STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 1 (Resident #1) of 5 residents reviewed for medication administration. The facility failed to ensure when the ADON was administered medications to Resident #1 on 04/30/2025 at 9:00 am in the common area, the ADON said the resident's medications loud when other residents was also in the common area. This failure could place residents at risk of resident identifiable and medical information being accessed by unauthorized persons. The findings were: Record review of Resident #1's face sheet, dated 05/02/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), malignant neoplasm of larynx (laryngeal cancer - cancer to a hollow tube in the middle of neck), dementia (group of thinking and social symptoms that interferes with daily functions), and Alzheimer's disease (destroys memory and other important mental functions). Record review of Resident #1's admission MDS assessment, dated 02/24/2025, revealed the resident's BIMS score was 99, which indicated the resident was unable to complete the interview, and the resident was dependent (helper does all of the effort) to chair-to-bed and tub/shower transfer. Observation on 04/30/2025 at 9:00 a.m., revealed Resident #1 was at the common area with other residents, and the ADON brought a medication cart and parked it at the common area, then took out Resident #1's medications from the cart. The ADON approached Resident #1 and gave the resident's medications. When the ADON gave medications to Resident #1, the ADON said what the medications the resident was receiving loud in the presence other residents. There were approximately 6 residents in the common area watching television. Interview on 04/30/2025 at 9:06 a.m., Resident #1 was unable to interview due to his cognitive impairment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/2025 at 9:07 a.m., the ADON acknowledged he said Resident #1's medications loud to the resident who was in the common area with other residents, and other residents might have overheard what kind of medications Resident #1 was taking. The ADON stated it violated Resident #1's privacy and confidentiality of the resident's medical information. Further interview with the ADON he said he should have taken Resident #1 to the resident's room or a private area and explained the medications to prevent the resident's medical information. Interview on 05/02/2025 at 3:04 p.m., the DON stated the ADON should have taken Resident #1 to the resident's room or private area and explained the medications to prevent the resident's medical confidential information. The DON said s Resident #1's medications loud at the common area might cause other residents to overhear Resident #1's medical and personal information, and it violated Resident #1's right regarding privacy and confidentiality of medical record. Record review of the facility policy, titled Statement of Resident Rights, undated, revealed 8. You have right to have facility information about you maintained as confidential.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of significant medication errors for 1 (Resident #2) of 5 residents reviewed for medications. The facility failed to ensure Resident #2 received his Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension from 09/14/2025 to 09/24/2024 (total 11 days) as ordered by the physician. The noncompliance was identified as PNC on 05/02/2025. The PNC began on 09/14/2024 and ended on 09/27/2024. The facility had corrected the noncompliance before the survey began. The deficient practice placed the residents at risk of not receiving desired outcomes from medications that are not administered according to physician's orders. Findings Included: Record review of Resident #2's face sheet, dated 05/02/2025, revealed the resident was [AGE] years old male, originally admitted [DATE], and re-admitted to the facility on [DATE] with diagnosis of acute on chronic diastolic heart failure (heart not able to fill properly with blood during the diastolic phase, reducing the amount of blood pumped out to the body), type 2 diabetes mellitus (not control blood sugars), hyperlipidemia (high levels of fat), hypertension (high blood pressures), and atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #2's annual MDS, dated [DATE], revealed Resident #2 had a BIMS score of 15 out of 15, which indicated his cognitive was intact, and the resident had supervision or touching assistance (helper provides verbal cues and/or touching and/or contact guard assistance as resident completes activity) to sit to stand, chair-to-bed, and toilet transfer. Record review of Resident #2's comprehensive care plan, dated 03/27/2024, revealed [Resident #2] has hypertension, and for intervention, follow parameters for hypertension medication as ordered. Record review of Resident #2's physician order, started 09/11/2024, revealed the resident had the order of Metoprolol Tartrate oral tablet 50 mg - give one tablet my mouth one time a day for hypertension - hold if systolic blood pressure less than 110 or pulse less than 60. Further record review of the physician order revealed this order was discontinued on 09/13/2024. Record review of Resident #2's nursing progress note, dated 09/13/2024, revealed [Resident #2]'s nurse practitioner assessed the resident and changed the order from Metoprolol Tartrate oral tablet 50 mg - give one tablet my mouth one time a day for hypertension to Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension per the resident's VA doctor's recommendation. Record review of Resident #2's physician order, dated 09/13/2024, revealed there was no order regarding start Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension on 09/14/2025. Further record review of the physician order, dated 09/25/2024, revealed Start Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension on 09/25/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's MAR from 09/01/2024 to 09/30/2024 revealed the resident received his Metoprolol Tartrate 50 mg on 09/11/2024, 09/12/2024, and 09/13/2024 as ordered. However, the resident did not receive his Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension from 09/14/2024 to 09/24/2024 (total 11 days). Resident #2 started receiving it from 09/25/2024. Record review of the facility investigation report, dated 09/25/2024, revealed the facility DON notified Resident #2's primary care physician and the resident regarding not receiving Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension from 09/14/2024 to 09/24/2024 (total 11 days - blood pressure was 118/54 on 09/18/2024, blood pressure was 108/49 on 09/19/2024, and blood pressure was 104/46 on 09/20/2024) because the facility nurses forgot updating the new medication on the system, the resident's primary care physician stated the resident's blood pressures during the 11 days were stable with other blood pressure medications such as Entresto oral tablet 24-26 mg for heart failure, Lasix oral tablet 40 mg for heart failure, and Spironolactone oral tablet 25 mg for hypertension, so just starting Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension as scheduled, and the resident stated he was stable and did not have any different feeling during the 11 days. Record review of the facility in-service, dated 09/27/2024, revealed the facility DON completed providing in-services regarding Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed to all facility nurses. Observation on 05/01/2025 at 8:55 a.m., revealed Resident #2 received his Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension as ordered. Interview on 05/02/2025 at 1:12 p.m., Resident #2 stated he received his blood pressure and heart failure medications as ordered, including Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension, and nurses checked his blood pressures a lot daily. Further interview with the resident said he knew he did not receive his Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension for 11 days 2024, but he was fine and did not have any change. Interview on 04/30/2025 at 11:37 a.m., LVN A stated the nurse knew Resident #2 did not receive his Metoprolol succinate extended-release oral tablet 50 mg one time a day for hypertension from 09/14/2024 to 09/24/2024, and she worked on 09/13/2024 from 6 am to 2 pm as Resident #2's charge nurse but did not recall if or not she received new order from Resident #2's nurse practitioner and updated the new order on the system because it was happened almost one years ago. The LVN A said if she received new order from doctors or nurse practitioners, she usually updated the new order on the system immediately, but for this situation, LVN A did not recall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/30/2025 at 12:18 p.m., the DON stated the facility did not know who did not update the order on the system because the nurse practitioner who gave the new order was not working anymore, and sometimes the nurse practitioner updated the new order directly to the facility system. The DON said after she knew Resident #2 did not receive the medication for 11 days, the DON notified it to the resident's primary care physician and resident and completed in-services to all nurses regarding updating medications on the system immediately after receiving new or changed orders. The DON stated Resident #2 was stable and did not have any negative effect because the resident received other medications for his heart failure and hypertension such as Entresto oral tablet 24-26 mg for heart failure, Lasix oral tablet 40 mg for heart failure, and Spironolactone oral tablet 25 mg for hypertension. The DON said she also conducted all nurses and medication aides' competency for medication administration on 09/27/2024 then allowed nurses and medication aides to work to the floor after they passed, the facility QAPI already discussed this issue, and the DON and ADON monitored regarding medications to every morning meeting and educated all nurses regarding updating new or changed medication to the system. DON said missing Resident #2's high blood pressure medication might cause high blood pressures. Interview on 04/30/2025 at 4:02 p.m., Resident #2's NP B stated she did not work as Resident #2's NP in September 2024, and sometimes nurses notified if the resident's blood pressures were out of parameter per the facility policy, but generally the resident's blood pressures were stable with medications. Record review of the facility policy, titled Medication Reconciliation, dated 04/10/2023, revealed This facility reconciles medication frequently throughout a resident's stay to ensure that the resident free of any significant medication error, and the facility's medication error rate is less than 5 percent - for daily process, obtain and transcribe any new orders in accordance with facility procedures and verify medications received match the medication orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #2) of 5 residents reviewed for medical records. The facility failed to ensure LVN A documented Resident #2's blood pressure after re-checking the blood pressure when MAC notified LVN A the resident's blood pressure was 101/34 on 04/05/2025. This failure placed resident at risk for missed treatment and care which could result in decline in health and well-being. Findings included: Record review of Resident #2's face sheet, dated 05/02/2025, revealed the resident was a [AGE] year old male, originally admitted [DATE], and re-admitted to the facility on [DATE] with diagnoses of acute on chronic diastolic heart failure (heart not able to fill properly with blood during the diastolic phase, reducing the amount of blood pumped out to the body), type 2 diabetes mellitus (not control blood sugars), hyperlipidemia (high levels of fat), hypertension (high blood pressures), and atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #2's annual MDS, dated [DATE], revealed Resident #2 had a BIMS score of 15 out of 15, which indicated he was cognitive was intact, and the resident had supervision or touching assistance (helper provides verbal cues and/or touching and/or contact guard assistance as resident completes activity) to sit to stand, chair-to-bed, and toilet transfer. Record review of Resident #2's physician order, started 09/25/2024, revealed the resident had the order of Metoprolol succinate extended-release oral tablet - give 50 mg by mouth one time a day for hypertension - hold if systolic blood pressure less than 110 or pulse less than 60. Record review of Resident #2's MAR from 04/01/2025 to 04/30/2025 revealed Metoprolol succinate extended-release oral tablet - give 50 mg by mouth one time a day for hypertension - hold if systolic blood pressure less than 110 or pulse less than 60 was scheduled at 6 a 1 (around 9 am), and on 04/05/2025, MA C held the medication because Resident #2's blood pressure was 101/34, and pulse was 72 per minute. Record review of Resident #2's nursing progress note, dated 04/05/2025, there was no nursing note regarding Resident #2's blood pressure (101/34) and holding the medication (Metoprolol succinate 50 mg). Interview on 04/30/2025 at 12:09 p.m., MA C stated she held Resident #2's Metoprolol succinate extended-release oral tablet on 04/05/2025 because the resident's blood pressure was 101/34, and the parameter said, hold if systolic blood pressure less than 110 or pulse less than 60, then she notified it to the charge nurse (LVN A) immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/2025 at 4:07 p.m., LVN A stated she remembered MA C notified her of Resident #2's blood pressure on 04/05/2025. LVN A said she re-checked Resident #2's blood pressure with a manual blood pressure cuff because the blood pressure monitor that MA C used to the resident's wrist sometimes had inaccurate readings. LVN A said she did not recall exactly, but when she re-checked the resident's blood pressure, it might be115/58, and she notified it to the resident's nurse practitioner as the facility protocol. Further interview with LVN A said she forgot documenting it on the nursing note on 04/05/2025 because she wrote it to another paper, and it was her mistake. LVN A stated she should have documented the blood pressure after she re-checked and what the nurse notified to the nurse practitioner on 04/05/2025, and missing and inaccurate documentation might provide incorrect care to the resident. Interview on 04/30/2025 at 4:02 p.m., Resident #2's NP B stated she did not recall if not she was notified Resident #2's blood pressure on 04/05/2025, but the facility nurses notified blood pressures of many residents to the nurse practitioner very well. Interview on 05/02/2025 at 3:04 p.m., the DON stated LVN A should have documented Resident #2's blood pressure after the nurse re-checked the blood pressure and what the nurse notified to the nurse practitioner on the nursing notes on 04/05/2025 because it was very important information for Resident #2's care, and missing and inaccurate documentation might provide incorrect care to the resident. Record review of the facility policy, titled Documentation in Medication Record, dated 10/24/2022, revealed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Resident #3) of 5 residents reviewed for infection control practices. The facility failed to ensure the ADON sanitized or washed her hands before administering medications to Resident #3. This deficient practice could place residents at risk for cross contamination and infections. The findings included: Record review of Resident #1's face sheet, dated 05/02/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), malignant neoplasm of larynx (laryngeal cancer - cancer to a hollow tube in the middle of neck), dementia (group of thinking and social symptoms that interferes with daily functions), and Alzheimer's disease (destroys memory and other important mental functions). Record review of Resident #1's admission MDS assessment, dated 02/24/2025, revealed the resident's BIMS score was 99, which indicated the resident was unable to complete the interview, and the resident was dependent (helper does all of the effort) to chair-to-bed and tub/shower transfer. Record review of Resident #3's face sheet, dated 05/02/2025, revealed the resident was a [AGE] year-old male, originally admitted on [DATE], and re-admitted to the facility on [DATE] with the diagnoses of alcoholic cirrhosis of liver (chronic liver damage from alcohol leading to scarring and liver failure), cellulitis of left toe (skin infection), malignant neoplasm of lung (lung cancer), and personal history of urinary tract infections (bladder infection). Record review of Resident #3's quarterly MDS, dated [DATE], revealed the resident's BIMS was 13 out of 15 which indicated the resident was cognitively intact, and the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating, chair-to-bed, and toilet transfer. Record review of Resident #3's care plan, dated 09/26/2023, revealed Resident had confusion related to increased ammonia levels and ascites and for intervention - monitor behaviors and increased confusion, and risk for respiratory infection due to age and resident lives in close proximity to others and for intervention - monitor facility for tends in respiratory infections. Observation on 04/30/2025 at 9:07 a.m., revealed the ADON completed administering medications to Resident #1, the ADON returned to the medication cart and prepared Resident #3's medications without sanitizing or washing his hands. Further observation on 04/30/2025 at 9:12 a.m., revealed the ADON administered medications to Resident #3 in the resident's room, then came out the resident's room without sanitizing or washing his hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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	Interview on 04/30/2025 at 09:21 a.m., the ADON acknowledged he did not wash or sanitize his hands when he prepared Resident #3's medications and administered the medication to Resident #3 after completing administering medications to a previous resident. The ADON said he should have washed or sanitized his hands when he administered medications to each resident to prevent possible infection and per the training for infection control. Interview on 05/02/2025 at 3:04 p.m., the DON said the ADON should have washed or sanitized his hands when he administered medications to each resident to prevent possible infection. The DON said this was an infection control issue. Record review of the facility policy and procedure, titled Procedure for oral med administration, undated, revealed Performs hands hygiene prior to handling medications and after med administration.