STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455970	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Health & Rehabilitation Center	1907 Refinery Rd Gainesville, TX 76240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment and to help prevent the development and transmission of communicable disease and infections for 1 of 2 residents (Resident #1) reviewed for infection control. CNA A failed to perform hand hygiene during gait belt transfer on 10/09/25 for Resident #1. This failure could place residents at risk of cross-contamination and the development of infections.Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dementia (condition with loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), hypertension (high blood pressure), generalized muscle weakness and cognitive communication deficit. Resident #1 required substantial/maximal assistance with ADLs. Observation on 10/09/25 at 10:26 AM revealed CNA A went to go get Resident #1's wheelchair down the hall in another room. CNA A brought the wheelchair in for Resident #1's transfer. CNA A did not perform hand hygiene prior to Resident #1's gait belt transfer. CNA A, who assisted on Resident #1's left side, and CNA B, who assisted on Resident #2's right side, were observed completing a 2 person gait belt transfer for Resident #1. Interview on 10/09/25 at 10:35 AM with CNA A revealed he should have washed his hands or sanitized them before the transfer of Resident #1. He stated he sanitized before going into room but then he did go get Resident #1's wheelchair down the hall. He stated he should have washed hands or sanitized before transferring Resident #1. Interviews on 10/09/25 at 1:00 PM and 1:29 PM with DON revealed she expected CNA A should have washed his hands or sanitized his hands prior to transferring Resident #1. She stated the risk to the CNA of not following proper hand hygiene placed resident at risk of infection. Review of facility's policy Hand Hygiene implemented in June 2025 reflected All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. Definitions: hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub.1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice It reflected under hand hygiene table condition of before performing resident care procedures.

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