STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455697	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Corpus Christi	202 Fortune Dr Corpus Christi, TX 78405

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 1 of 6 Residents (Resident #48) reviewed for reporting. In an interview with the ADM on 09/03/25 at 5:33 pm, he said he was informed about the incident with Resident #48 by the DON on or about 08/16/25, and since the DON was taking care of it, he had not remembered it when he and this state surveyor spoke on 09/03/25 at 5:06 pm. He said name-calling was verbal abuse, and he should have reported it to the state and local authorities. The facility did not report an allegation of verbal abuse on or about 08/16/25 per facility policy to the Administrator. Findings were: Record review of Resident #48's face sheet revealed a [AGE] year-old female who was admitted on [DATE]. Diagnoses included high blood pressure, diabetes, kidney disease, liver disease, heart disease, and paraplegia (the inability to voluntarily move the legs and loss of sensation in the lower part of the body, typically due to traumatic spinal cord injury). Record review of Resident #48's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating she was cognitively intact. She had upper body impairment and contractures. She was independent with eating and oral hygiene with adaptive utensils. She required substantial assistance with toileting, showering, and personal hygiene. She was able to roll left and right in bed using grab bars for assistance. She utilized a manual wheelchair which she could self-propel. She was always incontinent of bladder and bowel. Record review of Resident #48's care plan dated 11/09/22 indicated she had impaired mobility, loss of bowel tone, and physical limitations requiring a mechanical lift for transfers. In an interview and observation with Resident #48 on 09/03/25 at 2:05 pm, she said CNA C called her a dummy in the shower room a couple of weeks ago. She said she used a mechanical lift and was in the sling. She said she was crooked in the sling and wanted to sit up straighter because her head and neck were becoming uncomfortable. She said she was unable to straighten herself out, and that was when CNA C said to her, Sit up, dummy. She said the comment made her feel bad. She said she told the DON about it, and CNA C was no longer allowed to come into her room or shower her. Resident #48 was well-kempt and had no signs of abuse or odors. She said she was not fearful of CNA C, but things were not the same after she called her a dummy. In an interview with the OMB on 09/03/25 at 2:15 pm she said she did not know about the allegation of verbal abuse toward Resident #48 and this was the first time she had been informed of the incident. In an interview with the DON on 09/03/25 at 4:30 pm she said, she was informed by Resident #48 about the incident after it happened a couple of weeks ago. She said she spoke with the ADM about it and, together, decided that CNA C would not be suspended and would not be allowed to care for Resident #48. She said she did not report the incident to state or local authorities. She said name-calling was a form of verbal abuse, but she did not conduct an in-service. She said she did not know why the incident was not reported. She said she thought telling the ADM was enough. The facility's policy for reporting abuse was requested at this time. In an interview with the ADM on 09/03/25 at 5:06 pm, he said he was not informed about an incident with Resident #48. He said he would have remembered a verbal abuse allegation, especially since it was so recent, and would have reported it to the state. In an interview with CNA C on 09/03/25 at 5:24 pm, she said she was not allowed in Resident #48's room since Sunday, 2 weeks ago (08/17/25) because she supposedly called Resident #48 a dummy. She said the DON removed her from Resident #48's room, but she still worked in the same hall. She said she had worked at the facility for 3 years. She said Resident #48 wanted things her way, such as being laid down or showered right away. She said she told Resident #48 she needed help that Friday (08/15/25) due to a staffing change. She said she told Resident #48 she wanted to lay her down right after lunch (so she could make the 3 o'clock bingo game) instead of her usual nap time after the bingo game. She said Resident #48 told her she did not want to do that. CNA C said, when she got busy, she knew Resident #48 would get an attitude if she did not get her way. CNA C indicated she would get pulled in different directions throughout her shift because the facility changed from 3 CNAs (One for each hall) to 2 with a split (meaning 1 CNA each on 2 halls and 1 CNA worked where needed). She said Resident #48 required a mechanical lift for transfers, and she would have

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan which included the instructions for resident care needed to provide effective and person-centered care was implemented within 48 hours of admission for 1 (Resident #100) of 5 residents reviewed for baseline care plans. The facility did not develop a baseline care plan within 48 hours of admission for Resident #100. This failure could place residents at risk of not receiving person-centered care and/or services to meet their physical and/or psychosocial needs. Findings included: Record review of Resident #100's face sheet, dated 09/02/2025, revealed she was a [AGE] year-old female originally admitted on [DATE], readmitted on [DATE], and discharged on 09/02/2025. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (a lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants), Dyspnea (shortness of breath), and Dependence on Supplemental Oxygen (Oxygen therapy to help people with lung disease). Record review of Resident #100's orders, dated 08/28/2025, revealed orders for ProAir (medication to help patients with lung disease), Albuterol (a medication used to help increase airflow to the lungs), and admission to Hospice. Record review of Resident #100's baseline care plan, initiated 08/28/2025, revealed the baseline care plan had been added to Resident #100's chart, but it had never been completed. Record review of Resident #100's MDS admission assessment dated [DATE] revealed a BIMS score of 12, which revealed moderately impaired cognition and hospice care. In an interview on 09/03/2025 at 2:07 PM, the MDS nurse stated she should have completed the clinical portion of the baseline care plan for Resident #100, and the rest of the IDT should have completed the other sections, but it was obviously overlooked by everyone. She stated care plans never got overlooked, so she was not sure how this one got overlooked. She stated she had opened and dated it because it was in Resident #100's chart, but it was just never completed. In an interview on 09/03/2025 at 4:09 PM, the DON stated she thought the care plan for Resident #100 just got overlooked. She stated the MDS nurse should have put in the clinical portion of the baseline care plan, and the IDT should have filled in the other sections which belonged to them by discipline. She stated Resident #100 was a frequent flyer, and she had been there so many times, and the staff knew her, so she thought her information just got overlooked. In an interview on 09/04/2025 at 8:34 AM, MA-B stated the care plans were used to determine residents' wants, needs, likes, and/or dislikes. She stated she did not put in or update the care plans, and this was completed by the MDS nurse, the ADON, or the DON. In an interview on 09/04/2025 at 9:10 AM, the ADON stated she helped with the care plans when she needed to update something, but it was mostly created and updated by the MDS nurse, as it was their job to work on care plans. She stated she was not sure why the care plan for Resident #100 was never completed, but she thought it just got overlooked because the resident admitted at the end of the week, and Resident #100's care plan must have gotten missed. The ADON stated without a baseline care plan information regarding Resident #100's care could have gotten overlooked or missed. Record review of the facility's Care Planning - Interdisciplinary Team policy, with a revision date of 12/2024, revealed The Interdisciplinary Team was responsible for the development of resident care plans. The IDT includes, but is not limited to: the resident's attending physician, a registered nurse with responsibility for the resident, a licensed vocational nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of the food and nutrition services, to the extent practicable the resident and/or resident's representative, and other staff as appropriate or necessary to meet the needs of the resident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dialysis services were provided consistent with professional standards of practice for 1 of 1 resident (Resident #6) reviewed for quality of care. The facility failed to ensure Resident #6 had a physician's order to assess the dialysis shunt or fistula (a dialysis access which allows the removal of waste and extra fluid). The facility failed to monitor Resident #6's dialysis catheter by assessing for the thrill and bruit each shift. These failures could place residents at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #6's face sheet, dated 09/04/2025, revealed a [AGE] year-old male with an admission date on 03/09/2022 and readmission on [DATE]. Pertinent diagnoses included End Stage Renal Disease (when the kidneys no longer adequately filter waste products from the blood), Diabetes Mellitus Type 2 (a group of diseases which affect how the body uses blood sugar), and Dependence on Renal Dialysis (process of removing excess water, solutes, and toxins from the blood when the kidneys can no longer perform those functions naturally). Record review of Resident #6's quarterly MDS assessment, dated 06/20/2025, revealed Resident #6 was understood and was able to understand others. The MDS assessment indicated Resident #6 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment also indicated Resident #6 had a dependence on renal dialysis. Record review of Resident #6's comprehensive care plan, dated 03/25/2025, revealed Resident #6 received dialysis on Mondays, Wednesdays, and Fridays with a goal for Resident #6 to have no signs or symptoms of complications from dialysis through the review date. Interventions of this care plan included no blood pressure or venipuncture (blood draws) on extremity with dialysis access site. Record review of Resident #6's progress note, dated 08/19/2025, revealed Resident #6 had a left AV fistula placed (a procedure which connects an artery to a vein **AV - arteriovenous** to allow for a more durable access point for hemodialysis) and was noted to have sutures and Dermabond (a liquid topical skin adhesive) to the area. Record review of Resident #6's physician orders, dated 03/19/2025, revealed an order for Dialysis weekly on Mondays, Wednesdays, and Fridays. Record review of Resident #6's physician orders, after an interview with both the DON and the ADON, revealed there were new orders initiated today (09/03/2025) to include monitor left AV shunt/fistula for bleeding every shift; no blood pressures or venipuncture on extremity with dialysis site; monitor AV shunt/fistula to left arm for thrill (a palpable vibration felt over the fistula) and bruit (a sound produced by turbulent blood flow) every shift In an interview on 09/02/25 at 1:30 PM LVN-A stated to surveyor there was not an order to assess the shunt, but she knew it was supposed to be assessed. LVN-A stated she had assessed the dialysis shunt for thrill and bruit prior to sending to dialysis on Mondays, Wednesdays and Fridays. She stated she did not chart in the assessment in Resident #6's progress notes but charted it on his paperwork which went with him to dialysis. In an interview on 09/02/25 at 1:35 PM, the ADON stated to the surveyor she could not find an order for the nurses to assess the dialysis shunt, but there should have been. She stated Resident #6 had this shunt/fistula placed on the 8/19/25, which was when the order should have been put in. She stated assessing the shunt was a way to monitor it was working properly and had good blood flow. In an interview on 09/02/25 at 1:38 PM, the DON stated to the surveyor she could not find an order for the nurses to assess the dialysis shunt/fistula, but there should have been. She stated Resident #6 had this shunt/fistula placed on the 8/19/25, and the order should have been put in when the resident had the shunt placed. She stated the shunt/fistula needed to be assessed routinely to make sure it was functioning and working properly and not having complications, and she would obtain that order today. Record review of the facility's Physician Orders Policy, dated 02/2025, revealed The purpose is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. Physician orders are essential for the comprehensive care of residents.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 2 of 5 residents (Residents #42 and #89) reviewed for pharmacy services. 1. The facility failed to clarify the blood pressure parameters for Resident #42's Midodrine (a medication used to treat hypotension, or low blood pressure) orders started [DATE]. 2. The facility failed to administer Resident #42's and Resident #89's Midodrine per the recommended and prescribed order and blood pressure parameters in August of 2025. These failures could place residents at risk for complications and jeopardize their health and safety. 1. Record review of Resident #42's face sheet, dated [DATE], revealed a [AGE] year-old male with an admission date of [DATE]. Pertinent diagnoses included hypotension (low blood pressure). Record review of Resident #42's admission MDS assessment, dated [DATE], revealed a BIMS score of 15, which revealed intact cognition. The MDS also revealed an active diagnosis of orthostatic hypotension. Record review of Resident #42's physician orders, started [DATE] revealed an order for Midodrine 5 MG, give one tablet by mouth twice per day related to hypotension, no blood pressure parameters listed; a current active order, started [DATE], revealed an order for Midodrine 5 MG, give one tablet by mouth twice per day related to hypotension; Hold for blood pressure greater than 120/60. Record review of Resident #42's care plan, initiated [DATE], revealed a care plan related to hypotension with a goal to remain free of complications through review. Interventions included give medications as ordered. Record review of Resident #42's [DATE] MAR revealed Midodrine 5 MG, give 1 tablet by mouth two times per day related to Hypotension, started [DATE] and stopped [DATE]. Record review further revealed Midodrine was administered during this timeframe with no blood pressure parameters and no blood pressures recorded in the MAR for this medication. Record review of Resident #42's [DATE] MAR revealed Midodrine 5 MG, give 1 tablet by mouth two times per day related to hypotension (this order was used until [DATE]), then changed to Midodrine 5 MG, give one tablet by mouth twice per day related to hypotension, hold for blood pressure greater than 120/60. (this order was started [DATE]). Dates when Midodrine was administered incorrectly included: [DATE] 9:00 AM B/P 122/78 Administered[DATE] 9:00 AM B/P 120/65 Administered[DATE] 9:00 AM B/P 115/65 Administered[DATE] 5:00 PM B/P 109/66 Administered[DATE] 9:00 AM B/P 106/62 Administered[DATE] 9:00 AM B/P 122/62 Administered[DATE] 9:00 AM B/P 117/66 Administered[DATE] 9:00 AM B/P 104/67 Administered[DATE] 9:00 AM B/P 116/70 Administered[DATE] 9:00 AM B/P 111/66 Administered[DATE] 5:00 PM B/P 104/62 Administered[DATE] 5:00 PM B/P 109/62 Administered[DATE] 9:00 AM B/P 116/71 Administered 2. Record review of Resident #89's face sheet, dated [DATE], revealed a [AGE] year-old male admitted [DATE], and readmitted on [DATE]. Pertinent diagnosis included hypotension (low blood pressure). Record review of Resident #89's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 15, which revealed intact cognition. Record review of Resident #89's active physician orders, started [DATE] revealed an order for Midodrine 10 MG plus 2.5 MG equals 12.5 mg by mouth daily related to hypotension; Hold for blood pressure greater than 110/60. Record review of Resident #89's care plan, initiated [DATE], revealed a care plan related to hypotension with a goal to remain free of signs and symptoms of cardiac problems. Interventions included give medications as ordered. Record review of the Consultant Pharmacist's recommendations dated [DATE] revealed Resident #89 had an order for Midodrine which included parameters to hold if blood pressure was greater than 110/60. Per documentation on the eMAR it appears Midodrine was administered several times during June although blood pressure was over 110/60. Record review of the Consultant Pharmacist's recommendations dated [DATE] revealed Resident #89 had an order for Midodrine which includes parameters to hold if blood pressure was greater than 110/60. Per documentation on the eMAR it appears Midodrine was still being administered several times during July although blood pressure was over 110/60. Record review of Resident #89's [DATE] MAR revealed Midodrine 12.5 MG by mouth daily related to hypotension (started [DATE]), then changed to Midodrine 5 MG, give one tablet by mouth twice per day related to hypotension, hold for blood pressure greater than 120/60. (this order was started [DATE]). Dates when Midodrine was administered inaccurately included: [DATE] 6:00 AM B/P 107/63 Administered[DATE] 6:00 AM B/P 115/66 Administered[DATE] 6:00 AM B/P 100/62 Administered[DATE] 6:00 AM B/P 140/80 Administered[DATE] 6:00 AM B/P 146/89 Administered[DATE] 6:00 AM B/P 128/77 Administered[DATE] 6:00 AM B/P 114/80 Administered[DATE] 6:00 AM B/P 105/68 Administered[DATE] 6:00 AM B/P 97/65 Administered[DATE] 6:00 AM B/P 110/67 Administered[DATE] 6:00

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed and 1 of 1 nutrition room for storage, preparation, and sanitation. 1. The facility failed to ensure there were no personal items in the walk-in refrigerator or on the tray line. 2. The facility failed to ensure all items in the walk-in refrigerator were labeled and dated. 3. The facility failed to ensure there was an internal thermometer in the walk-in refrigerator. 4. The facility failed to ensure there was no ice accumulation in the walk-in freezer. 5. The facility failed to ensure that boxes of food in the walk-in freezer were sealed tightly and at least 18 inches from the ceiling. 6. The facility failed to ensure that juice guns were clean and not hanging over the edge of the prep table. 7. The facility failed to ensure all employees entering the kitchen had hairnets on. 8. The facility failed to ensure all electric stove top burners worked. 9. The facility failed to ensure the nutrition room kept up with freezer logs and expired food in a cabinet.10. The facility failed to ensure the cabinet beneath the nutrition room sink was free of leaks, personal items, and trash. These failures could place residents at risk for food contamination and food-borne illness. Findings were: Observation on initial tour of the kitchen on 09/02/25 at 8:15 am revealed two cans of soda on a shelf in the walk-in refrigerator that were not dated or labeled. There were three trays of beverages in the refrigerator that were neither labeled nor dated. There was no internal thermometer in the refrigerator. There was a thick accumulation of ice in the walk-in freezer, forming a 7-inch pyramid under the condenser. There was an 18-pound box of burritos in the walk-in freezer with the contents open to air. There was a 20-pound box of frozen cookie dough in the walk-in freezer with the contents open to air. A box on the top shelf of the walk-in freezer was less than 18 inches from the ceiling. There was a 20-pound box of frozen vegetables in the walk-in freezer with the contents open to air. One of 2 juice guns had a thick, red/black sticky substance in and on the inner nozzle. The 6-burner electric stove top had 2 elements that did not work. The MSA entered the kitchen without a hairnet and walked through the kitchen before this state surveyor stopped him. Observation during a return visit to the kitchen on 09/02/25 at 12:00 pm revealed a 36-ounce Styrofoam cup with a straw in it on the tray line while trays were being plated. Observation of the nutrition room on 09/03/25 at 10:00 am revealed a 10-ounce jar of asparagus had expired on 11/25/25. Documentation on the freezer temperature log had not been done since 08/11/25. The bottom of the cabinet beneath the sink had standing water throughout, a partially filled basin under the plumbing, 2 empty plastic bags, an empty plastic container, a corded coffee maker, and a personal drinking glass sitting in the water in the cabinet. There were black spots in the basin and in the cabinet. The cabinet floor was delaminated. In an interview with the DS on 09/02/25 beginning at 8:20 am, she said the two cans of soda in the walk-in refrigerator belonged to her. She said she was in a hurry when she came in and just set them there. She said the sodas should not have been in the walk-in refrigerator because the transfer of germs from handling the cans could cause cross-contamination to the food and make residents sick. She said staff had been in-serviced on labeling and dating everything in the walk-in refrigerator, freezer, and the regular refrigerator, as well as personal items. She said the internal thermometer for the refrigerator was in there, but she could not find it. She said they used the exterior digital thermometer to log temperatures. She said they were not comparing the external thermometer to the internal thermometers. She said there was no way to know if the temperatures were accurate. She said the ice accumulation in the freezer had been there for a while and had been addressed. She said the freezer had been fixed last month. She said maintenance was supposed to return and inspect it again. She said she was not sure how long the ice had been accumulating. She said boxes should not have been placed within 18 inches of the ceiling of the walk-in freezer because it could pose a fire hazard, and the sprinklers could be impeded. She said the food in the boxes in the walk-in freezer should have been sealed tightly inside the boxes to prevent damage and contamination to the frozen foods, such as frostbite and whatever might have been in the air. She said the juice guns were cleaned daily and did not know what the gunk was in the inner nozzles. She said the juice guns were supposed to be in a holster and not hanging from the machine, where someone or something could rub against the nozzles and contaminate them. She said the electric stove was supposed to be replaced several months ago, and she did not know what had happened, nor had she followed up recently. In an interview with the MSA on 09/02/25 at 8:30 am, he said, I usually wear a hairnet when I'm in the kitchen, I just didn't right now. He said he knew hairnets were required in the kitchen because he had been trained. He said hair was considered dirty and could cross-contaminate food. In an interview with the

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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	Provide and implement an infection prevention and control program. **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 (Resident #89) of 6 residents reviewed for infection control practices.1) The facility failed to ensure the WCN performed hand hygiene after removing gloves prior to performing wound care on Resident #89 and after sanitizing scissors. This failure could place residents at risk for healthcare associated cross-contamination and infections. Findings include:Record review of Resident #89's face sheet, dated 09/04/25, reflected a [AGE] year-old-male with an initial admission date of 06/01/23. Diagnoses included stage 4 (full thickness tissue loss, exposing underlying structures such as muscle, tendon, or bone) pressure ulcer of the sacral (tailbone) region and right ankle, type two diabetes (insufficient insulin production in the body), and high blood pressure. Record review of Resident #89's physician orders reflected:Stage 4 (full thickness skin loss and exposing of underlying tissues, including muscle and bone) pressure sore to sacrum (tailbone) clean with normal saline, pat dry with 4x4 gauze, apply collagen (protein that stimulates new tissue growth) and cover with dry dressing daily and as needed. Dated 09/02/25. Left hallux (big toe) stage 4 pressure sore, Clean with normal saline, pat dry with 4x4 gauze, apply hydrofera blue (antibacterial wound dressing) cut to size of wound bed wrap with kerlix and secure with tape on Monday's, Wednesday's, Friday's, and as needed. Record review of Resident #89's quarterly MDS dated [DATE] reflected a BIM score of 14 (cognition intact). During an observation on 09/03/2025 at 2:44 PM, the WCN took off her gloves after sanitizing scissors and did not perform hand hygiene before putting on new gloves and prior to performing wound care on Resident #89. In an interview on 09/03/2025 at 4:13 PM, the WCN stated she did not sanitize her hands after removing gloves when she cleaned the scissors because she did not have her hand sanitizer where she usually had it and it threw her off. The WCN stated she was nervous and forgot to sanitize her hands or perform hand hygiene after removing her gloves. The WCN stated it was important to perform hand hygiene after taking off gloves to stop the spread of infection and possible cross contamination. The WCN stated if Resident #89's wound came in contact with bacteria; it could get infected. In an interview on 09/03/2025 at 4:51 PM, the DON stated staff should sanitize or wash hands for at least 30 seconds with 20 seconds of friction. The DON stated it was important to wash hands to prevent the spread of infection. The DON stated the facility conducted a lot of in-services on infection control but could not state when the last hands-on in-service was for handwashing. Record review of Handwashing/Hand Hygiene policy not dated reflected:Policy StatementThis facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Indications for Hand Hygieneg. immediately after glove removal