

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Gainesville Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 O'Neal St 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 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** Based on observation, interview and record review the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment for two of 10 residents (Resident #18 and Resident #59) and four of 4 shared bathrooms (room [ROOM NUMBER] and 304, room [ROOM NUMBER] and 308, room [ROOM NUMBER] and 309, and room [ROOM NUMBER] and 312) reviewed for homelike environment. 1. The facility failed to ensure Resident #18's restroom tile around the toilet was in good working condition on 12/09/25. 2. The facility failed to ensure Resident #59's restroom toilet was working properly, and fan blower wires were not exposed in bathroom ceiling on 12/09/25. 3. The facility failed to ensure the restroom handrails were in good repair for bathrooms shared by room [ROOM NUMBER] and 304, room [ROOM NUMBER] and 308, room [ROOM NUMBER] and 309, and room [ROOM NUMBER] and 312. These failures placed residents at risk of resident restroom in an unsafe environment and a lack of homelike environment for residents. Findings included:1. Record Review of Resident #18's Annual Assessment reflected Resident #18 was admitted to the facility on [DATE] with included diagnoses of coronary artery disease and heart failure. Resident #18 had a BIMS score of 15 indicating her cognition was intact. Resident #18 was independent with toileting. Observation on 12/09/25 at 11:46 AM revealed Resident #18's bathroom tile of about 3 inches was missing around the sides of the toilet and 6 inches behind the toilet. There were rocks where the missing tile was. Interview with Resident #18 revealed the tile had been like this since about June 2025 2. Record Review of Resident #59's admission assessment dated [DATE] reflected Resident #59 [was admitted to the facility on [DATE] with diagnoses of hip fracture, dementia (significant cognitive decline severe enough to disrupt daily life) and polyneuropathy (condition affecting multiple peripheral nerves in different body parts are damaged). Resident #59 was moderately impaired with cognitive skills for daily decision making. Resident #59 was dependent with ADLs. Resident #59 was on hospice services. Interview on 12/09/25 at 11:20 AM with Resident #59's RP revealed the wires showing in ceiling of bathroom had been like that since admission. Resident #59's RP stated the toilet was clogged and had been like this for a while. She stated Resident #59 was on hospice services. Interview on 12/11/2025 at 2:50 PM with the Maintenance Director revealed toilets on hall 200, including Resident #59's toilet was clogged/not working properly for the last week. He stated the wires in the ceiling of Resident #59's bathroom was from the fan blower. He stated he was having difficulty finding a replacement cover for the fan blower. He stated Resident #18's toilet had been fixed where they had to drill through the bathroom floor. He stated he was aware of the missing tile around the toilet but had not gotten to it yet. Interview on 12/11/2025 at 1:36 PM with the Administrator revealed his expectations for repairs and maintaining the bathrooms were that everything worked and there was a home-like environment. He said staff have been educated on how to report issues in the electronic maintenance system, which notified him and the Maintenance Director immediately. He said the Maintenance Director has 30 days to fix an issue unless the facility needed to hire a contractor; then it depended on who was hired. He stated the impact on residents would be not having a homelike environment.3. An observation on 12/09/2025 at 10:15 am in the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] and [NAME] bathroom (a shared bathroom with two doors, connecting two separate bedrooms) for room [ROOM NUMBER] and 304 revealed the round handrails located in the bathrooms next to the toilets, were rusted around the lower part of the handrail where it was attached to the wall approximately 2 up the handrail. An observation on 12/09/2025 at 10:18 am in the [NAME] and [NAME] bathroom for room [ROOM NUMBER] and 308 revealed the round handrails located in the bathrooms next to the toilets, were rusted around the lower part of the handrail where it was attached to the wall approximately 3 up the handrail. An observation on 12/10/2025 at 10:45 am in the [NAME] and [NAME] bathroom for room [ROOM NUMBER] and 312 revealed the round handrails located in the bathrooms next to the toilets, were rusted around the lower part of the handrail where it was attached to the wall approximately 3 up the handrail. An observation on 12/11/2025 11:18 am in the [NAME] and [NAME] bathroom for room [ROOM NUMBER] and 309 revealed the round handrails located in the bathrooms next to the toilets, were rusted around the lower part of the handrail where it was attached to the wall approximately 2 up the handrail. In an interview on 12/10/2025 at 10:50 am with the Maintenance Director it was revealed that he was responsible for replacing or repairing grab bars in the facility if they were loose, broken or rusted. He said any staff, resident or guest could report needed repairs by scanning the QR code posted throughout the facility, which directed them to the facility's TELS system. In an interview on 12/10/2025 at 12:06 pm with CNA H she said she knew if there were repairs that needed to be repaired, she would notify the Maintenance Director. In a follow-up interview on 12/11/2025 1:15 pm with the Maintenance Director he said he was not aware of the rusted safety bars in the affected rooms. He said he would get them replaced now that he was made aware of them. In an interview on 12/11/2025 at 1:36 pm the Administrator stated his expectations for repairs and maintaining the bathrooms were that everything works and has a home-like environment. He said staff have been educated on how to report issues in TELS, which notifies him and the Maintenance Director immediately. He said the Maintenance Director has 30 days to fix an issue unless the facility needs to hire a contractor then it depends on who is hired. He said he was not aware of the rusted safety bars in the affected rooms. He said the impact would be resident rights and not having a homelike environment. Record review of the facility's Homelike Environment policy last revised February 2021 reflected Residents are provided with a safe, clean, comfortable and homelike environment. 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. Record review of the facility's Maintenance Service policy dated December 2009 revealed: 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. i. providing routinely scheduled maintenance service to all areas. j. others that may become necessary or appropriate.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of the State Long-Term Care Ombudsman of the residents' transfer or discharge and the reasons for the move, for 1 of 4 residents (Resident #24) reviewed for the discharge process. Resident #24 was discharged on 10/15/2025, 11/08/2025 and 11/26/2025 without a notice to the Long-Term Care Ombudsman. This failure could place residents at risk of not knowing their rights or receiving the services of the state Long-Term Care Ombudsman. The findings included: A record review of Resident #24's face sheet printed 12/11/2025 revealed diagnoses of Unspecified Fracture of Lower End of Right Humerus (a break near the elbow, causing pain, swelling, bruising, and stiffness), Calculus of Kidney (known as a kidney stones), Shortness of Breath, Obesity, Acute Kidney Failure, and Type 2 Diabetes. A record review of Resident #24's MDS assessment dated [DATE], reflected a BIMS score of 04 indicating his cognition was severely impaired, and most of his functional abilities required substantial to maximal assistance (the helper does more than half the effort) with his activities of daily living. A record review of Resident #24's electronic medical record revealed a progress note dated 10/15/2025 stating Resident #24 was transferred to the hospital. A record review of Resident #24's electronic medical record revealed a progress note dated 11/08/2025 stating Resident #24 left facility via ambulance. A record review of Resident #24's electronic medical record revealed a progress note dated 10/26/2025 stating Resident #24 was transferred to the emergency room. A record review of the facility's transfer and discharge summary revealed resident #24 was discharged on 10/15/2025, 11/08/2025 and 11/26/2025. A record review of the medical record revealed no evidence of a written discharge notice being provided to the LTC ombudsman on 10/15/2025, 11/08/2025, and 11/26/2025. During an interview with the Social Worker on 12/10/2025 she said she did not send any written notices to the Ombudsman. During an interview with the ADON on 12/10/2025, she said the charge nurse called the physician, DON, family, and Administrator, and documented in the EMR. She was not aware of anything given in writing. During an interview with the DON on 12/11/2025, she said the charge nurse verbally notified the family and documented the notification in their EMR. She said the impact on a resident/family if they were not informed, when the resident was transferred, was fear of not knowing where their loved one was and not getting the opportunity to be with the resident during a difficult traumatic time. During an interview with the Administrator on 12/11/2025, he said when a resident was transferred or discharged nursing verbally informed the responsible party, physician, and the ombudsman by calling them. During an interview with the facility's Ombudsman on 12/11/2025, she said the facility does not call her to inform her of transfers or discharges. She said in 2025 the facility sent a transfer/discharge report three times, in March, April, and Aug. A record review of the facility's Transfer or Discharge, Facility-Initiated Policy dated October 2022 revealed: 1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: a. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility. Notice of Transfer or Discharge (Emergent or Therapeutic Leave) 1. When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected. 2. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility. 3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b. The resident's health improves sufficiently to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is required by the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's urgent medical needs; ord. A resident has not resided in the facility for 30 days.4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements).5. Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer.6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments.Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.		

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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** Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 4 (Resident #2, Resident #3, Resident #19, and Resident #24) of ten residents reviewed for respiratory care.1. The facility failed to ensure Resident #2's oxygen tubing (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly when not in use on 12/09/2025.2. The facility failed to ensure Resident #3's oxygen tubing was stored properly when not in use on 12/09/2025. 3. The facility failed to ensure Resident #19's suction tubing (used to keep the airway clear) was stored properly when not in use on 12/10/2025.4. The facility failed to ensure Resident 24's oxygen tubing and CPAP (machine delivers continuous stream of air to keep airway open during sleep) mask was stored properly when not in use on 12/10/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #2 Record review of Resident #2's face sheet, dated 12/10/2025, reflected a [AGE] year-old female who admitted on [DATE]. The resident was diagnosed with COPD (disease of the lungs and airway that affects breathing). Record review of Resident #2's Quarterly MDS (tool used to assess health needs and functional capabilities) Assessment, dated 11/17/2025, reflected the resident was cognitively intact with a BIMS (tool used to assess cognitive function) score of 14 (no or very little cognitive impairment). The Quarterly MDS Assessment reflected active diagnoses which included COPD and respiratory failure. Record review of Resident #2's Comprehensive Care Plan, dated 09/09/2025, reflected the resident was at risk for respiratory infection, shortness of breath, and cough related to a diagnosis of COPD. Interventions included administration of oxygen and nebulizer treatments as ordered. Record review of Resident #2's Physician Order, dated 04/10/2025, reflected to administer oxygen via nasal cannula at 3 LPM at night as needed for shortness of breath and to maintain oxygen greater than 90% every shift. Record review of Resident #2's Physician Order, dated 11/21/2025, reflected Oxygen tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift. During an observation on 12/09/2025 at 9:41AM, Resident #2 was not in her room. An oxygen concentrator was next to her bed. Oxygen tubing was connected to the concentrator, and the tubing was on the floor. The oxygen tubing was not in a bag. Resident #3 Record review of Resident #3's face sheet, dated 11/17/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with respiratory disorder. Record review of Resident #3's Quarterly MDS Assessment, dated 11/13/2025, reflected the resident was cognitively intact with a BIMS score of 13 (no or very little cognitive impairment). The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #3's Comprehensive Care Plan, dated 11/10/2025, reflected the resident required supplemental oxygen and one of the interventions was to provide oxygen therapy as ordered. Record review of Resident #3's Physician Order, dated 11/21/2025, reflected to administer oxygen via nasal cannula at 3 LPM as needed for shortness of breath and to maintain oxygen greater than 90% every shift. Record review of Resident #3's Physician Order, dated 04/10/2025, reflected CPAP tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift. During an observation and interview on 12/09/2025 at 9:33 AM, Resident #3 was sitting in a wheelchair in her room. A portable oxygen concentrator was on the windowsill next to her bed. Oxygen tubing was connected to the concentrator. The oxygen tubing was not in a bag. Resident #3 stated she did not know the oxygen tubing was supposed to be in a bag. During an interview on 12/09/2025 at 9:48 AM, CNA E stated the oxygen tubing should have been in a bag. CNA E stated if she saw oxygen tubing on the floor, she replaced it with new tubing and put it in a bag. She stated it was important to prevent infection. During an observation and interview on 12/09/2025 at 9:52 AM, (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN C went with the surveyor to Resident #2 and Resident #3's room. She stated the oxygen tubing should have been stored in a bag. She stated the oxygen tubing collected germs and put the residents at risk for respiratory issues. LVN C removed the tubing and stated she would replace it and ensure it was in a bag. During an interview on 12/09/2025 at 3:20 PM, the ADON stated the expectation was for oxygen tubing to be stored in a bag for infection control. Resident #19Record review of Resident #19's face sheet, dated 12/10/2025, reflected a [AGE] year-old male who initially admitted on [DATE], and readmitted on [DATE]. Resident #19 had diagnoses which included traumatic brain injury (damage to the brain caused by an external physical force) and tracheostomy status (tube inserted through a surgical opening in the neck to help you breathe). Resident #19 was on hospice care.Record review of Resident #19's MDS Assessment and Care Screening, dated 09/08/2025, reflected a BIMS was not appropriate. Section C (Cognitive Patterns) indicated the resident was severely impaired with cognitive skills for daily decision making. Section O (Special Treatments, Procedures, and Programs) reflected oxygen therapy, tracheostomy care, and suctioning.Record review of Resident #19's Comprehensive Care Plan, dated 09/10/2025, reflected the resident had a tracheostomy and was at risk for increased secretions, congestion, and respiratory infections. One intervention was to monitor for suctioning of increased secretions and assess for relief. Record review of Resident #19's Physician Order, dated 09/04/2025, reflected to suction oral and respiratory secretions every shift as needed. During an observation and interview on 12/10/2025 at 7:11 AM, Resident #19 was lying in bed with his eyes closed. A suction pump was on the resident's nightstand next to the bed. Connective tubing was connected to the suction pump, and the tubing was on the floor under the edge of the bed. The connected tubing did not have a suction catheter (device to suction secretions) attached. RN D was in the hallway and stated the suction tubing should be in a bag. She stated she did not see it when she was in Resident #19's room earlier. RN D removed the connective tubing and discarded it. She stated it was important to avoid any type of infection to the resident. Resident #24Record review of Resident #24's Face Sheet, dated 12/10/2025, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #24 had diagnoses which included mild persistent asthma (causes the airway to narrow and can make breathing difficult) and pneumonia (infection in lung). Record review of Resident #24's Quarterly MDS Assessment, dated 11/05/2025, reflected moderately impaired cognition (noticeable decline in memory and thinking abilities) with a BIMS score of 12. The Quarterly MDS Assessment reflected respiratory treatments which included CPAP and oxygen therapy. Record review of Resident #24's Comprehensive Care Plan, dated 12/02/2025, reflected the resident required supplemental oxygen and one of the interventions was provide oxygen therapy as ordered. Record review of Resident #24's Comprehensive Care Plan, dated 12/02/2025, reflected the resident used a CPAP for sleep apnea. One intervention was to encourage the resident's use of the CPAP.Record review of Resident #24's Physician Order, dated 04/10/2025, reflected CPAP tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift.Record review of Resident #24's Physician Order, dated 11/21/2025, reflected Oxygen tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift every shift.During an observation and interview on 12/10/2025 at 7:31 AM, Resident #24 was lying in bed awake. Resident #24's oxygen tubing was connected to the oxygen concentrator next to his bed. The tubing was on the floor and not in a bag. Resident #24's CPAP mask was on the floor at the head of the bed. Resident #24 stated he removed the mask. LVN A came to Resident #24's room and stated Resident #24 removed the CPAP mask himself. She stated he wore it at night and oxygen during the day. She stated Resident #24 did not want to put oxygen on earlier. She stated it should have been in a bag to reduce infection. During an interview on 12/11/2025 at 11:05 AM, the ADON stated respiratory items should be stored in a bag when not in use. She stated it was important for infection control and prevention of respiratory infections. The ADON stated staff would be in-serviced on monitoring respiratory items. During an interview on 12/11/2025 11:43 AM, the DON stated all staff should observe if oxygen tubing was on the floor or not stored in a bag. She stated (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff members should report it directly to the nurse. She stated CNAs could remove tubing and alert the nurse to change the tubing. She stated the connective tubing for the suction machine should be changed weekly or as needed. She stated if it was on the floor, it should be changed. She stated it was important for infection control and the residents' health and safety. On 12/11/2025 at 1:20 PM, the Administrator stated the facility did not have a policy related to the storage of respiratory items when not in use. The facility did not submit a policy by the date, 12/11/25 and time of exit, 4:30pm.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards in the facility's only kitchen. 1. The facility failed to ensure fryer was free of sediments and failed to ensure oil had been replaced. 2. Dietary [NAME] I and Dietary Aide J failed to ensure hair was covered or properly restrained during lunch meal service on 12/11/25. These failures could place residents at risk for food-borne illness and contamination Findings included: 1. Observation on 12/09/25 at 10:43 AM revealed fryer revealed about 2 inches sediment around the edges of the fryer and food particles in dark brown oil. Interview on 12/09/25 at 10:45 AM with Dietary Manager revealed the fryer was last used on Friday (12/05/25) and the oil is supposed to be changed weekly on Friday. She stated it was not changed last Friday (12/05/25) since she was out of oil to replace it. She stated her shipment was coming and will be changed once she got the oil. 2. Observation on 12/11/25 at 11:58 AM revealed Dietary [NAME] I was putting food on resident lunch plates with uncovered hair about 0.5 inch above both ears and 0.5 inch in back of her head. Observation on 12/11/25 at 12:01 PM revealed Dietary Aide J's hair restraint was not covering about 1 inch in front of both ears and about 1.5 inches in back of her head. Interview on 12/11/25 at 12:18 PM with Dietary Manager revealed dietary staff not wearing effective hair restraints can place the risk of hair falling in the food and contaminating the food. She stated not changing the oil for the fryer or filtering the oil could place the food at risk of contamination. Record Review of the facility's policy Cleaning Instructions: Deep Fat Fryer dated 2023 reflected Fryers will be cleaned after each use. Procedure: 4. Oil should be changed at least every 10 times the fryer is used. When the oil starts to turn a dark brown, starts to smell or the consistency changes, it is time to change the oil. 5. Remove food particles from the oil after each use. The U.S. Food and Drug Administration Food Code, dated 2022, noted the following regarding body hair, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-serve and single-use articles.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 one (Resident #24) of five residents reviewed for care plans. The facility failed to ensure Resident 24's Comprehensive Care Plan reflected the use of oxygen therapy on 12/10/2025. This failure could place the residents at risk of not receiving the necessary care and services needed. Findings included: Record review of Resident #24's Face Sheet, dated 12/10/2025, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #24 had diagnoses which included mild persistent asthma (causes the airway to narrow and can make breathing difficult) and pneumonia (infection in lung). Record review of Resident #24's Quarterly MDS (tool used to assess health needs and functional capabilities) Assessment, dated 11/05/2025, reflected moderately impaired cognition (noticeable decline in memory and thinking abilities) with a BIMS (tool used to assess cognitive function) score of 12 (moderate cognitive impairment). The Quarterly MDS Assessment indicated Resident #11 received oxygen therapy. Record review of Resident #24's Comprehensive Care Plan, dated 12/02/2025 did not reflect oxygen therapy. Record review of Resident #24's Physician Order, dated 11/21/2025, reflected to administer oxygen via nasal cannula at 3 LPM as needed for shortness of breath and to maintain oxygen greater than 90% every shift. During an observation on 12/10/2025 at 7:31 AM, Resident #24 was lying in bed awake. Resident #24's oxygen tubing was connected to the oxygen concentrator next to his bed. During an interview on 12/10/2025 at 1:14 PM, the Regional Reimbursement Coordinator stated Resident #24 had a recent decline and a new order for oxygen therapy. She stated she would look at Resident #24's medical records and if he did not have a care plan for oxygen, she would add it. During an interview on 12/10/2025 at 1:40 PM, the Regional Reimbursement Coordinator stated Resident #24 did not have a care plan for oxygen and she added one. She stated it was important to ensure the resident's care plan was updated so he received the appropriate care. During an interview on 12/11/2025 at 11:05 AM, the ADON stated she and the DON checked residents' admission records and worked together to add care plans relating to residents' orders. She stated the MDS Coordinator followed up to ensure care plans were appropriate. She stated care plans included nursing interventions to help residents reach goals. She stated it was also a way to monitor new interventions. During an interview on 12/11/2025 11:43 AM, the DON stated it was important to ensure oxygen therapy was included in Resident #24's care plan. She stated if the resident was not getting the oxygen he needed, it could cause deoxygenation, confusion, or a change in condition. She stated when a care plan was added, tasks were assigned to different staff members, and everyone was able to see it. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered, revised March 2022, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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NAME OF PROVIDER OR SUPPLIER Gainesville Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 O'Neal St Gainesville, TX 76240	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were accurate and complete in accordance with acceptable professional standards for 2 (Residents #23 and #24) of 4 residents reviewed for clinical records.1. Resident #23 had an OOH-DNR in their record that was missing information in Section B, Declaration by legal guardian, agent, or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication.2. Resident #35 had an OOH-DNR in their record that the family member signed in sections they were not supposed to, the family member missed a required signature at the bottom, and the two witnesses to the family members signature did not sign until 14 days after the family member did.The facility's failure could place residents at risk for not receiving healthcare as per their or their legal representatives' wishes. Findings included:1.Record review of Resident #23's face sheet printed [DATE] revealed he was an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Cognitive Communication Deficit (difficulty in expressing or understanding messages due to impaired thinking skills), Dementia (significant decline in mental abilities), Major Depressive Disorder, and Dysphagia (difficulty starting a swallow, involving problems in the mouth or throat). Resident #23 was listed as having an OOH-DNR.Record review of Resident #23's last MDS was a change of condition assessment completed on [DATE] revealing he had a BIMS score of 04 indicating his cognition was severely impaired, and his functional abilities required substantial to maximal assistance (the helper does more than half the effort) with his activities of daily living.Record review of Resident #23's care plan revealed Resident #23 was an OOH-DNR per his advanced medical directive, with the goal being the Resident's right to decline, in advance, resuscitative measures at death would be honored. The interventions if arrest occurs CPR will not be given.Record review of the clinical record for Resident #23 revealed a DNR dated [DATE] with the following: section B - Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication - there was a signature and a printed name, but no date of when the OOH-DNR form was signed.2.Record review of Resident #35's face sheet printed [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Heart Failure, Age-Related Cognitive Decline (subtle decreases in thinking speed, multitasking, and word-finding), and Dementia (significant decline in mental abilities). Resident #35 did not have a resuscitation status documented on his face sheet.Record review of Resident #35's care plan revealed Resident was an OOH-DNR per his choice with the goal of resident's wishes to be honored and the interventions being CPR would not be given.Record review of the clinical record for Resident #35 revealed an OOH-DNR with two different dates. The first date in section B - Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication was dated [DATE] and the second date in section Two Witnesses dated [DATE]. The family member signed sections that they were not supposed to, including, section A Declaration of the adult person, section C Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication, and section E Declaration on behalf of the minor person, but missed a required signature at the bottom.In an interview on [DATE] with the Social Worker, who worked at the facility for 1 month, she said she was primarily responsible for completing the OOH-DNRs. She said the legal guardian, agent, or proxy who signed the OOH-DNR, must sign, date, and print their information in the legal guardian, agent, or proxy section and the two witnesses must witness the legal guardian, agent, or proxy sign the OOH-DNR's and then the witnesses would sign, date, and print their name under the Two Witnesses section of the form. The Social Worker said OOH-DNR was not valid if it was not completed correctly. She said in November she completed an OOH-DNRs audits.In an interview on [DATE] with the ADON, who has worked at the facility for 2.5 years, she said the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	OOH-DNR's were completed by the facility's part time Social Worker and usually the ADON and DON, if the part time Social Worker was not in the building. She was not sure how the form was to be filled out correctly and said she would need some training. In an interview on [DATE] with the DON, who has worked at the facility for 1 month, she said the facility had initiated OOH-DNR training for the charge nurses, and she received training on them yesterday by the Social Worker. She said a resident would be considered full code status (meaning they would receive CPR) until the OOH-DNR was completed properly. She verified that an audit was completed on OOH-DNR's in November. She said the impact on a resident if their advanced directive was not executed properly was administering care to the residents that they did not want. Record review of the facility's Advanced Directive policy dated [DATE] revealed under the section Policy Interpretation and Implementation: Upon admission the Social Service Director/designee will determine if the resident has any advanced directives in place and will provide the residents and/or the RP with written information regarding advance directives. Advance directives that have been completed will be copied and uploaded into the resident's EHR and the EHR will be updated to reflect whether or not the resident has executed any advance directive. Social Service Director/designee will meet with the newly admitted resident or RP within 72 hours of admission to orally review and discuss the written information referenced above and the importance of planning for end-of-life care, and to verify the code status of the resident. The discussion will be documented in the EHR. The Social Service Director/designee will complete an Advance Care Planning plan of care and indicate the resident's choice regarding advance directives and code status. The social worker/designee will also ensure that: a). Ensure that a copy of any OOH-DNR is uploaded into the EHR and that a copy was submitted to the physician for timely signature; and b) An order for code status is reflected in the EHR which will read either Full Code or Do Not Resuscitate based on the resident's advance directives. Social Service Director /designee will review all advance directives in the quarterly care plan meetings. At a minimum, advance directives must be reviewed with the resident and/or RP annually and upon any change of condition. Record review of the OOH-DNR Order instructions for issuing an OOH-DNR Order revealed: Purpose: The OOH-DNR Order complies with Health and Safety Code, Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. Applicability: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics, and emergency departments. Implementation: A competent adult person, at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The OOH-DNR Order may be executed as follows: Section A - If an adult person is competent and at least [AGE] years of age, he/she will sign and date the Order in Section A. Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B. Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C. Section E - If the person is a minor (less than [AGE] years of age), who has been diagnosed by a physician as suffering from a terminal or irreversible condition, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E. In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident and to ensure facility obtained documentation from hospice for 1 of 2 residents (Resident #59) reviewed for hospice care. 1. The facility failed to ensure there was a designated member of the interdisciplinary team for hospice coordination of care. 2. The facility failed to ensure Resident #59's hospice election form and physician recertification of terminal illness for Resident #59 was available. These failures place residents at risk of lack of coordination of care and decrease in quality of care. Record Review of Resident #59's admission assessment dated [DATE] reflected Resident #59 was admitted to the facility on [DATE] with diagnoses of hip fracture, dementia (significant cognitive decline severe enough to disrupt daily life) and polyneuropathy (condition affecting multiple peripheral nerves in different body parts are damaged). Resident #59 was moderately impaired with cognitive skills for daily decision making. Resident #59 was on hospice services. Record Review of Resident #59's Hospice K book revealed there was no election form and physician certification of terminal illness for Resident #59. Interview on 12/11/2025 at 11:32 AM with the DON revealed she could not find Hospice K's election form and physician certification of terminal illness for Resident #59. She stated the risk of the facility not having resident hospice documentation could place hospice residents at risk for inappropriate care. She stated she was not sure which facility staff member was the designated hospice coordination of care person She was not aware who the hospice liaison was. Review of facility's Hospice Program policy last revised July 2017 reflected Hospice services are available to residents at the end of their life.12. Our facility has designated (blank) to coordinate care provided to the resident by our facility staff and the hospice staff.d. Obtaining the following information from the hospice:.(2) Hospice election form (3) Physician certification and recertification of the terminal illness specific to each resident . Interview on 12/11/2025 at 2:59 PM with the DON revealed the hospice policy did not have a designated staff member for hospice coordination of care. She stated the risk was the hospice residents had no one to ensure the coordination of care for their hospice services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based 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 (Resident #11) of five residents reviewed for infection control. The facility failed to ensure CNA G performed hand hygiene and changed gloves during Resident #11's incontinent care on 12/10/2025. This failure could place residents at risk of cross-contamination and development of infections. Findings include: Review of Resident #11's Face Sheet, dated 12/11/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident had diagnoses which included dementia (decline in cognitive function that interferes with daily life) and diabetes mellitus (the body does not use insulin properly which leads to elevated blood glucose levels). Review of Resident #11's Quarterly MDS Assessment, dated 11/15/2025, reflected the resident had severely impaired cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated Resident #11 was incontinent of bowel and bladder. Review of Resident #11's Comprehensive Care Plan, dated 09/22/2025, reflected Resident #11 was incontinent of bowel and bladder related to cognitive deficit. One intervention was to clean resident after each incontinence episode. During an observation and interview on 12/10/2025 at 11:12 AM, CNA F and CNA G provided incontinent care for Resident #11. The curtain was pulled around the bed to provide privacy. The supplies were on the resident's bedside table and CNA G was wearing gloves. CNA G pulled down the front of the brief and cleaned the resident. CNA F knocked on the door and entered the room to assist CNA G. CNA F washed her hands in the resident's restroom and put on gloves. CNA F assisted Resident #11 to roll to his left side. CNA G cleaned the resident's bottom and removed the soiled brief. CNA G did not change gloves. CNA G picked up the clean brief and placed it under Resident #11. CNA F assisted Resident #11 to roll to his right side and CNA G straightened the brief under the resident and secured the tabs in the front. CNA G pulled up Resident #11's blanket and covered him. CNA F washed her hands in the resident's restroom before exiting the room. CNA G removed her gloves. She did not wash her hands or use hand sanitizer before leaving the resident's room. CNA G took the bag of trash to another room on the hall. Upon exiting the room, she applied hand sanitizer from a pump on the wall. CNA G stated she knew to change gloves if the resident had a bowel movement, but was not sure, if the brief was wet. CNA G stated she should have washed her hands or used hand sanitizer after removing the gloves. CNA G stated it was important to change gloves and use hand sanitizer for infection control when providing resident care. During an interview on 12/10/2025 at 11:37 AM, LVN B stated CNA G should have washed her hands after cleaning Resident #11. She stated CNA G should have washed her hands before exiting the resident's room. She stated it was important to prevent cross contamination and infection when caring for residents. During an interview on 12/11/2025 11:05 AM, the ADON stated after cleaning Resident #11, CNA G should have removed her gloves, washed her hands or used hand sanitizer, and put on clean gloves before touching anything else. The ADON stated CNA G should have washed or sanitized her hands before exiting the room. She stated it was important to prevent skin breakdown, urinary tract infection, or any skin infection. During an interview on 12/11/2025 at 11:43 AM, the DON stated it was important to perform hand hygiene during incontinence care to prevent infection and for skin integrity. She stated the staff were provided in-service training. Record review of the facility's policy entitled Standard Precautions, revised September 2022, reflected Hand hygiene is performed with ABHR or soap and water. before and after contact with the resident. after contact with items in the resident's room. after removing gloves. Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environments.		