STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675437	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Live Oak	8221 Palisades Drive Live Oak, TX 78233

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents had the right to send and receive mail, and to receive letters, package and other materials delivered to the facility or the resident through a means other than a postal service, including the right to privacy of such communications for 9 of 9 residents (confidential residents) reviewed for resident rights. The facility failed to ensure staff distributed mail received on Saturdays to the residents. This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life. The findings were: During a confidential resident group meeting 9 of 9 members in the group stated they never received mail on Saturdays because the Business Office didn't work on Saturdays but they did have a receptionist. During an interview on 05/23/25 at 10:12 am, with the Receptionist and Business Office Manager, the Receptionist stated he worked for the facility Monday to Friday as well as weekends. The Receptionist stated the Business Office Manager ensures mail is delivered to the residents daily from Monday to Friday. The Receptionist stated that mail delivery is inconsistent but if a package arrives, he makes sure to deliver it to the resident that day. If there are letters delivered, he puts it in the Business Office to sort out. During the interview on 05/23/25 at 10:12 a.m., the BOM stated mail delivered on a Saturday should be distributed on Saturday and told the Receptionist to go ahead and distribute any mail that had the resident's name on it.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Residents #32) of 8 residents reviewed for care plans. The facility failed to implement Resident #32 care plan to have his lateral supporting positioning device in order to assist with his upright posture to eat. This failure could place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. The findings included: Record review of Resident #32's admission record, accessed 05/20/25, reflected Resident #32 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include adult failure to thrive (decline seen in elderly individuals), protein-calorie malnutrition, dementia (group of symptoms affecting memory, thinking, and social abilities), lack of coordination, and major depressive disorder. Record review of Resident #32's quarterly MDS assessment, dated 02/12/25, reflected Resident #32 had a BIMS score of 10 out of 15, indicating moderate cognitive impairment. It reflected no weight changes in the past 6 months. Record review of Resident #32's comprehensive care plan reflected At times, [Resident #32] allows the staff to put a wedge on the right side of his chair to prevent him from leaning when eating his meal .[Resident #32] has lateral supporting positioning device attached to regular chair for meals to assist with upright posture while eating., revised 04/08/25. Dining observation for 05/20/25 lunch meal service started on 05/20/25 at 12PM. Interview and observation on 05/20/25 at 12:37 PM, Resident #32 was leaning to the right side of his wheelchair and had not touched his lunch meal. He revealed he was unable to sit upright to eat his lunch meal. He revealed he had a cushion for his chair to help him sit correctly. Interview and observation on 05/20/25 at 12:39 PM, Human Resources (HR) revealed she helped with meal service, but not all the time. She revealed she was not aware if Resident #32 needed a cushion while he was sitting down to eat. She revealed she would have to ask therapy. She proceeded to ask therapy person present at lunch meal service and this therapy person had to ask the director of therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 05/20/25 at 12:45 PM, Resident #70 revealed Resident #32 always had a cushion in his chair so he can sit up right at meals. She revealed it was important for him to have it so he can complete his meals. She revealed Resident #32 might get tired from leaning and trying to eat. Resident #70 revealed she was aware of this because she used to sit with Resident #32 all the time. Interview on 05/20/25 at 12:47 PM, ST N revealed Resident #32 typically did have cushion on his chair while eating to sit upright. Observation on 05/20/25 at 12:49PM, COTA O brought a cushion for Resident #32 and repositioned him at his table. Observation on 05/22/25 at 12PM revealed Resident #32 had a cushion on his chair and was sitting upright for lunch. Interview on 05/23/25 at 11:31 AM, CNA G revealed Resident #32 sat in his wheelchair and would slant to his side. She revealed he had a cushion that he used during meals because he leaned over and could not eat food properly. She revealed it was the therapy department's responsibility to communicate this with the staff. Interview on 05/23/25 at 12:58PM, the DOR revealed Resident #32 did need a cushion while eating because it helped him sit properly while eating. She revealed sometimes he did not need the cushion. She revealed this should be reflected in the care plan so the nurses knew how to care for resident. Interview on 05/23/25 at 01:55PM, the DON revealed she was not sure if cushion should be in the care plan, but nurses used the care plans in order to know how to care for resident. During exit conference on 05/23/25 at 05:00PM, the ADM revealed it was care planned for Resident #32 to use his cushion as needed and not all the time. Record review of facility's policy Comprehensive Care Plans, dated 02/10/2021, reflected It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 3 of 22 residents (Resident #11, Resident #92, and Resident #30) reviewed for accidents and hazards: 1. The facility failed to ensure Resident #11 did not have a large pair of nail clippers, and a pair of tweezers in her room. 2. The facility failed to ensure Resident #92 did not have a pair of sharp scissors and a disposable razor on her bedside table. 3. The facility failed to ensure Resident #30 did not have all-purpose cleaner in her restroom. These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: 1. Record review of Resident #11's face sheet dated 5/21/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included lack of coordination, dementia (a decline in cognitive function that interferes with a person's daily life and activities) with behavioral disturbance, age-related nuclear cataract (a type of cataract that develops in the center of the eye's lens making it harder to see clearly, especially in low light or when facing bright lights), and chronic pain. Record review of Resident #11's most recent quarterly MDS assessment dated [DATE] revealed the resident was able to see in adequate light, used corrective lenses, and was cognitively intact for daily decision-making skills. Record review of Resident #11's comprehensive care plan with revision date 3/5/25 revealed the resident had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner with interventions that included for supervision with personal hygiene and to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. During an observation and interview on 5/20/25 at 10:15 a.m., Resident #11 had a large pair of nail clippers and a pair of tweezers on the resident's bedside table next to her recliner on the right. Resident #11 stated she trimmed her own nails but did not or would not indicate if staff were aware she was in possession of the items. Observation on 5/21/25 at 8:32 a.m. revealed Resident #11 sitting up in her recliner with a large nail clippers and tweezers on the bedside table to the right of the resident's recliner. Observation on 5/22/25 at 8:28 a.m. revealed Resident #11 sitting up in her recliner with a large nail clippers and tweezers on the bedside table to the right of the resident's recliner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/22/25 at 11:21 a.m., CNA E acknowledged there were no residents in the facility she was aware of that could trim their own nails. CNA E stated she was very familiar with Resident #11 and she was stable enough to cut her own nails but would prefer to observe the resident cutting her nails. CNA E further stated the facility did not use tweezers. CNA E observed a large pair of nail clippers and a pair of tweezers on Resident #11's bedside table to the right of the resident's recliner. CNA E stated, she would question a resident having a pair of nail clippers, and if she was not sure they weren't supposed to have them would then notify the nurse. CNA E could not or would not directly acknowledge if Resident #11 could have the large pair of nail clippers or the tweezers in her possession. During an observation and interview on 5/22/25 at 11:34 a.m., RN F acknowledged the facility CNAs were responsible for providing ADL supervision such as shaving, showering, peri-care and nail care. RN F stated, unless the resident was a diabetic, then only the nursing staff could provide the residents with nail care. RN F stated she was not aware of any resident who was allowed to cut their nails or shave without supervision. RN F stated, Resident #11 was stable to do most of this stuff but would prefer to supervise the resident if she wanted to cut her nails. RN F stated the facility did not use tweezers. RN F observed a large pair of nail clippers and a pair of tweezers on Resident #11's bedside table to the right of the resident's recliner and stated the items observed needed to be removed. During an observation and interview on 5/22/25 at 11:40 a.m., ADON B, after seeing the State Surveyor and RN F in Resident #11's room stated to Resident #11 she could keep the tweezers as it was the resident's right to keep them but told the resident the nail clippers needed to be removed and would be stored away for her. During an interview on 5/22/25 at 11:41 a.m., ADON B stated, Resident #11 had a high BIMS score and was alert and oriented and could therefore keep the nail clippers. ADON B further stated, in this resident's case (Resident #11), she is alert and oriented and she could manage it. ADON B stated she did not know what the facility policy was for having the items in the resident's room, including tweezers and nail clippers. During an interview on 5/22/25 at 12:09 p.m., CNA G stated, nobody here can cut their own nails. I don't even cut a resident's nails; I always refer them to the nurse. CNA G further stated residents were not allowed to have nail clippers and the facility did not use tweezers. CNA G stated, those items could cause a resident to cut themselves. During an interview on 5/22/25 at 12:23 p.m., the DON stated, a resident's possession of scissors, nail clippers, tweezers, or disposable razors depended on the resident's BIMS score. The DON further stated she would refer a resident to the podiatrist if the resident were a diabetic. The DON stated it was a resident's right to have those items in their room. The DON then stated the facility had Ambassadors assigned to resident rooms who were supposed to check every morning and were supposed to be looking for those items. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/25 at 2:53 p.m., the DOR acknowledged she was assigned as a Quality of Life Specialist (Ambassador) and had been tasked with making rounds of resident rooms, including Resident #11. The DOR stated, part of the assigned rounds was to check for broken items, trash, and prohibited items, such as disposable razors. The DOR stated she was not aware of residents who were allowed to have disposable razors, scissors, or nail clippers. The DOR stated, those items were not safe for the residents to use on their own and would need help to use those items. The DOR stated, somebody else could wander in the room and have access to them (nail clippers, razors, scissors) and it was a potential for an accident. The DOR stated she had made rounds in Resident #11's room and did not recall seeing the large nail clippers or the tweezers, and further stated, I did not even think about it, but one of the things I do look for is disposable razors. The disposable razors should not be in the rooms, they should be disposed of in a sharp's container for safety reasons. Somebody who did not know how to use it could hurt themselves or cut themselves with it. 2. Record review of Resident #92's face sheet, dated 5/21/25, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included lack of coordination, contracture of muscle, and muscle weakness. Record review of Resident #92's most recent quarterly MDS assessment, dated 3/2/25, revealed the resident cognition was moderately impaired for daily decision making. Section GG revealed she required partial/moderate assistance with personal hygiene. Record review of Resident #92's comprehensive care plan with revision date 3/27/25 revealed the resident had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner. Performance deficit is related to fracture of sacrum (break of the bone at the back of the pelvis between the hip bones) pain, neuropathy, cauda equina syndrome (a medical emergency that happens when an injury or herniated disk compresses nerve roots at the bottom of your spinal cord. The cauda equina nerves communicate with your legs and bladder. It causes back pain, weakness, and incontinence), unilateral inguinal hernia (occurs when tissue, such as part of the intestine, protrudes through a weak spot in the abdominal muscles), history of falling, muscle weakness, loss of coordination with interventions that included extensive assistance with personal hygiene. Record review of Resident #92's comprehensive care plan with revision date. 3/27/25, revealed resident has a behavior problem as evidenced by: Resident was angry that she can no longer perform ADLs without assistance and will last out at staff and her friend that comes to visit with an intervention to Approach resident in a calm manner, call by name, speak slowly, and maintain eye contact. Talk while providing cares, allow time for a response, and do not rush. During an observation and interview on 5/20/25 at 1:10 p.m., Resident #92 had a small pair of sharp scissors on her bedside table and a disposable razor. Resident #92 stated she used the scissors to cut candy because I can't eat it directly and eat it with scissors. Resident #92 stated she could not think of what she wanted to say because her memory was not good. During a follow up observation and interview on 5/22/25 at 10:17 a.m. revealed Resident #92 was lying in bed. Her items on her bedside table had been rearranged and straightened up. The pair of scissors and disposable razor were still on the bedside table. Resident #92 stated she could use the razor to shave but could only use one had to shave because the other hand was crunched up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/25 at 10:19 a.m. the Staffing Coordinator stated all staff can check resident rooms for items they should not have. The Staffing Coordinator stated Resident #92 does not shave herself. The Staffing Coordinator stated the resident should not have the razor at her bedside table, an aide should have been assisting the resident with shaving, and then dispose of the razor in the sharp's container located in the residents in room bathroom. The Staffing Coordinator stated he was unsure where the scissors came from and picked them up and removed them from the room. The Staffing Coordinator stated he thought the razor and scissors came from family because the razor was not the same color as the razors the facility used. The Staffing Coordinator stated he would call to inform the family that the resident was not allowed to have those items. 3. Record review of Resident #30's admission record, accessed 05/20/25, reflected Resident #30 was a [AGE] year old female admitted to the facility on [DATE] with diagnoses to include lack of coordination, major depressive disorder, mild cognitive impairment, altered mental status, and age-related nuclear cataract (a type of cataract that develops in the center of the eye's lens making it harder to see clearly, especially in low light or when facing bright lights). Record review of Resident #30's quarterly MDS assessment, dated 02/14/25, reflected Resident #30 had a BIMS score of 15 out of 15, indicating intact cognition. able to see in adequate light and used corrective lenses. Record review of Resident #30's comprehensive care plan reflected [Resident #30] has impaired cognition and is at risk for further decline in cognitive and functional abilities related to: altered mental status ., revised 02/28/24, with interventions to include, Monitor for changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness . Interview and observation on 05/20/25 at 11:19 AM, Resident #30 had an all-purpose cleaner on the lower shelf of an open faced cabinet in her restroom. Resident #30 revealed she had seen the cleaner in her restroom and believed it was left there by housekeeping. Interview and observation on 05/20/25 at 11:22 AM, Housekeeper H confirmed there was an all-purpose cleaner in Resident #30's bathroom, but it did not belong to housekeeping because they clean with different sprays and put them back on her cart so that the residents don't hurt themselves. Interview and observation on 05/20/25 at 11:26 AM, the Housekeeping Supervisor revealed the all-purpose cleaner observed in Resident #30's restroom was the resident's property so housekeeping did not touch this cleaner. Interview and observation on 05/20/25 at 11:32 AM, LVN I revealed chemicals were not allowed in residents' rooms. She revealed sometimes family brought items in for Resident #30, but Resident #30 did not have any visitors today. LVN I revealed she expected her CNA to tell her about this. LVN I proceeded to take the all-purpose cleaner out of Resident #30's room and would inform family this was not allowed. Interview on 05/22/25 at 12:25 PM, the DON revealed no resident should have chemicals like all-purpose cleaner. She revealed every staff member oversaw seeing any prohibited items and taking them out of the residents' rooms as needed, even if families bring the items in the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/23/25 at 11:31 AM, CNA G revealed residents were not allowed to have all-purpose cleaner in their room and if she saw this, she would take it away for resident safety. She revealed she would report to nurse so the nurse could educate family if it was family that brought it in. Record review of the facility policy and procedure titled, Nail Care, revision date 1/1/25 revealed in part, . Purpose: To provide for personal hygiene needs and prevent infection .13. Return equipment to designated area and clean/dispose as indicated . Record review of the facility policy and procedure titled, Resident Rights, review date 2/20/21 revealed in part, .Policy: The facility will inform the resident both orally and in writing in language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility,,,Safe environment .The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 of 5 residents (Resident #66) reviewed for incontinent care: The facility failed to ensure CNA K provided incontinent care to Resident #66 in the order of cleanest to dirtiest, performed hand hygiene between glove changes, and CNA L changed her gloves and performed hand hygiene after touching soiled linen. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. Findings Included: Record review of Resident #66 admission record, dated 5/23/25, revealed an [AGE] year-old female resident admitted on [DATE] with diagnoses including dementia, enterocolitis due to clostridium difficile (a highly contagious bacterium that causes diarrhea), bacteremia (bacteria in bloodstream), and stage 3 chronic kidney disease (mild to moderate damage to the kidneys causing them to filter less waste and fluid from the body) . Record review of Resident #66's quarterly MDS assessment, dated 4/16/25, revealed the resident cognition was severely impaired for daily decision making. Section H revealed the resident was always incontinent of bladder and bowel. Record review of Resident #66's care plan, revised 3/27/25, revealed a care area for Resident #66 was incontinent of bowel/bladder related to limited mobility with an intervention to check frequently for wetness and soiling, and changing as needed. During an observation on 5/22/25 at 3:17 p.m. CNA K and CNA L provided incontinent care to Resident #66. CNA K and CNA L washed their hands and put on gloves. CNA K cleaned the resident's vaginal area, removed her gloves, did not sanitize her hands, and put on new gloves. CNA K and CNA L then turned Resident #66 to her side and CNA K cleaned her buttocks area. CNA K removed the brief from under resident #66 and threw it away. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. Resident #66 began to have a bowel movement and CNA K wiped her buttocks area again while rolling a pad up under her. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. CNA K then opened a new brief and put in on the resident. CNA K then applied barrier cream to the resident's buttocks. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. Both aides then turned the resident to her other side and CNA L then removed the soiled pad out from under the resident. CNA K then applied barrier cream to the resident's vaginal area. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. CNA L was wearing the same gloves from the start of the care then touches and fastens the new clean brief on Resident #66. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 5/22/25 at 3:27 p.m. CNA K and CNA L stated they perform hand hygiene by washing their hands prior to starting incontinent care and after it is complete. Both aides stated if their gloves become soiled or torn then they would need to perform hand hygiene. CNA K and CNA L stated to their knowledge they do not need to perform hand hygiene in between glove changes and never had training to sanitize their hands between glove changes. CNA L stated she did not think she needed to change her gloves after touching the soiled pad because her gloves were not visibly soiled. They both stated they had training for incontinent care as recent as two weeks prior. During an interview on 5/22/25 at 3:31 p.m. the Nursing Supervisor stated he was one of the staff responsible for training aides on incontinent care. The Nursing Supervisor stated staff had training to perform hand hygiene prior to providing care, after care, anytime hands are visibly soiled, or between glove changes. The Nursing Supervisor stated staff had little bottles of hand sanitizer they could take into the room with them during care. The Nursing Supervisor stated staff should clean the resident from cleanest to dirtiest and apply creams to the vaginal area first and then the buttocks to prevent infection. During an interview on 5/23/25 at 1:49 p.m. the DON stated staff should sanitize their hands between glove changes to prevent infection to the resident. The DON stated staff should have changed their gloves and performed hand hygiene after touching soiled items or wash with soap and water when hands were visibly soiled. Nurse aide competencies or training for incontinent care for CNA K and CNA L were request from the DON on 5/23/25 and not provided prior to exit. Record review of the facility's policy titled Incontinence Care, dated 4/17/14, reviewed last 2/14/20, stated Purpose: To outline a procedure for cleansing the perineum and buttocks after an incontinence episode . Procedure . 4. Wash hands 5. Put on non-sterile, latex-free gloves 6. Place linen or underpad beneath hips 7. Position on side turned away from caregiver 8. If feces present, remove with toilet paper or disposable wipe by wiping from front of perineum toward rectum. Discard soiled materials and gloves. Wash hands. 9. Put on non-sterile, latex-free gloves .

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	675437	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Live Oak	8221 Palisades Drive Live Oak, TX 78233

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 2 of 2 residents (Resident #89 and #53) reviewed for dialysis: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #89 and Resident #53. This failure could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: 1. Record review of Resident #89's face sheet dated 5/23/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included end stage renal disease (occurs when the kidneys can no longer function well enough to meet the body's needs) traumatic amputation of left foot, anemia in chronic kidney disease (an abnormal reduction in red blood cells due to impaired kidney function), and pain. Record review of Resident #89's most recent comprehensive MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and received dialysis treatments. Record review of Resident #89's Medication Administration Record, dated 5/21/25 revealed the following: - Check the shunt site for bleeding. If bleeding is present, apply pressure and notify the physician; every shift for monitor with start dated 4/27/25 and no stop date. - Do not take blood pressure on Left upper extremity with the shunt; every shift for Dialysis, with order dated 4/27/25 and no stop date. Record review of Resident #89's comprehensive care plan with revision date 5/7/25 revealed the resident received dialysis related to renal failure and was at risk for the potential complications of dialysis, with interventions that included to encourage the resident to attend scheduled dialysis appointment, monitor dialysis dressing and change as ordered, report abnormal bleeding to the physician, and monitor/document/report any signs or symptoms of infection to the access site such as redness, swelling, warmth, pain, or purulent drainage. Further review of Resident #89's comprehensive care plan revealed the resident attended dialysis treatments outside of the facility on Monday, Wednesday, and Friday. Record review of Resident #89's Hemodialysis Communication Records revealed the following: - 3/26/25: the dialysis center section was incomplete, and the post dialysis section was not signed or dated by the facility nurse. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 3/28/25: the post dialysis section was not completed by the facility nurse. - 4/2/25: the post dialysis section was not signed or dated by the facility nurse. - 4/7/25: the pre-treatment section and post-treatment section was not signed or dated by the facility nurse. - 4/9/25: the Hemodialysis Communication Record was not provided by the facility. - 4/11/25: the post dialysis section was not signed or dated by the facility nurse. - 4/14/25: the dialysis center section was not signed or dated, and the post dialysis section was not completed by the facility nurse. - 4/18/25: the Hemodialysis Communication Record was not provided by the facility. - 5/2/25: the Hemodialysis Communication Record was not provided by the facility. - 5/5/25: the Hemodialysis Communication Record was not provided by the facility. - 5/7/25: the Hemodialysis Communication Record was not provided by the facility. - 5/9/25: the Hemodialysis Communication Record was not provided by the facility. - 5/12/25: the Hemodialysis Communication Record was not provided by the facility. - 5/14/25: the Hemodialysis Communication Record was not provided by the facility. - 5/16/25: the Hemodialysis Communication Record was not provided by the facility. - 5/19/25: the Hemodialysis Communication Record was not provided by the facility. - 5/21/25: the dialysis center section was incomplete, and the post dialysis section was blank. During an observation and interview on 5/22/25 at 10:50 a.m., Resident #89 acknowledged he was getting dialysis treatments outside of the facility every Monday, Wednesday, and Friday. Resident #89 stated he was not aware of any paperwork given while at the dialysis center. Resident #89 raised his sleeve to expose his left upper arm and stated the area exposed was where the dialysis shunt was located. During an interview on 5/22/25 at 4:25 p.m., CNA C stated she was aware of at least two residents who received dialysis treatments and believed Resident #89 was one of them. CNA C stated the day shift nurses were responsible for ensuring the resident went to dialysis treatments and Resident #89 was usually in bed when she came on shift which was from 2:00 p.m. to 10:00 p.m. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/22/25 at 4:29 p.m., ADON A acknowledged Resident #89 went to dialysis treatments on Monday, Wednesday, and Friday. ADON A stated, the nursing staff were responsible for providing the dialysis clinic with the Hemodialysis Communication Record which they gave to the driver who was taking the resident to the dialysis clinic. ADON A further stated, the Hemodialysis Communication Record was turned into the facility nursing staff by the driver after the resident returned from the dialysis clinic. ADON A stated, we get the information and it's filed and uploaded into the medical chart. Not sure of the process. ADON A further stated, the Hemodialysis Communication Records were audited by the ADON or DON. ADON A reviewed the Hemodialysis Communication Record for Resident #89, dated 5/21/25 and acknowledged the form was incomplete and was missing the dialysis clinic information and the post-dialysis information by the receiving facility nurse was blank. ADON A stated LVN D accidentally documented Resident #89's post dialysis vital signs in the wrong section of the Hemodialysis Communication Record dated 5/21/25. During an interview on 5/22/25 at 4:38 p.m., LVN D acknowledged Resident #89's Hemodialysis Communication Record, dated 5/21/25 was missing information from the dialysis clinic and the nurses were responsible for notifying the dialysis clinic to obtain that information. LVN D stated she called the dialysis clinic but they put me on hold for 10 minutes, twice, and did not get a call back, and then filed the sheet in the resident's dialysis binder. LVN D stated, we cannot accept it (Hemodialysis Communication Record) because we have to know of any changes while at dialysis or how he (Resident #89) tolerated the dialysis treatment. I guess I should have communicated that to the DON or ADON. During a joint interview on 5/22/25 at 4:43 p.m., the DON and ADON B acknowledged, the Hemodialysis Communication Records were supposed to be completed and if there was any missing information from the dialysis clinic, the facility nurse was responsible for calling the dialysis clinic to obtain that information. The DON and ADON B acknowledged, the Hemodialysis Communication Record was not supposed to be filed until all of the information required was obtained. The DON stated, we need to know baseline while here and baseline results when they come back. The DON and ADON B acknowledged nobody was really auditing the Hemodialysis Communication Records to ensure they were completed. During a follow-up interview on 5/23/25 at 2:11 p.m., the DON acknowledged there was no process in place for keeping track of the Hemodialysis Communication Records. 2. Record review of Resident #53's admission Record dated 05/23/25 documented an [AGE] year old male admitted to the facility 10/23/20 and readmitted [DATE] with diagnoses that included severe sepsis with septic shock (a life-threatening condition where the body's response to an infection causes wide-spread inflammation and organ damage), acute kidney failure, dependence on renal dialysis, atelectasis (whole or partially collapsed lung) and dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (indicates the dementia is a result of another underlying medical condition and doesn't specify whether the dementia is mild, moderate, or severe). Record review of Resident #53's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating he is cognitively intact. The MDS also noted that he is on dialysis and uses a bipap for sleep apnea (a sleep disorder in which breathing repeatedly starts and stops). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #53's May 2025 Physician's Orders revealed he was on oxygen as needed and goes to dialysis 3 times per week on Tuesday, Thursday and Saturday. Orders also include checking the central line to ensure the dressing is dry and intact, and if not, reinforce with an occlusive dressing. Additionally, check the clamp to ensure closure every shift. Review of the dialysis communication sheets for Resident #53 revealed the following deficient areas: 4/24/25: The Hemodialysis Communication Record was not signed by the dialysis facility nurse or the facility nurse upon return after taking the vital signs. No other information concerning observation of the shunt was documented by either nurse. 4/26/25: The Hemodialysis Communication Record was not signed by the dialysis facility nurse after taking vital signs. 4/29/25: The Hemodialysis Communication Record had no observation of shunt following the return to facility. 5/1/25: The Hemodialysis Communication Record was not signed by the dialysis facility nurse who completed the vital signs. 5/6/25: The Hemodialysis Communication Record was not signed by the dialysis facility nurse who completed the vital signs. None of The Hemodialysis Communication Record forms had the resident's name, ID #, Room # or Physician' Name completed at the bottom of the form. During an interview with the DON on 5/23/24 at 4:00 pm, the DON stated the resident's name was not completed on the forms since they were placed in a binder with his name on it and then uploaded into their EMR. During an interview on 5/23/25 at 4:10 p.m., the Regional Nurse stated the facility did not have a policy in place for the dialysis communication records.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to not store chemicals on the bottom shelf of a refrigerator. 2. The facility failed to document freezer temperatures for May 14th closing temperature and May 15-19, and May 20th opening temperature. 3. The facility failed to not store personal beverages in the food preparation area. 4. The facility failed to ensure lettuce was stored in a closed container in the walk-in refrigerator. 5. The facility failed to take temperatures of pureed foods and cold foods from 05/18/25 to 05/22/25. The facility failed to take food temperature for 05/21/25 dinner. These failures could place residents at risk for food borne illness. The findings included: 1. Observation and interview on 05/20/25 at 09:53 AM, during initial kitchen tour, revealed there was a cleaning spray on the bottom shelf of a refrigerator and the same cleaning spray was placed near foods and left there while staff was prepping a meal. The CDM revealed the cleaning spray was not supposed to be in the refrigerator or near foods and staff were trained on this. She revealed the staff could have moved the cleaning spray away from the food preparation area while staff was prepping for meal. Observation and interview on 05/22/25 at 11:42AM, the CDM revealed there should not be a cleaning spray in the refrigerator to prevent cross contamination and for food safety. Record review of facility's policy Storage-Chemicals, revised October 2019, reflected It is the center policy to ensure all chemicals will be properly stored for safety and to prevent cross contamination with food . 1. The Dining Services Director ensures that all chemicals are stored in separate/secured area. 2. Record review and interview on 05/20/25 at 09:35AM, during initial kitchen tour, of Freezer Temperature Log for Non-24-Hour Operation for May reflected freezer temperatures were not written for May 14th closing temperature and May 15-19, and May 20th opening temperature. The CDM revealed she was not aware of why this was not filled out and she oversaw the temperature log being filled out appropriately. Interview on 05/22/25 at 11:42AM, the CDM revealed it was important to keep up with freezer temperatures for food safety, but the freezer was very cold, so she has not suspected the freezer had not been at appropriate temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Food Storage: Cold, revised October 2019, reflected 3. The Dining Services Direct/Cook(s) monitors that all frozen foods will be stored at temperature to maintain frozen state, target temperature is 10 (degrees F) or below. 3. Observation and interview on 05/20/25 at 09:35AM, during initial kitchen tour, revealed there were 2 personal beverages on the top shelf, above the food preparation area while a staff member was prepping food. Observation and interview on 05/22/25 at 11:42AM, the CDM revealed there should not be personal beverages in the kitchen or cleaning spray near food preparation areas to prevent cross contamination and for food safety. She revealed the staff members who had their beverages and prepared food near a cleaning spray were new and she re-educated them. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. 4. Observation and interview on 05/20/25 at 09:35AM, during initial kitchen tour, revealed lettuce that was uncovered in the walk-in refrigerator. The CDM revealed they did not cover the lettuce because they did not have a container to fit the lettuce in with a cover. The CDM revealed this did not affect the quality of the lettuce and it was okay to keep it uncovered with only a paper towel on top of it. Observation and interview on 05/22/25 at 11:42AM, the CDM revealed lettuce was in a closed container today, because she had washed it and it was now ready to be served. She revealed she did not think this lettuce needed to be covered prior to this. Record review of the facility's policy, Food Storage: Cold, revised October 2019, reflected 5. The Dining Services Director/Cook(s) ensures that all food items are stored properly in covered containers, labeled, and dated and arranged in a manner to prevent cross contamination. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. 5. Observation and interview on 05/22/25 at 11:42AM, the cook (unidentified) did not take temperatures for the pureed foods. The CDM revealed they did not have to take temperatures for pureed foods because they took the temperature when they prepared the pureed foods, and they also take temperatures of the regular foods which were in the same steam table. The CDM was not able to show any records of taking pureed foods' temperatures for 05/18-05/22/2025. The CDM further revealed if the foods for the regular diet were at the proper temperature, they did not need to take temperatures of the pureed foods. The CDM revealed they did not have to take temperatures for cold milk because they get the milk straight from the refrigerator when it's time for meal service. She also revealed they did not take temperatures of the milk because they would have to open the milk container to put the thermometer inside the milk liquid. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Final Cooking/Reheating Time & Temperature Log, dated 05/18-22, were reviewed 05/22/25 lunch meal service. The log reflected no temperatures taken for pureed foods and no temperatures taken for cold items. Record review of the facility's week 2 menu reflected Sunday (05/18/25) breakfast was scrambled eggs, sausage patty, wheat toast, and hot cereal; lunch was rosemary pork loin, Italian green beans, buttered pasta, and cherry pie; dinner was baked chicken thigh, roasted potatoes, cucumber salad, dinner roll, and mandarin oranges. Record review of Final Cooking/Reheating Time & Temperature Log, dated 05/18, reflected breakfast had 3 food items with temperatures documented: oatmeal, sausage, eggs; lunch had 3 food items with temperatures documented: pork loin, veggies, soup; dinner had 3 food items with temperatures documented: sandwich, veggies, soup. Record review of the facility's week 2 menu reflected Monday (05/19/25) breakfast was cheese egg bake, sausage patty, English muffin, and hot cereal; lunch was roast beef, broccoli, white rice, and lemon bar; dinner was chicken spaghetti, fried okra, dinner roll, ice cream. Record review of Final Cooking/Reheating Time & Temperature Log, dated 05/19, reflected breakfast had 3 food items with temperatures documented: french toast, sausage, eggs; lunch had 3 food items with temperatures documented: roast beef, rice, broccoli; dinner had 3 food items with temperatures documented: soup, chicken spaghetti, fried okra. Record review of the facility's week 2 menu reflected Tuesday (05/20/25) breakfast was French toast, sausage patty, and hot cereal; lunch was crabcake, mashed potatoes, dinner roll, spinach, and sugar cookie; dinner was polish sausage, egg noodles, carrots, cornbread, and apple crisp. Record review of Final Cooking/Reheating Time & Temperature Log, dated 05/20, reflected breakfast had 3 food items with temperatures documented: eggs, sausage, oatmeal, gravy; lunch had 4 food items with temperatures documented: crab patties, mashed potatoes, spinach, gravy; dinner had 3 food items with temperatures documented: soup, sausage, pasta. Record review of the facility's week 2 menu reflected Wednesday (05/21/25) breakfast was cheese omelet, sausage, and hot cereal; lunch was beef stew, rice pilaf, green beans, dinner rolls, and orange sherbet; dinner was BBQ pulled pork on a bun, tossed salad, baked potato, and tropical fruit cup. Record review of Final Cooking/Reheating Time & Temperature Log, dated 05/21, reflected breakfast had 3 food items with temperatures documented: eggs, sausage, oatmeal, gravy; lunch had 4 food items with temperatures documented: rice, soup, green beans, beef stew; dinner had 0 food items documented. Record review reflected there were no food temperatures take for 05/21/25 dinner. Record review of the facility's week 2 menu reflected Thursday (05/22/25) breakfast was scrambled eggs, sausage patty, wheat toast, and hot cereal; lunch was fried chicken, carrots with parsley, dinner roll, buttered noodles, and white pineapple upside down cake. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Final Cooking/Reheating Time & Temperature Log, dated 05/22, reflected breakfast had 4 food items with temperatures documented: eggs, sausage, oatmeal, gravy; lunch had 6 food items with temperatures documented: noodles, chicken, gravy, soup, mash, carrots. Interview on 05/23/25 at 01:30PM, the RD revealed the cleaning spray should not been in the fridge and personal beverages should not be in food preparation areas as it can cause cross contamination. The RD revealed every item should have their temperature taken, prior to meal service. With other questions, the RD further revealed she would have to refer to the policies to answer questions and the policies trumped anything she had to say. Interview on 05/23/25 at 01:55PM, the DON revealed it was important to make sure temperatures for the fridge and freezer, that contained food products, were taken so they could ensure food didn't go bad. She further revealed food temperatures needed to be checked, prior to service, to make sure they were at proper temperature. to make sure food was cooked properly, and to prevent food borne illness. Record review of facility's policy Food: Quality and Palatability, dated October 2019, reflected The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point and time and temperature guidelines as outlined in the Federal Food Code. Record review of the principles of Hazard Analysis Critical Control Point did not reflect any specifics to time and temperature recommendations. Record review of the FDA Food Code 2022 reflected, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3- 403.11(E) may be held at a temperature of 54°C (130°F) or above; or (2) At 5°C (41°F) or less.

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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** Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 3 of 8 residents (Resident #30, Residents #33, and Resident #66) reviewed for infection control. 1. The facility failed to ensure, during medication pass, MA M sanitized the blood pressure cuff between Resident #44, and Resident #30. 2. The facility failed to ensure LVN J wore a PPE gown while administering medication to Resident #33 via PEG tube ((an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate). 3. The facility failed to ensure CNA K and CNA L sanitized their hands between glove changes and changed their gloves after during incontinent care for Resident #66. These failures could place residents at risk for cross contamination and infection. The finding included: 1. Record review of Resident #30's admission Record, dated 5/23/25, revealed she was a [AGE] year-old woman admitted on [DATE] with diagnoses including heart failure, rash and other nonspecific skin eruption, seborrheic dermatitis (is a common skin condition that mainly affects your scalp. It causes scaly patches, inflamed skin, and stubborn dandruff.), and pneumonia (an infection that inflames the air sacs in one or both lungs). Record review of Resident #30's Quarterly MDS Assessment, dated 02/14/25, revealed the resident's cognition was fully intact for daily decision making. Record review of Resident #30's Care Plan, revised 5/18/25, revealed a care area for Resident #30 had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner. Performance deficits were related to cognitive impairment, functional limitations in range of motion or decrease mobility, activity intolerance, impaired imbalance coordination, and pain. Interventions included personal hygiene limited x1 assistance and report changes in ADLS of self-performance to nurse. During observations on 5/22/25 between 9:12 a.m. and 9:32 a.m. MA M took resident #44 blood pressure. MA A returned the blood pressure cuff to the cart. MA M then switched medication carts. MA M took the blood pressure cuff off the 400-hall cart and placed it on the 300-hall cart. MA M then took Resident #30's blood pressure without sanitizing the cuff prior. During an interview on 5/22/25 at 9:32 a.m. MA A stated she thought she had sanitized the blood pressure cuff but forgot. MA A stated she should sanitize the blood pressure cuff between residents to prevent cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #33's admission record, dated 5/23/25, revealed an [AGE] year-old male resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy, methicillin resistant staphylococcus aureus infections as the cause of disease classified elsewhere. Record review of Resident #33's quarterly MDS assessment, dated 4/22/25, revealed the resident cognition was intact for daily decision making. Record review of Resident #33's care plan, revised 3/27/25, revealed a care area for Resident #33 was on enhanced barrier precautions due to feeding tube and foley with interventions to ensure PPE was available for use on the resident. Record review of Resident #33's physician order summary, dated 4/16/25, revealed an order for enhanced barrier precautions every shift related to PEG tube/catheter, with a start date of 4/16/25, and no end date. During an observation on 5/22/25 at 3:49 p.m. LVN J administered a medication to Resident #33 through his PEG tube. LVN J wore gloves during the administration and did not wear a PPE gown. 3. Record review of Resident #66 admission record, dated 5/23/25, revealed an [AGE] year-old female resident admitted on [DATE] with diagnoses including dementia, enterocolitis due to clostridium difficile, bacteremia (bacteria in bloodstream), and stage 3 chronic kidney disease. Record review of Resident #66's quarterly MDS assessment, dated 4/16/25, revealed the resident cognition was severely impaired for daily decision making. Section H revealed the resident was always incontinent of bladder and bowel. Record review of Resident #66's care plan, revised 3/27/25, revealed a care area for Resident #66 was incontinent of bowel/bladder related to limited mobility with an intervention to check frequently for wetness and soiling, and changing as needed. During an observation on 5/22/25 at 3:17 p.m. CNA K and CNA L provided incontinent care to Resident #66. CNA K and CNA L washed their hands and put on gloves. CNA K cleaned the residents vaginal area, removed her gloves, did not sanitize her hands, and put on new gloves. CNA K and CNA L then turned Resident #66 to her side and CNA K cleaned her buttocks area. CNA K removed the brief from under resident #66 and threw it away. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. Resident #66 began to have a bowel movement and CNA K wiped her buttocks area again while rolling a pad up under her. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. CNA K then opened a new brief and put in on the resident. CNA K then applied barrier cream to the resident's buttocks. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. Both aides then turned the resident to her other side and CNA L then removed the soiled pad out from under the resident. CNA K then applied barrier cream to the resident's vaginal area. CNA K then removed her gloves, did not sanitize her hands, and put on new gloves. CNA L was wearing the same gloves from the start of the care then touches and fastens the new clean brief on Resident #66. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675437	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Live Oak	8221 Palisades Drive Live Oak, TX 78233

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview on 5/22/25 at 3:27 p.m. CNA K and CNA L stated they perform hand hygiene by washing their hands prior to starting incontinent care and after it is complete. Both aides stated if their gloves became soiled or torn then they would need to perform hand hygiene. CNA K and CNA L stated to their knowledge they do not need to perform hand hygiene in between glove changes and never had training to sanitize their hands between glove changes. They both stated they had training for incontinent care as recent as two weeks prior. During an interview on 5/22/25 at 3:31 p.m. the Nursing Supervisor stated he was one of the staff responsible for training aides on incontinent care. The Nursing Supervisor stated staff had training to perform hand hygiene prior to providing care, after care, anytime hands are visibly soiled, or between glove changes. The Nursing Supervisor stated staff had little bottles of hand sanitizer they could take into the room with them during care. During an interview on 5/23/25 at 1:49 p.m. the DON stated staff should sanitize their hands between glove changes to prevent infection to the resident. A facility policy for Enhanced Barrier Precautions was request on 5/23/25 at 1:55 p.m. At 3:51 p.m. the Administrator provided the QSO from CMS for EBP, dated March 20, 2024. The facility's policy for, infection control prevention and control program, was updated last on 10/27/2022. The policy did not mention or include information for EBP. The QSO, titled Enhanced Barrier Precautions in Nursing Homes stated .Regulations and Guidance: F880 . Infection Control The facility must 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 . Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements .)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to .(e) and following accepted national standards; .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Hand Hygiene, dated 11/12/2017, stated Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Policy Explanation and Compliance Guidelines: 1. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 2. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 3. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . Hand Hygiene Table . Condition . Before applying and after removing personal protective equipment (PPE), including gloves .