

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Glenview Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7625 Glenview Dr North Richland Hills, TX 76180	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)		

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment, for 3 of 18 residents (Resident #81, Resident #5, and Resident #18) reviewed for maintenance services. The facility failed to ensure Resident #81's ceiling tile was repaired and maintained around the air vent. The facility failed to ensure Resident #5's air vent was cleaned and free of debris. The facility failed to ensure a hole in the wall of Resident #18's room was repaired. The facility failed to ensure resident #18 had sufficient lighting in the bathroom. These failures could place residents at risk of living in an unclean, unsanitary, and accident-free environment which could lead to a decreased quality of life. Findings included: Record Review of Resident #81's Face Sheet, not dated, indicated a [AGE] year-old female with an initial admission date of 03/29/24 and a re-admission date of 05/13/24. Resident #81 had diagnoses of Senile Degeneration of the brain (a progressive decline in thinking, memory, and daily function), Dysphagia (difficulty swallowing), Atherosclerosis of Native Arteries (the buildup of plaque within the body's arteries), Adjustment Disorder (a mental health condition where someone experiences excessive emotional or behavioral symptoms in response to a stressful life event or change), Insomnia (a sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or not feeling rested after sleep, which disrupts daily activities), Lack of Coordination (difficulty in controlling and coordinating movements), Cognitive Communication Deficit (Attention and concentration difficulties), Dementia (a progressive loss of mental functions, such as memory, language, and reasoning), Delirium (a change in a person's mental state), Muscle Weakness, Anemia (a condition where the blood has a reduced ability to carry oxygen), and Hyperlipidemia (a condition in which there are abnormally high levels of lipids (fats) in the bloodstream). Record Review of Resident #5's Face sheet, not dated, indicated a [AGE] year-old with an admission date of 07/08/25. Resident #5 had diagnoses of Dementia (a progressive loss of mental functions, such as memory, language, and reasoning, Muscle weakness), Lack of Coordination (difficulty in controlling and coordinating movements), Type 2 Diabetes (when the body cannot use insulin correctly and sugar builds up in the blood), Hyperlipidemia (a condition in which there are abnormally high levels of lipids (fats) in the bloodstream), Bipolar Disorder a (mental health condition that causes extreme mood swings), Insomnia (a sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or not feeling rested after sleep, Chronic Pain, Visual loss, Hearing loss, Hypertension (where the force of blood against the artery walls is consistently too high), Vascular Disease (conditions that affect the body's blood vessels, including arteries and veins), and Chronic Kidney Disease (where the kidneys are damaged and cannot filter blood effectively). Record Review of Resident of #18's Face sheet, not dated, indicated a [AGE] year-old with an admission date of 03/25/25. Resident #18 had diagnoses of Traumatic Subarachnoid Hemorrhage (bleeding into the space between the brain and its surrounding membranes), Lack of Coordination, Cataracts (clouding of the eye's natural lens), Convulsions (where muscles contract and relax rapidly, causing uncontrolled shaking of the body), Psychotic Disorder (a mental health condition that causes a person to lose touch with reality), Adjustment Disorder (a mental health condition where someone experiences excessive emotional or behavioral symptoms in response to a stressful life event or change), Muscle Weakness, Communication Deficit (a difficulty or impairment in the ability to effectively receive, send, process, or comprehend information), Aphasia (a language disorder that affects a person's ability to communicate), and Hypokalemia (low potassium levels in the blood), Depression. An observation on 08/17/25 at 1:51 PM, of Resident #81's room reflected brown water stains on the ceiling tile around the air vent that had condensation on the vent. An observation on 08/17/25 at 2:26 PM, of Resident #5's room reflected gray flakes that covered the air vent. An observation on 08/18/25 at 10:30 AM, of Resident #18's room reflected a hole in the wall behind the door. In an observation and interview on 08/18/25 at 10:35 AM, Resident #5's bathroom light was dim. Resident #5 stated the light was so dim she could not see when she entered the bathroom. In an interview on 08/19/2025 at 1:15 PM, the Maintenance Director stated he was responsible for changing the ceiling tiles, cleaning the air vents, repairing holes in the walls, and changing out the light bulbs in the facility. He stated the risk of the brown stains on the ceiling tile with condensation on the air vent could cause internal black mold. He stated the risk of not repairing the hole in the wall could cause a resident to get their arm stuck in the wall or they could cut themselves. He stated the risk of the dim light in the resident's bathroom could cause a fall. In an interview on 08/19/2025 at 6:30 PM the ADM stated she expected the Maintenance Director to patch all</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) and refer all level II residents and all residents with possible serious mental disorder, intellectual disability, or a related condition for one (Resident #8) of one residents reviewed for PASRR screenings. The facility failed to ensure Resident #8's PASRR Level One screening accurately reflected their diagnosis of mental illness. This failure placed residents at risk of not receiving specialized therapy and equipment services they may benefit from. Findings included: Review of Resident #8's admission Record, dated 08/19/25, reflected he was a [AGE] year-old male, admitted on [DATE], and having diagnoses of cerebral infarction (stroke), unspecified dementia, severe with mood disturbance, delirium due to known physiological condition (occurring as an effect of a diagnosed disease process), bi-polar disorder current episode mixed, moderate (individual experiences both moderate manic and depressive symptoms simultaneously), and anxiety disorder. Review of Resident #8's quarterly MDS assessment, dated 05/16/25, reflected he was admitted to the facility from a short-term hospital stay. Resident #8 was usually able to understand others and be understood by others. His BIMs score was seven, indicating severe cognitive impairment. He displayed no signs of delirium or psychosis, no behavioral problems, and had no indicators of a mood problem during the assessment period. Resident #8 had impaired range of motion on one side of his upper body, and both sides of his lower body. He was able to feed himself but was dependent on staff for movement and ADL care. Review of Resident #8's care plans reflected the following: - A care plan created on 05/04/24, for of psychotropic medications for depression (sertraline and Depakote) - A care plan created on 05/22/24 for a history of trauma - A care plan created on 05/24/24 for impaired cognitive function or dementia, or impaired thought processes related to his stroke - A care plan created on 05/24/24 for depression and antidepressant medication Review of a psychiatry progress note, dated 08/04/25, reflected Resident #8's primary treating diagnosis was bipolar disorder, current episode mixed, moderate, and was on two medications which were each being used to treat multiple psychiatric diagnoses, including his primary diagnosis. Review of Resident #8's PASRR Level 1 Screening reflected the screening was done on 08/17/24, the day before Resident #8 was admitted to the facility, at an acute care hospital. Section C of the document reflected Resident #8 did not have a primary diagnosis of dementia, did not have mental illness, developmental disability, or intellectual disability. An interview on 08/19/25 at 5:37 PM with Regional MDS revealed if Resident #8 came from the hospital with a diagnosis of bi-polar, and the hospital marked it negative, she would have to enter the information as-is, as a draft, and try to get a new, correct form from the hospital. She said the admissions person, who received the form from the hospital when someone was admitted, did not review the form, and just scanned it in, and she (MDS) would be the one to review the form. She said she had a form she consulted with the diagnoses, because she could not remember them all. The surveyor asked for a copy of this list at that time, but did not receive one prior to exit. An interview on 08/19/25 at 6:11 PM with Regional MDS revealed the physician had moved Resident #8's dementia diagnosis to the primary spot, but she realized it was not there when the survey began. She said if a resident had mental illness when admitted, and the form was incorrect, MDS was to ask the admissions person to get a correct one from the hospital. She said it was important for the forms to be correct so that residents would have access to services available to them, but Resident #8 would not qualify for services, and his mental health needs were being addressed by the facility. Review of the facility policy Pre-admission Screening Resident Review (PASRR), revised 06/2020, reflected Purpose: To ensure that all Facility applicants are screened for mental illness and/or intellectual disability prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated. Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. (.)I. The Facility, as a medicaid certified nursing facility, ensures that Level I of the Preadmission Screening Resident Review (PASRR) is completed prior to admission of all applicants, regardless of payor, to determine if they are have a Mental Disorder (MD) or Intellectually Disabled (ID). A. All applicants to the Facility, whether or not they receive or are eligible for Medicaid, receive the Level I screening. (.) V. A negative Level I screen permits admission to proceed and ends the PASARR process, unless a possible serious mental disorder or intellectual disability arises later. A positive Level I screen necessitates an in-depth evaluation of the</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication was stored in locked compartments for 1 of 7 Medication Carts (Cart A) and 1 of 2 Treatment Carts (Cart B) reviewed for drug security. 1. A medication cart (Cart A) was left unlocked when not in use, unattended, and out of nurse's view while Resident #15 sat across from medication Cart A on 08/17/25. 2. A treatment cart (Cart B) was left unlocked when not in use and unattended on 08/17/25. These deficiencies could place residents at risk of medications loss, drug diversion, or harm due to accidental ingestion of unprescribed medications. Findings included: Record review of Resident #15's face sheet dated 08/18/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia (this is a brain disease that alters brain function and causes a cognitive decline). In an observation on 08/17/25 at 08:20 AM and at 08:45 AM, it was revealed a medication cart (Cart A) was unlocked and unattended with the lock mechanism out (indicating it was unlocked) against the nursing station facing the foyer with Resident #15 seated across from the unlocked and unattended medication cart (Cart A). There was no staff in sight of the unlocked Cart A. In an observation on 08/17/25 at 08:45 AM, it was revealed that the Treatment cart (Cart B) was unlocked and unattended with the lock mechanism out (indicating it was unlocked) outside the secure unit double doors against the wall facing outwards to the nursing station. There were no staff close or working from the unlocked treatment cart (Cart B). In an interview on 08/17/25 at 08:50 AM with LVN A it was revealed she was responsible for Cart A. She said she forgot to lock Cart A when unattended and out of sight. She stated the expectation was to lock and secure the medication cart when not in use. LVN A stated treatment cart (Cart B) was not left unlocked by her. She said the treatment nurse may have left it unlocked when she went to do wound care in a resident's room. She said all nursing staff were responsible for securing medication carts when not in use. She said the potential risk was a resident may get into the cart and grab something. In an interview with the DON on 08/17/25 at 10:56 AM, she revealed LVN A told her that she left the medication cart (Cart A) and treatment cart (Cart B) unlocked because she was in a hurry to go and stop the bleeding for a resident. She said LVN A said it was the urgent situation that lead to her quickly grabbing bandages and rushing to a resident's room leaving the carts unlocked. DON said Cart A and Cart B should not be left unlocked when not in nurse's view and not actively working in it. The DON said the actual treatment cart was locked inside the wound care nurse's office and Cart B was just overflow stock for weekend nurses to have access to bandages and creams and wound items that may not be on the medication carts. She said the expectation for all staff was that they would follow policy and procedure and lock and secure the medication carts and treatment carts when not in use. She said the risk was unauthorized access to the carts. DON stated she would do an in-service with LVN A. In an interview with ADON B on 08/18/25 at 1:00 PM, it was revealed she was the treatment nurse and did not leave Cart B unlocked when unattended. She stated Cart B was an overflow treatment cart for nurses. She said Cart B was an extra treatment cart for the nursing staff to use when she was not in the building and for PRN treatments by nurses. She said all the nurses have access to Cart B and were responsible for locking it up after use. She said it was a safety risk to the residents especially with betadine on the treatment cart could burn the eyes if accidentally exposed to the hands and into the eyes. Interview on 08/19/25 at 3:49 PM with Administrator it was revealed, the medication carts and treatment carts should be locked when they were out of sight and staff were not actively working in the carts. She said the expectation was that all staff would follow company policies and procedures and the expectation for all staff was to keep the residents safe. Record review of in-service one on one titled Corrective Action Memo completed by LVN A on 08/17/25 lead by DON revealed education to ensure medication/treatment carts are secured and locked when unattended to prevent unauthorized access and ensure resident safety. Record review of facility policy Administering Medication revised 08-2020 reflected 15. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering the medication, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is always maintained for all resident information by closing the MAR when not in use.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #2) of 8 residents, and 1 of 1 laundry room reviewed for infection control in that: 1. ADON B did not wear PPE during wound care for Resident #2 who was on Enhanced Barrier Precautions for wounds. 2. The facility failed to prevent cross contamination of three racks of clean residents' clothing by placing the racks in front of two washing machines in the soiled area of the laundry room. 3. The Laundry Aide failed to keep the clean laundry folding table clean, when she placed her shoes on the table next to residents' clean clothing. These failures could place residents at risk for infections due to lack of separation between clean and soiled laundry and by not following Enhancement Based Precautions. The findings included: Record review of Resident #2's face sheet dated 08/18/25 revealed a [AGE] year-old female who was admitted to the facility with pressure ulcer of the sacral region, stage 4 (this is a wound with full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts), unspecified wrist fracture and urinary tract infection. Record review of Resident #2's [NAME] MDS dated [DATE] revealed Resident #2 had a BIM's score of 14, indicating cognitively intact. Further review of MDS revealed Resident #2 had skin and ulcer treatment plans of pressure reducing device for bed, nutrition or hydration interventions to manage skin problem and pressure ulcer care. Review of Resident #2's physician orders dated 08/18/25 reflected resident was on Enhanced Barrier Precautions r/t wound: Staff members will wear a clean gown and gloves while performing high contact resident care activities to include Dressing, Bathing/Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tube, tracheostomy/ ventilator. every shift for Standard Precautions, order start date 04/28/25. Review of Resident #2's care plan, initiated 08/05/25, revealed: Focus: On Enhanced Barrier Precautions for wounds. Goal: Enhanced Barrier Precautions will be followed through review period. Interventions: Enhanced Barrier Precautions r/t sacrum wound requires dressing: Staff members will wear a clean gown and gloves while performing high contact resident care activities to include Dressing, Bathing/Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tube, tracheostomy/ventilator During wound care observation on 08/18/25 at 1:30 PM, revealed door signage for Resident #2 for Enhanced Barrier Precautions. ADON B did not put on a gown during wound care for Resident #2. In an interview on 08/18/25 at 1:50 PM, ADON B said that she forgot to wear a gown. She said that she did not know why she forgot to wear a gown. She said she was usually very careful to make sure that she followed all PPE precautions. She said the risk of not following EBP was spread of infection. Observation and interview of laundry room on 08/19/25 at 11:00 AM, revealed the laundry room had a clean area and a dirty area that were separated by a partial wall. Further in the laundry room revealed three racks of clothing placed a few feet in front of two washing machines on the soiled area of the laundry room next to a sink. Further observation on the clean area of laundry room on the folding table revealed a pair of black shoes placed on top of clothing facing upwards with the soles of the shoes up. The Housekeeping Supervisor stated that the Laundry Aide had placed the two racks of clean residents clothing in the area (dirty area) after sorting them from the dryer before transporting them out to residents. She said the third rack was for missing residents' items or items that could be donated to residents that had no clothing. She said the laundry room was small, and they tried to use the areas as best as they could. She said that the laundry aide should have placed the clean clothing racks on the clean area to avoid cross contamination. In an interview with the Laundry Aide on 08/19/25 at 11:10 AM, she said that the shoes were hers. She did not say why she put her shoes on top of the table that was used to fold residents clothing when she was asked by housekeeping supervisor. The Laundry Aide said she would move her shoes and that the risk of placing shoes in an area used for folding residents clothing was contamination of laundry items. The Laundry Aide said that it was easier for her to have the racks of clothing in the area by the washing machines because it was closer to the sorting table after taking the cloths out of the dryer. She said she could see how mixing dirty and clean could cause a risk of cross contamination. In an interview with the DON on 08/19/25 at 5:04 PM she said the expectation during wound care was for the nurses to wear a gown and gloves and to follow</p>		