STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676239	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Toscana at Cypress Woods	15015 Cypress Woods Medical Dr Houston, TX 77014

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents were free from abuse for 4 (CR #1 and Resident #2, and Resident #6 and Resident #7) of 6 residents. The facility failed to protect Resident #6 from being slapped by CR#1 resulting in CR#1 being grabbed by Resident #7 on 1/26/24 at 9:15 am. The facility failed to supervise CR#1, who was on 1:1 supervision, when CR#1 hit Resident #2 on 1/26/24 at approximately 5:30 p.m. This failure placed residents at risk of harm and injury. Findings included: Resident #6 Record review of Resident #6's face sheet dated 1/26/24 revealed Resident #6 was an [AGE] year old female resident who admitted on [DATE]. Diagnosis included hypertensive heart disease, muscle wasting and atrophy, heart failure, difficulty walking, and anxiety. Record review of Resident #6's Nurse Event note dated 1/26/24 at 15:26 (3:26 p.m.) revealed Resident #6 said another resident came over to her and tried to hit her in the eye and she pushed her away. Record review of Resident #6's Staff assessment dated revealed resident seen today to insure well-being to disagreement with peers. She is at baseline. Does not recall any occurrence of concern. Staff will continue to monitor. This writer will as well on rounds. Record review of Resident #6's progress note dated 1/26/24 at 14:05 (2:05 p.m) revealed CNA informed this nurse that they heard a loud noise coming from the hallway, upon arrival one of the resident's had another resident by the arm and was trying to force her out of the dining room and tried to close the door on the CNAs. Once they entered the dining room they asked Resident #6 what happened and she told them that CR#1 slapped her in the face. Upon my investigation when I asked Resident #6 what happened she said that resident tried to poke her in the eye and she pushed her away. No redness noted. Progress note completed by LVN B. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/7/25 at 9:13 am with Resident #6 she stated she vaguely remembers being slapped. She said it was someone being real stupid and then then she was dumb enough to get close. She said she threatened them real well and someoene even said she would get her back. She was hurting a little bit but figured it was her own fault. She tries to be be nice to people. She doesn't remember where she was hit. She can't remember if it was a resident or staff. She thinks it was a resident. The staff are very good here and not abusive. She doesn't' remember if Resident #7 pushed someone. She said hes a good man and its not fair to put him in it. Resident #7 Record review of Resident #7's face sheet dated 1/26/24 revealed Resident #7 is an [AGE] year old male that was admitted to the facility on [DATE]. Diagnosis included difficulty walking, hyperlipidemia, anxiety, and depression. Record review of Resident #7's progress note dated 1/26/24 at 14:18 (2:18 p.m.) revealed CNA informed this nurse that they heard a loud noise coming from the hallway, upon arrival Resident #7grabbed resident by the arm and was trying to force her out of the dining room and tried to close the door on CNAs. Once they entered the dining room they asked another resident what happened and she told them that CR#1 slapped her in the face. Upon my investigation when I asked Resident #6 what happened she said that resident tried to poke her in the eye and that she pushed her away, no redness noted. Note completed by LVN B. Record review of Resident #7's Staff assessment dated [DATE] at 11:52 am revealed resident seen today to insure well-being 2nd to disagreement with peers. He is at baseline, does not recall any occurrence of concern. Staff will continue to monitor. This writer will as well on rounds. Unknown who completed document. Record review of Resident #7's Nurse's event Note dated 1/26/24 at 14:37 (2:37 p.m.) revealed resident grabbed another resident arm and tried to push her out of the dining room. Completed by LVN B. In an interview on 2/7/25 at 9:12 a.m. with Resident #7 he said he's been here a long time. He said he goes here a long time. When asked about the incident and he just kept saying he's been here a long time. Record review of the CNA E written statement revealed on 1/26/24 around 9:15 am, myself and other CNA's were near the nurse station and heard CR#1 yelling and I heard 2 smacking sounds. We ran to lock unit and I saw Resident #7 holing CR#1's arm and pushing her out of the room and slamming the door closed. Resident #6 said that CR#1 slapped her. Residents were separated and nurse, DON and administrator were notified. Record review of CNA C's written statement dated 1/26/24 revealed at approximately 9:15 am myself and another CAN were near the nurses station and heard loud smacking noises and yelling coming from the lock unit. We immediately ran to the unit upon entering the unit we observed Resident #7 shoving Cr#1 out of the room. HE then slammed the door shut on CNA face. When we entered the room Resident #6 was holding her face and said CR#1 slapped the shit out of her. We then separated all the residents and informed the nurse in charge. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/6/25 at 2:24 p.m with CNA C she said CR#1 does not ring a bell in her memory. She hasn't worked on secured unit in forever. She doesn't remember the incident. She said she had been trained on a/n/e while she was here and she knew the abuse coordinator is the administrator and she would report a/n/e if she witnessed it. Record review of CNA A's written statement dated 1/26/24 at 9:15 am revealed I was giving patient care when everything transpired. In an interview on 2/6/25 at 2:38 p.m. with CNA A, she said she can't recall the incident. She said If you have a written statement then that's what it was. She can't remember it right now because its been so long. She didn't work other parts of the building. She said she was probably on the unit but was in a room. If its wrote then that's what it is. She had been trained on a/ne and completed inservices. Record review of CNA B's written statement dated 1/26/24 revealed I was in a room giving patient care I did not witness the incident with CR#1 On 2/7/15 at 9:50 am a telephone call was placed to CNA B. No vm set up. CR#1 Record review of CR#1's face sheet dated 2/7/2025 revealed she was a [AGE] year-old female resident at the time of the incident. CR#1's original admission date is 11/7/2022. Diagnoses included Alzheimer's, Bipolar, Dementia, restlessness and agitation, and Anxiety. CR#1 was discharged on 1/26/24. Record review of CR#1's Quarterly MDS dated [DATE] revealed CR#1 was severely cognitively impaired . Record review of CR#1's undated Care plan revealed CR#1 required anti-psychotic medication for dx of bipolar disorder, current episode manic severe with psychotic features. CR#1 had potential to demonstrate physical behaviors, poor impulse control, she hit another resident. Staff should assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Give the resident as many choices as possible about care and activities. Monitor/document/report to MD of danger to self and others. Staff to do UA to rule out UTI. Staff to watch resident one on one. Date initiated 9/12/23. Record review of CR#1's progress notes revealed Resident slapped another resident. Note was completed by LVN A on 1/26/24 at 18:13 (6:13 p.m.). Record review of Event Nurses' Note dated 1/26/24 at 18:16 (7:16 pm) revealed CR#1 very anxious noted picking up tables and chair, no grimacing noted. CR#1 noted very anxious and packing and noted slapping another resident. Document completed by LVN A. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR#1's Progress Note dated 1/26/24 at 10:03 am, revealed CNA informed this nurse that they heard a loud noise coming from the hallway, upon arrival one of the resident's had a resident by the arm and was trying to force out of the dining room and tried to close the door on the CNA's. Once they entered the dining room they asked another resident what happened and she told them that CR#1 slapped her [Resident #6] in the face. Upon my investigation when I asked Resident #6 what happened she said that resident tried to poke her in the eye and that she pushed her away. No redness noted to Resident #6's face. No bruises or redness noted to CR#1's arm. No c/o voice. Progress note completed by LVN B Record review of CR#1's Staff assessment dated [DATE] at 17:35 (5:35 p.m.) revealed Resident has become volatile. Impression: Psychosis. Staffed with provider who directed Inpatient psychiatric care for further evaluation and stableingation (stabilization) There was not any note of who completed the assessment. Record review of CR#1's Discharge summary dated [DATE] at 22:30 (10:20 p.m.) completed by LVN A revealed CR#1 had behaviors noted, slapping another resident, order to send CR#1 to [behavioral hospital] for eval and treat. Resident #2 Record review of Resident #2's Face sheet dated 2/7/25 revealed Resident #2 is an [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included generalized anxiety disorder, acute kidney failure, type 2 diabetes, muscle weakness, schizophrenia, and Alzheimer's disease. Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 3 indicating severely cognitively impaired. Record review of Resident #2's undated Care plan revealed Resident #2 had a potential for being afraid due to another resident hit her. Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Record review of Resident #2's progress notes revealed this writer was making rounds when the CNA came to inform of incident upon coming to the dining room. During dinner resident was sitting at the table with her [family member], when this writer was told that another resident had slapped Resident #2, upon assessment no redness to resident's face, resident was calm no complaints of pain. Effective date was 1/26/24 at 17:30 (5:50 pm) completed by LVN A. Record review of Event Nurse's note completed by LVN A on 1/26/24 at 18:00 (6pm) revealed Resident #2 was sitting for dinner at table with her [family member] when another resident slapped her. No complaints of pain verbalized. No injury noted. Resident #2 unable to state what occurred but stated not in pain and calm. No distress noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Facility's Provider Investigation Report revealed on 1/26/24 at 5:30 p.m. in the memory care unit CR#1 slapped Resident #2 in the Dining room during dinner. LVN B completed assessment and Resident #2 had on injury or redness to face. Resident #2 had no pain and was calm. Resident Safety maintained; CR#1 maintained on 1:1; Physical and Mental Assessment provided; Psyche Consult for all residents involved; Trauma Informed Assessment; Staff /Resident's interviews initiated; In-service Abuse/Neglect initiated; AD HOC QAPI held. It is noted that on 1/26/2024 at approximately 5:30 pm, Resident #2 was eating dinner with other residents and visiting with her [family member]. CR#1 initially came into the dining room and tried to flip the table over. CNA stopped her from flipping table. CR#1 then, on her way out, stopped and slapped Resident #2 across the face. No redness or injury noted. Note: This is the 2nd incident today with CR#1 slapping another resident. Maintain Resident Safety by monitoring; Continue 1:1 supervision. CR#1 sent out for behavioral eval and treatment. In an interview and observation on 2/6/25 at 9:35 a.m. with Resident #2, she said she didn't remember being hit or slapped by any other resident. Resident #2 was observed in her bed eating breakfast. She did not have any skin bruising, tears or other concerns for her skin. She said she feels fine when she was asked if she felt safe. In an interview on 2/5/25 at 12:30 p.m. with the DON , she said CR#1 had an episode of slapping people and she remembered Resident #2 just happened to be sitting there. She doesn't remember if family was there. The incident with Resident #2 was the second incident that day. In an interview on 2/6/25 at 11:16 a.m. with Family Member she said she was in the memory care unit sitting at a table with Resident #2. She said there were two tables, her and Resident #2 were sitting at one table, and another resident (CR#1) was lifting the other table and she was trying to turn the table over. Resident #2 was sitting at the table and then the lady (CR#1) slapped her on the face, and she (Family Member) screamed and said, She slapped my mama!. There were not any staff in the room when this happened. It didn't take a long time for staff to come. The incident happened during meal time and this happened in the second room with the tables, during lunch or dinner. She said that staff came to see what happened and staff just looked at her and said, Are you fine Resident #2? Resident #2 said yes. When CR#1 slapped Resident #2, Family Member started hollering and staff came in and took CR#1 out of the room. She did not know which staff. Record review of Provider investigation report revealed written statement from Family Member dated 1/29/24 One Friday the 26 of January, [CR#1] came in and [Resident #2] was eating dinner with other and she tried to turn the table over, then the CNA had her to stop. Then as she was walking out touching and messing with others she slapped [Resident #2] and I held [Resident #2] and told her to stop and I called for help. The CNA came in and got her. [sic] In a telephone interview on 2/6/25 at 2:38 p.m. with CNA A, she said she used to work at the facility as a CNA. She cannot recall the incident. She said if surveyor had a written statement then that's what it was. She can't remember the incident right now because it was so long ago. She said she didn't work other parts of the building and she was probably on the secured unit but was in another resident's room. Record review of Provider investigation report revealed there was not a written statement from CNA A. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Telephone attempts were made on 2/6/25 at 9:50 a.m. to CNA B. No voicemail box was set up. CNA B never called back. Record review of Provider investigation report revealed written statement from CNA B dated 1/26/24 revealed I was passing hall trays at the time of the incident, I did not witness anything. In an interview on 2/6/25 at 2:44 p.m. with LVN A, she stated she worked the secured unit all the time. She was familiar with Resident #2 and CR#1. She said she worked in the evening. She was not sure about the morning incident, she didn't witness the morning incident. She doesn't know who was working that day. She stated that when CR#1 had bad days, there were a few incidences. There were a couple residents that don't like the other person. CR#1 had a few people that she didn't really like. She said they would notify family, administrator, DON, and separate residents when an incident occurs between residents. She said they would do interventions. They would watch them. She stated when a resident is placed on 1:1, that means staff would be right there with resident. She said the nurses really don't do 1:1 monitoring, but they try to help out. She said it would be hard on locked unit to do 1:1 monitoring. She stated when CR#1 had incidences she was placed on 1:1. She confirmed that she signed the 1:1 Sheet for CR#1 (dated 1/26/2024). She said she didn't see CR#1 slap a resident that evening. She said she wouldn't leave the 1:1. She said she can't remember everything but she is pretty sure she didn't leave CR#1's side on 1/26/2024. She said a resident slapping another resident is considered abuse. In an interview on 2/7/25 at 9:57 a.m. with the DON, she stated she vaguely remembers the incident in the morning with CR#1. She said that morning was the first episode of CR #1 hitting someone. She stated that standard protocol during resident-to-resident incident was that the staff would separate residents, call MD and get orders and notify family. She said the facility may have put CR#1 on 1:1, but she wasn't 100% sure. She said 1:1 protocol can last as little as 8 hours or until medications are received or 2 to 3 days. She stated 1:1 supervision means an employee is always with resident. If a staff needs to take a break, the other employee will step in. The DON reviewed and confirmed that the initials on the 1:1 monitoring sheet belonged to the Assistant Business Office Manager. The DON stated she was not aware that a staff was not with CR#1 at the time CR#1 hit Resident #2 on that same day (1/26/2024), later that evening (5:30 p.m.). She said CR #1 was on 1:1 supervision when she hit the second resident later that same day (1/26/2024), but even if staff was with CR#1 on the 1:1 supervision, there was not a guarantee that Resident #2 would not have been hit if someone was with her 1:1. During passing of trays the expectation was that staff should still be with their 1:1 resident.In an interview on 2/7/25 at 10:09 a.m. with the Assistant Business Office Manager she confirmed that she signed off on the 1:1 monitoring sheet. She stated CR#1 was acting out and having behaviors so the DON and Administrator asked her to sit with CR#1. She thought the behavior was CR#1 was hitting other residents. She said she was 1:1 with her for CR#1. She said she didn't know who took over 1:1 Supervision when she left. She said she told LVN A she was leaving. When she left, someone else would've taken over. During the time she was on 1:1 monitoring with CR#1 she would walk with her and then sit a little. CR#1 was agitated. She didn't have any injuries. She didn't see her hit anyone. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/7/25 at 10:09 a.m. with the Assistant Business Office Manager she confirmed that she signed off on the 1:1 monitoring sheet and was providing 1:1 care for CR #1 on 1/26/2024, after she hit a resident that morning. She stated CR#1 was acting out and having behaviors so the DON and Administrator asked her to sit with CR#1. She thought the behavior was CR#1 was hitting other residents. She said she was 1:1 with her for CR#1. She said she didn't know who took over 1:1 Supervision when she left. She said she told LVN A she was leaving. When she left, someone else would have taken over. During the time she was on 1:1 monitoring with CR#1 she would walk with her and then sit a little. CR#1 was agitated. She didn't have any injuries. She didn't see her hit anyone. In a telephone interview on 2/7/25 at 10:26 a.m. with the former Administrator he stated that he does not recall if CR#1 was on 1:1. He referred to the DON. He said it was his normal protocol to place residents on 1:1 to ensure safety. He cannot say whether or for sure if it did or did not happen. He said he didn't remember a whole lot about it. Record review of the Monitoring Chart dated 1/26/24 revealed Frequency of Monitoring 1:1 for CR#1. The Assistant Business Office Manager initialed from 1330 through 1430 (1:30 p.m. through 2:30 p.m.). The Monitoring chart revealed LVN A signed off as monitoring CR#1 on 1:1 supervision from 1400 (2pm) through 2230 (10:30 p.m.). Record review of the Facility's undated Event Reporting Policy revealed in part 8. Interventions: Include and care plan any required interventions or supervision to help prevent further occurrence of the event . Record reveiw of the facility's abuse policy dated March 2018 revealed residents have the right to be free from abuse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 3 Residents (Resident #3, #4 and #5) observed for infection control, in that: MA A failed to sanitize blood pressure cuff after each use for Resident #3, and Resident #5 MA A failed to use proper hand hygiene while passing medications to Resident #3, Resident #4, and Resident #5. MA A failed to maintain a clean work space/med cart while passing medications to Resident #3, Resident #4 and Resident #5. These failures place residents at risk of cross contamination and infections. Findings included: Resident #3 Record review of Resident #3's face sheet dated 2/7/25 revealed Resident #3 was a [AGE] year old female resident who admitted on [DATE]. Diagnoses included chronic kidney disease, type 2 diabetes, hypertension and dementia. Record review of Resident #3's physician's orders dated 8/5/24 revealed Lisinopril Oral Tablet 20 MG (Lisinopril), Give 20 mg by mouth one time a day for HTN HOLD, FOR spb less than 110 dbp less than 60 or HR <60. Resident #4 Record review of Resident #4's face sheet dated 2/7/25 revealed Resident #4 is a [AGE] year old female who admitted on [DATE]. Some Diagnoses included Dementia, anxiety disorder, ataxic gait (abnormal walking pattern by uncoordination and instability), hyperlipidemia (high levels of fat in blood), and osteoporosis . Record review of Resident #4's physician's orders dated 10/28/24 revealed may crush meds or open capsules PRN. Record review of Resident #5's face sheet dated 2/7/25 revealed Resident #5 is a [AGE] year old female resident who admitted to the facility on [DATE]. Diagnoses included Encephalopathy (disturbance of brain function causing memory loss), epilepsy (seizure disorder), hypertension (high blood pressure), Dementia, and hyperlipidemia. Record review of Resident #5's physician's orders dated 3/27/24 amLODIPine Besylate Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth two times a day for HTN hold for SBP < 100 or pulse < 60. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 2/6/25 at 9:39 a.m. revealed MA A had a box of food on the med cart and he was eating with the blood pressure cuff and thermometer next to the food. There was a cup of pudding on the car without a lid or cover on top. MA A stated he said he was eating breakfast. He said he just had a bite to see how it tasted. He said a staff just brought it to him and he was not intending to eat it. MA A then placed the food in the bottom drawer of the med cart. Observation of medication pass on 2/6/25 at 9:40 revealed MA A placed the blood pressure cuff on Resident #3's wrist and took blood pressure without sanitizing his hands, cart or blood pressure cuff after eating his breakfast. MA A administered medications to Resident #3 without wearing gloves, washing hands, or sanitizing his hands or cart. Without washing or sanitizing hands, MA A then pulled Resident #4's medications out of the cart and set them on top of the cart. MA A crushed medications and when pouring the crushed medications in the cup some fell on the cart. MA A then brushed the medication off the cart onto the floor with his hand. MA A used the bed remote which was on the floor and adjusted Resident #4's bed. MA A administered medications to Resident #4. MA A then put on gloves but did not wash or sanitize hands or cart. MA A proceeded to grab the blood pressure cuff, closed the bathroom door and proceeded to check Resident #5's blood pressure. MA A did not sanitize the blood pressure cuff. MA A kept gloves on and dug in his pocket for keys, dropped something on the floor and picked it up and put it back in his pocket and then pulled and prepped medications. MA A adjusted Resident #5's bed with the remote that was on the floor and administered medications. MA A then removed and discarded gloves and then used hand sanitizer from the cart to sanitize his hands. In an interview on 2/6/25 at 10:10 am with MA A, he stated that he normally sanitized the cart before he started meds and then when he finished passing medications. MA A said ideally he should sanitize cart in between each resident, but he didn't today because none of the other residents touched the cart. MA A said he would agree that he should have sanitized his cart after he was eating on it. MA A said he should wash his hands after each resident. MA A said he did wash his hands after each resident. MA A then said that he didn't wash his hands or sanitize because he didn't touch the residents. MA A said he only sanitized one time because he touched a bed rail. He said the blood pressure cuff should be sanitized after every use. He said he didn't do it because he just missed it. When MA A was asked about the crushed meds getting on the cart if he should brush them off, he said he didn't honestly realize he did that. MA A stated the risk to the residents for not sanitizing or using proper hand hygiene is cross contamination. MA A said he didn't wash or sanitize hands after eating because he thought he had gloves on while eating . In an interview on 2/7/25 at 9:57 am with the DON, she said absolutely not there should not be food on the med cart. She said staff should not store food on the med cart. She said MA A should have done all three, sanitize hands, wash hands, and sanitize cart. She said MA A should sanitize blood pressure cuff between each use. MA A should wash his hands or sanitize hands between each person. She said the risk to residents is passing infection. Record review of the facilities Fundamentals of Infection Control Precautions policy dated 3/2024 revealed in relevant part Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: Before and after eating or handling food (hand washing with soap and water); Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); After handling soiled equipment or utensils; After removing gloves or aprons. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676239	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Toscana at Cypress Woods	15015 Cypress Woods Medical Dr Houston, TX 77014

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 - Some	Record review of the facilities Medication Administration Procedures dated 2003 revealed in relevant part The medication cart and surrounding work area must be always clean.