

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Cityview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5801 Bryant Irvin Rd Fort Worth, TX 76132	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35152</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible for contaminated sharps disposal bins, attached to 1 (LVN A) of 2 nurse medication carts and 1 of 1 Wound Care Carts, on Station Two Wing, reviewed for hazards in that:</p> <p>LVN A failed to ensure contaminated sharps in the sharps bin attached to the Nurse Medication Cart she was responsible for, on Station Two Wing, were below the full line.</p> <p>LVN B failed to ensure contaminated sharps in the sharps bin attached to the Wound Care Cart, on Station Two Wing, were below the full line.</p> <p>These failures placed residents at risk of being exposed to contaminated sharps and possible blood borne pathogens.</p> <p>Findings included:</p> <p>An observation on 05/10/24 at 12:59 PM revealed the treatment cart parked against the wall, in a common area by Station 2 Nurses Station. The lid on the plastic insert inside the sharps bin attached to the cart was half open. Sharps were filled to the top of the bin approximately two inches past the marked fill line. Residents and family member were across from the cart.</p> <p>An observation and interview on 05/10/24 at 1:07 PM revealed a Nurse Medication cart parked against the Nurses Station, in the hall leading to the Therapy Room. The used sharps in the sharps bin attached to the cart were filled past the fill line. LVN A stated the cart was hers and it was one of two Nurse Medication Carts in the Station Two Wing of the facility. She said the sharps bins should not be filled past the fill line because the lid would not close properly if it were. She said she realized the sharps bin was past the fill line and said it posed a hazard to both staff and residents because they could get stuck by sharps. She said the hall where her cart was parked was very busy with people going to and from therapy. She stated the nurses were responsible to ensure the sharps bins were changed as needed. She said she had been in-serviced on sharps safety but did not recall when.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/10/24 at 1:10 PM, ADON C stated the contaminated sharps bins should never be filled past the fill line to ensure safety of staff and residents. He said the lids did not close properly when the sharps bins were filled past the fill line and residents, or staff could get stuck with a contaminated needle. He stated there were two Nurse Medication Carts and on Treatment cart on Station Two Wing. He said LVN B was responsible for the Treatment Cart and LVN A was responsible for the cart in the hall on the way to the Therapy Gym.</p> <p>In an interview on 05/10/24 at 2:28 PM, LVN B stated he was responsible for the Treatment cart and should have replaced the full sharps bin. He said when sharps bins were too full, the lids did not close properly, and residents could get stuck by a contaminated needle. He said nurses were responsible for changing the bins when they were full.</p> <p>In an interview on 05/10/24 at 3:22 PM, the DON stated the nurses should know to change the sharps bins when they were full. She said she had provided in-services on sharps safety but did not recall when the last one was. She said when the bins got full, the lids may not close properly and may pose a risk of hazard to both residents and staff. She said the facility was responsible for ensuring the safety of residents and staff.</p> <p>In an interview on 05/10/24 at 3:50 PM, the Administrator stated he expected staff to follow the facility policy and ensure resident safety. He said nurses were responsible for ensuring they kept their carts safe, and this included changing out full sharps bins.</p> <p>Record review of the facility's policy titled, Sharps Safety, dated 11/01/23, reflected, . To keep everyone knowledgeable, provide training not only for new staff, but also for existing staff. New or used sharps should be disposed of in a designated sharps only container. Designated staff should monitor the sharps container's fill level to ensure it does not get overfilled beyond 3/4 full as that can contribute to workplace injuries .</p>