STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455930	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Rehabilitation and Healthcare Center	1700 N Washington Pilot Point, TX 76258

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #29, Resident #73, and Resident #82) of eighteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #29, Resident #73, and Resident #82's rooms were in a position that was accessible to the resident on 01/14/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #29 Review of Resident #29's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old female admitted on [DATE]. Resident #29 was diagnosed with muscle weakness and gait abnormalities. Review of Resident #29's Quarterly MDS Assessment, dated 12/24/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated that Resident #29 was dependent to staff for toileting hygiene, shower, dressing, and personal hygiene. Review of Resident #29's Comprehensive Care Plan, dated 11/18/2024, reflected the resident had an ADL self-care performance deficit and interventions included provide extensive assist for dressing, bed mobility, personal hygiene, and toilet use. Observation on 01/14/2025 at 9:40 AM revealed Resident #29 was in her bed, with her eyes closed. It was observed that the resident's call light was on the floor at the foot of the bed. Observation and interview on 01/14/2025 at 2:03 PM revealed resident #29 was in her bed, awake. When asked about what she used when she needed to call the staff, the resident did not answer. Resident #73 (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #73's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old male admitted on [DATE]. Resident #73 was diagnosed with muscle weakness and lack of coordination. Review of Resident #73's Quarterly MDS Assessment, dated 10/28/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 05. The Quarterly MDS Assessment indicated that Resident #73 required maximal assistance for toileting hygiene, dressing, bed mobility, and transfer. Review of Resident #73's Comprehensive Care Plan, dated 01/14/2025, reflected the resident had an ADL self-care performance deficit and interventions included provide maximal assistance for toileting hygiene, dressing, bed mobility, and transfer. Observation and interview with Resident #73 on 01/14/2025 at 9:45 AM revealed the resident in his bed, awake. It was observed the resident's call light was on the floor and stuck between the bed and the wall. When asked about his call light, the resident just shrugged his shoulders. Observation and interview with CNA A on 01/14/2025 at 10:15 AM, CNA A stated call lights were important for the residents because that was how they called the staff if they needed something or if they needed assistance. She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. She said the call lights were for independent and dependent residents. She went inside Resident's #29's room and pulled the call light from the floor and put it beside the resident. CNA A then went inside Resident # 73's room and saw the call light was stuck between the wall and the bed. She pulled the call light and put it beside the resident. She said she did not notice the call lights were not with Resident #29 and Resident #73 during her morning round that. Resident #82 Review of Resident #82's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old male admitted on [DATE]. Resident #82 was diagnosed with muscle weakness and lack of coordination. Review of Resident #82's Quarterly MDS Assessment, dated 11/27/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated that Resident #82 required maximal assistance for toileting hygiene, shower, dressing, and personal hygiene. Review of Resident #82's Comprehensive Care Plan, dated 01/14/2025, reflected the resident had an ADL self-care performance deficit and interventions included provide maximal assistance for toileting hygiene, shower, dressing, and personal hygiene. Observation and interview with Resident #82 on 01/14/2025 at 9:34 AM revealed the resident was in his wheelchair, awake. It was observed that the resident's call light was hanging by the wall and coiled around where the call light was connected. He said he was transferred to the room the night before because his roommate tested positive for COVID-19. He said the staff did not place the call light near him. He said he could not reach the call light that was on the wall. He said he needed to go out of his room so he could call a staff because he needed something. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with CNA B on 01/14/2025 at 10:20 AM, CNA B stated call lights should be with the residents at all times so they could call the staff when they needed something. She said the residents might fall trying to get the call light or trying to do some activities that needed assistance. she went inside Resident #82's room and saw the call light on the wall. She pulled the call light on the wall and placed it where the resident could reach it. She said she did not notice the call light was not with the resident during her morning rounds. In an interview with the DON on 01/15/2025 at 11:03 AM, the DON stated call lights were inside the residents' rooms for a reason. He said the residents used the call lights to call for assistance, a glass of water, pain medication, or because they needed to be changed. The DON said without the call lights, the residents would not be able to tell the staff what they needed and eventually their needs would not be met. The DON added when the residents could not reach their call lights, unfavorable incidents, like falls, could happen. The DON said all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the resident's room when they do their rounds and ensure the call lights were within reach of the residents before they leave the room. The DON said he would educate the staff about the importance of call lights for the residents and would include the issue on their IDT meeting. In an interview with LVN C on 01/15/2025 at 11:20 AM, LVN C stated call light should be with the residents at all times, whether independent or dependent. He said he was also responsible in checking if the call lights were with Resident #29, #73, and #82 because he was the nurse in-charged for their care. He said without the call lights, their needs would not be met. He said he would do his round and check if the call lights were with the residents. In an interview with the Administrator on 01/15/2025 at 11:39 AM, the Administrator stated call lights should be within the reach of the residents at all times. She said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. She said the residents also use the call lights if they needed to be changed or they needed a pain medication. the Administrator said the residents might fall trying to get up and get what they needed. She said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. She said she would collaborate with the DON about the issue regarding call lights. Record review of facility's policy Resident Call System reviewed 03/28/2023 revealed Policy: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation . Policy Interpretation and Implementation . 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 6 (Rooms #1, #2, #3, #4, #5, and #6) of 10 resident rooms and the hallway floors reviewed for cleanliness and sanitization. The facility failed to ensure that Resident Rooms #1, #2, #3, #4, #5, and #6 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 01/14/25 at 10:35 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt-like debris. An observation on 01/14/25 at 10:39 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt-like debris. The bottom of the bedside table had red stains on it. An observation on 01/14/25 at 10:42 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt-like debris. An observation on 01/14/25 at 10:47 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt-like debris. Inside the mini fridge revealed hairbrushes, a towel, and two sandwiches wrapped in white napkins. An observation on 01/14/25 at 10:50 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt-like debris. An observation on 01/14/25 at 10:53 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt-like debris. In an interview on 01/15/25 at 02:05 PM, the Administrator was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, #5, and #6. She stated housekeeping was responsible for cleaning the outside of the air condition units in the resident rooms. She stated she would consider purchasing hand vacuums to assist with removing the dirt particles between the outer vents. She stated the risk of the area not being addressed could impact residents' respiratory system. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/16/25 at 10:10 AM, Housekeeper L stated she had been at the facility 1 year. She was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, #5, and #6. She stated housekeeping was responsible for cleaning the outside of the air condition units in the resident rooms. She stated she had a challenging time removing the dirt particles from between the vents, but she would meet with the house keeping supervisor to see how the units could be clean more thoroughly. She stated the risk of the air condition units not being thoroughly cleaned could impact residents' health. In an interview on 01/16/25 at 10:19 AM, Housekeeping Supervisor stated she had been at the facility nearly 3 years. She was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, #5, and #6. She stated she had met with the Administrator on 01/15/25 to solve how to clean the air condition units better. She stated the risk to the residents having the dirty air condition unit could impact their health. Review of the facility's policy on Homelike Environment (February 2021) revealed Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment;

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' bed was free from any physical or chemical restraints imposed for purposes of discipline or convenience for 4 (Resident #1, #5, #25, and #29) of 5 residents reviewed for physical restraints, The facility failed to obtain physician orders or a physician assessment as of 01/16/25 for Residents #1, #5, #25, and #29, for the usage of a scoop mattress prior to installing the mattress to assist in fall prevention. This failure could prevent residents from having an environment that was free from any physical or chemical restraints. Findings included: Resident #1 Record review of Resident #1's Face Sheet, dated 01/16/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included restlessness and irritation, and cerebral palsy (movement disorder). Record review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, he had a Brief Interview for Mental Status (BIMS) score of 00, (severe cognitive impairment) and for ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #1's physician's orders, dated 01/14/25, reflected no physician's orders for a scoop or bolster mattress. Record review of Resident #1's Comprehensive Care plan, dated 01/15/25, reflected air mattress with boosters as an intervention for fall prevention. Resident #5 Record review of Resident #5's Face Sheet, dated 01/16/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included repeated falls, muscle weakness, and lack of coordination. Record review of Resident #5's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 04, (severe cognitive impairment) and for ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #5's physician's orders, dated 01/15/25, reflected no physician's orders for a scoop or bolster mattress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Comprehensive Care plan, dated 0/18/24, reflected no scoop or bolster mattress as an intervention for fall prevention. Resident #25 Record review of Resident #25's Face Sheet, dated 01/16/25, reflected he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included repeated adult failure to thrive, muscle weakness, and lack of coordination. Record review of Resident #25's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 06, (severe cognitive impairment) and for ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #25's physician's orders, dated 01/15/25, reflected no physician's orders for a scoop or bolster mattress. Record review of Resident #25's Comprehensive Care plan, dated 0/18/24, reflected no scoop or bolster mattress as an intervention for fall prevention. Resident #29 Record review of Resident #29's Face Sheet, dated 01/16/25, reflected he was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included seizures, muscle weakness, and lack of coordination. Record review of Resident #29's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 00, (severe cognitive impairment) and for ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #29's physician's orders, dated 01/14/25, reflected no physician's orders for a scoop or bolster mattress. Record review of Resident #29's Comprehensive Care plan, dated 0/18/24, reflected a scoop mattress as an intervention for fall prevention. Observations on 01/14/25 from 10:00 AM to 11:00 AM, revealed Residents #1, #5, #25, and #29 had a scoop or bolster mattress on their bed, which restricted their movement in bed. In an interview on 01/15/25 at 10:00 AM, LVN D and the DON were asked if Residents #1, #5, #25, and #29 had physicians' orders for a bolster and scoop mattress, and the DON stated he was not sure, but he would check. After checking, he stated the residents did not have physicians' orders, which would be required for the residents to have a scoop or bolster mattress. The DON stated the physician would need to complete an assessment to ensure that the scoop or bolster mattress would not injure or restrain the resident. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Physical Restraints and Involuntary Seclusion (03/2023) reflected Patients/Residents have the right to be free from any physical restraint imposed for purposes of discipline or convenience and when not required to treat the patient's/resident's medical condition. Patients/Residents have the right to function at their highest practicable level in the least restrictive environment possible.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for three (Resident #36, Resident #68, and Resident #79) of fifteen residents reviewed for Care Plans. 1. The facility failed to ensure Resident #36's care plan for catheter, dated 12/17/2024, had appropriate interventions. 2. The facility failed to ensure Resident #68's care plan for catheter, dated 10/02/2024, had appropriate interventions. 3. The facility failed to ensure Resident #79's care plan for catheter, dated 01/09/2025, had appropriate interventions. These failures could place the residents at risk of not receiving the necessary care and services needed. Findings included: 1. Record review of Resident #36's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 was diagnosed with infection to surgical site to sacrum. Record review of Resident #36's Quarterly MDS Assessment, dated 12/03/2024, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had skin problem to her surgical wound and had an indwelling catheter (device to drain the urine from the urinary bladder to a collection bag). Record review of Resident #36's Comprehensive Care Plan, dated 12/17/2024, reflected Resident #36's care plan for indwelling catheter related to skin breakdown on sacrum had only one intervention listed. The only intervention indicated was to check for kinks each shift. Record review of Resident #36's Physician Order, dated 09/05/2024, reflected Foley Catheter Care Q Shift and PRN. In an interview with Resident #36 on 01/14/2025 at 1:36 PM, Resident #36 stated she had a catheter but was removed the day before because she was having abdominal pain. She said she had the catheter because of her wound in her bottom. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Wound Care Nurse on 01/15/2025 at 8:51 AM, the Wound Care Nurse stated Resident #36 had a wound to her sacrum that was present during her admission. She said she had a catheter to facilitate healing of the wound. 2. Record review of Resident #68's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #68 was diagnosed with urinary retention (the urinary bladder does not empty completely). Record review of Resident #68's Quarterly MDS Assessment, dated 01/03/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated the resident had an indwelling catheter. Record review of Resident #68's Comprehensive Care Plan, dated 10/02/2024, reflected Resident #68's care plan for indwelling catheter related to urinary retentions had only one intervention listed. The only intervention indicated was to monitor, record, and report signs and symptoms of urinary tract infection. Record review of Resident #68's Physician Order, dated 10/02/2024, reflected Foley Catheter Care Q Shift and PRN. Observation and interview with Resident #68 on 01/14/2025 at 11:05 AM revealed the resident was sitting in his recliner, awake. It was observed that he had a catheter hanging on his walker. He said he had the catheter because he had an issue with his bladder. Observation and interview with the MDS Coordinator on 01/15/2025 at 9:34 AM, the MDS Coordinator stated care plans were done so the staff would know the care needed by the residents. she said if a resident had a catheter, there should be a care plan for catheter. She said the care plan was comprised of problem areas, the goals, and the interventions. She said the interventions should address the underlying problem of the residents. She opened Resident #36's profile and saw the resident had orders for her catheter and was triggered in the MDS for indwelling catheter. When she opened the resident's care plan, she saw the indwelling catheter was listed as one of the problem list. She also saw that there was only one intervention listed. She said there should be more interventions listed like check for trauma, monitor for signs and symptoms of urinary tract infection related to the catheter, check for signs and symptoms of discomfort, monitor the color of the urine, and cover with privacy bag. After looking at Resident #36's care plan, she opened Resident #68's care plan and saw the same thing. She said she would update the care plans for both residents and would input the interventions for indwelling catheter. In an interview with the DON on 01/15/2025 at 11:03 AM, the DON stated every resident needed a thorough care plan to ensure the residents received the care needed. The DON said the care plan should be in place so the staff providing care would be on the same page and without the care plan, there could be confusion with the care of the residents. The DON said the care plan should reflect the resident's problem lists, the goals, and the interventions. He said a care plan would not be a care plan without appropriate interventions. He said, with indwelling catheters, staff should monitor for urinary tract infection, discomfort, distension of the bladder, cloudiness of the urine, and if there were blood in the urine. He said with only one intervention could be considered an incomplete care plan. He said the expectation was every care plan would be resident-centered and complete. He said he would coordinate with the MDS Coordinator to audit to the care plans of the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 01/15/2025 at 11:39 AM, the Administrator stated all the care plans of the residents should have all the interventions needed by the residents. She said without the care plan, the staff would not know and understand what kind of care to provide. The Administrator concluded that the expectation was for the staff to ensure that the residents' care plan were complete and individualized. She said he would coordinate with the DON to make sure all the residents were care planned. 3. Record review of Resident #79's Face Sheet, dated 01/16/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #79 was diagnosed with urinary retention. Record review of Resident #79's Comprehensive MDS Assessment, dated 01/02/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter. Record review of Resident #79's Comprehensive Care Plan, dated 01/09/2025, reflected Resident #79's care plan for indwelling catheter related to history of malignant neoplasm of the prostate had only one intervention listed. The only intervention indicated was to monitor for signs and symptoms of discomfort on urination and frequency. Record review of Resident #79's Physician Order, dated 12/29/2024, reflected Foley Catheter Care Q Shift and PRN. Observation and interview with Resident #79 on 01/16/2025 at 9:02 AM revealed the resident was in the dining area finishing his breakfast. It was observed that the resident had a catheter leg bag secured to the right leg. When asked how long he had the catheter, the resident did not reply. In an interview with LVN D on 01/16/2025 at 9:12 AM, LVN D stated Resident #79 had a catheter because he had an issue with his prostate. She said before he goes out of his room, they would replace his catheter with leg strap because the resident had the tendency to drag his catheter. In an interview with the MDS Nurse on 01/16/2025 at 9:43 AM revealed the MDS Coordinator was advised that Resident #79 also only had one intervention for his indwelling catheter. She said she would check on it and update it accordingly. Record review of facility's policy, Care Plans, Comprehensive Person-Centered reviewed Jan. 2023 revealed Policy Statement: A comprehensive, person-centered care plan . is developed and implemented for each resident . 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful . 11. Care plan interventions are chosen only after careful data gathering . a. When possible, interventions address the underlying source(s) of the problem area(s).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, and record review, the facility failed to ensure each residents environment remained as free from accident hazards as possible for 1 (Resident #30) of 9 residents reviewed for environmental hazards. The facility failed to ensure Resident #30 did not have pointed scissors in his room on 01/14/2024. This failure could place the resident and other residents who came into the room at risk for injury. Review of Resident #30's Face Sheet, dated 01/16/25, reflected that resident was an [AGE] year-old male initially admitted on [DATE]. Resident #30 had a diagnosis of dysphagia (difficulty swallowing) following other cerebrovascular disease (condition that impacts blood vessels in the brain). Review of Resident #30's Quarterly MDS (tool to assess health and functional capabilities) Assessment, dated 01/13/2025, reflected that Resident #30 had impaired cognition with a BIMS score of 11. Section I did not reflect dementia or a mood disorder. Section I reflected Resident #30 had cognitive communication deficit and other abnormality of gait and mobility. Review of Resident #30's Comprehensive Care Plan, dated 12/06/2024, reflected Resident #30 had impaired thought processes. One intervention was COMMUNICATION: Use his preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions. Turn off TV, radio, close door etc. He understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. In an interview and observation on 01/14/25 at 09:40 AM, Resident #30 was lying in bed. Resident #30's wheelchair was parked close to the bed. Prior to leaving the room, surveyor bumped into the wheelchair and a pair of large scissors fell to the floor. The ends were not rounded. Resident #30's wheelchair had a piece of foam wrapped around the arms of the wheelchair. Resident #30 stated he kept the pair of scissors in the opening between the foam and arm of the wheelchair. Resident #30 stated at times he used the scissors to cut the sides of a soiled brief when he was in the restroom. The DON was in the hall at that time and notified of scissors in Resident #30's room. He stated he would take care of it. In an interview on 01/14/25 at 02:20 PM, RN G stated Resident #30 used the scissors to cut extra paper (old activity schedules) up for scratch paper. RN G pointed at a stack of letter size sheets that had been cut up into fourths for scratch paper. She stated the resident kept the scissors inside the foam piece that is wrapped around the arm of his wheelchair. While in the room, the resident agreed for RN G to assess his skin. RN G lowered his pants and assessed the skin around Resident #30's brief to ensure he had not caused any injury. Observation revealed there was no redness, scratches, or any injury on Resident #30's skin. RN G stated she had never heard Resident #30 used scissors to cut off his brief. RN G agreed an accident could result in the resident harming himself when using the scissors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/14/25 at 02:28 PM, LVN E stated she had never heard Resident #30 used his scissors to cut the briefs on the sides to remove them. She stated she had thought it was ok for Resident #30 to use the scissors for activities. LVN E stated the scissors had been removed from the resident's room and given to her and she understood an accident could occur involving the resident or another resident who might have found the scissors. In an interview on 01/14/25 at 02:36 PM, the Activities Director stated she provided Resident #30 with a daily chronicle. She stated she had never seen him cutting the papers. The Activities Director stated she allowed residents to use scissors when she was observing them. She stated she made sure residents only used scissors with rounded edges. In an interview on 01/16/25 at 09:16 AM, the DON stated the facility did not have a policy about residents or family members bringing in personal items like scissors. The DON stated it posed a danger and was not safe for the resident to have the scissors in his room. He stated if staff sees something like that, it should be removed and documented. He stated it was important to educate family about the dangers and to care plan it. He said it was important for the resident to have rights, but there are other residents in the environment too. He stated it was important for staff to be diligent about safety awareness and any danger to residents and he will in-service them about it. The facility did not provide a policy about environmental hazards. In an interview on 01/16/25 at 09:16 AM, the DON stated there was not a facility policy regarding a resident or family member bringing sharp objects like scissors into a resident's room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observation, interview, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 4 (Resident #16, #28, #40, and #38) of 14 residents reviewed for Respiratory Care. 1. The facility failed to ensure Resident #16's breathing mask for her nebulizer (machine that turns liquid medication into a mist breathed directly into the lungs) was properly stored when not in use on 01/14/2025. 2. The facility failed to ensure that Resident #28's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored when not in use on 01/14/2025. 3. The facility failed to ensure that Resident #40's nasal cannula was properly stored when not in use on 01/14/2025. 4. The facility failed to ensure that Resident #38's nebulizer mask (medication is inhaled through) was properly stored when not in use on 01/14/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #16's Face Sheet, dated 01/16/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 was diagnosed with anemia (low blood cells). Record review of Resident #16's Comprehensive MDS Assessment, dated 11/24/2024, reflected the resident had a score of 99 on her BIMS summary score suggesting that the resident was not able to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had anemia. Record review of Resident #16's Comprehensive Care Plan, dated 11/04/2024, reflected the resident tested positive for COVID on 01/25/2022 and one of the interventions was to observe for signs and symptoms of respiratory issues. Record review of Resident #16's Physician Orders, dated 11/02/2024, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally every 4 hours as needed for SOB ONE VIAL Q 4-7 HOURS. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 01/14/2025 at 9:20 AM revealed Resident #16 was in her bed, awake. A nebulizer machine was observed beside the room's sink. Beside the nebulizer machine was a breathing mask that was not bagged. The part of the breathing mask that would touch the face when using was touching a bottle of sanitizer. Resident #16 did not respond when asked how long she had been using the breathing mask. In an interview with LVN C on 01/14/2025 at 11:33 AM, LVN C stated he was not sure for whom the breathing mask was. He opened the profiles of both residents occupying the room. He said the breathing mask was for Resident #16. He said the order was to administer as needed. He went inside the room and saw the unbagged breathing mask beside the room's sink. He said he did not notice during his rounds that the breathing mask was not inside a bag. He said it should be bagged to prevent cross contamination. He said the issue was not if the resident was using it or not, the breathing mask should be bagged. LVN C went to the storage room and took a new breathing mask and a plastic bag. In an interview with the DON on 01/15/2024 at 11:03 AM, the DON stated the breathing mask was supposed to be in a bag when the resident was not using it to prevent cross contamination and worsening of respiratory issues the resident might already had. He said the expectation was for the staff to be mindful and make sure the breathing was bagged when the resident was not using it. He said it did not matter if the order was daily or as needed, the breathing mask must be in a bag or do not leave a breathing mask inside the room and just get one if needed by the resident. He said he would conduct an in-service about respiratory care. In an interview with the Administrator on 01/15/2025 at 11:39 AM, the Administrator stated everything the residents were using should be kept clean to prevent infection. She said she would coordinate with the DON to educate and re-educate the nursing staff to bag the breathing mask if not in use. She said the DON will also in-service the staff about the respiratory care issue. 2. Review of Resident #28's Face Sheet, dated 01/16/2025, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #28 had a diagnosis of chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident #28's Quarterly MDS Assessment, dated 07/05/2024, reflected resident had a moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #28's Comprehensive Care Plan, dated 10/22/2024, reflected resident has oxygen therapy r/t ineffective gas exchange. Interventions included For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus. Give medications as ordered by physician. Monitor/document side effects and effectiveness. Review of Resident #28's Physician Order, dated 04/24/2024, reflected O2 at 2 liters per minute via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 sat >90% every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 01/14/2025 at 09:52 AM revealed Resident #28 lying in bed with her eyes closed. Resident #28's wheelchair was next to the bed with a portable oxygen cannister on the back of the wheelchair. Resident #28 was receiving oxygen at 2 LPM (rate of oxygen flow) via the nasal cannula tubing connected to the oxygen cannister on the wheelchair. The resident's oxygen concentrator was next to the head of the bed. The oxygen tubing connected to the concentrator was on the floor between the concentrator and the nightstand. The tubing was not bagged. 3. Review of Resident #40's Face Sheet, dated 01/16/25, reflected Resident #40 was a [AGE] year-old female admitted on [DATE]. Resident #40 had a diagnosis of chronic obstructive pulmonary disease. Review of Resident #40's Physician Orders, dated 09/09/24, reflected O2 at 2 liters per minute via nasal cannula PRN. May titrate to 2-4 LPM to keep 02 sats >92% as needed for Shortness of Breath, Wheezing, 02 sat less than 90%. Obtain vital signs BID two times a day document vs q shift. Review of Resident #40's Quarterly MDS Assessment, dated 11/01/2024, reflected resident had a moderate impairment in cognition with a BIMS score of 08. Section I reflected resident was treated for chronic obstructive pulmonary disease. Review of Resident #40's Comprehensive Care Plan, dated 11/02/2024, reflected resident has oxygen therapy. O2 at 2 liters per minute via nasal cannula PRN. May titrate to 3-4 LPM to keep O2 sats >90%. One intervention was monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate. An observation on 01/14/25 at 10:04 AM revealed an oxygen concentrator in Resident #40's room. The concentrator was next to a cabinet with drawers. Oxygen tubing was connected to the concentrator and placed in the top drawer of the cabinet. The oxygen tubing was not bagged. 4. Review of Resident #38's Face Sheet, dated 01/16/25, reflected Resident #38 was a [AGE] year-old male. Resident #38 admitted on [DATE] with asthma (chronic lung disease causing the airway to narrow and can make breathing difficult) and shortness of breath. Review of Resident #38's Quarterly MDS Assessment, dated 11/25/24, reflected Resident #38 had intact cognition with a BIMS score of 15. Section I reflected Resident #38 was treated for asthma and shortness of breath. Review of Resident #38's Comprehensive Care Plan, dated 10/23/24, reflected the resident has unspecified asthma. One intervention was to give nebulizer treatments as ordered. An observation on 01/14/25 at 8:45 am revealed a nebulizer on Resident #38's nightstand. The nebulizer mask was connected to the nebulizer and the mask was placed on top of the nebulizer. It was not stored in a bag. In an interview on 01/14/25 at 09:55 AM, LVN D stated the oxygen tubing should have been bagged to prevent contamination. She removed the tubing and stated she was going to get new oxygen tubing. In an interview on 1/14/25 at 09:58 AM, CNA F stated the oxygen tubing should have been stored in a bag to keep it clean. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/14/25 at 10:35 AM, the DON stated the oxygen tubing and nebulizer masks should have been stored in bags when not used to prevent contamination. The DON stated he was going to follow up with the nurses to be sure those were corrected. During an interview on 01/14/25 at 10:42 AM, LVN E stated all respiratory items should have been bagged when not in use to prevent contamination and infection. In an interview on 01/16/24 at 10:45 AM, the ADON stated respiratory items were to be stored in bags when residents were not using them. She stated she tells the nurses if oxygen tubing is found on the floor, throw it away and get new tubing. She said her expectation is for all oxygen tubing and nebulizer masks to be stored in bags at all times when not in use by a resident. She stated this was an important measure to prevent contamination of these items. After record review of the facility's policy for Oxygen Administration on 01/16/2025 at 10:44 AM, a policy for bagging the nasal cannula and breathing mask was verbally requested on 01/16/2025 at 10:54 AM but was not provided prior to exit.

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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. 45055 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. 1. The facility failed to ensure staff were wearing the appropriate hair and beard coverings. 2. The facility failed to ensure the food stored in the refrigerator and freezer were labeled with the date the product was received from the vendor. 3. The facility failed to ensure that the sugar and flour bins were cleaned. 4. The facility failed to ensure the ice scoop in the facility kitchen was cleaned. 5. The facility failed to ensure the food in the dry storage area was labeled with the product was received from the vendor. 6. The facility failed to ensure the food stored in the freezer was properly sealed from air-borne contaminants. 7. The facility failed to ensure foods being transported to resident rooms and the memory care unit were properly concealed from air-borne contaminants. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 01/14/25 from 9:16 AM to 9:25 AM in the facility's only kitchen reflected: The ice scoop, hanging in a blue plastic holder, had a brownish substance and white stains along the bottom of the holder. One large tray containing three 2- pound packages of bologna and one 2-pound package of ham, located in the refrigerator, did not have the date the product was received from the vendor. One large plastic container of raw, chopped up celery, located in the refrigerator, did not have a date the product was received from the vendor. One large bag or frozen okra, located in the freezer, had a large tear in the bag, exposing the food to airborne contaminants. One bag of frozen waffles, located in the freezer, had a large tear in the bag, exposing the food to airborne contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One small bag of an unknown frozen food substance, located in the freezer, was not labeled and did not have the date the product was received from the vendor. Two large boxes of cookie dough, located in the freezer, had a large tear in the bag, exposing the food to airborne contaminants. Two large white storage bins, containing sugar and flour, had dark dirt-like stains on the outside of the containers and dark dirt-like stains within the opening and inside walls of the containers. Two packages of hamburger buns, containing 12 buns each, located in the dry storage area was not labeled with the date the product was received from the vendor. Two packages of large tortillas, located in the dry storage area were not labeled with the date the product was received from the vendor. In an observation and interview on 01/16/25 at 10:05 AM, the Dietary Manager was observed preparing food in the kitchen and he was not wearing a beard guard. The DM was observed to have a beard approximately 1/2 inch in length. The DM stated a beard covering should be worn to prevent hair from falling into the food. In an observation on 01/15/25 at 11:45 AM, [NAME] S was observed in the kitchen area placing food trays on the serving steam table, and had no head covering on his head. His hair was approximately 1/2 inch in length. He was asked where his hair covering was, and he proceeded to grab one and placed it on her head, before going back to plating the food. A dining observation on 01/15/24 at 12:39 PM revealed Kitchen Aide B transporting the food cart to the Memory Care Unit. There were two trays sitting on top of the cart and one of them included a bowl of uncovered desert. The other tray included a bowl of uncovered desert and a bowl of uncovered green beans. Two residents were observed walking up to, and then standing over the cart and looking at the trays, before staff redirected them. An observation and interview on 01/15/25 at 01:25 PM revealed three food test trays, that were being observed and tasted by the Surveyor, being removed from the food transfer cart, and all three-desert bowls were uncovered. The DM stated the bowls should have been covered during the transfer from the kitchen to the residents to avoid any food contamination. The DM stated he completed in-services on properly transporting food, food storage, and kitchen sanitation. In an interview on 01/15/25 at 01:35 PM, the DM stated that he had been the DM for nearly 3 months. He stated he had cleaned the sugar and flour bins twice since being at the facility. He stated that the ice scoop holder should have been cleaned after every shift at night. He was shown pictures of the concerns observed in the kitchen area. He stated that he thought it was being cleaned but it was not. He stated he needed to check behind them again. He stated the risk to the resident of not addressing the issues mentioned was residents could get food poison. He was made aware that [NAME] S was observed placing food on the steam table and he was not wearing a head covering. The DM stated [NAME] S should have been wearing a head covering to prevent food contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/15/25 at 02:05 PM, the Administrator was shown pictures of the concerns observed in the facility's only kitchen. She stated she would follow up with the DM to address the concerns. She stated the concerns observed could result in residents experiencing food contamination. The Administrator was advised of the concern of food being transported to residents eating in their rooms and in the memory care unit without a cover, and she stated she would follow up with the DM to address the concerns. She stated the concerns observed could result in residents experiencing food contamination. An interview on 01/16/25 at 01:05 PM, Kitchen Aide B stated that she always transported the deserts desserts and other items that were in bowls, uncovered. She stated she never knew that it needed to be covered. She stated moving forward she would ensure all foods were covered properly when transporting food to residents. She stated the risk of not covering the food when transporting it, could result in germs being spread. Record Review of the facility's policy on Food Storage and Supplies dated October 2022, revealed, Foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). All items must be dated with the date that the food was delivered. The food service area shall be maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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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** 47743 Based observation, interview and record review the facility failed to establish and 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 two (Resident #36 and Resident #39) of eight residents reviewed for Infection Control. 1. The facility failed to ensure CNA A and CNA B changed their gloves and performed hand hygiene while providing incontinent care to Resident #36 on 01/14/2025. 2. The facility failed to ensure CNA B performed hand hygiene while providing incontinent care to Resident #39 on 01/14/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #36's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 was diagnosed with personal history of urinary tract infections and cerebrovascular disease (reduction of blood flow to the brain). Record review of Resident #36's Quarterly MDS Assessment, dated 12/03/2024, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #36's Comprehensive Care Plan, dated 12/17/2024, reflected the resident had actual impairment to ski integrity related to wound to sacrum and one of the interventions was to provide incontinent care as needed. Observation on 01/14/2025 at 9:54 AM revealed CNA A and CNA B were about to do incontinent care to Resident #36. Both CNAs washed their hands before putting on their gloves. CNA A went the resident's right side, while CNA B went to the resident's left side. CNA B unfastened the brief and pushed it between the resident's thighs. CNA A placed the wipes and the brief beside the resident's right leg. After placing the wipes and the brief beside the resident's right leg, CNA A put a plastic bag on the trash can. After putting the plastic bag on the trash can, CNA A proceeded with incontinent care without changing her gloves. CNA A cleaned the perineal (area between the legs) area using the front to back technique. After cleaning the perineal area, both CNAs assisted the resident to roll to her left side. CNA A cleaned the resident's bottom. After cleaning the resident's bottom, CNA A took the brief that was placed beside the resident's right leg and placed it under Resident #36. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. The resident was rolled back, both CNA A fixed the brief. CNA B helped in fixing the brief. She did not change her gloves when she touched the soiled brief at the beginning of incontinent care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455930	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Rehabilitation and Healthcare Center	1700 N Washington Pilot Point, TX 76258

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA A on 01/14/2025 at 10:15 AM, CNA A stated she was not aware she did not change her gloves after placing a plastic bag on the trash can. Said she should have changed her gloves and sanitized her hands after touching the trash can because the trash was not only presumed dirty but was dirty. Said she also should have changed her gloves and sanitized her hands after cleaning the resident's bottom and before touching the new brief because whatever germs that she touched from the soiled bottom and soiled brief would eventually transfer to the new brief. Said her actions could cause transfer of germs and infection. She said she needed to be mindful with how she did incontinent care. In an interview with CNA B on 01/14/2025 at 10:47 AM, CNA B stated she assisted CNA A with incontinent care for Resident #36. She said she unfastened the soiled brief and tucked it between the thighs of the resident. She said she also helped in fixing the brief when CNA A was done cleaning the resident. She said because she touched the soiled brief, she should have changed her gloves before touching the new brief because her gloves were already considered soiled. She said the resident could have urinary tract infection because the new brief would be considered dirty. 2. Record review of Resident #39's Face Sheet, dated 01/16/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #39 was diagnosed with cerebral infarction (stroke). Record review of Resident #39's Comprehensive MDS Assessment, dated 11/25/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident was always incontinent for bladder and bowel. Record review of Resident #39's Comprehensive Care Plan, dated 11/24/2024, reflected the resident had incontinence and one of the interventions was to provide pericare after each incontinent episode. Observation on 01/14/2025 at 10:32 AM revealed CNA B was about to do incontinent care for Resident #39. She washed her hands before putting on a pair of gloves. When she was about to prepare the brief and the wipes, she realized there was no wipes inside the room. She said she would go out to get some wipes. When CNA B returned inside the room, she put on a pair of gloves and proceeded with incontinent care. She did not wash her hands again or sanitize her hands before doing incontinent care. In an interview with CNA B on 01/14/2025 at 10:47 AM, CNA B stated she washed her hands when she first entered Resident #39's room. She said after washing her hands, she realized she did not have any wipes to use that was why she went out of the room. She said when she went back inside the room, she should have washed her hands again because she touched the door knobs and other things when she went out of the room. She said her hands were deemed dirty again when she touched the door knob and other things. She said hand washing was important to prevent infection. In an interview with the DON on 01/15/2025 at 11:03 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. (continued on next page)

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	455930	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the staff should have washed her hands again when she went back into the room because the staff touched something else when she went out of the room. He said gloves should be changed after touching the trash can and the soiled brief to prevent transfer of microorganisms to any clean items. He said the rule of the thumb was, when you were in doubt, wash the hands and change the gloves. he said the expectations were staff would wash their hands before incontinent care and staff would wound change their gloves before touching anything clean. He said he would do and in-service about hand hygiene and infection control and would randomly monitor the staff doing direct care. He said the issue would also be included in their IDT meeting so everybody would know the issue and discuss the measures that could be implemented. In an interview with LVN C on 01/15/2025 at 11:20 AM, LVN C stated hands hygiene was included in all the procedures of any care. He said the staff should do hand hygiene before and after any care like incontinent care. He said gloves should be changed after touching the trash can and after cleaning the residents' bottom to prevent cross contamination and development of infection. He said he would remind the CNAs on his hall to wash their hands and change their gloves as appropriate. In an interview with the Administrator on 01/15/2025 at 11:39 AM, the Administrator stated not washing the hands before any care, not changing the gloves from soiled to clean could contribute to cross contamination and infection. She said the expectation was for the staff to follow the policy and procedures pertaining to infection control. She said she would coordinate with the DON on how to handle the issue about infection control and hand hygiene. Review of facility policy, Handwashing-Hand Hygiene Policy and Procedures revised 10-2020 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . k. After handling used dressings, contaminated equipment, etc. Applying and removing Gloves . 1. Perform hand hygiene before and after applying non-sterile gloves. Review of facility policy, Perineal Care revised 04/16/2024 revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . Steps in the Procedure . 2. Wash and apply gloves . For a female resident . b. wash perineal area . 10. Remove gloves . 11. Wash and dry hands thoroughly.