STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455895	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points at Lake Highlands Nursing and Rehab	9009 White Rock Tr Dallas, TX 75238

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to review and revise the person-centered comprehensive care plan for 1 (Resident #55) of 7 residents reviewed for comprehensive care plan revisions.The facility failed to revise Resident #55's comprehensive care plan to include a diagnosis of dementia.This failure could place residents at risk of not receiving appropriate interventions to meet their current health needs.Record review of Resident #55's face sheet, printed 03/31/26, reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia (decline in mental function) developed 03/20/24, acute kidney failure (sudden loss of kidney function), heart failure (heart muscle doesn't pump blood and oxygen to support other organs), chronic obstructive pulmonary disease (progressive, treatable lung disease), and age-related osteoporosis (brittle and fragile bones due to loss of bone density).Record review of Resident #55's quarterly MDS assessment, dated 03/09/26, reflected a BIMS score of 12, which indicated mild to moderate cognitive impairment. Section I - Active Diagnoses revealed I4800, Non-Alzheimer's Dementia was checked.Record review of Resident #55's comprehensive care plan, last reviewed 01/09/2026, revealed there was no focus area, goals, or interventions for Resident #55's dementia diagnosis.During an interview on 03/31/2026 at 12:14 p.m., the MDS Coordinator stated the nurse or ADON on the unit updated care plans. He stated the care plan triggered every 3 months at which time MDS reviewed it. He stated the review included the residents' diagnosis, in relation to goals and interventions in the care plan, to ensure the care plan was personalized. He stated if a diagnosis was missed, staff would not know the targeted behaviors and interventions. He stated he did not know why the diagnosis was missing.During an interview on 03/31/2026 at 12:32 p.m., LVN J stated she was unaware of Resident #55's dementia diagnosis. She stated nurses were not responsible for updating care plans. She stated if care plans were not accurate, residents may not receive medications and appropriate care. During an interview on 03/31/2026 at 12:32 p.m., the DON stated nurses were responsible for updating the care plan for any acute changes. She stated updated care plans gave CNAs and nurses knowledge and education of the care needed for residents. She stated there were quarterly care plans and she was unsure why the care plan failed to address the dementia diagnosis. She stated the expectation was for nurses to learn and know the policy and procedures related to revising care plans.Review of the facility's undated Comprehensive Care Planning policy reflected in part, Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 7 residents (Resident #2, #12, #24, #91, #126, #144, and #156) of 10 residents reviewed for ADLs. The facility failed to ensure: Resident #24, Resident #91, Resident #144 had their fingernails trimmed on 03/29/2026.Resident #126 had her fingernails trimmed and cleaned and facial hair trimmed on 03/29/2026.Resident #156 had his fingernails cleaned and trimmed on 03/29/2026.Resident #2 had her fingernails trimmed and cleaned on 03/29/2026.Resident #12 had his fingernails trimmed and cleaned on 03/29/2026 These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and skin breakdown, and a decreased quality of life.1. Record Review of Resident #2's Quarterly MDS assessment dated [DATE] as a [AGE] year-old female with initial admission date of 11/25/2025 to the facility. Her pertinent diagnoses included: Diabetes mellitus (elevated blood glucose levels), cerebral infarction (is a condition caused by a blockage in blood vessels supplying the brain, resulting in tissue death). Her BIMS score was 12, which indicated Resident #2's cognition was moderately impaired. Resident #2 was dependent on staff for her personal hygiene. Review of Resident #2 's Comprehensive Care Plan, revised 11/26/2025 reflected, Focus: [Resident #2] has an ADL self-care performance deficit . Interventions: Assist with personal hygiene as required. In an observation on 03/29/2026 at 10:35 AM, revealed Resident #2 had long nails on both hands, they were approximately 0.3cm in length extending from the tip of his fingers. The nails were discolored tan and the underside had dark brown colored residue. Resident #2 was confused unable to answer questions. 2. Review of Resident #12 Quarterly MDS assessment, dated 02/17/2026, reflected Resident #12 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included need for assistance with personal care, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and muscle wasting. Resident #12 had a BIMS of 04 which indicated Resident #12's cognition was severely impaired. Resident#12 extensive assistance with transfer, and personal hygiene. Review of Resident #12's Comprehensive Care Plan dated 08/11/25 reflected the following: Focus: resident#12 has an ADL self-care performance deficit. Interventions: Bathing requires staff for assistance. In an observation on 03/29/2026 at 10:49 AM, revealed Resident #12 was lying in his bed. The nails on both hands were approximately 0.4cm in length extending from the tip of his fingers. The nails were discolored tan. Resident #12 had communication deficit. He did not answer questions. In an interview on 03/29/2026 at 11:51 AM, LVN B stated that Nurses and CNAs were responsible for clipping residents' fingernails. She stated that for residents with diabetes, Nurses were responsible for trimming fingernails as needed. LVN B stated the risks of long, dirty fingernails included skin tears, increased risk of infection and decreased quality of life. LVN B stated she would trim and clean both Resident #2 and #12's nails. 3. Record Review of Resident #24's MDS assessment dated [DATE] reflected she was a [AGE] year-old female with an admission date of 12/21/2018, diagnoses included Need for assistance with personal care, Schizophrenia (a chronic, severe mental disorder affecting thoughts, perceptions and emotions), Drug induced subacute Dyskinesia (Involuntary muscle movements). Resident #24 had a BIMS score of 00 indicating severe cognitive impairment. Record Review of Resident #24's Care Plan with revision date 07/08/2025 reflected . at times Resident #24 can be aggressive and hit or bite the staff. An interview and observation on 03/29/2026 at 02:57 PM, Resident #24 was sitting in her room, she had long fingernails and toenails measuring approximately 0.3-0.5 inches in length extending from the tip of her fingers and toes. Resident #24 stated she would like them to be trimmed by the facility staff. 4. Record Review of Resident #91's MDS assessment dated [DATE] reflected she was a [AGE] year-old female with an admission date of 06/11/2021, diagnoses included Unspecified Dementia (Memory loss), Category 5 Blindness on both eyes. Resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#91 had a BIMS score of 04 indicating severe cognitive impairment. Resident #91 was dependent on facility staff for toileting hygiene. Record Review of Resident #91's Care Plan with initiated date 11/12/2019 and revision date 06/18/2025 reflected Resident #91 had potential to be physically aggressive related to Dementia and Paranoid Schizophrenia. Goal: Resident #91 will not harm self or others. An interview and observation on 03/29/2026 at 11:34 AM, with Resident #91 revealed she was sitting in the TV area. Resident #91 had long fingernails on her left hand measuring approximately 0.4-0.5 inches in length extending from the tip of her fingers. Resident #91 stated she would like them to be trimmed. 5. Record Review of Resident #126's Annual MDS assessment dated [DATE] as a [AGE] year-old female with initial admission date of 8/11/2007 to the facility. Her pertinent diagnoses included: Hypertension (high blood pressure), Diabetes mellitus (elevated blood glucose levels), Hyperlipidemia (elevated lipid levels in blood), Contractures of muscles (long-lasting shortening of muscles leading to stiff joints and reduced mobility), Multiple sclerosis (disease that causes breakdown of the protective covering of nerves). Her BIMS score was 7, which indicated Resident #126 had severe cognitive impairment. Resident #126 was dependent on staff for her personal hygiene. Review of Resident #126 's Comprehensive Care Plan, revised 3/29/2026 reflected, Category: [Resident #126] has an ADL self-care performance deficit related to Multiple Sclerosis.Interventions: PERSONAL HYGIENE: [Resident #126] requires assistance by staff with personal hygiene and oral care. In an interview and observation on 03/29/2026 at 2:23 PM, Resident #126 had multiple chin hairs and long and jagged fingers nails on both hands measuring approximately 0.2 - 0.4 inches in length extending from the tip of her fingers. Resident #126 stated that she may have her nails cut later. She stated that she would like her fingernails and facial hair trimmed due to concerns about her appearance. 6. Record Review of Resident #144's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 12/14/2024, diagnoses included Unspecified Dementia (Memory loss), Need for assistance with personal care. Resident #144 had a BIMS score of 02 indicating severe cognitive impairment. Resident #144 needed supervision with self-care such as toileting hygiene. Record Review of Resident #144's Care Plan dated 05/19/2022 with revision date 12/06/2023 reflected Resident #144 had ADL self-care performance deficit. Interventions:.requires skin inspection weekly observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. (Revision 09/09/2025). Care Plan with revision date 03/21/2026 reflected Resident #144 had an open abscess wound to the left chest. Interventions: Educate Resident #144 that prevention of abscess starts with good hygiene. An interview and observation on 03/29/2026 at 12:19 AM, Resident #144 was sitting in the dining area, he had long fingernails on both hands measuring approximately 0.4-0.5 inches in length extending from the tip of his fingers. Resident #144 stated he would like them to be trimmed. 7. Record Review of Resident #156's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 03/04/2026, diagnoses included Hemiplegia and Hemiparesis following cerebral infraction affecting right dominant side (Paralysis and weakness affecting the right dominant side following a stroke), Aphasia following cerebral infraction (Acquired language disorder caused by damage to the brain followed by stroke), Type 2 diabetes mellitus (Elevated blood sugar levels). Resident #156 had BIMS score of 00 indicating severe cognitive impairment. Resident #156 needed moderate assistance with toileting hygiene and showers. Record Review of Resident #156's Care Plan with an initiation date of 03/25/2026 and revision date of 03/29/2026 reflected he had Diabetes Mellitus. Interventions. Encourage Resident #156 to practice good general health practices.good hygiene. Resident #156 had an ADL self-care performance deficit.Goal: Resident #156 will improve current level of function in . Personal Hygiene. Interventions: Toilet use: Resident #156 requires assistance hand washing. Bathing: Check nail length and trim and clean on batch day and as necessary. If diabetic, the nurse will provide toenail care. An interview and observation on 03/29/2026 at 11:02 AM, Resident #156 was sitting in the TV area, he had long and dirty fingernails on both hands measuring approximately 0.3-0.4 inches in length extending from the tip of his fingers. Resident #156 stated his fingernails (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were too long and he would like them to be trimmed. An interview on 03/29/2026 12:27 PM, CNA M revealed she has worked at the facility for 8 years. CNA M stated the CNAs were responsible for cleaning and trimming resident fingernails, the nurses completed the nail care for residents who were diagnosed with Diabetes. She stated several residents residing in the secured unit refused fingernail care, but they would go back later to reattempt, she would notify the nurse if the resident still refused fingernail care. She stated long and dirty fingernails put residents at risk for infections and skin tears. She stated the most recent in-service training she received on fingernail care was a month ago. CNA M stated she started providing fingernail care to some of the residents that morning and she will continue to do so, once the interview was over. In an interview and observation on 03/30/2026 at 11:21 AM, CNA F stated Resident #126 had long, dirty fingernails and facial hair that required trimming. CNA F stated CNAs were responsible for providing nail care, including trimming and cleaning fingernails, as well as trimming facial hair, unless the resident had diabetes. She stated nail care should be provided on shower days and as needed. CNA F stated the risks of long, dirty fingernails included potential skin tears, and failure to trim facial hair in a female resident could result in loss of dignity. She stated that she will provide nail care to the resident after the interview was completed. In an interview on 03/30/2026 at 3:45 PM, LVN G stated that Nurses and CNAs were responsible for clipping residents' fingernails. He stated that for residents with diabetes, Nurses were responsible for trimming fingernails. He stated that CNAs were responsible for trimming facial hair for female residents on shower days. He stated that the expectation was CNAs provide ADL care to residents on shower days and as needed. LVN G stated the risks of long, dirty fingernails included skin tears and increased risk of infection. He added that failure to trim facial hair in female residents could result in decreased quality of life. In an interview on 03/30/2026 at 3:51 PM, ADON H stated her expectation was that ADL care be provided as needed, particularly during shower days. She stated that CNAs were responsible for providing nail care, including trimming fingernails and facial hair, unless the resident had a diagnosis of diabetes. She stated that charge nurses were responsible for monitoring this care. ADON H stated that residents having long, dirty fingernails and untrimmed facial hair in female residents could result in lapses in infection control and dignity concerns. An interview on 03/30/2026 3:55 PM, CNA J revealed she was working at the facility for 8 years, she stated the CNAs were responsible to clean and trim resident's fingernails, the nurses were responsible to do so if the resident was diabetic. CNA J stated the residents who stayed in the secured unit could not take care of their personal hygiene, even if a resident refused fingernail care, she would reattempt and if they still refuse then report to her charge nurse. CNA J stated not cleaning and trimming fingernails could cause skin tears, infections. An interview on 03/30/2026 4:24 PM, RN O revealed she was working at the facility for a month, she stated the Charge nurse was responsible to clean and trim resident's fingernails. She stated not cleaning and trimming fingernails put residents at risk for skin scratches, injury and infections. She stated she had received training on fingernail care as a new hire. An interview on 03/30/2026 4:40 PM, CNA N revealed she was working at the facility for two years, she stated the CNAs were responsible for cleaning and trimming resident fingernails, nurses were responsible to do fingernail care if the resident was diabetic. She stated that not cleaning/trimming resident fingernails could lead to injuries and infections. She stated she received in-service on fingernail care a week ago. On 3/31/2026 at 11:53 AM, a request was made for the facility's general ADL policy. The Administrator stated the facility did not have a general ADL policy. An interview on 03/31/2026 12:48 PM, the DON revealed she was working at the facility for a month. She stated that the CNAs and the nurses were responsible for keeping the resident's fingernails clean and trimmed. The DON stated either the nurse, or CNAs could trim the fingernails of residents who were diagnosed with diabetes. The DON stated that not cleaning and trimming resident's fingernails could lead to the risk for skin tear, harming self or others and infections. The DON stated she was new to the facility, and she would set up training for staff on fingernail care. Record Review of undated facility policy titled Nail Care, nursing Policy and Procedure [NAME] ADL HG 03-10.0 reflected Nail management is (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common. Ingrown toenails are also common in the elderly. Fungal infections of the toenails, dry, brittle ridges and thickening of the nails all occur in the elderly with some frequency. NAIL CARE, ESPECIALLY TRIMMING, IS PERFORMED BY A PODIATRIST IN THOSE WITH DIABETES AND PERIPHERAL VASCULAR DISEASE.Goals1. Nail care will be performed regularly and safely.2. The resident will free from abnormal nail conditions3. The resident will be free from infection.Procedure. When performed at bath time, the nail care can be done following the procedure or as a separate procedure when needed at the convenience of the resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food prepared that conserved nutritive value, flavor, and appearance for 6 residents (Resident #s 11,29,72,87,129, and 133) of 6 residents on pureed diet.Cook A failed to follow the recipe for the pureed potato salad served for lunch service on 03/30/26.This failure could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included:Record Review of the facility's recipes to scale document for Monday, March 30, 2026, Lunch reflected, . Potato Salad,Yield :6 Serving Size: 1 # 8 Scoop . Instructions: .Place in a blender or food processor. Add liquid, if needed (example reserved juice, reserved liquid, or milk) to assist with pureeing. Puree with a blender or food processor until smooth. NOTE: Water should not be used as a liquid to puree foods. If needed, gradually add thickener. Serve: #8 scoop .Record Review of Resident diet roster dated 3/29/26 Lunch meal reflected, Resident #s 11, 29, 72, 87, 129, and 133 were on pureed texture diet.During an observation on 03/30/2026 at 11:27 AM, [NAME] A was observed preparing pureed (pureed food is cooked food that has been ground, pressed, blended, or sieved to the consistency of a creamy paste or liquid) potato salad. [NAME] A added an unmeasured amount of water from a steel pot located next to the pureeing machine to the prepared potato salad prior to pureeing. The amount of water added was not measured, and no standardized recipe was referenced during preparation. [NAME] a then added about 1 tablespoon of thickener to the mixture. [NAME] A then pureed the potato salad and mixed the pureed mixture using a spatula. Using the same spatula, [NAME] A portioned the pureed potato salad into six individual plastic cups. Portions were not measured, and [NAME] A was observed estimating portion sizes, filling each cup to approximately one-half cup. She then placed the six cups on a bed of ice in preparation for service. During an interview on 3/30/26 at 1:30 PM with the Dietary Manager, she stated that when preparing pureed foods, liquids such as gravy, milk, or sauces should be added to the original food rather than water, as the use of water can dilute both flavor and nutritive value. She further stated that the expectation was that a standardized scoop be used to portion pureed foods. However, the cook used a spatula instead, which could result in inaccurate portion sizes. The Dietary Manager stated that this practice could cause residents to miss required portions, leading to decreased food intake, compromised nutritional value, and potential weight loss. She confirmed that water was not included as an ingredient in the standardized recipe. She stated that there was no specific policy addressing standardized recipes; however, staff were expected to follow standardized recipes designed for the facility and use appropriate portion sizes when serving food.During an interview on 03/30/26 at 2:13 PM, [NAME] A reported that she did not review the standardized recipe prior to food preparation. She stated that she added water instead of the liquid specified in the standardized recipe to adjust the consistency of the pureed potato salad. She acknowledged that not following the standardized recipe could decrease the nutritional content of the meal. [NAME] A further stated that after pureeing the food, she used a spatula to thoroughly mix the contents. She then used the spatula to portion the pureed salad into small individual cups, estimating each portion to be approximately one-half cup. She stated that she should have used a #8 scoop, which equals 1/2 cup (4 oz), to ensure accurate portion control.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, record reviews and interviews, the facility failed to provide each resident with at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care for 1 of 5 halls (A1) reviewed for designated meal service times.The facility failed to provide lunch according to the designated meal service schedules on multiple occasions.This deficient practice could place residents at risk of low blood sugar levels, increased stress levels, slowed metabolism rates, weakened immune systems, malnutrition, weakened hearts, and organ failures.Record review of the facility's undated posted meal service reflected breakfast mealtime was 7:30 a.m., lunch mealtime was 12:30 p.m., and dinner mealtime was 5:30 p.m.During an observation on 03/29/2026 at 12:30 p.m., in the facility's dining room on hall A1, residents sat at tables for the lunch meal service. Observation revealed food trays arrived by staff at 1:25 p.m. and distributed. During an observation on 03/30/2026 at 12:30 p.m., in the facility's dining room on hall A1, residents were seated in the dining room at the tables. Observation revealed food trays arrived by staff at 1:20 p.m. and served. During an interview on 03/29/2026 at 2:25 p.m., CNA K stated lunch trays arrived daily 45-60 minutes after the 12:30 p.m. scheduled lunch time. She stated kitchen staff brought the lunch trays into the dining room, the nurse checked the tickets for accuracy before being distributed by CNAs. She stated hall A1 was served last.During an interview on 03/29/2026 at 2:38 p.m., CNA L stated meal trays arrived late because C1 hall was served first, then halls C2, B2, A2, and A1 was served last.During an interview on 03/30/2026 at 1:13 p.m., CNA J stated lunch arrived at A1 Hall 45 minutes after the scheduled lunch time. She stated the serving time depended on who was in the kitchen.During an interview on 03/30/2026 at 1:47 p.m., the Dietary Manager stated once meals were prepared in the kitchen, kitchen staff walked the trays to the different hall dining rooms, and the nurses and CNAs distributed the trays once on the hall. She stated the expectation was for residents to receive their trays within 40 minutes after the scheduled mealtime. She stated the halls that contained more residents took more time. She stated 40 minutes after scheduled mealtime was a reasonable timeframe. She stated staffing was sufficient to provide meals in the scheduled time frame.Record review of the facility's undated Resident Meal Service policy, indicated in part, We strive to provide meals and HS snacks to all residents in a timely manner.

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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. Based on observations, interviews and record review, the facility failed to store food in accordance with professional standards for food service safety for the facility's only kitchen in that:The facility failed to ensure food items in the kitchen were appropriately covered and food item discarded after the expiry date on 3/29/2026.These failures could affect residents who received their meals from the facility's kitchen, by placing them at risk for food-borne illness, if consumed and food contamination. Findings included:Observation on 03/29/2026 at 9:11 AM revealed approximately oneˆhalf pitcher labeled as nectarˆthick water with a useˆby date of 03/26/26 was left in the walkˆin refrigerator.Observation on 03/29/2026 at 9:15 AM revealed multiple frozen sweet roll dough items and frozen beef steak fritters were stored in open cardboard boxes and left exposed to frigid air in the walkˆin freezer.In an interview and observation on 3/29/26 at 9:20 AM with Dietary Aide E, she stated that everyone in the kitchen was responsible for covering food items. She stated that usually dietary aides were responsible for making thickened water for service and should be discarded after expiration date. She stated the risk of not appropriately covering food items and discarding expired items was food contamination and possible food borne illness in residents.In an interview on 3/30/26 at 1:30 PM, the Dietary Manager stated that her expectation was that all food items in the kitchen be covered at all times. She stated that while some frozen food items may have small slits in the packaging to prevent ice crystal formation, leaving frozen food items exposed to frigid air by not completely closing the cardboard box was not acceptable. She stated that everyone working in the kitchen, including cooks, dietary aides, and herself, was responsible for ensuring food items were properly covered. She further stated that expired food should be promptly discarded once it has reached its expiration date to prevent foodborne illness in residents if consumed. She stated that the risk of not appropriately covering food items included crossˆcontamination of food and decreased food quality. She further stated that, as the Dietary Manager, she provided frequent inˆservices to all kitchen staff on appropriate food storage practices.In an interview on 03/30/26 at 2:13 PM, [NAME] A stated that everyone working in the kitchen was responsible for ensuring that food items were properly covered at all times and not exposed to air. She stated that failure to cover food items could result in crossˆcontamination and could cause residents to become ill. [NAME] A further stated that dietary aides were responsible for preparing and dating nectarˆthickened water and that any expired thickened water should be discarded and not served to residents, as consumption could cause residents to become sick.Record review of facility policy titled, Food Storage and Supplies, undated reflected, . 4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Any product with a stamped expiration date will be discarded once that date passes.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes the services that attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 32 residents (Resident #87) who were reviewed for care planning. The facility failed to create a comprehensive care plan to maintain the placement of Resident #87's Scopolamine Base Patch (used to manage excessive drooling) as ordered by his physician. This failure could affect residents by placing them at risk by not having their physician orders followed, choking on his saliva, and loss of dignity. Record review of the MDS assessment dated [DATE] revealed Resident #87 as a [AGE] year-old male initially admitted to the facility on [DATE]. Resident #87's diagnoses included: non-Alzheimer's dementia, hypertension, chronic kidney disease, and lack of coordination. Review revealed Resident #87 had 0 for a BIMS score, which meant that he had severe cognition issues and was rarely/never understood. Resident #87 required partial to moderate assistance with ADLS. The resident was incontinent of bowel and bladder. Record review of Resident #87's care plan dated 1/6/2026 showed Resident #87 required extensive one person assistance with ADLS. Review of the care plan revealed no documentation to ensure the Scopolamine Base Patch was still in place. Record review of physician orders dated March 31, 2026, indicated Resident #87 was prescribed Scopolamine Base Patch 72 Hour 1.5 MG on 1/12/2026 to manage Sialorrhea (excessive drooling). Record review of the resident's MAR for March 2026 showed the Scopolamine patch administered on 3/29/2026 in the AM, exact time was not indicated. In an observation on 03/29/2026 at 2:07 PM Resident #87 was observed in the activity room of the secured unit with other residents in a manual wheelchair, his nails and hair were groomed, he was observed to be drooling, the front of his red t-shirt was soaked with drool from chest to waist, and there was towel on his lap. The resident was greeted; an interview was attempted but he was found to be non-interviewable. In an observation and interview on 03/29/2026 at 2:08 PM, LVN S reported the physician prescribed a patch for Resident #87 to wear behind either ear to reduce drooling. Observation revealed LVN S inspecting the resident and LVN S found the patch stuck to the resident's shirt. LVN S reported the patch must have fallen off. In an observation on 03/30/2026 at 3:31 PM, Resident #87 was observed on the secured unit. He was sitting alone in his wheelchair at the end of the hall without the Scopolamine Base Patch behind either ear. He was observed wearing a gray polo style shirt that was wet with drool from chest to belly. In an interview with RN O on 03/30/2026 at 3:33 PM. she stated she was scheduled as the charge nurse on the secured unit. RN O reported to have been employed at the facility for approximately a month. RN O reported the resident had a patch to address drooling and she did not know why Resident #87 did not have the patch on. She reported no one told her that the patch was missing. RN O stated she was not sure if the previous nurse was informed. RN O stated her shift started at 3:00 PM today (03/30/36). She reported the Intervention for the missing patch was to replace the patch. She reported that the resident could choke on his saliva without wearing the patch. In an interview with CNA N on 03/30/2026 at 3:38 PM, she reported she was supposed to check for the Scopolamine Base Patch when changing his shirt. CNA N stated she last changed his shirt around 1 pm and stated the patch was there. CNA N stated the expectation was to notify the charge nurse that Resident # 87's patch was off or missing. In an interview with the MDS coordinator administrator on 03/31/2026 at 11:27 AM it was revealed that ADON updates the care plan and the MDS will review it after. The care plan review triggers every three months. If there was a change or update before the three-month review, ADON will make the MDS coordinator aware of the change so that the care plan can be updated. He reported that he was not aware that Resident #87 was taking off his patch. He reported the impact to the resident of not care planning could result in the resident not getting his medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON T on 03/31/2026 at 12:14 PM it was revealed that ADON, nurses, and the MDS coordinator were all responsible for updating the care plan. If the update was acute the MDS coordinator was to make the update. He stated that the nurse documents resident needs in progress notes, CNAs notify the nurse of concerns, and the nurse or ADON updates the care plan through communication with MDS via text or morning meetings. ADON T said the impact was that Resident #87 secretes a lot and messes up his shirt and impact dignity. The health implication to the resident was excessive secretions. In an interview on 03/31/2026 at 12:48 PM with the DON, she stated that she has been employed at the facility for a little over a month and believes nurses can update care plans. She reported the charge nurse or ADON can make any acute changes to the care plan. She stated that she was still confused about who should update the care plans. She reported that the MDS coordinator should put in any diagnosis into the care plan. She stated that the health implication of Resident #87's unmanaged drooling could result in skin issues because of the excessive wetness of his shirt, she added that it also impacts the resident's dignity to not be in a clean and dry shirt. She stated she was made aware this day of concern for Resident #87's ability to maintain his patch. She reported her expectation was for the nurse on the unit to check in with the residents at minimum every three hours in addition to a CNA providing care to ensure that physician's orders were followed and the resident's patch was on. She reported that she has now planned an intervention for the resident and staff will call his physician to determine if there were other medical options. She stated it was care planned now that staff will check for the patch throughout the day. Review of the undated facility policy, Comprehensive Care Planning revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, consistent with professional standards of practice for one (Resident #89) of one resident reviewed for tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) care. The facility failed to ensure RN D followed the procedure for tracheostomy care for Resident #89 on 03/30/26 by:Changing his gloves and performing hand hygiene before applying a clean trach drainage spongeUsing sterile technique when inserting the inner cannula into the resident's trach. These failures could place residents at risk for respiratory infections.Review of Resident #89's Comprehensive MDS assessment, dated 03/16/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS was 99 which meant Resident #89 was unable to complete the assessment interview. Her active diagnoses included acute respiratory failure with hypoxia (absence of oxygen), tracheostomy status (a surgical procedure creating an opening in the neck to provide a direct airway). In Section O-Special Treatments, Procedures, and Programs it revealed he required tracheostomy (trach) care during the 14 days look back period. Review of Resident #89 's care plan dated 03/11/2026, reflected, Focus: [Resident #89] has tracheostomy. Goal: . resident will have no signs/symptoms of infection . Interventions: . Use universal precautions . Review of Resident #89's Consolidated Physician's orders dated March 2026, reflected, .Tracheostomy care every shift and as needed.In an observation on 03/30/26 at 8:26 AM revealed RN D washed his hands; he donned gown and clean gloves. He cleaned the bedside table, and he put supplies on it. Without changing gloves, RN D removed and discarded the tracheostomy stoma dressing. RN D removed and discarded dirty gloves; he donned clean gloves without performing hand hygiene. He opened the tracheostomy kit and placed it on a bedside table. RN D removed and discarded the dirty gloves and donned sterile gloves from the tracheostomy kit without performing hand hygiene. RN D attached the suction to the resident's in-line suction line and inserted the suction line into the trach 2 times. RN D then cleared the line and turned off the suction machine. He discarded the suctioning catheter. Without changing gloves RN D wet the gauze with normal saline and wiped the stoma site with the wet gauze. RN D then picked up the stoma drainage sponge and placed it around the tracheostomy tube while wearing the same gloves. RN D then changed his gloves without performing any kind of hand hygiene. He then removed the disposable inner cannula from inside the resident's tracheostomy, he discarded it. RN D changed gloves without performing hand hygiene and then picked up a new inner cannula and inserted it into the trach and locked it. He removed his gloves, his gown, and sanitized his hands. In an interview with RN D on 03/30/26 at 8:52 AM he stated he was supposed to perform hand hygiene before and after trach care. He stated he knew the procedure was supposed to be a sterile procedure to reduce the risk of cross contamination and stated he supposed to wear a sterile glove to insert the inner cannula. Review of RN D's Competency checks for tracheostomy care reflected he was skills checked on 11/07/25 and deemed competent in trach care. In an interview with the DON on 03/30/26 at 8:52 AM revealed hand hygiene was to be performed anytime a staff member went from a dirty procedure to a clean procedure. She stated that trach care was to be an aseptic/sterile technique. She stated failure of staff to follow proper procedures could result in infections. Review of the facility's policy, Tracheostomy Care dated August 2024, reflected, The purpose: To maintain patency of the airway. To prevent infection of the airways and the area around the tracheostomy tube. To prevent excoriation of the area around the tracheostomy tube. Process . 10. Suction tracheostomy, if necessary. 11. When suctioning is complete, remove gloves and cleanse hands. Put on clean gloves. 12. Remove soiled dressing and inner cannula (if using a disposable cannula) and discard in waste bag. 13. Remove gloves. Discard in waste bag and cleanse hands.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 1 of 22 (Resident #112) residents observed for pharmacy services. CMA R failed to ensure Resident #112's medications were administered by leaving a cup containing medications on her bedside table for the resident to take later without supervision. This failure could place residents who received medications from CMA A by placing them at risk for medication errors and receiving less than therapeutic benefits from medications.Review of Resident #112's MDS assessment, dated 02/29/26, revealed a [AGE] year-old female admitted to facility on 02/29/26 with diagnoses included: Atrial Fibrillation or Other Dysrhythmias (Atrial fibrillation (AFib) is the most common form of arrhythmia), hypertension (high blood pressure), Diabetes Mellitus (elevated blood sugar), depression (a serious, common mood disorder causing persistent sadness, loss of interest, and functional impairment), Thyroid Disorder (occur when the butterfly-shaped gland in the neck produces too much (hyperthyroidism) or too little (hypothyroidism) hormone, disrupting metabolism), Seizure Disorder or Epilepsy (A seizure is a single, temporary disruption of brain electrical activity, while epilepsy is a chronic neurological condition characterized by recurrent, unprovoked seizures), and Anxiety Disorder (excessive, persistent fear or worry that interferes with daily life) . The BIMs score was 07 indicating the Resident #112's cognition was severely impaired. Review of Resident #112's March 2026 physician's orders included morning medication of Gabapentin (for neuropathy), Amiodarone (for heart rhythm problems), Potassium Chloride (for hypokalemia), Sertraline (for depression), Apixaban (for Atrial Fibrillation), Divalproex Sodium (for Seizure), Buspirone (for Anxiety), and Levothyroxine Sodium (for Hypothyroidism). Review of Resident#112's physician's order on 03/30/26 revealed: 1-Levothyroxine Sodium Oral Tablet 50 MCG (Levothyroxine Sodium) Give 1 tablet by mouth in the morning for Hypothyroidism. 2-Potassium Chloride ER Tablet Extended Release 20 MEQ Give 1 tablet by mouth in the morning for hypokalemia. 3-Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 3 tablet by mouth in the morning for depression GIVE 3 TABS TO EQUAL TO 150MG. 4-Apixaban Oral Tablet 2.5 MG(Apixaban) Give 1 tablet by mouth two times a day for Atrial Fibrillation. 5-Divalproex Sodium Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for Seizure. 6-busPIRone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth three times a day for Anxiety. 7-Gabapentin Oral Tablet 100 MG (Gabapentin) Give 1 tablet by mouth one time a day for neuropathic pain. Observation of Resident #112's room on 03/29/26 at 12:11 PM, revealed a medication cup located on the bedside table contained medications in tablets form (one big oblong white tablet, one big oblong orange tablet, three medium clear blue oblong tablets, one round yellow tablet, one medium oblong white tablet, two round white tablets, and one white capsule). The resident was confused and talking about worms under her skin, fingernails, and all over her cover (no worms were noticed by this surveyor). Resident#112 stated that her medications were in the cup and she would take it. In an observation and interview on 03/29/26 at 12:25 PM, CMA R confirmed that she dispensed Resident #112's medications that morning and left them on the bedside table and left the room, she said it had been about 30 minutes since. CMA R was unable to give any explanation for leaving the medications at the bed side and note watching Resident#112 take her medications. CMA R stated that medications were to be administered to the residents, and she should stay with the resident to make sure the resident took the medication. CMA R stated that there was no excuse for not monitoring Resident #112 to make sure she took the medication. CMA R stated the risk of not watching the resident take her medications and keeping it unattended at bedside could be the resident may not take her medication, she may drop it, and if another resident walked into the room and took the medication, he/she may have an allergic reaction. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/31/26 at 1:05 PM, the DON stated her expectations were for the nurses and CMAs to visually observe the resident taking their medication (ingest, inhale, apply) unless specifically ordered otherwise. The DON stated medications must never be left unattended in a resident's room, as this poses a safety risk, could lead to missed doses, wrong dosages, or potential overdoses. Review of the facility's policy dated 10/25/2017 Medication Administration Procedure revealed, 1. All medications are administered by licensed medical or nursing personnel. 2. Medications are to be poured, administered and charted by the same licensed person. 4. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered. 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record.

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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. Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 6 medication carts observed for medications labeling and. The Hall C2 medication cart contained an insulin bottle of Lispro injection 100 unit/ml with no open date. This failure could place residents at risk for not receiving the therapeutic benefit of the medication or adverse reaction to expired medication. During observation and interview on 03/30/26 at 1:47 PM, the medication cart for Hall C2 with LVN J, observation of top-drawer holding insulin, found an insulin bottle of Lispro insulin with no open date. LVN J stated she used the insulin bottle and gave Resident #2 her insulin doses at breakfast and lunch time administration. LVN J stated insulin expired 28 days after opening it and a negative outcome could be the medication loses potency and could be ineffective. During an interview on 03/31/26 at 1:05 PM, the DON stated daily the charge nurses were supposed to check for any expired medications in the medication carts and the pharmacists checked the medication carts monthly. The DON stated Lispro insulin was good for 28 days after opening, and she expected the nurses to label and date all insulin in the cart with open date. The DON stated this was supposed to be completed to prevent side effects like being ineffective if they were expired, also chemical composition of the medications could change if the medication was expired. Record review of policy review titled Medication Storage in the Facility 2025 reflected, .13. Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exits.

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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 control program designed to prevent the development and transmission of infection for 2 residents (Resident #140 and Resident #190) of 5 residents observed for infection control. The facility failed to ensure:CNA C changed gloves and completed hand hygiene during incontinent care for Resident #140 on 3/29/26.CNA Q performed hand hygiene while providing incontinence care to Resident #190 on 03/29/26. CNA P and CNA Q wore proper PPE while performing incontinent care for Resident#190 ,who was in enhanced barrier precautions for indwelling medical devices on 03/29/26. These failures could place residents at risk for infection and cross contamination of pathogens and illness.Resident # 140Record review of the Quarterly MDS assessment dated [DATE] reflected Resident #140 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included cerebral infarction (a condition caused by a blockage in blood vessels supplying the brain, resulting in tissue death), hemiplegia (paralysis that affects one entire side of the body causing severe loss of muscle function, strength, and control) affecting left side, and elevated blood pressure. Resident #140's BIMS score of 14, which indicated Resident #140's cognition was intact. The MDS assessment indicated Resident #140 required maximal assistance with toileting hygiene. Observation on 03/29/26 at 10:20 AM revealed CNA C and CNA V entered Resident #140's room to provide incontinence care. Both CNAs washed their hands and donned gloves, CNAC unfastened Resident #140's brief, she then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. She rolled resident on her side, CNA V supported resident when she was on her side. CNA C wiped the resident's buttock area with peri-wipes, front to back, then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. She rolled the resident on her back onto the clean brief. Once finished, she fastened the resident's brief. Without changing gloves CNA C covered resident and she lowered the resident's bed to low position. Both CNAs removed and discarded gloves and washed their hands. In an interview on 03/29/26 at 11:32 AM, CNA C stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA C stated failing to provide proper care and exposed the residents to infections. Resident #190Record Review of Resident #190's quarterly MDS assessment, dated 03/25/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's BIMs score was 03 indicating the resident's cognition was severely impaired. His diagnoses included cerebral infarction(a type of ischemic stroke caused by a blockage in brain blood vessels, resulting in a lack of oxygen and brain cell death), end stage renal disease (permanent kidney failure where function falls below 10-15%, making it impossible to survive without dialysis or a transplant) dependent on renal dialysis (a life-sustaining treatment for kidney failure), sever sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage and organ failure), acute embolism (a sudden blockage of an artery, typically caused by a traveling blood clot (thrombus), fat globule, air bubble, or other foreign material, resulting in restricted blood flow and tissue damage) and thrombosis (the dangerous formation of a blood clot (thrombus) inside a vessel, obstructing blood flow, often causing pain, swelling, and redness (typically in legs) or serious emergencies like heart attacks, strokes, or pulmonary embolisms) of right internal jugular vein. Record review of Resident #190's Care Plans dated 03/26/26, reflected focus: Resident is on enhanced barrier Precautions. Goal: There will not be any transmission of infection from or to the resident. Intervention: Gloves and gown should be donned if any of the following activities are to occur linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Perform hand sanitation before entering the room and prior to leaving the room Posting at the residents room entrance indicating the resident is on enhanced barrier precautions. Therapy should use gown and gloves, when transfer training, mobility (continued on next page)

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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	training, or other high-contact activity. Focus: The resident has an ADL Self Care Performance Deficit. Goal: The resident will maintain or improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Interventions: Assist with personal hygiene as required. Observation on 03/29/26 at 10:59 AM revealed Resident #190 was on Enhanced barriers precautions related to indwelling foley catheter and feeding tube. There was signage on the left side of the door that informed visitors/staff he was on enhanced barrier precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. CNA P and CNA Q entered Resident #190's room without any form of PPE, there was PPE cart inside the Resident#190 room on the right side of the entrance. Both CNAs washed hands, donned gloves and procced to do incontinent care for Resident#190 without wearing gowns. CNA Q on the right side of the bed uncovered Resident#190, unfastened his brief, and pushed it between Resident#190 legs. CNA Q using wipe on per stroke cleaned Resident#190 front area including the foley catheter tube. CNA Q with the help of CNA P turned Resident#190 to his right side, Resident#190 brief was wet and had smear of bowel movement. CNA Q removed dirty gloves, washed hands and put on clean gloves. CNA Q removed the dirty brief put it in a plastic bag, got clean brief put it under Resident#190. CNA Q using wipes on at a time cleaned Resident#190 buttocks area and finished putting the clean brief on Resident#190 without changing gloves or performing any kind of hands hygiene (Sanitizing or washing). Both CNAs adjusted Resident#190 in his bed and covered him. CNA P removed gloves, washed hands, gathered linen and trash bag, and exited the room. CNA Q removed gloves and washed hands before exiting the room. Interview with CNA Q on 03/29/26 at 11:18 AM revealed she knew that she was supposed to wear gown for the resident peri care, because he was in EBP, but she forgot. She stated she was nervous. She stated she was in-serviced regarding different types of infection control including proper hands hygiene and wearing appropriate PPE. She stated she knew that she was supposed to change gloves with hands hygiene going from dirty to clean tasks during residents' incontinent care. She stated the risk of not following proper hands hygiene and wearing proper PPE to residents' cross contamination and development of infection. Interview with CNA P on 03/29/26 at 11:22 AM revealed he knew that he was supposed to wear gown for any high contact with residents in EBP, but he forgot. He stated he was nervous. He stated he was in-serviced regarding different types of infection control. He stated the risk of not wearing proper PPE in enhanced barriers precautions residents' rooms was exposing himself and others to the development of infection and spreading germs from one resident to another resident. Interview with the DON on 03/31/26 at 1:05 PM revealed staff were to sanitize their hands before caring for the residents when going from clean to dirty and after-caring. She stated CNAs where trained to perform hand hygiene between change of gloves. She stated the staff should follow proper infection control policies, and wear gowns before they touch any resident that had a port of entry. The DON stated the risk was spreading infection to residents. She further stated to protect residents from anything staff may harbor in their body. She stated she would educate all nursing staff, and she would do random rounds for monitoring. Record review of the facility's policy, Fundamentals of Infection Control Precautions, updated March 2024, reflected, .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 . After removing gloves or aprons.