

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	
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 - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to personal privacy was provided for 1 of 6 residents (Resident #1) reviewed for resident rights. The facility failed to ensure CNA A and CNA B pulled the curtain and covered Resident #1's genitalia while providing a bed bath on 6/17/26. This failure could place residents at risk of humiliation, diminished quality of life, loss of dignity, and self-worth. Findings included: Record review of Resident #1's face sheet, dated 6/24/26, indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including quadriplegia (unable to move body, typically caused from damage to the spinal cord in the neck), gastrostomy (also called PEG tube-soft tube inserted through the skin and abdominal wall directly into the stomach), colostomy (surgical procedure to bring part of the large intestine out through the abdominal wall to an opening on the outside of the body for feces to be collected in a bag), neuromuscular dysfunction of bladder (unable to control urine flow), and aphasia (inability to speak). Record review of Resident #1's quarterly MDS assessment, dated 5/04/2026, indicated he had no speech and was rarely/never understood and sometimes understood others. Resident #1 was unable to complete the BIMS because he was rarely/never understood. Resident #1 was dependent on staff assistance for all ADLs. Resident #1 was always incontinent of urine. Resident #1 did not have bowel incontinence because he had a colostomy. Record review of Resident #1's undated Care Plan indicated he had a problem area of Activities of Daily Living Resident #1 was dependent on staff for all his ADLs. Record review of video footage, dated 6/17/26 beginning at 9:21 AM and ending at 9:24 AM, indicated CNA A and CNA B were bathing Resident #1 in the bed closest to the window, with the window blinds closed. The door to the room was closed, but the curtain was not pulled to block the view of Resident #1 if someone entered the door. Resident #1 was completely naked and fully exposed during the bathing of his front and back sides. CNA A and CNA B did not cover Resident #1's private areas during the bathing process. During an interview on 6/24/26 at 9:19 AM, Resident #1's family member said the staff bathed him like they were washing an object and not a human and left him fully exposed during his bed baths. Resident #1's family representative said staff could at least cover his private parts because no one wants to just lay there fully naked and exposed. Resident #1's family representative said anybody could walk in and the curtain was not pulled. During an observation on 6/24/26 at 2:59 PM, Resident #1 was lying in bed with head of the bed elevated. He appeared clean and no odors were noted. Resident #1 was non-interviewable. During an interview on 6/25/26 11:52 AM, the DON viewed the video dated 6/17/26 beginning at 9:21 AM and she identified the staff members as CNA A and CNA B. The DON said staff should provide privacy for the residents during bathing to promote dignity and to provide a safe space. The DON said CNA A and CNA B should have pulled the curtain and they should have covered Resident #1 with a sheet or towel to cover his genital area. The DON said if staff were bathing the top half of the resident, then they should cover the bottom half of the resident or if they were bathing the bottom half, they should cover the top half of the resident, so they were not just lying there fully exposed. The DON said if it was her family member receiving a bed bath, she would want them covered for dignity and privacy. The DON said she knew it was a dignity issue. The DON said her staff had been repeatedly in-serviced and she (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675444
		If continuation sheet Page 1 of 13

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	felt like she was beating a dead horse.During an interview on 6/25/26 at 2:46 PM, CNA A said her and CNA B bathed Resident #1 on 6/17/26. CNA A said they should have pulled the privacy curtain during Resident #1's bath to provide him privacy if someone walked in the door. CNA A said they should have kept a towel or something over his private areas for privacy and dignity. CNA A said she did not have a reason why they did not pull the curtain or cover his private areas while bathing Resident #1. CNA A said she would not want to be bathed by someone and left fully uncovered for anyone to see. CNA A said it would be a dignity issue.During an attempted interview, CNA B was called on 6/25/26 at 1:13 PM and there was no answer, the voicemail was full and was unable to leave a message. At 1:14 PM, CNA B returned the call and was informed of the reason for calling and she stated she could not talk at that time and did not know when she would be available and hung up.During an interview on 6/25/26 at 2:05 PM, the ADM said if residents were not covered while receiving a bed bath, it created a lack of dignity. The ADM said even if the door was closed, and the curtain was not pulled, someone could walk in and no one would feel comfortable in any state of well-being lying there fully exposed. The ADM said he expected his staff to follow the facility's policies and provide the residents with privacy and be treated with dignity.Record review of the facility's grievance logs for April, May, and June of 2026 did not reveal Resident #1's family had filed a formal grievance/complaint.Record review of the facility's policy titled, Resident Rights, dated revised August 14, 2022, indicated, . The staff will abide by and protect resident rights in accordance with state and federal guidelines. Staff will abide by resident rights as outlined within CMS State Operations Manual Appendix PP.Record review of the facility's policy titled, Bathing, dated revised February 12, 2020, indicated, .Staff will provide bathing services for residents within standard practice guidelines. perform hand hygiene and apply clean gloves. provide privacy and assist the resident to a comfortable position.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 5 residents reviewed for ADLs (Residents #1.)1. The facility failed to reposition Resident #1 at least every two hours on the 6/10/26 10:00 PM to 6:00 AM (6/11/26) shift.2. The facility failed to ensure LVN F provided appropriate incontinent care to include cleansing Resident #1's skin to his front and back private areas on 6/11/26.3. The facility failed to ensure CNA E turned Resident #1 to cleanse urine from his skin on the back side of his body or to check under the pad for wetness on 6/16/26.4. The facility failed to ensure CNA C provided appropriate incontinent care to include cleansing Resident #1's skin to his front and back private areas or turning Resident #1to check his under pad for wetness on 6/17/26.These failures could place residents at risk of not receiving care and services to meet their needs, resulting in poor care, risk for skin breakdown, feelings of poor self-esteem, and lack of dignity.Findings included:Record review of Resident #1's face sheet, dated 6/24/26, indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including quadriplegia (unable to move body, typically caused from damage to the spinal cord in the neck), gastrostomy (also called PEG tube-soft tube inserted through the skin and abdominal wall directly into the stomach), colostomy (surgical procedure to bring part of the large intestine out through the abdominal wall to an opening on the outside of the body for feces to be collected in a bag), neuromuscular dysfunction of bladder (unable to control urine flow), and aphasia (inability to speak).Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he had no speech and was rarely/never understood and sometimes understood others. Resident #1 was unable to complete the BIMS because he was rarely/never understood. Resident #1 was dependent on staff assistance for all ADLs. Resident #1 was always incontinent of urine. Resident #1 did not have bowel incontinence because he had a colostomy.Record review of Resident #1's undated Care Plan indicated he had problem areas including:Activities of Daily Living and was dependent on staff for all ADLs with interventions to assist with daily care needs and daily living tasks.Incontinent of bowel and bladder with interventions including to assist with toileting needs and to check and change, keep clean and dry.Urinary incontinence related to neurogenic bladder with interventions including monitor skin for redness when providing care, hygiene as needed after every incontinent episode to maintain dignity, and provide adult briefs/pullups/pads, assist with changing as needed.Diagnosis of Quadriplegia with interventions including to provide assistance with all ADLs and mobility, position for comfort and reposition every two hours as tolerated, and to monitor skin integrity.At risk for skin breakdown due to incontinence and impaired mobility with interventions including to assist resident to turn and reposition frequently, keep skin clean and moisturized, and pressure relieving mattress and chair cushion.Record review of Resident #1's skin assessments, dated 6/10/26 and 6/17/26, indicated he did not have any skin issues.Record review of video footage, dated 6/11/26 beginning at 12:05 AM, Resident #1 was lying on his back, eyes closed, with his right hand on top of his pillow laid across his abdomen with his television remote and call light attached.Record review of video footage, dated 6/11/26 beginning at 12:31 AM, Resident #1 was lying on his back, eyes closed, with his right hand on top of his pillow laid across his abdomen with his television remote and call light attached.Record review of video footage, dated 6/11/26 beginning at 1:17 AM, Resident #1 was lying on his back, eyes closed, with his right hand on top of his pillow laid across his abdomen with his television remote and call light attached.Record review of video footage, dated 6/11/26 beginning at 2:09 AM, Resident #1 was lying on his back, eyes closed, with his right hand on top of his pillow laid across his abdomen with his television remote and call light attached.Record review of video footage, dated 6/11/26 beginning at 2:13 AM, Resident #1 was lying on his back, eyes closed, moving his right hand on top of his pillow laid across his abdomen/chest area with his television remote and call light attached.Record review of video footage dated 6/11/26 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	beginning at 2:24 AM, Resident #1 was lying on his back, eyes closed, with his right hand on top of his pillow laid across his abdomen/chest area with his television remote and call light attached. Record review of video footage, dated 6/11/26 beginning at 2:48 AM, Resident #1 was lying on his back, eyes closed, with his right hand around the bottom of his pillow and it was pulled up to his upper chest area and had his television remote and call light attached. Record review of video footage dated 6/11/26 beginning at 2:58 AM, Resident #1 continued lying on his back, eyes closed, with his right hand around the bottom of his pillow and it was pulled up to his upper chest area and had his television remote and call light attached. Record review of video footage, dated 6/11/26 beginning at 3:15 AM, Resident #1 was lying on his back, eyes closed, with his right hand over the top of his pillow laid across his chest and had his television remote and call light attached. Record review of video footage, dated 6/11/26 beginning at 3:42 AM, Resident #1 was lying on his back, eyes closed, with his right hand over the top of his pillow laid across his chest and had his television remote and call light attached. LVN D entered the room carrying feeding tube supplies. LVN D provided care to Resident #1's feeding tube. LVN D, at 3:48 AM, removed old feeding tube supplies and placed them in the trash and removed his gloves and left the view of the camera. LVN D returned at 3:52 AM and placed a stack of linens on the end of the bedside table, which included a blue under pad, a sheet, and towels, then adjusted the feeding pump and left the room. Record review of video footage, dated 6/11/26 beginning at 6:36 AM, Resident #1 continued lying on his back, awake, with his right hand on top of his pillow laid across his abdomen area with his television remote and call light attached. The stack of linens continued to be sitting on the end of the bedside table, which included a blue under pad, a sheet, and towels. Record review of video footage, dated 6/11/26 beginning at 8:39 AM, Resident #1 continued lying on his back, awake, with his right hand on top of his pillow laid across his abdomen area with his television remote and call light attached. The stack of linens continued to be sitting on the end of the bedside table, which included a blue under pad, a sheet, and towels. Record review of video footage, dated 6/11/26 beginning at 9:16 AM, Resident #1 continued lying on his back, awake, with his pillow laid across his abdomen with his television remote and call light attached. The stack of linens continued to be sitting on the end of the bedside table, which included a blue under pad, a sheet, and towels. LVN F entered the camera view wearing gloves. At 9:17 AM, LVN F was at Resident #1's bedside and she lifted Resident #1's left arm and positioned a towel across his chest and under his chin. LVN F then pulled his covers down and with her left hand pulled his adult brief from between his legs and threw it in the trash. LVN F then, with the same gloves on, pushed Resident #1's bedside table to the side and walked to the other side of the bed (by window) and obtained a new adult brief, opened it and then proceeded to place the brief between Resident #1's legs and over his front private area and pulled his gown down. LVN F did not cleanse Resident #1's skin prior to applying a new adult brief on him and did not roll him to cleanse his skin on his back private areas and did ensure the pad under him was not wet. Record review of video footage, dated 6/16/26 beginning at 2:25 PM, CNA E was at Resident #1's bedside wearing gloves. CNA E lifted his pillow that was laid across his lap with his television remote and call light attached and pulled back the bed covers under the pillow. CNA E moved the pillow toward the foot of the bed. CNA E then walked around the end of the bed and picked up a package of wipes from the dresser at the end of the bed. CNA E obtained a clean adult brief and wipes from the package and then set the brief on top of Resident #1's pillow with his television remote and call light attached. CNA E then raised Resident #1's bed covers and pulled his adult brief from between his legs using both gloved hands and threw it in the trash. CNA E then used the wipes to clean Resident #1's front private areas. CNA E used the same gloved hands to place the clean adult brief over his front private area and then pushed the remainder of the brief down between his legs. CNA E removed Resident #1's gown and replaced it with a clean gown. CNA E then pulled his gown down, pulled his covers up over him, placed a towel over his chest and under his chin, wiped both sides of his mouth with the corners of the towel, placed his pillow over his abdomen with his television remote and call light attached, and then removed her gloves and threw them in the trash. CNA E did not roll Resident (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#1 to cleanse his skin on his back private areas and did ensure the pad under him was not wet. Record review of video footage, dated 6/16/26 beginning at 3:03 PM to 4:01 PM, showed Resident #1's family member entered his room and performed various tasks including cutting the flaps off the adult briefs. At 4:01 PM, Resident #1's family member removed two pillows that were stuffed under Resident #1's left side and placed them in a chair. Resident #1's family member removed her phone from her pocket and took a picture of Resident #1's under pad. Record review of a picture, dated 6/16/26 with a time of 4:01 PM, showed Resident #1's under pad with a dark yellowish brown outer ring that extended from approximately Resident #1's middle back area to below his buttocks, which indicated the under pad had not been changed and the urine was old and had dried and then been wet again and dried again. Record review of video footage, dated 6/17/26 beginning at 2:22 AM, CNA C entered Resident #1's room and walked over to the call light button on the wall and pushed the button. CNA C walked to the end of Resident #1's bed, moved the covers and repositioned Resident #1's feet from being crossed and CNA C was not wearing gloves or a gown. CNA C then, with her bare hands, picked up Resident #1's pillow from over his abdomen, with his television remote and call light attached, with her right hand and then pulled the covers down, raised his gown, and grabbed his adult brief with her bare left hand and pulled it out from between his legs and threw it in the trash. CNA C then walked out of the view of the camera and returned wearing gloves. CNA C walked around to the other side of the bed and obtained a clean adult brief and placed the top of the brief over Resident #1's front private areas and then pushed the other end between his legs. CNA C did not cleanse Resident #1's skin prior to placing a clean brief on him and did not turn him to clean his bottom side or to check his under pad for wetness. During an interview on 6/24/26 at 9:19 AM, Resident #1's family member said she had reported to the nurses on several occasions about Resident #1 being soiled to the point of being soaked in urine up his back and staff were not cleaning his urine off of his skin when they performed incontinent care and often just removed the soiled brief and put a clean one back on and not even checking to see if his under pad was wet. Resident #1's family member said the staff were supposed to be repositioning him at least every two hours and there was one night it did not appear he was repositioned all night after midnight. Resident #1's family member said she wanted Resident #1 to be cared for, kept clean and dry, and repositioned for comfort and to prevent skin breakdown. During an observation and interview on 6/24/26 at 1:15 PM, Resident #1 was lying in bed and appeared clean with no odors noted. CNA A and CNA G were at bedside and said Resident #1 had a shower that morning and had been sitting up in his chair and they had just gotten him back to bed. During an observation and interview on 6/25/26 at 11:23 AM, LVN F said she had worked at the facility for about 12 years. LVN F viewed the 6/11/26 video of her in Resident #1's room and said she did not wear a gown while providing care. LVN F said his adult brief/pad was soaked with urine and she felt it needed to be taken care of immediately. LVN F said she could tell Resident #1 was soaked and his gown was wet from either urine or sweat. LVN F said she removed his adult brief and put a dry one on him. LVN F said Resident #1 was soaked and she changed his adult brief, so he would not continue to soak himself more and then went and told the aide he needed everything changed. LVN F said Resident #1 appeared he had not been changed in quite a while. LVN F said she occasionally came in on the morning shift and found Resident #1 was soaked. LVN F said she told the aides to always round immediately after coming in, to ensure the residents were clean and dry. During an observation and interview on 6/25/26 at 11:52 AM, the DON viewed the videos and identified the staff members present in the videos. The DON said residents who could not turn themselves should be repositioned and checked for incontinence at least every two hours to prevent skin breakdown. The DON said she expected staff to be checking the resident's under pad for wetness also during incontinent care. The DON said staff should be cleansing the resident's skin, clean the front private areas first and then clean the back too. The DON said it should be common sense because urine runs down because of gravity and if the resident was a male and was lying on their back, the under pad would most likely be wet also. The DON said Resident #1's family member cuts the flaps/tabs off the adult briefs and just (continued on next page)		

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CNA C said a resident should be turned every two hours and checked for incontinence, so the resident did not get bed sores and was relieved of pressure. CNA C said the resident could get a bed sore and contractures if they were not turned and repositioned at least every two hours. CNA C said she always checked the under pad when Resident #1's adult brief was wet because the pad could be wet too, and most likely was. CNA C said it was important to cleanse the skin of urine to be clean, and no one wanted to be dirty. CNA C said she did not remember if she worked the night of 6/10/26 into the 6/11/26 morning (10 PM to 6 AM shift), but if she was scheduled she most likely worked her shift. CNA C said she rounded on residents at least every two hours to check for incontinence and turned and repositioned the residents. During an attempted interview on 6/25/26 at 1:30 PM, CNA E was called but there was no answer and was unable to leave a voicemail. CNA E was sent a text message on 6/25/26 at 1:32 PM requesting a return call. CNA E did not return call prior to exiting the facility. Per the DON, CNA E no longer worked for the facility. During an attempted interview on 6/25/26 at 1:45 PM, LVN D was called but there was no answer and was unable to leave a voicemail. LVN D was sent a text message on 6/25/26 at 2:45 PM requesting a return call. LVN D did not return call prior to exiting the facility. During an interview on 6/25/26 at 2:05 PM, the ADM said he would expect staff to follow the facility's policies and cleanse the resident's skin during incontinent care to prevent the potential for skin breakdown. He said he would expect the staff to turn and reposition residents to prevent pressure injuries and potential for skin breakdown. The ADM said it was mortifying to think residents were not being cleaned during incontinent care. Record review of the facility's Nursing assignment schedule for 6/10/26 indicated CNA C was assigned to Resident #1's hall on the 10:00 PM to 6:00 AM (6/11/26) shift. Record review of CNA C's time punches from 6/10/26 indicated she clocked in at 10:07 PM, clocked out at 1:58 AM (6/11/26), clocked back in at 2:20 AM, and clocked out at 6:00 AM. Record review of the facility's grievance logs for April, May, and June of 2026 did not reveal Resident #1's family had filed a formal grievance/complaint. Record review of the facility's Training In-service Form with the in-service topic of Two-hour Rounding and Repositioning and dated 6/15/26 indicated LVN F had signed the in-service form. The in-service did not indicate CNA C, LVN D, or CNA E had received or signed the in-service. Record review of the facility's policy titled, Perineal Care, dated reviewed April 2024, revealed, . Staff will provide perineal (private areas) care in accordance with the standard of practice to prevent skin breakdown and infection . Procedure: . 2. Assemble supplies. Utilize disposable wipes or if periwash was used, use washcloth and warm water in clean basin . 3. Perform hand hygiene. Apply clean gloves . 5. Perineal Care for Male: . b. Drape resident with linens to provide privacy . d. Wash tip of penis at urethral meatus (opening at the end of the penis) first using circular motion . Clean from the meatus outward . Discard wipe/washcloth and repeat until penis is clean . f. Cleanse the shaft of the penis and scrotum with new washcloth or wipe. Gently lift scrotum to clean skinfolds underneath . 7. Lower legs and assist resident to side lying position . 8. Turn resident to clean all areas of buttocks with new wipe or section of washcloth wiping front to back to remove feces present. Observe for redness, bruising, open skin, rash, or other abnormalities . 9. Dispose of gloves and used supplies and perform hand hygiene . 10. Apply new gloves and place new brief and change linens as needed . 11. Position resident comfortably with call light in reach . Record review of the facility's policy titled, An Overview of Wound Care dated July (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2018, indicated, . Purpose . To provide guidance for educational purposes about skin and wound care with an emphasis on Pressure Ulcers/Injuries and other common wounds . Pressure ulcers/injuries are mainly caused by increased time of a bony prominence against a surface . These wounds can develop very rapidly and take a long time to close . These wounds are significant and can be attributed to a perception of poor care provided by healthcare institutions and clinicians . the main goal of prevention and treatment is to reduce the amount of time a person is in one position while focusing on bony prominences, while addressing other factors that may increase the amount of risk of breakdown or further problems . can lead to local and systemic infections, increased pain, and death . Repositioning . or relieving constant pressure is a common, effective intervention for an individual with a pressure ulcer/injury or who is at risk of developing one . repositioning is critical for a resident who is immobile or dependent upon staff for repositioning, as the resident is unable to small movements on their own that would help to relieve prolonged pressure to one area . many clinicians recommend position change off-loading hourly for dependent residents who are sitting or who are in a bed or a reclining chair with the head of the bed or back of the chair raised 30 degrees or more . the care plan for a resident who is reclining and is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity . this may include repositioning at least every two hours or more frequently depending upon the resident's condition and specific needs .		

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NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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 prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #1) reviewed for infection control practices.1. The facility failed to ensure LVN D wore a gown and gloves while providing direct care to Resident #1, who was on EBP, while performing PEG tube care on 6/11/26.2. The facility failed to ensure LVN D did not place paper towels that had fallen onto the floor back into Resident #1's bed on 6/11/26.3. The facility failed to ensure LVN F wore a gown and gloves while providing direct care to Resident #1, who was on EBP, while performing incontinent care or flushing his PEG tube on 6/11/26.4. The facility failed to ensure LVN F changed her gloves and performed hand hygiene after performing incontinent care on Resident #1 prior to providing care to his PEG tube.5. The facility failed to ensure CNA E wore a gown and gloves while providing direct care to Resident #1, who was on EBP, while performing incontinent care and changing his gown on 6/16/26.6. The facility failed to ensure CNA E changed her gloves and performed hand hygiene after performing incontinent care and prior to touching Resident #1, his bedding, pillow, and clean gown.7. The facility failed to ensure CNA C wore a gown and gloves while providing direct care to Resident #1, who was on EBP, while providing incontinent care on 6/17/26.8. The facility failed to ensure CNA C and LVN D wore gown and gloves while providing direct care to Resident #1, who was on EBP, while pulling Resident #1 up in bed on 6/17/26.9. The facility failed to ensure CNA A and CNA B wore gown and gloves while providing direct care to Resident #1, who was on EBP, while performing a bed bath on 6/17/26.10. The facility failed to ensure CNA A and CNA G wore gown and gloves while providing direct care to Resident #1, who was on EBP, while performing a mechanical lift transfer from wheelchair to bed and positioning him in bed on 6/24/26. These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection. Findings included: Record review of Resident #1's face sheet, dated 6/24/26, indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including quadriplegia (unable to move body, typically caused from damage to the spinal cord in the neck), gastrostomy (also called PEG tube-soft tube inserted through the skin and abdominal wall directly into the stomach), colostomy (surgical procedure to bring part of the large intestine out through the abdominal wall to an opening on the outside of the body for feces to be collected in a bag), neuromuscular dysfunction of bladder (unable to control urine flow), and aphasia (inability to speak). Record review of Resident #1's quarterly MDS assessment, dated 5/04/2026, indicated he had no speech and was rarely/never understood and sometimes understood others. Resident #1 was unable to complete the BIMS because he was rarely/never understood. Resident #1 was dependent on staff assistance for all ADLs. Resident #1 was always incontinent of urine. Resident #1 did not have bowel incontinence because he had a colostomy. Resident #1 had a feeding tube. Record review of Resident #1's undated Care Plan indicated he had problem areas including: Activities of Daily Living and he was dependent on staff for all his ADLs. Incontinent of bowel and bladder. Needed to be lifted mechanically using a lift with two staff. Feeding tube necessary for nutritional needs due to dysphagia (unable to swallow). Enhanced Barrier Precautions with interventions of gown and gloves during high contact activities as outlined in guidelines. Needs ostomy care for a colostomy and peg tube with intervention for ostomy care per MD order. Record review of Resident #1's Physician Orders, dated 5/27/26-6/25/26, included orders for: Enhanced Barrier Precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities) every shift with an order date of 6/13/25. Peg-tube dressing change on night shift with an order date of 6/18/25. Peg-tube flush 30-50 cc water before and after medications every shift, use 30-50 cc of water flush between each (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a towel from over Resident #1's chest and begun to unsnap the left sleeve of his gown and then reached behind his neck to untie the gown, wearing the same gloves used to perform incontinent care. CNA E then leaned over the top of Resident #1 to unsnap the sleeve of his gown on the other arm and then pulled the gown off of him. CNA E placed a clean gown on Resident #1 while allowing the front of her clothes to contact his bedding and clean gown. CNA E then pulled his gown down, pulled his covers up over him, placed a towel over his chest and under his chin, wiped both sides of his mouth with the corners of the towel, placed his pillow over his abdomen with his television remote and call light attached, and then removed her gloves and threw them in the trash. CNA E did not change her gloves or wear a gown throughout the care she provided to Resident #1. Record review of video footage, dated 6/17/26, beginning at 2:22 AM, CNA C entered the Resident #1's room and walked over to the call light button on the wall and pushed the button. CNA C walked to the end of Resident #1's bed, moved the covers and repositioned Resident #1's feet from being crossed and CNA C was not wearing gloves or a gown. CNA C then with her bare hands, picked up Resident #1's pillow from over his abdomen, with his bed remote and call light attached, with her right hand and then pulled the covers down, raised his gown, and grabbed his modified adult brief with her bare left hand and pulled it out from between his legs and threw it in the trash. CNA C then placed both of her hands in the pockets of her shirt and walked out of the view of the camera and returned wearing gloves, but she still did not have a gown on. CNA C walked around to the other side of the bed and obtained a clean modified adult brief and placed the top of the brief over Resident #1's front private areas and then pushed the other end between his legs. CNA C did not cleanse Resident #1's skin prior to placing a clean brief on him and did not turn him to clean his bottom side. LVN D entered the room and put on gloves but did not put on a gown. CNA C removed Resident #1's sheet, repositioned his feet and pillow under his feet and allowed her clothing and long hair to touch the resident's bedding. CNA C placed Resident #1's pillow with his bed remote and call light attached onto his abdomen. LVN D and CNA C grabbed the draw sheet under Resident #1 and pulled him up toward the head of the bed. LVN D raised Resident #1's head using the bed remote and CNA C adjusted the sheet covering his feet and they exited the room. CNA C did not change her gloves or wear a gown throughout the care she provided to Resident #1. LVN D did not wear a gown throughout the care he provided to Resident #1. Record review of video footage, dated 6/17/26, beginning at 9:21 AM, CNA A and CNA B were positioned on each side of the bed, bathing Resident #1 in the bed closest to the window. Resident #1 was completely naked and fully exposed during the bathing of his front and back sides. CNA A and CNA B wore gloves but did not wear a gown while providing a bed bath to Resident #1. CNA B washed Resident #1's left leg and worked her way up to his abdomen and chest. CNA A and CNA B both took towels and dried Resident #1. CNA B obtained a black bottle (later determined to be coconut body oil) and squirted some in CNA A's hand and then in her own hand, still wearing the same gloves used to wash Resident #1. CNA A and CNA B both start rubbing the oil over Resident #1. CNA B started rubbing the oil on Resident #1's legs, then across his abdomen, and then she put more oil in her same gloved hand and begun rubbing the oil all over his head, face, and neck. CNA A reached over Resident #1 and grabbed the pad under him and pulled him toward her and let the pad fall back onto the bed while she held him on his side. CNA B wetted a wash cloth with soap and water and leaned against the bed while she washed Resident #1's back, back private area and discarded the wash cloth. CNA B wetted another washcloth and washed Resident #1's back private area again, while CNA A used a towel to dry his back and then his back private area. CNA B used a towel previously used to dry Resident #1 to wipe the bed mattress and then she squirted more oil into CNA A's same gloved hand, and she rubbed oil over his back, buttocks, and back of legs. CNA B obtained clean draw sheet and an under pad and rolled them halfway and as CNA A pulled the resident against her, CNA B stuffed it under Resident #1 wearing the same gloves. CNA B then pulled Resident #1 toward her as CNA A removed the old linen and pulled the clean linen from under the resident. CNA A and CNA B rolled Resident #1 onto his back and the video ended. CNA A and CNA B did not change their gloves or wear (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a gown throughout the care provided to Resident #1. During an observation and interview on 6/24/26 at 1:15 PM, Resident #1 was lying in bed and appeared clean with no odors noted. CNA A and CNA G were positioned on each side of Resident #1's bed and both were wearing gloves, but they were not wearing gowns. There was a mechanical lift in the room. CNA A and CNA G said they had just performed a mechanical lift to put Resident #1 back to bed after he had his shower and had sat up in his chair. CNA A and CNA G pulled Resident #1 up toward the head of the bed, pulled his covers up over him, and placed his pillow with his television remote and call light attached, over his abdomen within his reach. CNA A and CNA G did not wear a gown while providing care to Resident #1. During an interview 6/24/26 at 1:39 PM, CNA A and CNA G said Resident #1 was on EBP because he had a feeding tube. CNA A and CNA G said they were supposed to wear gloves and a gown when providing direct patient care. CNA G said they just had an in-service about EBP not long ago. CNA A and CNA G said EBP was to protect them and the resident from getting infections and so they do not spread infections from resident-to- resident. CNA A and CNA G said Resident #1 had been up in his wheelchair and they performed a two person transfer with the mechanical lift back to his bed and then repositioned him for comfort. CNA A and CNA G said they were not wearing the required gown and gloves for a resident on EBP. CNA A and CNA G said if they were not wearing the required gown and gloves while providing direct care to a resident on EBP, they could spread infection to the resident or to other residents and even themselves. CNA A and CNA G said Resident #1 did not like to be up in his chair and he was trying to get out of his chair and they just rushed and forgot to put a gown on. During an observation and interview on 6/24/26 at 2:59 PM, Resident #1's family member was at his bedside and LVN F came into the room and was putting on a gown and gloves. Resident #1's family member asked LVN F what the gown was for and LVN F said they were supposed to be wearing a gown and gloves every time they provided care to Resident #1. Resident #1's family member said the staff never wear a gown while providing care to Resident #1. During an interview on 6/25/26 at 11:23 AM, LVN F said she had worked at the facility for about 12 years. LVN F said EBP was to protect the resident from infections, so staff did not bring in any bugs/infections to resident and to protect themselves also. LVN F said she knew a resident was on EBP by having the PPE cart outside their door and the resident should have some type of paper on the outside of the door to say what time of isolation they were on. LVN F said residents on EBP were any residents with a feeding tube/PEG, wounds, urinary catheters, or any indwelling medical devices. LVN F said staff should be wearing a gown, mask and gloves anytime they entered a resident's room who was on EBP. LVN F said if staff did not wear the required gown and gloves for a resident on EBP, staff could bring in infection and put the resident at risk for bacteria to enter the open areas. LVN F viewed the 6/11/26 video of her in Resident #1's room and she said she did not wear a gown while providing care. LVN F she said his adult brief/pad was soaked with urine and she felt it needed to be taken care of immediately. LVN F said she could tell Resident #1 was soaked and his gown was wet from either urine or sweat. LVN F said she removed his adult brief and put a dry one on him. LVN F said, Oh my, I didn't change my gloves. LVN F said she should have changed her gloves prior to handling Resident #1's feeding tube/PEG tube. LVN F said she could have passed any bacteria from the perineal area (private area) to his feeding/PEG tube and caused an infection. LVN F said Resident #1 was soaked and she changed his adult brief, so he would not continue to soak more and then went and told the aide he needed everything changed. LVN F said Resident #1 appeared he had not been changed in quite a while. During an interview on 6/25/26 at 11:52 AM, the DON viewed the videos and identified the staff members present in the videos. The DON said LVN D should have been wearing a gown and gloves while providing care to Resident #1's PEG tube on the 6/11/26 video beginning at 3:46 AM. The DON said LVN F should have been wearing a gown while providing direct care to Resident #1 on the 6/11/26 beginning at 9:16 AM and LVN F should have changed her gloves after performing incontinent care and prior to providing PEG tube care. The DON said CNA E should have been wearing a gown and should have changed her gloves after providing incontinent care before touching Resident #1, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his clean gown, or his bedding in the video on 6/16/26 beginning at 2:25 PM. The DON said CNA E no longer worked at the facility. The DON said CNA C should have been wearing gloves and a gown when she was providing incontinent care to Resident #1 and changed her gloves before touching his bedding in the video on 6/17/26 beginning at 2:22 AM and LVN D should had been wearing a gown also when he assisted to pull Resident #1 up in bed. The DON said CNA A and CNA B should had been wearing a gown while bathing resident #1 and they should had changed their gloves after bathing him, before rubbing him down with oil, and they should had started from the head and worked their way down in the video on 6/17/26 beginning at 9:21 AM. The DON said staff should be changing their gloves when going between the resident's front perineal areas to back perineal areas and change their gloves between each interaction, such as between incontinent care and PEG tube care, when visibly soiled take them off, and when going from bottom to the head they should change their gloves. The DON said if staff were not changing their gloves appropriately, they could spread infection from one area to another. The DON said the purpose of EBP was to prevent possible infection, to prevent whatever was on the staff from getting on the residents with entry ways for infection, such as PEG tubes, PICC lines (long-term intravenous [IV] line inserted into a vein in the arm and ends near the heart), tracheostomies (artificial airways), urinary catheters, and wounds. The DON said the staff knew which residents were on EBP because they had blue name tags, indicating the resident was on EBP. The DON said the sign on the door was not required for residents on EBP. The DON said staff should be wearing a gown and gloves for residents on EBP during hands on care/interactions. The DON said not following the facility's Infection Control and EBP policies, placed the residents at risk for infections. The DON said her staff had been repeatedly in-serviced and she felt like she was beating a dead horse. During an attempted interview on 6/25/26 at 1:13 PM, CNA B was called but there was no answer, the voicemail was full and was unable to leave a message. At 1:14 PM, CNA B returned the call and was informed of the reason for calling and she stated she could not talk at that time and did not know when she would be available and hung up. During an interview on 6/25/26 at 1:28 PM, CNA C said she did not remember not wearing gloves to remove Resident #1's brief on 6/17/26. CNA C said she just removed Resident #1's brief and replaced it, so it would not be the same one on him from the previous shift. CNA C said she had reviewed the EBP policy and it was to prevent the spread of infection and for infection control. CNA C said there was a blue sign if a resident was on EBP. CNA C said if a resident was on EBPs, staff should be wearing a gown, gloves, and a mask. CNA C said the purpose of a resident being on EBP was so staff did not infect them, and they did not infect her. CNA C said she did not know Resident #1 was on EBP. CNA C said the resident could get sicker if staff were not wearing the appropriate PPE and the resident was on EBP. CNA C said staff should change their gloves when they were soiled. CNA C said staff should wash the resident's face first and work down the resident and not go from their bottom up. CNA C said gloves should be changed before touching other items in the room to not spread germs everywhere else. During an attempted interview on 6/25/26 at 1:30 PM, CNA E was called but there was no answer and was unable to leave a voicemail. CNA E was sent a text message on 6/25/26 at 1:32 PM requesting a return call. CNA E did not return call prior to exiting the facility. Per the DON, CNA E no longer worked for the facility. During an attempted interview on 6/25/26 at 1:45 PM, LVN D was called on 6/25/26 at 1:45 PM but there was no answer and was unable to leave a voicemail. LVN D was sent a text message on 6/25/26 at 2:45 PM requesting a return call. LVN D did not return call prior to exiting the facility. During an interview on 6/25/26 at 2:05 PM, the ADM said EBP was to prevent the potential spread of infection from person to person throughout the facility. The ADM said if staff were not following the EBP policy, there was a risk of spreading infection from staff to resident or resident to staff, and to other residents in the facility. The ADM said he expected staff to be following the facility's Infection Control and EBP policies to prevent the potential to spread infection and it was also just uncleanliness. During an interview on 6/25/26 at 2:46 PM, CNA A said neither she nor CNA B wore EBP when they bathed Resident #1 on 6/17/26 and only wore gloves. CNA A said they should have (continued on next page)		

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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	changed their gloves after bathing Resident #1 and before rubbing him down with the oil. CNA A said they should have started putting oil on him with clean gloves and started from his head and worked their way down. CNA A said they should not have used the same gloves they bathed him with to put oil on him because the gloves were dirty and could spread germs and infection and it just was not clean. CNA A said they should have changed their gloves before handling Resident #1's clean linen to prevent the spread of infection. CNA A said it was an infection control issue. Record review of the facility's Training In-service form, dated 5/11/26, with the in-service topic of EBP, Policy & Procedure, with the policy attached to the in-service indicated CNA A and CNA G had signed the in-service form. The in-service did not indicate CNA B, CNA C, LVN D, CNA E, or LVN F had received or signed the in-service. Record review of the facility's policy titled, Infection Control, dated revised February 2025, revealed, . 1. Standard/universal Precautions were intended to prevent the exposure of non-intact skin and mucus membranes of health care workers to other's blood and body fluids. Personnel will routinely use appropriate precautions when contact with the blood or other body fluids except sweat of any resident was likely . 2. Gloves were an appropriate barrier for protection from blood or body substances likely to soil the hands. Vinyl, latex gloves, or other gloves approved for medical use to provide equal barrier protection . gloves were worn when . 1. Touching blood and body fluids . 2. Touching mucous membranes or non-intact skin of all residents . 3. Touching urine, stool or vomituous of any resident (e.g. while changing linens of incontinent resident; cleaning a resident following incontinence) . 6. Anytime required by the facility Policies and Procedures or regulations . Key Points . 1. B. Gloves were changed if contaminated with blood or body fluids before touching other parts of the same resident . 2. Hands were washed immediately after gloves were removed, before contact with another resident or the environment. May us alcohol-based hand sanitizer if hands were not visibly soiled . 3. Hands were washed or decontaminated prior to donning gloves . Record review of the facility's policy titled, Enhanced Barrier Precautions, dated revised March 2025, revealed, . Many residents in nursing homes are at increased risk of becoming colonized and developing infections with Multidrug-resistant organism (MDROs). This facility utilizes Enhanced Barrier Precautions (EBP) as a strategy to decrease transmission of CDC-targeted and epidemiologically important MDROs when Contact Precautions do not apply . Definitions: . Enhanced Barrier Precautions was not isolation . Standard/Universal Precautions were safety precautions used for every resident. Since you cannot identify every resident who may transmit infection, you must treat all human body fluids as if they were known to be infections . Enhanced Barrier Precautions was in infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ 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 (personnel protective equipment) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . Indications . 1. Infection or colonization with CDC (Centers of Disease Control and Prevention) a targeted MDRO when Contact Precautions do not otherwise apply . 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . c. Indwelling medical device include central lines, urinary catheters, feeding tubes . 3. High contact Resident Care Activities a. Dressing b. Bathing/showering c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use . feeding tube . Communication . 1. Indicate the residents who were on EBP by subtle means, such as an alternate color or the resident's name badge on door, to maintain a home-like environment .		