "General Infection Prevention and Control Nursing Policies" with a revision date of 08/21,and "Glove Usage" with a revision date of 05/11, and "Hand Hygiene" with a revision date of 08/21, that included washing hands and/or sanitizing with alcohol gel between glove changes and changing gloves between different resident tasks. On 10/06/23, the Director of Nursing assessed resident #36 with no negative findings noted. On 10/03/23, the Director of Nursing completed on on one education with Licensed Practice nurse #3 on policy titled "General Infection Prevention and Control Nursing Policies" with a revision date of 08/21, Hand Hygiene" with a revision date of 08/21, that included hand hygiene with donning and doffing gloves and how to properly sanitize the geometer. On 10/6/23, the Director of Nursing assessed	

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with a revision date of 10/17 revealed under "Purpose: To cleanse hands to prevent transmissions of infection or other conditions and to provide clean health environment for residents, staff and visitors". This review revealed under "Procedure ...#4. Before and after applying gloves; #9. Wearing gloves does not replace the need to perform hand hygiene".

Review of the facility policy titled, "Glove Usage" with a revision date of 5/11 revealed under, "When to use gloves: #2. After touching a resident's excretions, secretions, blood, body fluids or contaminated items, gloves must be changed if care of that resident has not been completed".

Review of the facility policy titled "Blood Glucose Quality Control" with a revision date of 9/23 revealed, under, "Maintenance of Blood Glucose Monitoring Systems: Always clean the meter after each use. Gently wipe and clean surface of the meter with a disinfectant wipe per facility policy ..."

Resident #6

An observation on 10/03/23 at 2:42 PM, of Resident #6 receiving a treatment to the left heel revealed that the Licensed Practical Nurse (LPN)/Treatment Nurse entered the room, used hand sanitizer, put on gloves, cleaned the left heel, changed her gloves, and failed to use hand sanitizer or wash her hands before donning the clean gloves and completing the treatment.

An interview on 10/04/23 at 12:34 PM, with the LPN/Treatment Nurse confirmed that she did not sanitize or wash her hands between changing resident #78 with no negative findings noted. On 10/5/23, the Director of Nursing completed one-on-one education with Licensed Practical Nurse #2 on policy titled "General Infection Prevention and Control Nursing Policies" with a revision date of 08/21, that included using a barrier when placing medicines on surfaces.

* All Seventy-Five residents have the potential to be affected by the deficient practice.

* Beginning 10/3/23, the Director of Nursing and/or the Staff Development Nurse immediately initiated in-services with Registered Nurses and License Practical Nurses on policy titled "General Infection Prevention and Control Nursing Policies" with a revision date of 08/21, "Glove Usage" with a revision date of 05/11, "Blood Glucose Quality Control" with a revision date of 09/23, and policy titled "hand Hygiene" with a revision date of 08/21, that included washing hands and/or sanitizing with alcohol gel between glove changes and changing gloves between different resident tasks, hand hygiene while donning and doffing gloves and how to properly sanitize the Glucometer, and using a barrier when placing medicines on surfaces.
In-services will be on going until all Registered Nurses and Licensed Practical Nurses have been in-serviced. The facility Quality Assurance committee meeting was held on 10/13/23, with the committee consisting of the Administrator, Director of Nursing, Medical Director,

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F 880	Continued From page 9 gloves during the treatment. She confirmed she should have sanitized between changing gloves to prevent the spread of infection. An interview on 10/04/23 at 12:42 PM, with the Director of Nursing (DON), confirmed that the policy on wound care states to sanitize in between changing gloves and that it is done to prevent the spread of infection. A review of Resident #6's Physician Orders revealed an order dated 9/05/23, "Stage 2 to left heel cleanse with NS (normal saline), pat dry, paint with betadine and leave open to air daily until healed." A review of the Face Sheet for Resident #6 revealed the resident was admitted to the facility on 11/16/22 with a diagnosis of Peripheral Vascular Disease, Hypertension and Gastro-esophageal Reflux Disease. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #6 was cognitively intact. Resident #39 An observation and interview on 10/3/23 at 9:48 AM, with LPN/Treatment Nurse and Nurse Practitioner (NP) revealed that LPN/Treatment Nurse put gloves on when she entered Resident #39's room, assisted the NP in turning the resident, suctioned the resident, removed the old dressing from the wound on the left buttock, performed the wound care and applied the new dressing without removing the dirty gloves or	F 880	Social Service Director, Maintenance Supervisor and Infection Preventionist with policies titled " "General Infection Prevention and Control Nursing Policies" with revisions 08/21, and "Glove Usage" with revision date 05/11, "Hand Hygiene" with revision date 08/21, and "Blood Glucose Quality Control with revision date 09/23 with no changes made to the policies. * Beginning 10/09/23, the Director of Nursing and/or Staff Development Nurse will monitor by observation on form titled "Med pass/treatment technique infection control" med pass and/or treatment technique provided by nurses to ensure infection control adhered with glove changes, hand hygiene, glucometer use, and use of barriers as required on eight resident weekly for four weeks then monthly for three months. The Quality Assurance committee will address concerns identified from the reviews monthly for four months and make recommendation or changes as needed. the Quality Assurance committee will meet 10/27/23 and then monthly thereafter for four months to review monitoring of procedures and policies to ensure compliance achieved until resolved.	

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performing hand hygiene. An interview with LPN/Treatment Nurse after leaving the resident's room revealed that she should have removed her dirty gloves after removing the dressing, performed hand hygiene, and put on clean gloves before performing the wound care. She stated that not removing the old gloves and performing hand hygiene was an infection control issue and could have caused an infection.

An interview on 10/4/23 at 12:15 PM, with LPN/Infection Control Nurse confirmed that gloves should be changed, and hand hygiene performed between a dirty site to a clean site to prevent the spread of infections. She stated that the LPN/Treatment Nurse had received in-services regarding this.

An interview on 10/4/23 at 12:45 PM, with the Director of Nurses (DON) confirmed that the LPN/Treatment Nurse should have removed her gloves and performed hand hygiene after removing the old wound dressing and before cleaning the wound. She confirmed that this needed to be done in order to prevent the spread of infection.

Record review revealed that LPN/Treatment Nurse attended in-services regarding infection control and hand hygiene on 6/13/23, 8/18/23 and 8/21/23.

Record review of Resident #39's "Wound Assessment Report" dated 10/2/23 revealed the resident had a Stage 2 pressure ulcer to her left buttock that was identified on 10/2/23 with treatment indicated as; Cleanse with normal saline (NS), pat dry, apply hydrogel, and cover with foam dressing daily until healed.

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Record review of Resident #39's "Face Sheet" revealed the resident was admitted to the facility on 7/19/19 with admitting diagnoses that included Acute embolism and thrombus unspecified deep veins of lower extremities.

Record review of Resident #39's MDS with an ARD of 7/18/23 revealed in Section C a BIMS score of 04, which indicates the resident is severely cognitively impaired.

Resident # 36

An observation of blood glucose finger stick for Resident #36 on 10/03/23 at 11:00 AM, revealed Licensed Practical Nurse (LPN) #3 performed the glucose check, removed her gloves, and did not perform hand hygiene. She walked to the medication room to get insulin, returned to the medication cart, prepared the ordered insulin, and applied a new pair of gloves, neglecting to perform hand hygiene. She entered the resident's room and administered five (5) units of NovoLog per sliding scale to the residents' left upper arm. LPN #3 removed her gloves, exited the room, and performed the required documentation in the computer, but did not perform hand hygiene. LPN #3 applied new gloves and cleaned the glucometer with a Sani-Cloth, wiping the exterior of the machine for approximately 15 seconds. She removed her gloves and did not perform hand hygiene. During an interview at this time she revealed she normally wrapped the machine in a Sani-Cloth and allowed it to sit for two (2) or three (3) minutes, but confirmed she did not do that this time. The SA (State Agency) and LPN #3 verified the wet (contact) time on the back of the

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Sani-Cloth wipes was 2 minutes. LPN #3 confirmed that she did not allow the disinfecting wipe to stay in contact with the machine for 2 minutes and that this could lead to cross contamination and infection. She also confirmed that she did not perform hand hygiene after changing gloves during glucose check and insulin administration. She stated, "I've got hand sanitizer right here but forgot to use it." She revealed handwashing was important to prevent cross contamination between rooms and the spread of infection.

An interview with the Director of Nursing (DON) on 10/03/23 at 1:25 PM, confirmed that the glucometer should be cleaned and remain wet according to the wet (contact) time on the disinfecting wipes to prevent the spread of infection. She revealed that hand hygiene should be done anytime gloves are removed to prevent the spread of infection.

An interview on 10/04/23 at 9:26 AM with the LPN/Infection Control Nurse revealed that staff should look at the disinfecting wipe bottle to determine the wet (contact) time and wrap the glucometer with the wipe for the time specified on the bottle. She revealed the purpose of performing hand hygiene and wiping the glucometer for the wet (contact) time was to prevent the spread of infection.

Record review of the "Inservice Training" revealed an in-service was conducted for "Infection Control" on 2/1/23 that included, "Hand hygiene". In-Service revealed, "Wash hands with soap and water for at least 20 seconds or use alcohol-based hand rub."

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Record review of the "Inservice Training" revealed an in-service was conducted for "Glucometer Cleaning" on 6/15/23 that included, "Always clean between uses. Sani-cloth wet time 2 mins (minutes). Glucometer must be wrapped in wet cloth for 2 mins. Clorox wet time -3 mins. Glucometer must be wrapped in wet cloth for 3 mins. Use tissue as barrier when sitting down in residents' room."

Record review of the "Inservice Training" revealed an in-service was conducted for "Infection Control: glucose meter" on 8/14/23 that included, "Glucose meter must be disinfected between every use. Sani cloth -wet time 2 min (minutes)-air dry: Clorox wipes wet times 3 min-air dry time on bottle ..."

Record review of Resident #36's Electronic Medication Administration Record (EMAR) revealed an order dated 6/02/21," Blood Glucose Finger Sticks Before Meals & (and) Bedtime ..."

Record review of Face Sheet revealed Resident # 36 was admitted to the facility on 10/09/20 with medical diagnoses that included Type 2 Diabetes Mellitus, Heart Failure, Unspecified Dementia, Malignant Neoplasm of Corpus Uteri and Parkinson's Disease.

Record review of the MDS with an ARD of 7/12/23 revealed under section C, a BIMS score of 14, which indicates Resident # 36 is cognitively intact.

Resident # 78

The facility provided documentation on letter head dated 10/04/23 that read, "The facility

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medication administration policy covers adhering to infection control procedures however it does not specifically state that a barrier is to be used."

An observation and interview during medication pass on 10/04/23 at 8:40 AM, with LPN #2 revealed Resident #78 was to receive an Albuterol and a Trelegy inhaler. LPN #2 removed the inhalers from the medication cart and laid them both on the surface of the medication cart, while preparing the other oral medications. LPN #2 entered the resident's room, she laid both inhalers on the resident's bedside table. She administered Resident #78's medications and after completion laid both inhalers back down on the bedside table while preparing a nebulizer treatment. LPN #2 exited the room, laid both inhalers on the surface of the medication cart, picked them up and placed them back inside the medication cart. LPN #2 confirmed that she should have used a barrier when laying the inhalers down to prevent cross contamination.

An interview with the LPN/Infection Control Nurse on 10/04/23 at 9:35 AM, confirmed that a barrier must be used when carrying things into the resident's rooms. She revealed that this was an infection control issue and the staff have had in-services regarding use of a barrier during medication pass.

An interview with the Director of Nursing (DON) on 10/04/23 at 9:40 AM, revealed that staff know they should be using a barrier when taking anything inside a resident's room. She revealed that this should be done to prevent the spread of infection.

Record review of Resident #78's Electronic

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F 880	Continued From page 15 Medication Administration Record (EMAR) revealed, an order dated 9/06/23, "Trelegy Ellipta 100 MCG (microgram)-62.5 MCG -25 MCG Powder For Inhalation-: 1 Puff By Mouth Daily". Record review of Resident #78's EMAR revealed an order dated, 9/06/23," Albuterol Sulfate HFA (Hydrofluoroalkane) 90 MCG/Actuation Aerosol Inhaler: 2 Puffs Via Inhalation by Mouth Daily". Record review of the Face Sheet for Resident #78 revealed the resident was admitted to the facility on 9/06/23 with medical diagnoses that included Chronic Obstructive Pulmonary Disease and Nicotine Dependence. Record review of the MDS with an ARD of 9/13/23 revealed under section C, a BIMS score of 15, indicating Resident # 78 is cognitively intact.	F 880		