

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of Laredo		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 McPherson Rd Laredo, TX 78041	

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)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408</p> <p>Based on observation, interview, and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community, for 5 of 7 residents (Residents #17, #19, #26, #33, and #56) reviewed for individual in-room activity programming, as evidenced by:</p> <ol style="list-style-type: none"> 1. Resident #17 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 2. Resident #19 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 3. Resident #26 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 4. Resident #33 did not have an in-room activity plan developed and implemented to meet his individual interests, abilities, and needs. 5. Resident #56 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. <p>This failure could place the residents at risk for isolation, decline in cognitive status, and decreased feelings of well-being within their environment.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #17 <p>(continued on next page)</p>

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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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Resident #17's Face Sheet, dated 3/14/2024, revealed an [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: hypertension (high blood pressure); atrial fibrillation (abnormal heartbeat); congestive heart failure (the heart does not pump blood as well as it should and cannot supply enough blood to meet the body's needs); cerebral infarction (stroke); speech and language deficits following cerebrovascular disease (difficulty or not able to speak); chronic obstructive pulmonary disease (lung disorder that affects breathing); hypothyroidism (thyroid disorder); and gastro-esophageal reflux disease (back-up of stomach acid into the throat).</p> <p>Review of Resident #17's Annual MDS Assessment, dated 6/04/23, revealed the BIMS was not able to be completed and the resident had short-term and long-term memory problems. The assessment documented the staff had assessed the resident's activity preferences as listening to music.</p> <p>Review of Resident #17's comprehensive care plan revealed a care plan dated 10/17/23 that documented the resident was unable to participate in activities due to bedrest. The documented goal was for the resident to enjoy individual activities and maintain the highest level of independence daily and ongoing over the next 90 days. The documented approaches were to schedule activities in room daily and to create an activity plan based on the resident's preferences.</p> <p>Review of the Activity Progress Note dated 2/15/24 revealed Resident #17 had attended the valentine party along with her family and everyone was in good spirits. The note documented the resident would continue to be brought to music events.</p> <p>Observation on 3/12/24 at 10:05 AM revealed Resident #17 was lying on her left side in bed with positioning pillows between legs. The resident's feet were swollen. She was using oxygen via nasal cannula and had a feeding tube. Resident #17's eyes were open, and she was making vocal noises and coughing. The head of the bed was elevated. She did not respond verbally when her name was spoken.</p> <p>Observation on 3/12/24 at 4:25 PM revealed Resident #17 was in bed with oxygen in use and the tube feeding infusing via pump. Resident #17 made eye contact but did not speak.</p> <p>In an interview on 3/14/24 at 11:36 AM, the Activity Director stated she talked with Resident #17 in her room and the resident understood. She stated Resident #17 could look at magazines. The Activity Director stated Resident #17 did not verbalize a lot, but she did understand and did try to respond. She stated she tried to see Resident #17 in her room [ROOM NUMBER] times per week and tried to engage the resident in conversation. The Activity Director stated she though Resident #17 would benefit from outdoor activity, such as sitting on the patio. She stated she needed to let the CNAs know in the morning if she had something planned for the residents who were usually in their beds in their rooms.</p> <p>2. Resident #19</p> <p>Review of Resident #19's Face Sheet, dated 3/14/2024, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: hemiplegia affecting left nondominant side (left sided weakness); osteoporosis (deterioration of bone tissue causing bones to become weak and brittle); cerebral infarction (stroke); hypertension (high blood pressure); fractured right femur (right hip fracture); osteoarthritis (degenerative joint disease that results from breakdown of joint cartilage and underlying bone); pain; hyperlipidemia (high cholesterol); anxiety disorder; and major depressive disorder.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Nursing Note, dated 1/22/24, revealed Resident #19 fell from her wheelchair and landed on her right hip. She was transferred to the emergency room and was admitted to hospital.</p> <p>Review of the Nursing Note, dated 1/26/24, revealed Resident #19 returned to the facility from the hospital with a diagnosis of fracture of unspecified part of neck of right femur (right hip fracture).</p> <p>Review of Resident #19's comprehensive care plan revealed it was revised 1/26/24 to address history of falls, fracture right hip, and pain.</p> <p>Review of Resident #19's Activity Assessment, dated 1/26/24, revealed the following:</p> <p>Average Time Involved in Activities: Some - from 1/3 to 2/3 of time.</p> <p>Recent Changes to Activity Involvement: Decrease in activity involvement.</p> <p>Reason for Recent Activity Change: other - fall injury.</p> <p>Review of Resident #19's Medicare 5-day MDS Assessment, dated 2/02/24, revealed a BIMS score of 13 out of 15 (cognitively intact); pain management; fall with major injury; activity preferences: participate in religious practices - very important; listen to music, animals/pet, current news, group activities, go outside - somewhat important.</p> <p>Review of Resident #19's comprehensive care plan revealed a care plan dated 2/05/2024 that documented the resident was unable to participate in activities due to bedrest. The documented goal was for the resident to enjoy individual activities and maintain the highest level of independence daily and ongoing over the next 90 days. The documented approaches were to schedule activities in room daily and to create an activity plan based on the resident's preferences.</p> <p>Review of the Activity Note, dated 2/20/24, revealed documentation Resident #19 has decreased her attendance in activities due to a fall at the facility but will return to attend when she recovers. Resident is visited in her room to check in with her and hope for a speedy recovery.</p> <p>Review of Resident #19's Social Service Note, dated 2/20/24, revealed documentation the annual / readmission care plan was reviewed with the IDT at this time. Resident has decreased activities participation due to having fall incident and fracture recovery process. Resident continues yelling at times during the day when wanting attention or needing pain medication. Sometimes resident will request to be seated in wheelchair but at this time is not safe for her to be up in wheelchair due to history of falls and fracture. Continue to monitor her behavior.</p> <p>Observation on 3/11/24 at 12:34 PM revealed Resident #19 was lying in a low bed and had not yet been served the lunch meal.</p> <p>Observation on 3/11/24 at 12:41 PM revealed Resident #19 was lying in bed, was awake, and the television was on in the room.</p> <p>During an observation and interview on 3/12/24 at 5:21 PM, Resident #19 was resting in bed. She stated she liked to attend parties and singing activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 3/14/24 at 12:10 PM, the Activity Director stated Resident #19 had been on bedrest since she fell a couple weeks ago. She stated the resident liked to color, enjoyed pet visits (dog) every month, and playing loteria (Spanish bingo). The Activity Director stated the resident attended group activities when able and used to lead the rosary prayer group. The Activity Director stated she only visited Resident #19 last week for this month and had brought her a Coke.</p> <p>3. Resident #26</p> <p>Review of Resident #26's Face Sheet, dated 3/14/24, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: unspecified intellectual disabilities; nonpsychotic mental disorder; epileptic seizures (a brain condition that causes recurring seizures); chronic kidney disease (gradual loss of kidney function that can lead to kidney failure); hypothyroidism (thyroid disorder); hyperlipidemia (high cholesterol); dysphagia (swallowing problem); and gastrostomy status (feeding tube).</p> <p>Review of Resident #26's Annual MDS Assessment, dated 8/16/2023, revealed the BIMS was not able to be completed. The assessment documented the staff had assessed the resident's activity preferences as listening to music. No other activity preferences had been selected.</p> <p>Review of Resident #26's comprehensive care plan, dated 1/24/2018, revealed a care plan documented the resident did not demonstrate interest in organized activities and documented a goal for the resident to participate in activities within her capabilities. The documented approaches included in-room visits 3 times weekly for sensory stimulation, invite the resident to activities, and familiarize the resident with the nursing home environment and activity programs on a regular basis.</p> <p>Review of Resident #26's Quarterly Activity Assessment, dated 2/25/24, revealed documentation for the resident's goal to accept one-to-one activity visits for at least 15 minutes 2 times weekly. The assessment documented the resident was in good health and would be visited in-room [ROOM NUMBER] times weekly for conversation and sensory stimulation and would attend any special events during the next 90 days. The assessment documented to remind the resident of special events and escort her to and from her room.</p> <p>Observation on 3/12/24 at 10:37 AM revealed Resident #26 was lying in bed, rolling around, and making grunting noises. She was observed to have a feeding tube. The resident's bed had padded half side rails and a fall mat was on the floor at the bedside.</p> <p>In an interview on 3/14/24 at 6:03 PM, the Activity Director stated she did not have documentation of in-room visits with Resident #26. She stated she was in Resident #26's room last week and hung some pictures in her room and played some music, but she did not document this.</p> <p>4. Resident #33</p> <p>Review of Resident #33's Face Sheet, dated 3/14/2024, revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: mood disorder with depressive features; pain; and dementia with anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #33's Admission MDS Assessment, dated 10/12/23, revealed a BIMS score of 12 out of 15 (moderate cognitive impairment) and his activity preferences of current news and favorite activities were somewhat important.</p> <p>Review of Resident #33's comprehensive care plan revealed a care plan dated 10/19/23 which documented the resident had very little participation in activities. The documented goal was for the resident to participate in activities of choice over the next 90 days. The approaches included Social Service visits to discuss interests and past social patterns in the community, refer to psychological counseling/mental health specialist, provide privacy for family and friend visits, provide opportunities for increased socialization, introduce to other residents, encourage social conversations, and one-to-one visits.</p> <p>Review of the Activity Assessment, dated 1/26/24, revealed the resident participated in Socialization activities and had attended a coffee social and one-to-one activity visits 2 times weekly. (The assessment did not specify the type or topic of one-to-one activity.)</p> <p>Observation on 3/12/24 at 10:55 AM revealed Resident #33 was lying on his back on low bed with floor mats on both sides of bed. The resident's eyes were closed. A geri-chair was observed in a corner of the room. (A geri-chair is a specialized reclining chair that offers more versatility and support than a conventional wheelchair can provide.)</p> <p>Observation on 3/12/24 at 4:41 PM revealed Resident #33 was lying on his back in bed and was hollering loudly speaking in Spanish.</p> <p>In an interview on 3/14/24 at 12:03 PM, the Activity Director stated Resident #33 had been brought to group activities in a geri-chair. She stated he started yelling and screaming. She stated he was very hard of hearing. She stated he came to a coffee social and was calm while he drank coffee, and then became anxious. The Activity Director stated Resident #33 had hearing impairment and behavioral concerns.</p> <p>5. Resident #56</p> <p>Review of Resident #56's Face Sheet, dated 3/14/2024, revealed an [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: Parkinson's disease (chronic and progressive movement disorder with tremors, stiffness, and slowing of movement); chronic obstructive pulmonary disease (lung disorder affecting breathing); anxiety disorder; restlessness and agitation; depression; hypertension (high blood pressure); dementia; hyperlipidemia (high cholesterol); chronic embolism and thrombosis of lower extremities (blood clots in legs); and edema (fluid retention).</p> <p>Review of Resident #56's Annual MDS Assessment, dated 9/04/2023, revealed a BIMS score of 3 out of 15 (severely cognitively impaired). The resident's activity preferences had been completed by staff and no activity preferences were selected.</p> <p>Review of Resident #56's comprehensive care plan revealed a care plan dated 3/07/2023 that documented the resident was unable to tolerate usual activities due to poor endurance. The care plan goal was to continue one-to-one visits. The care plan was revised 2/09/2024 and included a documented approach to assess the resident's response to new activity plan and modify as needed, and create an activity plan based on resident's preferences.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 3/11/24 at 1:29 PM revealed Resident #56 was resting on her right side in bed using oxygen via nasal cannula. She was awake, alert, and made eye contact when her name was spoken. Floor mats were located on both sides of her bed.</p> <p>Observation on 3/12/24 at 3:57 PM revealed Resident #56 was resting on her back in bed.</p> <p>In an interview on 3/14/24 at 11:16 AM, the Activity Director stated she visited Resident #56 in her room. She stated Resident #56 was sometimes assisted into a geri-chair but she was never taken out of her room. The Activity Director stated Resident #56 could not participate in physical activities. The Activity Director stated she would open the window blinds, turn on the television, or play music on her iPhone for the resident. The Activity Director stated she did not document any notes in the resident's record or complete an activity assessment. She stated she only completed assessments for new admissions, re-admissions, and yearly's (annual assessments). The Activity Director stated she spoke with the Super CNA (lead CNA) about getting Resident #56 up in a geri-chair to see if she could tolerate sitting up and how long. She stated Resident #56 had not attended any group activities. The Activity Director stated she did not think she had seen Resident #56 this month. She stated she tried to see all the residents every month.</p> <p>In an interview on 3/14/24 at 11:36 AM, the Activity Director stated she had not developed specific in-room activity plans for the residents who remained in their rooms. She stated she did not keep documented records of one-to-one visits with individual residents and did not document the date, time, or what she did during her visits with individual residents. The Activity Director stated she completed Activity Assessments when they populated for residents who were new admissions or re-admissions from the hospital after she received a prompt to complete an assessment in the electronic health record system.</p> <p>In an interview on 3/14/24 at 7:41 PM, the DON stated the Activity Director should have an activity log with documentation of in-room activities. She stated the Activity Director was probably nervous because it was her first survey. She stated she would explain to her what was needed.</p> <p>Review of the facility's Recreation Services policy and procedure for Individual Programming, dated 12/1999, revealed [in part]:</p> <p>Policy</p> <p>Regularly scheduled programming will be provided to all residents who are unable and/or unwilling to attend group activities.</p> <p>Purpose</p> <p>Individual programming ensures that all residents who are unable and/or unwilling to participate in group programs have consistent, goal-oriented, and individualized recreation opportunities.</p> <p>Individual interventions: Structured individual programs will be developed based on each resident's assessed needs.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Scheduling: The individual program will be provided according to a consistent schedule identifying specific days of the week, the time frame in which the program will occur, and residents who will receive services within the specified time frames.</p> <p>Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical and cognitive functioning needs. These approaches will reflect the resident's lifestyle and interests and will be incorporated into the interdisciplinary care plan .</p> <p>Individual participation record: Specific service provided and resident response to the activity will be documented on an Individual Participation Record and utilized to evaluate progress toward goal attainment.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>27938</p> <p>Based on observation, interview, and record review the facility failed to ensure that the daily nurse staffing information, including the facility name, the current date, the total number and actual hours worked by RNs, LVNs, and CNAs, and the resident census, was posted on a daily basis for 3 of 3 staffing postings reviewed for daily staffing.</p> <p>The facility failed to update the daily staffing information posting on (include the dates) to reflect the actual hours worked by licensed and unlicensed staff.</p> <p>This failure could affect residents, their families, and facility visitors by placing them at risk of not having access to information regarding staffing data and facility census.</p> <p>Findings included:</p> <p>Observation on 03/11/24 at 10:00 am, revealed the daily staffing pattern was posted on the door of the medication room however the staffing information revealed the number of staff scheduled for each shift 6A-2P, 2P-10P, and 10P-6A. The staff posting should include the actual time worked during that shift for each category and type of nursing staff.</p> <p>Observation on 03/12/24 at 10:30 am, revealed the daily staffing pattern was posted on the door of the medication room did not reflect the actual hours worked by licensed and unlicensed staff.</p> <p>Observation on 03/13/24 at 11:00 am, revealed the daily staffing pattern was posted on the door of the medication room did not reflect the actual hours worked by licensed and unlicensed staff.</p> <p>Observation on 03/14/24 at 10:00 am, revealed the daily staffing pattern was posted on the door of the medication room did not reflect the actual hours worked by licensed and unlicensed staff.</p> <p>During an interview with the DON on 03/14/24 at 6:20 pm, She stated she knew that it is a requirement that the Nurse Staffing Posting should be updated and posted daily, but the Administrator posts the staffing sheet. She further stated failure to post the actual hours worked could cause confusion on staffing and resident care issues and not give the public an accurate number of staff and staff hours present on any given shift.</p> <p>During an interview with the Administrator on 3/14/24 at 8:30 pm, stated, he posts the staffing pattern on a daily basis and not posting the actual hours worked was an oversight on his part and not having the actual hours staff works each shift could give the residents and the public inaccurate information on the number of staff working and hours worked on any given shift</p> <p>Review of the facility policy titled Posting Direct Care Daily Staffing Numbers, revised July 2016, showed [in part]:</p> <p>Policy Interpretation and Implementation</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>1. Within two (2) hours of the beginning of each shift .will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .</p> <p>3 .The information recorded on the form shall include:</p> <p>a. The name of the facility.</p> <p>b. The date for which the information is posted.</p> <p>c. The resident census at the beginning of the shift for which the information is posted.</p> <p>d. Twenty-four (24)-hour shift schedule operated by the facility.</p> <p>e. The shift for which the information is posted.</p> <p>f. Type (RN [registered Nurse], LPN [Licensed Practical Nurse], LVN [Licensed Vocational Nurse], or CNA [Certified Nursing Assistant]) and category (licensed or non-licensed) of nursing staff working during that shift.</p> <p>g. The actual time worked during that shift for each category and type of nursing staff.</p> <p>h. Total number of licensed and non-licensed nursing staff working for the posted shift</p> <p>41944</p> <p>FACILITY</p> <p>Sufficient and Competent Nurse Staffing</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</p> <p>Based on 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 one of three residents (Resident # 81) reviewed for infection control practices.</p> <p>CNA A failed to perform hand hygiene and change gloves as appropriate while providing incontinence care for Resident #81.</p> <p>This failure could place residents at risk for cross contamination and the spread of infection.</p> <p>Finding include:</p> <p>Record review of Resident #81's face sheet, dated 03/12/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #81 had diagnoses which included UTI (infection of the urinary tract), retention of urine, and hemiplegia (paralysis of one side of the body).</p> <p>Record review of Resident #81's MDS Annual Assessment, dated 12/17/23 reflected Resident #81 was dependent with most ADLs and was always incontinent of bowel and bladder. Resident #81 had a BIMS score of 10 (moderate cognitive impairment).</p> <p>Observation and interview on 3/12/24 at 10:42 a.m. of incontinence care for Resident #81 revealed CNA A, before the start of care, washed her hands and gathered supplies. She then donned gloves and removed Resident #81's urine soiled brief. She did not sanitize her hands or change gloves before she placed a clean sheet, pad, and brief on the bed partially underneath the resident and touched the dirty linen and incontinent pad which was still laying on the bed. She then performed incontinent care and removed the soiled linen and her gloves and sanitized her hands. She applied new gloves and finished making the bed and fastened the resident's brief. She gathered the soiled supplies in a bag and washed her hands before leaving the room. She stated she knew she should have changed gloves and sanitized her hands before touching the clean linen and brief. She stated this could lead to in infection.</p> <p>In an interview on 3/12/24 at 10:50 AM, CNA A did not speak English but was able to relay through an interpreter that she had received infection control training recently. CNA A stated cross contamination was mixing clean with dirty and that she should have washed her hands before she retrieved Resident #81's clean brief and fastened it. She stated Resident #81 could get an infection for not following good infection control practice.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of Laredo		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 McPherson Rd Laredo, TX 78041	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/12/24 at 10:50 AM the DON stated she was aware of some of the concerns raised about infection control practices. She explained the wound care nurse was responsible for infection control in the facility. She stated the Nurses trained and monitored staff with return demonstration. The DON stated aides were expected to follow standard precaution which included washing hands and changing gloves while providing care. She stated CNA A knew she should change gloves and sanitize her hands when touching a clean area after removing a soiled brief. She stated failure to practice good hand hygiene could result in an adverse outcome for the resident due to infection.</p> <p>Record review of the facility's policy and procedure for Handwashing/Hand Hygiene, dated as revised February 2018, reflected the following [in part]:</p> <p>Policy Statement:</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors</p> <p>6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations:</p> <p>a. When hands are visibly soiled; and</p> <p>h. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile.</p> <p>7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:</p> <p>b. Before and after direct contact with residents</p> <p>f. Before donning sterile gloves.</p> <p>g. Before handling clean or soiled dressings, gauze pads, etc.</p> <p>ii. Before moving from a contaminated body site to a clean body site during resident care .</p> <p>m. After removing gloves</p>		