STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675162	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Nursing and Rehabilitation Center	3201 N Ware Rd McAllen, TX 78501

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interviews, observations and record review, the facility failed to ensure the resident had the right to personal privacy during medical treatment for 4 (Resident #156, Resident #52, Resident #71, and Resident #133) of 7 residents reviewed for resident rights. The facility failed to ensure MA A closed the door or the curtain during medication administration for (Resident #156, Resident #52, Resident #71, and Resident #133) on 05/12/2026. This failure could place residents at risk of not having their personal privacy maintained during medical treatment.Findings included: During an observation on 05/13/2026 at 7:20 a.m., MA A kept the door and the curtain open while administering medications to Resident #156. During an observation on 05/13/2026 at 7:30 a.m., MA A kept the door and the curtain open while administering medications to Resident #52. During an observation on 05/13/2026 at 7:37 a.m., MA A kept the door and the curtain open while checking Residents #71's blood pressure. She then proceeded to administer medications which included ophthalmic (eye) medication. During an observation on 05/13/2026 at 7:49 a.m., MA A kept the door and the curtain open while checking Resident #133's blood pressure. She then proceeded to administer medications. In an interview on 05/13/2026 at 8:00 a.m., MA A stated that she was supposed to close the door and the curtain before checking the blood pressures and administering medications to Resident #156, Resident #52, Resident #71, and Resident #133. She stated that she forgot to do it. MA A stated that closing the door and the curtain was important to provide the residents with privacy. In an interview on 05/13/2026 at 8:47 a.m., ADON B stated that staff did not need to provide privacy when checking blood pressure because it was not considered invasive. She also stated that she did not believe the door or curtain needed to have been closed when administering oral medications. However, ADON B stated that privacy should have been provided, especially when administering eye drops. She stated that providing privacy was important to promote resident dignity. ADON B stated that the last in-service training regarding medication administration had been completed approximately 4-6 weeks prior. In an interview on 05/13/2026 at 2:06 p.m., the DON stated that MA A should have closed the door, the curtain, and the blinds prior to administering medications to residents unless the residents specifically requested otherwise. She stated that if resident had requested otherwise, staff ensured that it was care planned. The DON stated staff should have provided privacy when administering medications to promote dignity, as it was their right. She stated that the staff had recently been trained on medication administration and had completed a return demonstration. Record review of the facility's policy, Medication Administration dated 10/24/2022, revealed: Policy Explanation and Compliance Guidelines: 6. Explain Purpose of Visit 7. Provide Privacy 8. Obtain and record vital signs, when applicable or per physician orders. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an effective pest control program, to keep the facility free of pests for 2 (Resident #83 and Resident #57) of 8 residents reviewed for pests. The facility failed to ensure Resident #83 and Resident #57's room was free from roaches. This failure could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life.Findings included: Record review of Resident #83's face sheet dated 05/13/2026 revealed an [AGE] year-old female admitted on [DATE] with a diagnosis of Alzheimer's Disease, Dementia, Major Depressive Disorder, Senile Degeneration of Brain, Dysphagia, Unspecified Psychosis, Legal Blindness, Delusional Disorders, Hypertension(high blood pressure) and Muscle wasting and Atrophy, not elsewhere classified. Record review of Resident #57's face sheet dated 05/13/2026 revealed an [AGE] year-old female admitted on [DATE] with a diagnosis of Alzheimer's Disease, Vascular Dementia, Radiculopathy Lumbar Region, Depression, Unspecified Psychosis, Dysphagia, Hypertension (high blood pressure) and Muscle wasting and Atrophy, not elsewhere classified. During an observation on 05/11/2026 at 2:58 p.m., revealed a live roach on the floor in Resident #83 and Resident #57's restroom. This observation was pointed out to LVN F, by the time she got to the restroom it was no longer visible. In an interview on 05/11/2026 at 2:58 p.m., LVN F stated pest control came last week and sprayed for pests. She stated that she rounds every two hours and has not seen roaches. LVN F stated that roaches could be an infection control issue for the residents. In an interview on 05/11/2025 at 3:20 p.m., CNA H stated that when she first began working at this facility approximately five years ago, she would see roaches in the facility. However, she has not seen them anymore. She stated that roaches were a concern because they could negatively affect residents with respiratory issues. CNA H further stated that roaches could crawl on residents and create an infection control issue. She stated that she had not seen pest control services during her shift. In an interview on 05/11/2026 at 3:29 p.m., CNA J stated that she had not seen any roaches or other bugs in the facility. She stated that she had not seen pest control services and believed they may come during another shift. CNA J stated that it was important for the facility to not have roaches for the safety of residents because roaches carry bacteria. In an interview on 05/11/2026 at 3:34 p.m., LVN K stated that she had not seen any roaches or bugs in the facility. She stated that she had not seen pest control services. LVN K stated that it was important for the facility to remain free of roaches because it was unhygienic and unsanitary. She further stated the residents in the unit were not fully aware, and she was unsure how they would respond if they were to see a bug. In an interview on 05/13/2026 at 10:44 a.m., Maintenance Director stated that roaches or any other pests have not been an issue. He stated that it depends on the weather, and that it had been raining over the past couple of days. The Maintenance Director stated pest control had informed him that when it rains, there were usually more roaches and ants, but would go away once the rain stops. He stated he had seen the black sugar ants and roaches primarily in the 100, 200, and 600 halls, but indicated that different residents had occupied those rooms at that time. The Maintenance Director stated that one resident was dirty, and he had seen ants in his food. He stated the CNAs, nurses and other staff members were responsible for documenting sightings in the pest control binder. The Maintenance Director stated that if a resident voices a sighting he would notify the aide and the aide would document it. He stated that pest control services came every month and treated both the inside and outside of the building. The Maintenance Director stated that it was important for there not to be any roaches because they could enter through the sewage pipes or dry wall insulation and potentially come into contact with residents. In an interview on 05/13/2026 at 2:25 p.m., the administrator stated that to her knowledge, there was not a pest control issue at the facility. She stated that pest control services were scheduled for once a month, but if needed, they would come more frequently. The administrator stated that if there were any random pest sightings, staff would document them in the (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pest control book. She stated that there was a book at each nurse's station. She stated that it was important for the facility to remain free of roaches or any bugs because that was infection control issue. The Administrator stated on 05/13/2026 at 11:25 a.m. that the facility did not have a Pest Control Policy, only the contract. Record review of Pest Control sighting logbooks revealed 2 entries for the month of 05/11/2026- roach in room [ROOM NUMBER] and roach in the 500-shower room. There were 7 entries for the month of April 2026-noted roaches in rooms 104, 105, 108, 110, 301, in the 300 hall, in the 500 hall, and 3 large roaches in room [ROOM NUMBER]. Record review of Pest Control Invoice, dated 04/02/2026, revealed the following services, Regular Pest Service and Flying Insect Program. Under General Comments/Instructions: Talked to contact, looked over sighting log and inspected and treated rooms 301, 108, 104, 105, and 108. Interior . Inspected and treated all common areas, kitchen, laundry, offices, dining, employees area, hallways cleaned and replaced glue in MCTs and ILT. Exterior .Inspected and treated perimeter of building and replaced baits in rodent bait stations. Record review of the Pest Control Sales Agreement dated September 2022, revealed the following: Covered pests are cockroaches, rats, mice, and ants (exclude pharaoh, fire and carpenter ants). Exterior treatments for covered ant species are limited .The initial term of the agreements is 3 years from the date hereof and shall automatically renew for additional terms of one year thereafter.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 8 residents (Residents #2) reviewed for dignity. The facility failed to ensure Resident #2 was provided oral care on a regular basis.This failure could place residents at risk for decreased quality of life, quality of care, and self-esteem.Findings included:Record review of Resident #2?s face sheet dated 03/27/26 reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE]. Diagnoses included encephalopathy (a change in how the brain functions, including confusion or agitation. It can be temporary, or it could permanently damage the brain. It can be caused by an infection or an underlying condition. Treatment depends on the cause), altered mental status, high blood pressure, abdominal mass, kidney failure, left kidney cancer, urine retention due to obstruction, prostate enlargement, and diabetes. Record review of Resident #2?s quarterly MDS assessment dated [DATE] reflected the resident had active diagnoses including stroke, non-Traumatic and traumatic spinal cord and Brain Dysfunction, progressive Neurological Conditions, Hip and Knee Replacement, Fractures and Other Multiple Trauma, cancer, anemia, high blood pressure, kidney failure, diabetes, dementia, depression, and malnutrition. Resident #2 ?s BIMS score of 01 indicated severe cognitive impairment.Record review of Resident #2?s care plan dated 10/07/25 reflected he was admitted to hospice on 04/04/26. The goal was shift focus to achieving quality of life rather than restoration of health with intervention ordered. Interventions were Assess for pain-Provide pain management as per MD. Date Initiated: 04/04/2026. Assess, support, and be sensitive to personal, cultural and religious values, beliefs, and practices. Date Initiated: 04/04/2026. Bedside comfort case: focus all care on patient comfort. Vital signs, daily personal care, assist with ADL's provide quiet, calm environment. Acknowledge resident, speak to resident. Date Initiated: 04/04/2026. Resident #2 has an ADL self-care performance deficit r/t limited mobility, metabolic encephalopathy, hydronephrosis (kidney disease), after a motor vehicle accident. Date Initiated: 10/07/2025.Interventions included, is dependent on staff for oral hygiene. Date Initiated: 04/06/2026 Revision on: 04/06/2026 , and The resident requires (total assistance) by (X1) staff with personal hygiene and oral care. Date Initiated: 04/06/2026 Revision on: 04/06/26.Observations of Resident #2 on 05/11/26 at 3:22 pm revealed he was not responsive to voice. His eyes were closed and respirations were even and unlabored. He was wearing humidified oxygen at 2 liters per minute via nasal cannula. His mouth was partially open and had a crusted substance over his tongue and connecting his upper and lower lips. The substance was clear/brown in color. (see IMG)In an interview with CNA F and CNA G on 05/11/26 at 3:27 pm, both CNAs said hospice came in daily, had been at the facility today, and the hospice nurse was responsible for oral care. They did not know what time hospice was at the facility, who the hospice nurse was, or what the name of the hospice company was. Together, they looked at Resident #2's crusty mouth and said it did not look like his mouth had been cleaned for a while. CNA G said she thought they should clean his mouth. They said he was on hospice for a couple of months. Then CNA G said she was sure the CNAs should clean mouths.Record review of the facility policy dated 05/26/23, titled, Activities of Daily Living (ADLs) under Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living:1. Bathing, dressing, grooming and oral care. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the resident had the right to be treated with respect and dignity for 1 (Resident #28) of 8 residents reviewed for respect and dignity. The facility failed to get Residents #28's consent to search personal possessions, resulting in confiscating items without notice. This failure placed residents at risk of anxiety, frustration, and decreased quality of life. The findings included:Record review of Resident #28's face sheet dated 2/18/26 reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE]. Diagnoses included diabetes, high blood pressure, morbid obesity, eye problems related to diabetes, urine retention due to obstruction, and prostate enlargement. Record review of Resident #28?s quarterly MDS assessment dated [DATE] reflected the resident had behavioral symptoms including rejection of care that occurred 4 to 6 days, but less than daily. His BIMS score was 15, indicating he was cognitively intact, and was on a regular diet. Record review of Resident #28?s care plan dated 05/08/22, reflected he had access to order items from an on-line store and received packages from the on-line store almost daily. Interventions included, Resident #28's preferences will be respected. Date Initiated: 12/22/23. Resident #28 receives daily to QOD (four times a day) packages from an on-line store with various (unable to determine items) due to residents' privacy of mail. Date Initiated: 02/19/26. Resident #28 may at times refuse to allow staff to do room safety checks or go through his belongings Date Initiated: 07/24/25. Resident #28 wishes to be discharged to an Assisted Living facility although, discharge date more than 3 months away. Date Initiated: 05/11/2026.Record review of a grievance written by Resident #28 dated 04/16/26 reflected he was upset during a care plan meeting because his glass olive oil bottle was confiscated in early March, 2026. The item was removed without prior notification. The AA informed him the glass container was not permitted due to safety concerns. He voiced not being notified in advance of this change in regulations and requested better communication. Facility follow-up dated 04/16/26: Resident #28's olive oil was returned to him after it was poured into a plastic container. Record review of Resident #28's progress note dated 04/17/26 at 10:03 am: Note Text: Care Plan meeting held today with resident and IDT, reviewed code status, diagnoses, diet, weight, therapy, and activities. Also reviewed items he can and cannot have in his room. He had some concerns and voiced wanting to relocate to an assisted living. Record review of progress notes dated 04/01/26 to 05/12/26 revealed Resident #28 often refused care and changed appointments on his own. Observation and interview on 05/12/26 at 8:59 a.m., Resident #28 was in his room, the walls were filled with shelves loaded with various items from top to bottom. The floor was sticky and the room smelled of urine and body odor. He said he liked his room, the food, the staff, and the facility. He said the food had improved a great deal. In an interview with Resident #28 on 05/12/26 at 3:11 pm, he said he was ok with the memo about contraband but was more upset about them going through his grocery bag without his consent. He said he did not get the prohibited items list until after the facility confiscated his olive oil that was in a glass bottle in a plastic grocery bag. He said the prohibited items list was posted in the facility by the ADM on March 1, 2026. He said he placed a grocery order on March 4, 2026, that was delivered to the front desk the same day. He said he did not know about the list because he was bed bound at the time and no one told him about it or gave him a copy of it. He said no reimbursement or replacement was offered at the time. He said a month or so later, during a care plan meeting, he got the oil back after they poured it into a plastic jar he bought. He said he would have wanted to be present during the search and would have told them they could not search his bags. In an interview with the ADM on 05/13/2026 at 10:00 am, she provided an in-service sheet dated 02/10/26 titled Resident Education on prohibited items. Resident #28's name was not on the list. She said the flyer was posted on the front board after letting the residents know about the prohibited items list. She said they sent a media (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alert (not sure when) to inform the rest of the residents and a letter to families today (05/12/26). She said the poster and letter was initiated because another resident had a large glass globe he left in the dining room during an event and she was fearful it would get broken or used as a potential weapon. She said she suggested Resident #28 write a grievance regarding his concern about his groceries. She said the AA received the open plastic bag of groceries and when she set it down, she heard something that sounded like glass and could see it was a glass bottle. She said the AA removed the glass bottle (before) she took Resident #28 his grocery bags and gave the bottle to her (ADM). She said she immediately spoke with Resident #28 and he was not overly upset. She said they (Resident #28 and herself) discussed items about safety. She said he expressed being upset about the product being removed from his grocery bag without asking him first. She said she told staff not to remove items from open bags but to let her know of any questionable or contraband items. She said the product that was removed from Resident #28's grocery bag should not have been removed because it was his privacy and personal items. She said she did not remember how long it took to get the product back to him- maybe that afternoon. In an interview with the AA on 05/13/2026 at 10:27 am, she said she was asked by the receptionist to take the delivery to the resident. She said she saw through the plastic bag that there was a green glass bottle in it. She said she took out the glass bottle and told the nurse (unknown) because the residents were not supposed to have glass. She said she let Resident #28 know she removed the glass bottle and gave him a copy of ?the list' (the contraband/prohibited items list). She said he told her it was the first time he saw the list. She said he was upset by the tone of his voice. She said he said something to her about reimbursement and that was when she told the ADM. She said Resident #28 wanted to speak with her again because he was upset about the olive oil in a green glass bottle. She said she told him she took it out of the plastic grocery bag and reminded him of contraband and then he wanted reimbursement. The ADM had already been informed by the nurse and the ADM was already on her way to talk to him. She said she had taken him mail several times after that, but he never brought it up again. Record review of an in-service sign-in sheet dated 02/10/26, titled, Resident education on prohibited items did not include Resident #28's name on it. Record review of the facility's undated Prohibited Items List included: Medications (prescribed and over the counter), Sharp items (knives, blades, razors, nail clippers, etc., Cigarettes, Vapes, Cigarettes, Cigars, Hookah, and Tobacco products, Matches and lighters, Alcohol products (rubbing or drinking), Aerosol cans (Lysol, body sprays, glade, etc.), Glass items (vases, picture frames, colognes and perfumes), Weapons (guns), Laundry/Housekeeping items (Clorox, etc.), Extension cords, appliances (microwave, coffee makers, Keurig, etc.), Plug in air fresheners, no flammable items, no items to be placed on the overhead light. This list is not inclusive, and the facility has the right to remove items deemed hazardous. Facility staff will notify the responsible party when prohibited items are removed. Record review of the facility's Resident Rights manual revised 07/14/20 under Statement of Resident Rights:You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate or retaliate against you for exercising your rights. If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint with the facility administrator or with the Texas Department of Human Services by calling [PHONE NUMBER]. You have a right to: (4) be treated with courtesy, consideration, and respect; (13) access money and property you have deposited with the facility and to an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on behalf of you; (14) keep and use personal property, secure from theft or loss.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide a safe, clean, comfortable, and homelike environment, including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 8 residents (Resident #11) reviewed for resident rights. The facility did not ensure Resident #11's toilet was free from stains on 05/13/26. This failure could place residents at risk for an unsafe environment and unsanitary environment. Findings included: Record review Resident #11's admission record, dated 05/13/26, reflected a [AGE] year-old male with a readmission date of 01/19/26 and an admission date of 03/11/22. His relevant diagnoses included metabolic encephalopathy (a syndrome of global brain dysfunction caused by an underlying systemic or chemical imbalance in the body), type 2 diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels), and glaucomatous optic atrophy (a group of eye diseases that damage the optic nerve). Record review of Resident #11's quarterly MDS assessment, dated 04/23/26, reflected a BIMS score of 12, which reflected his cognition was moderately impaired. Record review of Resident #11's quarterly care plan, dated 05/06/26, reflected a problem [Resident #11] has an ADL self-care performance deficit r/t confusion, weakness, hx of falls, and osteopathy d/t hx of polio to left leg. Date initiated 01/14/24 and revised 01/20/26. Interventions included functional performance: personal hygiene: [Resident #11] requires supervision or touching assistance for personal hygiene. During an interview and observation on 05/13/26 at 10:00 a.m., Resident #11 was observed sitting in wheelchair. Resident #11 said the only concern he had was that his toilet was not clean. He said he had already complained to the housekeeping staff, but the problem continued. Resident #11 said he had noticed housekeeping was not cleaning the toilet for about one week ago. Resident #11 said it frustrated him having to see his toilet dirty. With Resident #11's permission, this surveyor inspected his restroom. The toilet bowl had black spots around the rim, one side of the base had yellow stains, hair, and was missing a bolt cover. During an interview and observation on 05/13/26 at 10:23 a.m., CNA O said would round residents every two hours and during her rounds she would ensure the residents' restrooms were clean. She said she would check to make sure there were no sharps, no spills on the floor, and that the toilet bowl and floor were clean. CNA O was observed as she looked inside Resident #11's toilet bowl and base and said, I will call the housekeeper to come clean it. CNA O said, the housekeeper had just cleaned Resident #11's room. CNA O said had not seen Resident #1's toilet dirty in the past few days. CNA O said a negative outcome to Resident #11 having a dirty toilet would be an infection control issue. During an interview and observation on 05/13/26 at 10:30 a.m., Housekeeper P said she had been assigned to Resident #11's hall on 05/12/26 and 05/13/26. She said she had just cleaned Resident #11's room, but since he was asleep, she did not clean his restroom because she did not want to wake him up. Housekeeper P did not remember if she cleaned the toilet on 05/12/26 and on 05/13/26. She first said she had not wanted to wake him up and then added that she had not been feeling well and might have forgotten to clean his toilet on 05/12/26 and 05/13/26. Housekeeper P said she had not received any complaints from Resident #11. Housekeeper P said a negative outcome to Resident #11 would be that he would complain. During an interview on 05/13/26 at 11:00 a.m., the Housekeeping Supervisor said it was his responsibility to ensure all resident's rooms were thoroughly cleaned and disinfected on a daily basis. He said he would randomly inspect resident's rooms to ensure housekeepers were doing what they were supposed to do. He said he had not checked Resident #11's room himself and had not received any complaints from him about the cleanliness of his restroom. The Housekeeping Supervisor said a negative outcome to Resident #11 would be infection control. During an interview on 05/13/26 at 11:15 a.m., the Administrator said it was the responsibility of housekeepers to ensure the residents' rooms were cleaned and disinfected daily. The (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator said it was the housekeeper supervisor to ensure the housekeepers were doing their job. She said she had not received any complaints from Resident #11 about the cleanliness of his room. She said a negative outcome to Resident #11 not having a clean toilet would be infection control. The Administrator said the facility did not have a policy related to housekeeping. She provided undated General Housekeeping Procedure used by the housekeeping department. Record review of the facility's General Housekeeping Procedure undated reflected: . 7-Step Cleaning Process:Step 5: Clean and disinfect toilet, includes the tank, seat, bowl, and base.Use a separate rag with disinfectant to wife down every areaUse [NAME] mop to disinfect inside of the bowlUse bowl cleaner only on the insure of the bowl.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure an assessment accurately reflected the resident's status for 1 (Resident #84) of 8 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #84 MDS assessment was accurately coded for Hospice Care. This failure could place residents at risk for receiving inappropriate care due to an inaccurate assessment data not reflecting their actual status and needs. Findings Included: Record review of Resident #84's face sheet dated 05/13/2026 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Pertinent diagnoses included: Alzheimer's Disease, Type 2 Diabetes (high levels of sugar in blood), Hypertension (high blood pressure), Unspecified Dementia, Anxiety Disorder, Mood Disorders. Record review of Resident #84's Comprehensive MDS assessment dated [DATE] revealed: BIMS score of 00 indicating Resident #84's cognition was severely impaired. Section O0110 - Special treatments, procedures, and programs - section K1 Hospice Care was not marked as being received. Record review of Resident #84's care plan initiated on 03/06/2026 reflected Resident #84 was under Hospice Care. Interventions included assess coping strategies and respect resident wishes, consult with physician and social services to have Hospice care for resident in the facility, and encourage support system of family and friends. Record review of Resident #84's Order Summary printed on 05/13/2026 reflected an order for Hospice Care dated 03/06/2026. In an interview on 05/12/2026 at 6:21 p.m. with MDS N, she stated that she and another MDS nurse share the responsibility for completing the facility's MDS assessments. She confirmed that she was the one who completed the MDS assessment for Resident #84 dated 03/09/2026. MDS N verified that Hospice Care was not marked on Resident #84's MDS assessment. She stated that it had been an oversight on her part. She stated that it was important for the MDS assessment to be completed accurately because it affected Hospice reimbursement and reflected that the resident was receiving Hospice services. In an interview on 05/13/2026 at 2:06 p.m., the DON stated that she had two full time MDS nurses and one part time who oversaw completion of the MDS assessments for the facility. She stated that there was oversight in place to ensure MDS assessments were completed accurately. She has quality managers review the MDS assessments to verify that no coding items were missed. The DON stated that Hospice services were discussed prior to the resident's admission. She further stated that stand up meetings were conducted at the end of the day to triple check the MDS assessments. The DON stated the MDS assessment should be completed accurately to ensure appropriate overall resident care. Record review of CMS's RAI version 1.17.1 dated October 2019 revealed section: O0110: Special Treatments, Procedures, and Programs a. On admission b. while a resident c. at discharge K: Hospice care O0100K, Hospice care Code residents identified as been in the hospice program for terminally ill persons where an array of services is provided where the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 1 (200-hall binder) of 6 controlled medication binders reviewed for pharmacy services. The facility failed to ensure controlled medications were accurately accounted for when LVN Q failed to sign the narcotic medication count sheet during shift change on 05/12/2026. This failure could place residents receiving controlled medications at risk of medication discrepancies, diversion, medication errors, and lack of accountability for controlled substances. Findings Included: Record review of the 200-hall medication aide cart-controlled substance binder revealed LVN Q failed to sign the narcotic medication count sheet during shift change (2p.m-10p.m.) on 05/12/2026 at 3:30 p.m. In an interview on 05/12/2026 at 3:40 p.m., LVN Q stated that she was responsible for signing on and off on the narcotic count sheet at the beginning and end of her shift when she received and hands off the controlled medications. She stated that two nurses were required to sign during shift change to verify reconciliation of the controlled medication count. LVN Q confirmed that her signature was missing today, 05/12/2026 on the count sheet and stated she forgot to sign it. She stated that the signatures were important to ensure accountability and verification that the controlled medications were counted by both oncoming and off-going nurses. LVN Q stated if a discrepancy was identified and she did not document that the count was completed, responsibility could fall on her. She acknowledged that failure to sign the narcotic sheet prevents an accurate audit trail for controlled medications. LVN Q also stated that she had training on documentation of controlled substances about a month ago. In an interview on 05/13/2026 at 8:47 a.m., ADON B stated that she does oversee the narcotic book and reviews it periodically, approximately a couple of times per month, while checking medication carts. She stated that staff received education regarding controlled medication documentation upon hire and during medication administration training. She said she also conducts ongoing checks year-round to ensure staff correctly log controlled medications in and out of the narcotic book. ADON B stated that maintaining accurate controlled medication counts and identifying if any medications were missing. She further stated that discrepancies could indicate possible drug diversion and would require investigation. ADON B stated that staff were instructed to count the controlled medications before accepting the medication cart and to avoid correcting discrepancies prior to verifying the count themselves. In an interview on 05/13/2026 at 2:06 p.m., the DON stated the ADONs oversee the controlled medications books and routinely monitor them throughout the day. She stated the nurses were instructed not to leave their shift until the controlled medication count has been completed. The DON stated that the facility operates on three shifts and that whichever nurse assumes responsibility for the medication cart was required to sign the controlled medication book when taking over and handing off the cart. She stated the policy emphasizes the importance of completing and documenting the narcotic count to ensure the count was properly performed and verified. The DON stated that if the count was not signed, it would be considered incomplete. She stated that LVN Q was new but knows that she was required to sign the narcotic count sheet. She stated that signatures were important because they provide proof that the controlled medication count was completed. Record review of the facility's policy titled Documentation of Controlled Substance dated 10/01/2019 revealed Policy: Medications included In the Drug Enforcement Administration (DEA), classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Controlled Substances Record documentation will be maintained accurately. Definition: The controlled substances record refers to the document(s) utilized to track controlled substances on a shift-to-shift basis from the point of receipt through destruction/discharge. These documents may also be referred to as controlled substance book or (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	proof of use sheet. Procedure: 4. Medications listed in Schedule II, III, IV, and V, are stored under double lock in a locked cabinet, medication cart drawer, or safe designated for that purpose, separate from all other medications. Controlled substance keys are kept on a separate key ring and are always in the possession of the Licensed Nurse or Certified Medical Aide who has been designated responsible for medication administration and signed for those controlled substances and the Controlled Substances Record at the change of shift. 7. Two Licensed nurses or Medical Aide or combination thereof, are responsible to complete a count of all controlled substances at the change of shift or any time that the narcotic keys are surrendered from one nurse to another. 8. A licensed nurse or medical aide on the shift reporting for duty counts all medication with the licensed nurse or medical aide going off duty. The nurse coming on duty should be overseeing both the Controlled Substances Record and each sealed unit dose card The licensed nurse or medical aide on both shifts will ocunt and sign the Controlled Substances Record in each others presence. If there is a discrepancy in the count, DO NOT SIGN the record. Report the discrepancy to the supervisor or the Director of Nursing immediately. 9. THE LAST SIGNATURE IN THE CONTROLLED SUBSTANCES RECORD WAS RESPONSIBLE FOR THE COUNT.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were secured and stored securely, maintained within their expiration dates, and labeled properly in accordance with currently accepted professional principles and standards for 1 of 2 medication carts (500 Hall Medication Cart) and 2 of 2 medication storage rooms (500 Hall Medication Storage Room and 600 Hall Medication Storage Room) reviewed for labeling and storage. The facility failed to dispose of a bottle of over the counter (OTC) anti-acid tablets from the 500 Hall Medication Cart which had an open date of 05/02/25. The facility failed to properly label a vial of lidocaine (local anesthetic medication used to induce temporary numbness or loss of feeling in specific skin areas) with an open or expiration date from the 500 Hall Medication Cart. The facility failed to ensure expired medications that were to be disposed of were placed in a locked cabinet from the 500 Hall Medication Storage Room. The facility failed to properly label a box of opened OTC sore throat lozenges and an opened box of OTC anti-diarrhea tablets with open dates from the 600 Hall Medication Storage Room. This failure could place the residents at risk of gaining access to unlocked medications that were not prescribed to them and place the facility at risk of drug diversion. Findings included: In an observation and interview on 05/12/26 at 3:06pm of the 500 Hall Medication Cart, a bottle of OTC anti-acid tablets was discovered to have an open date of 05/02/25. RN D stated medication carts should not have any expired medications in them. RN D stated that the carts should have been reviewed at the beginning and end of each shift. RN D stated it was important not to have expired medications in the cart because medications could have been given to residents, and it could have damaged their health. In an observation and interview on 05/12/26 at 3:09pm of the 500 Hall Medication Cart, a vial of lidocaine was discovered not to have an open date or an expiration date. RN D stated that the lidocaine vial should have been placed in a box or clear bag with a label on it. RN D stated it was important to properly label medications with open or expiration dates because it placed residents at risk of receiving expired medications and could have caused harm. In an observation and interview on 05/12/26 at 3:18pm in the 500 Hall Medication Storage Room, there was an unlocked cabinet which contained expired medications. RN D stated the medications were expired medications that needed to be disposed of. RN D stated he knew medications were supposed to be locked but did not know why they were not in the indicated locked cabinet. RN D stated it was important to have expired medications locked because nurses could accidentally administer those medications to residents, which in turn could have harmed residents. In an observation and interview on 05/12/26 at 3:29pm in the 600 Hall Medication Storage Room, there was an open box of OTC sore throat lozenges with no open date and an open box of OTC anti-diarrhea tablets with no open date. RN E stated he was unaware of the opened boxes. RN E stated it was important to have open dates because one needed to know the shelf life of the medication. RN E stated that an effect on not having an open date on medications was that the medication could be expired and if given to residents, residents could have a decline in their health. RN E stated medications rooms were checked and cleaned out monthly. During an interview on 05/13/26 at 9:55am ADON C stated she oversaw Hall 500 and Hall 600. ADON C stated OTC anti-acids were good for a year after an open date, then they needed to be discarded. ADON C stated that all medications that were for destruction had to be under lock and key. ADON C stated that all medications had to have an open date at the time the medication was opened. ADON C stated medication carts get checked for expired and unlabeled medications on a weekly basis. ADON C stated it was the responsibility of all the nurses to check for those things. ADON C stated that the medication rooms were also checked on a weekly basis to keep it as clear as possible. ADON C stated nurses were frequently reminded to check for expired medications and medications not labeled properly. During an interview on 05/13/26 at 1:50pm the DON stated medication carts and medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms are constantly being checked. The DON stated that the pharmacist and the pharmacist technician also assist with checking. The DON stated that the manager on duty checked and logged whatever needed to be discarded and placed it into the proper cabinet. The DON stated in-services (teachings) had already been started on checking for expired medications and ensuring all medications were properly labeled. Record review of the facility's Expiration Dating and Expired Medications policy, dated revised 10/01/19, revealed Procedure 1. All medications received from the pharmacy will have an expiration or beyond use date clearly stated on the label or medication container. 5. For multi-dose vials of injectable drugs: A. Date and initialed when opened 8. It is the responsibility of all nurses who administer medications to monitor for the expiration dates of the medications. Expired medications will not be administered in the facility. All expired medications will be disposed of per Facility policy. Record Review of the facility's Discontinued Medications policy, dated revised 03/22/23, revealed Procedure 2. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until disposed of or returned to the pharmacy if credit is allowed. Medications are removed from medication cart immediately upon receipt of an order to discontinue to avoid inadvertent administration.

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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 on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #2 and #4) of 8 residents reviewed for infection control practices. The facility failed to ensure: CNA F and CNA G performed hand washing or change gloves during peri care on Resident #2. -oxygen tubing and humidifier bottle was labeled, dated, in a protective sheath, and kept off the floor for Resident #2. -foley bags were kept off the floor for Resident #2 and Resident #4. These failures could place residents at risk of exposure and/or possible transmission of communicable diseases and infections. The findings included:1.Record review of Resident #2?s face sheet dated 03/27/26 reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE]. Diagnoses included encephalopathy (a change in how the brain functions, including confusion or agitation. It can be temporary, or it could permanently damage the brain. It can be caused by an infection or an underlying condition. Treatment depends on the cause), altered mental status, high blood pressure, abdominal mass, kidney failure, left kidney cancer, urine retention due to obstruction, prostate enlargement, and diabetes. Record review of Resident #2?s quarterly MDS assessment dated [DATE] reflected the resident had active diagnoses including stroke, non-Traumatic and traumatic spinal cord and Brain Dysfunction, progressive Neurological Conditions, Hip and Knee Replacement, Fractures and Other Multiple Trauma, cancer, anemia, high blood pressure, kidney failure, diabetes, dementia, depression, and malnutrition. Resident #2?s BIMS score of 01 indicated severe cognitive impairment. Record review of Resident #2?s care plan dated 10/07/25 reflected the following care areas:-Resident #2 has an ADL self-care performance deficit r/t limited mobility, metabolic encephalopathy, hydronephrosis (kidney disease), after a motor vehicle accident. Date Initiated: 10/07/2025. Interventions included, The Resident is dependent on staff for personal hygiene. Date Initiated: 04/06/2026. -Resident #2 has the need for Enhanced Barrier Precautions due to: (Foley catheter) Assist with ADL care as indicated Date Initiated: 10/28/2025.Interventions included, Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high-contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as indicated. Date Initiated: 10/28/2025 -Resident #2 has infection bacterial MRSA (Methicillin-resistant staphylococcus aureus-a type of staph bacteria resistant to several common antibiotics.MRSA is very contagious, spreading through skin-to-skin contact or touching contaminated objects, surfaces, and personal items, affecting both patients and healthy individuals) Date Initiated: 04/02/2026 Revision on: 04/06/2026. -Resident #2 has a (Foley) Catheter: Terminal condition Grade 4 clear cell renal cell carcinoma/Urinary retention/BPH.Date Initiated: 10/17/2025 Revision on: 01/09/2026Interventions included, Position catheter bag and tubing below the level of the bladder and away from entrance room door.Date Initiated: 10/17/2025-Resident #2 is at risk for shortness of breath (SOB) r/t Anxiety, Decreased energy and fatigue, Decreased lungExpansion Date Initiated: 04/06/2026Interventions included Admin O2 as ordered to maintain o2 saturation at or above 92% Date Initiated: 05/11/2026.Record review of Resident #2's active physician orders dated 03/27/26 documented: -Change O2 tubing every week on Sunday and PRN.-03/27/26: Monitor that collection bag is off the floor and hung below bladder level every shift. -- Observations on 05/11/26 at 3:22 pm, revealed Resident #2 was in his room in bed, unsheathed oxygen tubing was on the floor attached to the resident via nasal cannula. The oxygen concentrator had a bottle for humidification. Neither the oxygen tubing nor the humidifier bottle was labeled, dated, or initialed. Resident #2's foley catheter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag was lying on the floor, next to and slightly under the bed. CNA F and CNA G were starting incontinent care on Resident #2. CNA G slid the foley bag out of her way. Neither of them washed their hands prior to donning gowns & gloves per EBP guidelines. Using his drawsheet, Resident #2 was turned to his left side by CNA F. CNA G performed peri care using single wipes x4. She did not change her gloves after discarding the soiled wipes. Utilizing his drawsheet, Resident #2 was turned to his right side by CNA G. CNA F gathered and discarded Resident #2's soiled brief and without changing gloves, she placed a clean brief under Resident #2. Resident #2 was returned to his back by CNA G. Still using his same drawsheet, Resident #2 was repositioned up in his bed by both CNAs. They touched his pillow, smoothed his clothing, and replaced his bed covers while still wearing soiled gloves. In an interview with CNA F and CNA G on 05/11/26 at 3:27 pm, CNA G said she was supposed to change her gloves. CNA F said she did not change gloves either because they like to clean him quickly because he's on oxygen. Neither could verbalize the process required for peri care. CNA G said she did not notice the foley catheter bag on the floor. CNA F said the O2 tubing was supposed to be in a bag, and off the floor, because of contamination. They said Resident #2 was on hospice for a couple of months. They both said they received training for peri care and neither could say when their most recent training was. 2. Record review of Resident #4's face sheet dated 04/19/26 reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE]. Diagnosis included urine retention. Record review of Resident #4?s quarterly MDS assessment dated [DATE] reflected the resident had an active diagnosis of in-dwelling foley catheter due to obstructive uropathy Resident #4?s BIMS score of 09 indicated moderate cognitive impairment. Record review of Resident #4?s care plan dated 05/02/22 reflected he was dependent on staff for all ADL's. Resident #4 has an Indwelling Foley Catheter r/t Urinary Retention and Obstructive Uropathy. Date Initiated: 04/20/2026 Revision on: 05/06/2026. Record review of Resident #4's active physician orders dated 04/20/26 indicated: *Indwelling Urinary Catheter: Irrigate catheter with (30mls) of NS as needed, Indwelling Urinary Catheter: Change 18F catheter as needed, insert Foley Catheter 16F with 30cc balloon every shift for urine retention related to retention of urine, monitor that collection bag is off the floor and hung below bladder level every shift. *Ciprofloxacin Tablet 500 MG (milligrams) Give 1 tablet via G-Tube every 12 hours for UTI (urinary tract infection) for 5 days 5/10/26. Observations and interview with Resident #4 in his room on 05/12/26 at 9:50 am, revealed his foley catheter collection bag was laying on the floor, and the privacy bag was hanging on the siderail of his bed. The collection bag was in view of the hallway through the door. Resident #4 was unable to describe why or how long he had a foley catheter. Resident #4 had an IV (intravenous catheter) in his left wrist for antibiotics due to an URI (upper respiratory infection) and was receiving another antibiotic via PEG for a UTI (urinary tract infection). In an interview with ADON C on 05/13/2026 at 11:20 am, she said she had been the ICP (Infection Control Preventionist) at this facility since Feb. 2026. She said O2 should never be on the floor, should always have a sheath, and always be labeled and dated. She said they only changed humidifiers before they were empty, but they should always be dated. She said both enteral feeding and the water had to be dated and labeled. She said every 2 halls had an ADON and everyone was responsible for labeling and dating tubing. She said the managers did rounds every morning; 4 ADON's, 1 DON, ADM, MDS, SW. She said she was assigned to the 600 hall and she checked infection control. She said she should be checking the entire facility-IV's, Foley's, Tubing, oral care, privacy bags and collection bags, etc. She said the managers did check-offs on peri care about every three months. She said all staff had to change gloves in between clean & dirty areas. She said she trained staff upon hire and monthly. She said the facility did not have a policy regarding oxygen tubing. In-services for infection control were requested at this time but not received. In an interview with LVN L and LVN M on 05/13/26 at 1:38 pm, LVN L said she was the full-time treatment nurse at the facility. LVN L and LVN M both said they were not involved in training staff for infection control. They said staff received in-services from ADON C regarding infection control, but did not know how often or when the most recent training occurred. They both said staff should at least follow (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the guidelines for infection control when performing peri care or anything else that required gloves, gowns, face shields; any kind of precautions; EBP or isolation. They both said dirty or soiled gloves should never be used-they should be discarded and depending on the level of soil on the dirty gloves, alcohol based hand rub could be used or soap and water hand washing per standards (meaning >20 seconds). Record review of the undated facility document titled, [NAME] Nursing Procedures, eighth edition, Evidence-Based Bedside Care page 360, Special Considerations for humidifiers. Replace a bedside humidifier unit every 7 days or as determined by your facility.page 387, Indwelling urinary catheter care. Do not place the drainage bag on the floor, to reduce the risk of contamination and subsequent UTI. Record review of the facility policy dated 11/24/25, titled, Enhanced Barrier Precautions under Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions:Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.4. High-contact resident care activities include: d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: .urinary catheters.h. Wound care: any skin opening requiring a dressing. 9. Additional epidemiologically important MDROs may include, but are not limited to: Methicillin-resistant Staphylococcus aureus (MRSA). Record review of the facility policy dated 10/24/22, titled, Perineal Care under Policy Explanation and Compliance Guidelines:6. Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate. 10. Re-position resident in supine position. Change gloves if soiled and continue with perineal care. Record review of the facility policy dated 05/13/23, titled, Infection Prevention and Control Program under Policy Explanation and Compliance Guidelines: l. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 4. a All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed accordance with our facility's established hand hygiene procedures. Record review of the facility policy dated 10/24/22, titled, Hand Hygiene under Policy: All staff will perform hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub, also known as alcohol-based hand rub. 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.