STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46425 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 9 of 15 confidential residents. The facility failed to ensure 9 of 15 confidential residents were provided, through postings in prominent locations; the Grievance Procedure, were provided access to the Grievance form, were provided information in regard to who the facility grievance officer was, their contact information, and how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews and Record Review during Resident Council on, 04/08/2025 at 2:30pm, 9 of confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. Nine Residents attended the meeting, the 9 Residents in attendance had all been Residents of the facility for 6 plus months. Observed prominent postings on 4/09/2025 at 3:17pm; the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available and there was no access to submit a Grievance anonymously. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 4/10/2025 at 1:14pm; the ADM stated he was the Grievance Officer for the facility. The ADM stated he was responsible for the review of Grievances and assign them to department heads. The ADM stated the Grievance form was kept at the Nurses' Station, the ADM's office, the Activity Director's Office, and all department heads should have Grievance forms. The ADM stated the Residents cannot obtain a Grievance form without asking staff for the form. The ADM stated staff complete Grievance forms for Residents, Residents do not ask for forms and complete them on their own. The ADM stated there was no procedure for Residents to submit grievances anonymously. The ADM stated the facility should resolve grievances as soon as possible once they were submitted. The ADM stated he assigned the grievance to the appropriate department, that department addresses the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated he monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated he will also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated he was responsible for ensuring staff were trained on the Grievance process. The ADM stated he was not aware the Grievance procedure was not being discussed in Resident Council. Record Review of the Grievance Policy last updated in 2017. Policy Statement: All grievances filed with the facility will be investigated and corrective actions will be taken to resolve the grievance. Policy Interpretation and Implementation: 1. The facility will make available information on how to file a grievance available to residents, family, and staff. 2. The Administrator or designed will assign the responsibility of investigating the grievance. 3. Each Resident grievance form will include the date and time and details of the grievance. 4. The Administrator or designee will record and maintain all grievances in the Grievance Log. 5. The Resident Grievance form will be filed with the Administrator or designee and the resolution will be identified within three working days of the concern. 6. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 3 working days of the filing of the grievance. 7. If during the investigation abuse, neglect, misappropriation and/or injuries of unknown source are identified, the facility will refer to the Abuse Policy. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and b. Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievances for period of no less than 3 years from the issuance of the grievance decision.

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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** 43150 Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, as well as describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 18 residents (Residents #23 and #36) reviewed for care plans in that: The facility failed to ensure that Resident #23's care plan was revised, updated, and individualized with interventions and goals to address Resident #23's vison. The facility failed to ensure that Resident #36's care plan was revised, updated, and individualized with interventions and goals to address Resident #36's vision, activities, and pressure ulcers. This failure could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized or individualized plans developed to address specific needs or concerns. Findings included: Resident #23: Record review of Resident #23's face sheet, dated 04/10/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include: dementia, high blood pressure, major depressive disorder, vitamin D deficiency, insomnia, malignant neoplasm of prostate (prostate cancer that develops when abnormal cells form and grow in the prostate gland). Record review of Resident #23's Comprehensive Minimum Data Set (MDS), dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 12, which indicated the resident's cognition was mildly impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: (CAA that triggered and not Care Planned) 16. Pressure Ulcer Section MO100. Determination of Pressure Ulcer/ Injury Risk: Clinical assessment completed and formal assessment instrument/tool. Section MO150. Risk of Pressure Ulcers/Injuries: listed as 1 meaning Resident #23 was at risk for pressure ulcers. No interview was completed with Resident #23 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36: Record review of Resident #36's face sheet, dated 04/08/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include acid reflux, type 2 diabetes, high blood pressure, osteoarthritis, urinary tract infection, retinal vascular appearance, bilateral, major depressive disorder. Record review of Resident #36's Admission's Minimum Data Set (MDS), dated [DATE], revealed: Section B1000. Vision - coded 1 = impaired - sees large print, but not regular print in newspapers/books. Section B1200. Corrective Lenses-Listed as Resident #36 had corrective lenses. Section C Brief Interview for Mental Status score revealed a score of 14, which indicated the resident's cognition was intact. Section M Skin Conditions revealed that Resident #36 was at risk for pressure ulcers but the section for pressure ulcers was left blank and incomplete. Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) 03. Visual Function 10. Activities 16. Pressure Ulcer Record review of Resident #36's care plan, dated 12/20/24, revealed no care plan for visual function. Record review of Resident #36's care plan, dated 12/20/24, revealed no care plan for activities. Record review of Resident #36's care plan, dated 12/20/24, revealed no care plan for pressure ulcers. Resident #36 was not available for interview. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/25 at 11:58 AM, the Administrator stated that care plans were updated on admission with the resident and upon occurrences. The Administrator stated that the purpose of care plans would be to provide accurate representation to provide care. The Administrator stated that the negative potential outcome for not completing care plans would be reflective to the care plan status. The Administrator stated that the system in place would be quarterly care plan meetings and randomly audit care plans upon MDS completion. The Administrator stated that he had been trained with care plans a couple of years ago and on the job training. The Administrator stated that the direct care plan staff uses the care plan. The Administrator stated that he would be responsible for overseeing the care plans. During an interview on 04/10/25 at 12:04 PM, the DON stated that she was familiar with the facility's policy on care plans. The DON stated that the purpose of a care plan would be to ensure that the resident plan of care is followed through. The DON stated that it was the instructions for how to care for the resident. The DON stated that the negative potential outcome for not completing care plans would be care not being followed through for the resident and a missed opportunity to care for the resident. The DON stated that the system in place should have been to follow up through morning meetings and completing care plans through the completion of the MDS. The DON stated that care plans should have been completed and it was important to make sure they have been completed. The DON stated that care plans were to be looked at by the IDT team to better plan for resident care. The DON stated that the MDS Coordinator should have updated the care plans. During an interview on 04/10/25 at 1:07 PM, the MDS Coordinator stated that she was familiar with the facility's policies for care plans. The MDS Coordinator stated that the purpose of a care plan is individualized for each resident for their care. The MDS Coordinator stated that the negative potential outcome of not ensuring that care plans were completed was that residents may not receive the care that they would have needed. The MDS Coordinator stated that once the MDS was completed she will make sure that the care plan was lined up with the care plan. The MDS Coordinator stated that they would have also received information about the resident in the morning meeting and she would start to make sure that the care plan reflected the resident's needs. The MDS Coordinator stated that people that use the care plans were everyone actually but mainly nursing staff. The MDS Coordinator stated that she had been trained with care planning with the Regional MDS once in the past six months. The MDS Coordinator stated that a care plan was an individualized plan of care. The MDS Coordinator stated that she was responsible for making sure that care plans were completed along with the DON and ADON. Record review of facility policy, Care Plans, Comprehensive Person Centered, date revised December 2016, revealed: Policy Statement: 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. Policy Interpretation and Implementation: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: a. includes measurable objectives and time limits. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. g. incorporates identified problem areas h. incorporates risk factors associated with identified problems. i. build on the resident's strengths. j. reflects the resident's expressed wishes regarding care and treatment goals. k. reflects the resident's expressed wished regarding care and treatment goals. l. identifies the professional services that are responsible for each element of care. j. reflects the resident's expressed wishes regarding care and treatment goals. k. reflects treatment goals, timetables, and objectives in measurable outcomes. l. identifies the professional services that are responsible for each element of care. m. aid in preventing or reducing decline in the resident's functional status and/or functional levels. n. enhances the optimal functioning of the resident by focusing on a rehabilitative program. o. reflects currently recognized standards of practice for problem areas and conditions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident's physician (or primary healthcare provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. The comprehensive, person-centered care plan is developed within 7 days of the completion of the required comprehensive assessment (MDS). 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. 14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from the hospital stay. d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43150 Resident #29 Care Planning 04/09/25 02:41 PM record review shows discrepancies' with several of the care plan not being care planned. 04/10/25 12:26 PM It was determined that resident had several triggered MDS items that were not care planned. Resident #40 Care Planning 04/10/25 12:25 PM It was determined that resident had several triggered MDS items that were not care planned. Resident #145 Care Planning

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43150 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 meal (lunch meal) reviewed for palatability, attractiveness, and appetizing. The facility failed to ensure foods were at appropriate temperatures. The facility failed to ensure proper handwashing during preparation of foods. The facility failed to provide edible (unburnt) food to residents. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and food borne illnesses. The findings included: The following observations were made on 04/09/25 at 11:05 AM during observation of lunch meal preparation: Kitchen staff member A was observed several times with handwashing throughout the cooking process and did not wash her hands for the stated 15 seconds with soap. There were several times throughout the observation process that kitchen staff member had just rinsed her hands with water and then dried her hands. Kitchen staff member A was observed at 11:21 AM, picking up potatoes and a pan with her bare hands and not properly washing hands first then she grabbed gloves and put them on. Kitchen staff member A was observed at 12:41 PM with gloves on and using her fingers to pick up brisket off the serving bar and threw the piece of brisket back on the steam table in with the other brisket. Kitchen staff member was observed serving burnt rolls to the residents. Kitchen staff member was observed using her hands to place rolls on each resident's plate. Kitchen staff member was observed picking out burnt pieces of potatoes while she was putting food on each resident's plate to be served. Kitchen staff member A had left hot dog buns open in the package for approximately 37 minutes. Observations of temperatures taken at 1:06 PM revealed: (regular plate) roast: 120 degrees, potatoes: 101. 8 degrees, carrots: 122.9 degrees. (Puree) roast: 139.6 degrees, potatoes: 149.5 degrees, carrots: 135.3 degrees, (Mechanical) roast: 108.7 degrees, potatoes: 115.3 degrees, carrots: 109.8 degrees. During a confidential interview, it was stated that food temperatures of the food served were not warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/09/2025 at 1:16 PM, ten plates were left on the table with barely any food being eaten. During an interview on 04/10/25 at 2:06 PM, kitchen staff member A stated that she had been trained in the kitchen by another staff member, nine years ago. The kitchen staff member A stated she was nervous during the observations. The Kitchen staff member A stated that the negative outcome of not following policy was that residents would not eat and then it could affect their weights and health. During an interview on 04/10/25 at 2:29 PM, the Administrator stated he expects that staff will follow the policy and ensure sanitary process is followed. The Administrator stated that the staff should follow kitchen and food safety and overall infection control. The Administrator stated that food should be edible with appearance, taste, and temperature. The Administrator stated that the outcome of not following these policies could cause illness and cross contamination. The Administrator stated that residents should receive food that were safely stored and prepared. The Administrator stated that overall, he was responsible for the staff. The Administrator stated that the staff were trained in the kitchen, and it was the responsibility of the kitchen supervisor to ensure the staff were trained. During an interview on 04/10/25 at 2:59 PM, the Kitchen Supervisor stated she expects staff to follow the policy for food temperatures and hand washing. The Kitchen Supervisor stated that if staff do not follow the policy then residents could get sick. The Kitchen Supervisor stated that she will educate staff through in-services, and she will monitor the effectiveness by closely monitoring and continue education. Record review of the facility policy and procedure titled, Food Preparation and Service, dated April 2019 reflected the following: Policy Statement: Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: 5. Food preparation staff adhere to proper hygiene and sanitation to prevent the spread of foodborne illnesses. Food Service Distribution: 6. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use. Food Preparation, cooking, and holding times: 1. The danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promote rapid growth of pathogenic microorganisms that cause foodborne illnesses. 2. Potentially hazardous foods include meats, poultry, seafoods, cut melon, eggs, milk, yogurt, and cottage cheese. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit. 4. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then recooked) may cause foodborne illness. 7. Fresh, frozen, or canned fruits and vegetables are cooked to a holding temperature of 135 degrees. Food Service Distribution: 1. Proper hot and cold temperatures are maintained during food service. Foods that are held in the temperature danger zone are discarded after 4 hours. 2. The temperatures of foods held in the steam tables are monitored throughout the meal by food and nutrition services staff. 3. Steam tables are never used to reheat food. 4. Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. 6. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use. Record review of the facility policy and procedure titled, Handwashing/ Hand Hygiene, dated August 2019 reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel should follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 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. a. Before or after coming on duty. f. Before donning sterile gloves. m. After removing gloves. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. Before and after eating or handling food. p. Before and after assisting a resident with meals. 9. The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. Washing Hands: 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 5. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 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 6 of 10 residents (Residents #41, #32, #98, #38, #195, #40) reviewed for infection control. 1. MA A failed to sanitize the blood pressure cuff between resident use for Resident #41 and Resident #32. 2. MA A failed to sanitize the blood pressure cuff between resident use for Resident #32 and Resident #98. 3. MA A failed to sanitize the blood pressure cuff between resident use for Resident #98 and Resident #38. 4. CNA C failed to utilize hand hygiene between glove changes during incontinence care with Resident #195. 5. CNA B failed to change gloves and perform hand hygiene during incontinence care with Resident #40. These failures could place residents at risk for cross contamination and infection. The findings include: During a medication administration observation on 4/09/2025 at 8:34AM MA A used the blood pressure cuff to take Resident #41's blood pressure. At 8:38 AM, MA A used the same blood pressure cuff to take Resident #32's blood pressure. No sanitation of equipment was conducted before or after using the blood pressure cuff on Resident #41 or Resident #32. During a medication administration observation on 4/09/2025 at 8:38AM MA A used the blood pressure cuff to take Resident #32's blood pressure. At 8:42 AM, MA A used the same blood pressure cuff to take Resident #98's blood pressure. No sanitation of equipment was conducted before or after using the blood pressure cuff on Resident #32 or Resident #98. During a medication administration observation on 4/09/2025 at 8:42AM MA A used the blood pressure cuff to take Resident #98's blood pressure. At 9:08 AM, MA A used the same blood pressure cuff to take Resident #38's blood pressure. No sanitation of equipment was conducted before or after using the blood pressure cuff on Resident #98 or Resident #38. Record review of Resident #195's undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident #195 had a past medical history of cerebral infarction (a type of stroke caused by a blockage of blood flow to the brain, leading to tissue damage and potential cell death), type two diabetes, and urinary tract infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #195's MDS dated [DATE] Section H- Bladder Bowel revealed she was always incontinent of bowel and bladder. During an observation of incontinence care on 4/09/2025 at 10:28 AM, CNA C cleaned Resident #195's buttocks, removed contaminated gloves, and donned clean gloves. CNA C failed to utilize hand hygiene between glove change. Record review of Resident #40's undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident 340 had a medical history of major depressive disorder, cerebrovascular disease (conditions that affect the blood vessels and blood supply to the brain), and retention of urine. Record review of Resident #40's MDS dated [DATE] Section H- Bladder Bowel revealed she was always incontinent of bowel and bladder. During an observation of incontinence care on 4/09/2025 at 11:02 AM, CNA B cleaned Resident #40's buttocks, removed dirty brief and placed clean brief on Resident #40. CNA B failed to change gloves and utilize hand hygiene prior to placing clean brief on Resident #40. During an interview on 4/10/2025 at 10:00AM with MA A, she stated the DON was the infection preventionist. She stated she had been rained on infection prevention earlier this year. She stated she had been trained to disinfect the blood pressure cuffs before and after use. She stated the potential negative outcome of not disinfection the BP cuff could be spreading infection between residents. She stated she knew she had to disinfect the BP cuff with the disinfecting wipes but forgot to do so. During an interview on 4/10/2025 at 10:30AM with CNA C, she stated the ADM was the infection preventionist. She stated she had been trained on infection control and the last training occurred March 2025. She stated she had been trained to use hand hygiene between glove changes. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be spreading infection. She stated the DON and ADON do competencies all the time and will check them off on hand hygiene. She stated she did notice she failed to wash her hands between glove changes but had forgotten to do so. During an interview on 4/10/2025 at 10:36AM with CNA B, she stated the DON and ADON were the infection preventionist. She stated she had been trained on infection prevention and her last training was approximately a month and a half ago. She stated she had been trained to change gloves when going from dirty to clean. She stated the potential negative outcome of not changing gloves when going from an area of dirty to clean could be spreading bacteria. She stated she had changed her gloves once and forgot to change them again after she cleaned the resident's bottom. (continued on next page)

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	675093	A. Building B. Wing	04/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2025 at 10:49 AM with the DON, she stated she was the infection preventionist. She stated staff were trained on infection control upon hire, quarterly and as needed. She stated she was unsure of the last training date due to having just started at this facility in January 2025. She stated there was an infection control training scheduled for this month. She stated she expected her staff to wash their hands immediately upon removing their gloves. She stated the potential negative outcome of not changing their gloves and performing hand hygiene could be the spread of infection and an outbreak. She stated staff had been trained to disinfect the blood pressure cuffs and she expects staff to disinfect the blood pressure cuffs before and after resident use. She stated the potential negative outcome of not disinfecting the blood pressure cuff between residents could be the spread of infection. During an interview on 4/10/2025 at 11:27AM with the ADM, he stated the ADM, and DON were the infection preventionist. He stated staff were trained on infection control upon hire, annually and as needed. He stated there was an infection control in-service approximately six weeks ago. He stated staff had been trained on washing their hands when changing gloves. He stated the potential negative outcome of not performing hand hygiene between glove changes could be spreading infection. He stated staff had been trained to change gloves when going from a dirty area to a clean area. He stated the potential negative outcome of not changing gloves and performing hand hygiene could be the spread of infection and contaminants. He stated staff had been trained to disinfect the BP cuff between resident use. He stated the potential negative outcome of not disinfecting the BP cuff could be the spread of contaminants and infection. Record review of facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment last revised October 2018 revealed: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard. .c. Non-critical items are those that come in contact with intact skin but not mucous membranes. (1.) Non-critical resident care items include bedpans, blood pressure cuffs . (2.) Most non-critical reusable items can be decontaminated where they are used. Record review of facility policy titled Handwashing/Hand Hygiene last revised August 2019 revealed: .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: .h. Before moving from a contaminated body site to a clean body site during resident care; . .m. after removing gloves;