STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675532	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that at the time each resident was admitted , the facility must have physician orders for the resident's immediate care, for 1 of 8 residents (Resident #31) reviewed for isolation contact precautions and intravenous line maintenance orders. Resident #31 was admitted on [DATE] with an immediate need for isolation contact precautions (essential measures in healthcare settings to prevent the spread of infections, particularly those that can be transmitted through direct or indirect contact with patients or their environment) and intravenous access maintenance, which he did not receive for 4 days until 5/26/2026. These failures could place residents at risk for delayed care and the spread of infectious disease.The Findings included: A record review of Resident #31's admission record dated 6/8/2026 revealed an admission date of 5/22/2026 with diagnoses which included klebsiella pneumoniae (a bacterium naturally found in the human gut and respiratory tract) and urinary tract infection (UTI; an infection that occurs when bacteria enter any part of the urinary system.) A record review of Resident #31's hospital clinical record dated 5/21/2026 revealed Resident #31 was diagnosed with a multi-drug-resistant organism UTI and treated with IV antibiotics which he received through a PICC line and was cared for under isolation contact precautions. A record review of Resident #31's admission MDS dated [DATE] revealed Resident #31 was an [AGE] year-old male admitted for recovery care after a hospitalization. Resident #31 was assessed with the ability to understand others and make himself understood. Resident #31 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. Resident #31 was assessed with an indwelling urinary catheter, had intravenous access, and a multi-drug-resistant organism. A record review of Resident #31's admission Report Form dated 5/22/2026 revealed LVN B documented a report she received from Resident #31's hospital RN. LVN B documented Resident #31 had a need for contact isolation precautions and intravenous antibiotic meropenem. A record review of Resident #31's nursing Progress notes revealed LVN A documented on 5/23/2026 at 12:03 AM that Resident #31 was admitted the evening of 5/22/2026 with an indwelling PICC line, PICC line present to right AC sic[ante-cubital, the space in between the forearm and the upper arm, above the elbow]. A record review of Resident #31's physician's orders, dated 6/10/2026, revealed the physician prescribed for Resident #31 to receive medications and therapies as follows:- On 5/26/2026, contact precautions due to bacteremia klebsiella (the presence of viable bacteria in the bloodstream), every shift.- On 5/26/2026, meropenem (a powerful, broad-spectrum carbapenem antibiotic used to treat severe and multi-drug-resistant bacterial infections), 1 gram intravenous every 8 hours for 2 weeks.- On 5/26/2026, sodium chloride 0.9% (a normal saline flush) syringe, flush PICC line with 10ml normal saline before and after medications.- On 5/26/2026, Monitor for signs of PICC complications including infiltration, occlusion, leaking, . catheter displacement.- On 5/26/2026, Secure PICC line appropriately to reduce risk of accidental dislodgement. Maintain infection prevention practices including hand hygiene and proper use drain line care. A record review of Resident #31's care plan dated 6/8/2026 revealed Resident #31 has an infection and a PICC line (Peripherally Inserted Central Catheter, is a thin, flexible tube inserted into a peripheral vein in the arm and threaded through to a larger vein near (continued on next page)

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

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the heart), start date 5/26/2026; Resident is on antibiotics for urosepsis, multidrug-resistant organism, and is at risk for adverse reactions. Follow universal standard precautions to prevent cross contamination and spread of infection. Resident has a PICC line for an administration of medications, IV therapy, fluids, antibiotics, . and is at risk for infection, occlusion, . complications associated with central line use. Notify physician promptly of signs of infection, inability to flush line, . swelling, pain, . During an interview on 6/8/2026 at 12:15 PM, Resident #31 stated he was admitted [DATE] from the hospital where he was treated for an infection. Resident #31 stated he received antibiotics which he received through his PICC line on his right arm. Resident #31 stated he was treated in an isolation room at the hospital, and the staff wore gowns and gloves. During an interview on 6/9/2026 at 5:20 PM, LVN C stated she worked as the charge nurse on 5/26/2026 from 6:00 AM to 6:00 PM and recognized Resident #31 was a newly admitted Resident who was admitted on [DATE]. LVN C stated she assessed Resident #31 with a PICC line but had no orders to maintain the PICC line patent, had a diagnosis of Klebsiella Pneumoniae of the urine without antibiotics to control the infection, or infection prevention or control contact precautions in place. LVN C stated she assessed Resident #31 with no decline in health status and gave a report to the physician. LVN C stated that the physician gave new orders for contact isolation precautions, IV meropenem, and PICC line care. LVN C stated she had received reports from previous nurses that Resident #31 had a need for contact precautions, but Resident #31 did not have any signage to indicate he was under isolation contact precautions. LVN C stated she had developed and implemented the contact isolation precautions and PPE supplies at the resident's door side on 5/26/2026. LVN C stated she had reported the new orders and contact isolation to her superior, the DON. During an interview on 6/10/2026 at 4:01 PM, RN D stated she was the facility's admissions coordinator, and, in that capacity, she had coordinated with the hospital case manager to receive Resident #31 as a new admission. RN D stated Resident #31 was being discharged from the hospital with the need for a contact isolation room, a PICC line and an indwelling Foley catheter. RN D stated Resident #31 had a need for isolation contact precautions because Resident #31 was diagnosed with a multi drug resistant organism, Klebsiella pneumoniae of the urine. RN D stated she had reviewed the new admission with the IDT and planned to receive Resident #31 on the evening of 5/22/2026 and gave a report to LVN B that afternoon. RN D recalled LVN B, on 5/22/2026, had received a report from the hospital RN who was discharging Resident #31 who was cared for with a PICC line and under isolation contact precautions. During an interview on 6/10/2026 at 4:20 PM LVN B stated she was the charge nurse on 5/22/2020 from 6:00 AM to 6:00 PM and at 6:00 PM she gave report to LVN A. LVN B stated she had received report from RN D and the hospital RN with care details for Resident #31. LVN B stated she documented on an admissions report worksheet that Resident #31 had an infection of the urine which needed contact isolation, a need for meropenem (a drug which cannot be given other than by intravenous access; meropenem cannot be given orally. It is exclusively administered via intravenous (IV) infusion), and a Foley catheter. LVN B stated she shared the worksheet with LVN A when she gave a report to LVN A during the change of shift nurse-to-nurse report on 5/22/2026 around 6 pm. During an interview on 6/10/2026 at 5:42 PM LVN A stated she could not recall the events of 5/22/2026 and stated any documentation she made regarding residents specifically Resident #31 was accurate. LVN A stated standard practice was for a nurse to secure orders for newly admitted residents to meet their basic immediate needs within 24 hrs. LVN A was informed that she documented on 5/23/2026 at 12:03 AM that Resident #31 had a PICC line and a record review of Resident #31's baseline care plan did not reflect the PICC line. LVN A stated a PICC line would have been an immediate need for flushing to keep the line patent (in nursing and medical jargon, patent [pronounced PAY-tent] means that a tubular anatomical structure, passage, or airway is open, unobstructed, and clear) with orders for flushes. LVN A did not recall receiving a report from LVN B, but that the report would have been standard practice with information about expectant new residents. LVN A stated she worked the 6:00 PM to 6:00 AM shift and she believed Resident #31 may have arrived on 5/22/2026 sometime between 6:00 PM and 11:00 PM (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/22/2026 evidencing her note on 5/23/2026 at 12:03 AM. LVN A stated the potential risk for residents who did not have their physician orders to meet their immediate needs was that they may not have received the immediate care to meet their basic needs. During an interview on 6/11/2026 at 4:10 PM the DON stated she had recognized that Resident #31 was admitted on [DATE] and had gone 4 days without orders for his isolation contact precautions, antibiotic IV medication, and PICC line care orders. The DON stated the expectation was for newly admitted residents to receive immediate care with their basic needs supported by physicians orders upon their admission. Specific to Resident #31 the orders would include PICC line care, isolation contact precautions, and IV antibiotics. The DON stated that the care was developed and implemented with the coordination of the IDT which included the continuity of care between the admissions coordinator and the floor nurses. The DON stated each member of the IDT had their own unique role and responsibility to ensure each resident received their immediate care needs and LVN A had a unique role in that she was the admissions nurse responsible for assessing Resident #31 with a need for isolation contact precautions, PICC line care, and IV antibiotic medications, for which she was expected to report to the physician and support the physician's orders for the care. The DON stated the failure could place residents at risk for potential lack of care and the spread of infection by cross contamination. The DON stated she had reviewed the facility's infection prevention and control surveillance for the period 5/22/2026 through 6/11/2026 which revealed zero incidents of infections throughout the facility with Klebsiella Pneumoniae. A record review of the United States of America's Centers for Disease Prevention and Control's website: https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings updated September 2024, accessed 6/16/2026, revealed, Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. A record review of the facility's undated, untitled, quality of care policy revealed, Purpose: To ensure that each resident receives the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with comprehensive assessments, individualized care plans, professional standards of practice, and applicable federal and state regulations. Policy: The facility shall provide care and services consistent with each resident's needs, preferences, goals, and rights. Care shall be person centered, evidence based, and designed to promote optimal quality of life, prevent avoidable decline, and achieve the best possible outcomes. The facility will comply with all applicable Federal and state requirements, including those outlined under F-tags related to quality of care and will maintain systems to monitor, evaluate, and improve the quality of services provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care. The baseline care plan must be developed within 48 hours of a resident's admission; include the minimum healthcare information necessary to properly care for a resident, for 1 of 8 residents (Resident #31) reviewed for care plans for immediate needs. Resident #31 was admitted on [DATE] with immediate needs for care with an intravenous device, a PICC line (Peripherally Inserted Central Catheter, is a thin, flexible tube inserted into a peripheral vein in the arm and threaded through to a larger vein near the heart) and a need for isolation contact precautions (essential measures in healthcare settings to prevent the spread of infections, particularly those that can be transmitted through direct or indirect contact with patients or their environment) without care plans to support his immediate needs. These failures could place residents at risk for an PICC line (when the intravenous (IV) catheter has developed a blockage or obstruction) and the spread of infectious diseases.The findings included: A record review of Resident #31's admission record dated 6/8/2026 revealed an admission date of 5/22/2026 with diagnoses which included klebsiella pneumoniae (a bacterium naturally found in the human gut and respiratory tract) and urinary tract infection (UTI; an infection that occurs when bacteria enter any part of the urinary system). A record review of Resident #31's hospital clinical record dated 5/21/2026 revealed Resident #31 was diagnosed with a multi-drug-resistant organism UTI and treated with IV antibiotics which he received through a PICC line and was cared for under isolation contact precautions. A record review of Resident #31's admission MDS dated [DATE] revealed Resident #31 was an [AGE] year-old male admitted for recovery care after a hospitalization. Resident #31 was assessed with the ability to understand others and make himself understood. Resident #31 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. Resident #31 was assessed with an indwelling urinary catheter, had intravenous access (a PICC line), and a multi-drug-resistant organism. A record review of Resident #31's admission Report Form dated 5/22/2026 revealed LVN B documented a report she received from Resident #31's hospital RN. LVN B documented Resident #31 had a need for contact isolation precautions and intravenous antibiotic meropenem (a powerful, broad-spectrum carbapenem antibiotic used in hospitals to treat severe and multi-drug-resistant bacterial infections.) A record review of Resident #31's nursing Progress notes revealed LVN A documented on 5/23/2026 at 12:03 AM that Resident #31 was admitted the evening of 5/22/2026 with an indwelling PICC line, PICC line present to right AC sic[ante-cubital, the space in between the forearm and the upper arm, above the elbow]. A record review of Resident #31's baseline care plan dated 5/22/2026 revealed that LVN A documented immediate care needs for Resident #31 which did not include his need for a PICC line nor infection control isolation contact precautions. During an interview on 6/8/2026 at 12:15 PM Resident #31 stated he was admitted [DATE] from the hospital where he was treated for an infection. Resident #31 stated he received antibiotics which he received through his PICC line on his right arm. Resident #31 stated he was treated in an isolation room at the hospital, and the staff wore gowns and gloves. During an interview on 6/10/2026 at 4:01 PM RN D stated she was the facility's admissions coordinator, and, in that capacity, she had coordinated with the hospital case manager to receive Resident #31 as a new admission. RN D stated Resident #31 was being discharged from the hospital with the need for a contact isolation room, a PICC line and an indwelling [NAME] catheter. RN D stated Resident #31 had a need for isolation contact precautions because Resident #31 was diagnosed with a multi drug resistant organism, Klebsiella pneumoniae of the urine. RN D stated she had reviewed the new admission with the IDT and planned to receive Resident #31 on the evening of 5/22/2026 and gave a report to LVN B that (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	afternoon. RN D recalled LVN B, on 5/22/2026, had received a report from the hospital RN who was discharging Resident #31 who was cared for with a PICC line and under isolation contact precautions. During an interview on 6/10/2026 at 4:20 PM LVN B stated she was the charge nurse on 5/22/2020 from 6:00 AM to 6:00 PM and at 6:00 PM she gave report to LVN A. LVN B stated she had received report from RN D and the hospital RN with care details for Resident #31. LVN B stated she documented on an admissions report worksheet that Resident #31 had an infection of the urine which needed contact isolation, a need for meropenem (a drug which cannot be given other than by intravenous access; meropenem cannot be given orally. It is exclusively administered via intravenous (IV) infusion), and a Foley catheter. LVN B stated she shared the worksheet with LVN A when she gave a report to LVN A during the change of shift nurse-to-nurse report on 5/22/2026 around 6 pm. During an interview on 6/10/2026 at 5:42 PM LVN A stated she could not recall the events of 5/22/2026 and stated any documentation she made regarding residents specifically Resident #31 was accurate. LVN A stated standard practice was for a nurse to develop a baseline care plan for newly admitted residents to meet their basic immediate needs within 24 hrs. LVN A was informed that she documented on 5/23/2026 at 12:03 AM that Resident #31 had a PICC line and a record review of Resident #31's baseline care plan did not reflect the PICC line. LVN A stated a PICC line would have been an immediate need for flushing to keep the line patent (in nursing and medical jargon, patent [pronounced PAY-tent] means that a tubular anatomical structure, passage, or airway is open, unobstructed, and clear) with orders for flushes. LVN A did not recall receiving a report from LVN B, but if she had received the report, it would have been a standard practice with information about expectant new residents. LVN A stated she worked the 6:00 PM to 6:00 AM shift and she believed Resident #31 may have arrived on 5/22/2026 sometime between 6:00 PM and 11:00 PM 5/22/2026 evidencing her note on 5/23/2026 at 12:03 AM. LVN A stated the potential risk for residents who did not have their baseline care plan fully completed was that they may not have received the immediate care needed to meet their basic needs. During an interview on 6/11/2026 at 4:10 PM the DON stated due to the state's investigation, she had recognized that Resident #31 had no baseline care plan. The DON stated the expectation was for newly admitted residents to receive immediate care with their basic needs with a baseline care plan which was to be developed and implemented within 24 hours of their admission. The DON stated that the baseline care plan was developed and implemented with the coordination of the IDT which included the continuity of care between the admissions coordinator and the floor nurses. The DON stated that each member of the IDT had their own unique role and responsibility to ensure each resident received their immediate care needs. The DON stated the potential risk for residents who did not have their immediate needs care planned could be they would not receive their immediate care needs. A record review of the facility's undated, untitled, care plan policy revealed, Purpose:To ensure that each resident receives individualized, coordinated care based on assessed needs, preferences, goals, and clinical condition.Policy Statement:The facility will develop and maintain a comprehensive, person-centered care plan for each resident. Care plans will be created, reviewed, and revised by an interdisciplinary team and will reflect the resident's physical, psychosocial, emotional, and functional needs.Procedure:1. Assessmento A comprehensive assessment will be completed upon admission and as required thereafter.o Assessment findings will identify resident strengths, needs, risks, preferences, and goals.2. Care Plan Developmento An individualized care plan will be developed within the timeframe required by applicable regulations.o The care plan will include:ˆ Identified problems and needsˆ Measurable goals and expected outcomesˆ Interventions and services to be providedˆ Responsible disciplines and staff.4. Interdisciplinary Team Involvemento The care plan will be developed and reviewed by the interdisciplinary team, including nursing, therapy, dietary, social services, activities, and other relevant disciplines.5. Implementationo Staff will provide care according to the documented care plan.o Care plan interventions will be communicated to all appropriate staff. This policy will comply with all applicable federal, state, and local regulations governing long-term care services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 (4) residents in that: Resident #4's Care Plan did not include his diagnosis of PTSD and interventions. This could affect all residents with care plans and could result in a decrease in care. The Findings: Record review of Resident #4's face sheet dated 6/10/206 revealed his admit date was on 9/5/2025, re-admitted on [DATE] with diagnoses of PTSD (post-traumatic stress disorder). Record review of Resident #4's Physician visit dated 5/22/2026 revealed his diagnosis included PTSD. Record review of Resident #4's Quarterly MDS dated [DATE] revealed his BIMS was 15/15 (cognitively intact), and active diagnosis included PTSD. Record review of Resident #4's Physician visit dated 5/22/2026 revealed his diagnosis included PTSD. Record review of Resident #4's care plan dated 4/22/206 revealed it did not include his diagnosis of PTSD. Interview on 6/10/2026 at 4:48 PM the DON stated she did not see PTSD in Resident #4's care plans. The DON stated it was important to have the diagnosis PTSD in Resident #4's care plan for staff to show interventions, such as avoiding certain triggers. Thes DON stated she was responsible for ensuring the resident's diagnoses and care were in the care plans. Record review of the policy, PTSD Management in Long-Term Care no date, Purpose: To provide guidelines for the identification, assessment, treatment, and support of residents with PTSD while promoting dignity, safety, trauma informed care, and psychological well-being. Policy, the facility shall provide person centered trauma informed care for residents with a diagnosis or history of PTSD. Definitions, PTSD; a mental health condition that may develop following exposure to traumatic events. Trauma informed care; cares that recognizes the impact of trauma and seeks to avoid re traumatization. Procedures; 2. Care planning; Develop individualized interventions and document resident preferences and triggers. Record review of the policy, Care Plan (no date) revealed, To ensure that each resident receives individualized, coordinated care based on assessed needs, preferences, goals and clinical condition. Policy Statement: The facility will develop and maintain a comprehensive, person-centered care plan for each resident. Care Plans will be created, reviewed, and revised by an interdisciplinary team and will reflect the residents' physical, psychological, emotional, and functioning needs. Procedure: 1. Assessment, Assessment findings will identify resident strengths, needs, risk, preferences, and goals. 2. The Care plan will include: identified problems and needs, Measurable goals and expected outcomes, interventions and services to be provided and responsible disciplines and staff. Interdisciplinary Team Involvement: The care plan will be developed and received by the interdisciplinary team, including nursing, therapy, dietary, social services, activities, and other relevant disciplines. 5. Implementation, staff will provide care according to their documented care plan, care plans interventions will be communicated to all appropriate staff. 6. Review and revision; Care plans will be reviewed regularly, and revised when: The residence conditions changes, Goals are achieved or no longer appropriate, new needs or risk are identified, regulatory review schedules require updates. 7. Care plan development, reviews, revisions, and resident participation will be documented in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 8 residents (Resident #31) reviewed for continuity of care. CNA E entered Resident #31's isolation contact precautions room without personal protection equipment (PPE). This failure could place residents at risk of the spread of infectious diseases.The findings included: A record review of Resident #31's admission record dated 6/8/2026 revealed an admission date of 5/22/2026 with diagnoses which included klebsiella pneumoniae (a bacterium naturally found in the human gut and respiratory tract) and urinary tract infection (UTI; an infection that occurs when bacteria enter any part of the urinary system.) A record review of Resident #31's hospital clinical record dated 5/21/2026 revealed Resident #31 was diagnosed with a multi-drug-resistant organism UTI and treated with IV antibiotics which he received through a PICC line and was cared for under isolation contact precautions. A record review of Resident #31's admission MDS dated [DATE] revealed Resident #31 was an [AGE] year-old male admitted for recovery care after a hospitalization. Resident #31 was assessed with adequate vision. Resident #31 was assessed with the ability to understand others and make himself understood. Resident #31 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. Resident #31 was assessed with an indwelling urinary catheter, had intravenous access, and a multi-drug-resistant organism. A record review of Resident #31's admission Report Form dated 5/22/2026 revealed LVN B documented a report she received from Resident #31's hospital RN. LVN B documented Resident #31 had a need for contact isolation precautions and intravenous antibiotic meropenem. A record review of Resident #31's physician's orders revealed the physician prescribed for Resident #31 to receive medications and therapies as follows:- On 5/26/2026, contact precautions due to bacteremia klebsiella (the presence of viable bacteria in the bloodstream), every shift. A record review of Resident #31's care plan dated 6/8/2026 revealed Resident #31 has an infection, start date 5/26/2026; Resident is on antibiotics for urosepsis, multidrug-resistant organism, and is at risk for adverse reactions. Follow universal standard precautions to prevent cross contamination and spread of infection. During an observation on 6/8/2026 at 11:15 AM, revealed Resident #31's room with signage which reflected, Stop Contact Precautions Everyone Must: Clean their hands including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment clean and disinfect reusable equipment before use on another person. During an observation on 6/8/2026 at 11:20 AM, revealed CNA E answered Resident #31's call light without putting on any PPE. During an interview on 6/8/2026 at 12:58 PM, Resident #31 stated he was admitted [DATE] from the hospital where he was treated for an infection. Resident #31 stated he was treated in his room under isolation, and the staff sometimes wore gowns and gloves. Resident #31 stated he had just been visited by the CNA who answered his call light for repositioning care. Resident #31 stated the CNA had not worn PPE, and sometimes staff don't wear the gowns. During an interview on 6/8/2026 at 2:10 PM CNA E she had entered Resident #31's room to answer call lights without putting on any PPE. CNA E stated Resident #31 had an infection of the urine and an indwelling urinary catheter. CNA E stated she would wear PPE when she provided any urinary catheter care but did not need to wear PPE if she was not providing catheter care. During an interview on 6/9/2026 at 4:20 PM LVN C stated she was Resident #31's charge nurse and Resident #31 was cared for under isolation contact precautions. LVN C stated on 5/26/2026 she had developed and implemented the contact isolation precautions and PPE supplies at Resident #31's door side. LVN C stated CNA E was her CNA and cared for Resident #31. LVN C (continued on next page)

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	675532	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated CNA E had been trained to wear PPE whenever she entered Resident #31's room. LVN C stated she would re-educate CNA E for compliance. LVN C stated the potential risk for residents if staff failed to wear PPE in isolation contact rooms was the spread of infections. During an interview on 6/11/2026 at 4:10 PM the DON stated her expectation was for all staff who entered a contact isolation room to provide hand hygiene, don a gown, and gloves prior to entering the room and to remove the PPE prior to exiting the room. The DON stated if staff did not wear PPE in isolation contact precaution rooms the potential risk for residents could be the spread of infections. A record review of the facility's undated, untitled, quality of care policy revealed, Purpose: To ensure that each resident receives the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with comprehensive assessments, individualized care plans, professional standards of practice, and applicable federal and state regulations. Policy: The facility shall provide care and services consistent with each resident's needs, preferences, goals, and rights. Care shall be person centered, evidence based, and designed to promote optimal quality of life, prevent avoidable decline, and achieve the best possible outcomes. The facility will comply with all applicable Federal and state requirements, including those outlined under F-tags related to quality of care and will maintain systems to monitor, evaluate, and improve the quality of services provided. Infection Prevention and Control; staff shall: Follow standard precautions and transmission based precautions; perform hand hygiene according to established guidelines; personal protective equipment; . A record review of the United States of America's Centers for Disease Prevention and Control's website: https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings updated September 2024, accessed 6/16/2026, revealed, Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interviews, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition, for 1 of 1 laundry departments reviewed for laundry equipment. 1 of the 2 commercial washing machines was inoperable for longer than 8 months. This failure could place residents at risk for not having timely laundry service.The findings included: During an observation and interview on 6/8/2026 at 1:00 PM revealed the facility's laundry department had 2 commercial washers of which only 1 functioned. Laundry Aide F stated she was the laundry staff for the day and used the 1 functioning commercial washer. LA F stated she was able to keep up timely laundry services with the 1 washer but at times keeping up with timely laundry services was challenging with only 1 washer for all the residents. LA F stated the broken washer had been out of service for longer than 8 months. During an observation and interview on 6/10/2026 at 3:00 PM revealed the facility's laundry department had 2 commercial washers of which only 1 functioned. Laundry Aide G stated she was the laundry staff for the day and used the 1 functioning commercial washer. LA G stated she was able to keep up timely laundry services with the 1 washer but at times keeping up with timely laundry services was challenging with only 1 washer for all the residents. LA G stated the broken washer had been out of service for longer than 8 months. During an interview on 6/11/2026 at 4:10 PM the Administrator stated she and the facility's Owner had become aware that 1 of the 2 facility commercial washers was not working and the washer was under the manufactures' warranty; however, the facility was unsuccessful in securing service from the vendor for the past 8 months. The Administrator stated that for the time being the laundry department was able to keep up timely laundry services. The Administrator stated she would follow up with the facility's Owner and explore alternate options for repairing the washing machine. A policy was requested (and as of 6/17/2026) a policy had not been provided. The Administrator stated the facility followed HHSC guidelines.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 (1 hair salon, 1 kitchen) facility in that: The kitchen drains on floor, near the dish machine, did not have a grate on it.Hair salon was not sanitary, including 3 brushes with hair, hair on several hair curlers and the sink drain filter had a glob of hair.These failures could place residents at risk by residents' germs being spread, that use the hair salon and could allow pests to enter the facility through the kitchen floor open drain. The Finding: 1.Observation on 6/09/2026 at 8:08 AM in the kitchen, with the FSM near the dish machine, revealed an open drain on the floor with no grate. Interview on 6/09/2026 at 8:08 AM in the kitchen, with the FSM confirmed an open drain on the floor with no grate. The FSM stated she was not sure how long the open drain did not have a grate. The FSM stated they had no pests and they were waiting for the Maintenance supervisor to start working at the facility to let him know about it. Interview on 6/09/2026 at 4:19 PM the FSM stated she had told the MS a week or 2 weeks ago, but she had discussed with the new MS, he started Monday, 6/8/2026. The FSM stated the former MS left the position on Friday, 6/5/2026. Record review of the policy, Drain cover (no date) revealed, Purpose, to maintain a safe, sanitary, and complaint food service department by ensuring that all floor drains in the dietary department are equipped with property fitting properly or covers all times. Policy statement, all floor drains located within the dietary department shall have securely fitted grades or drain covers in place during operation and where the area is not in use. Drain grades help prevent pest entry, reduce the risk of foreign material entering the drainage system, minimize slip and trip hazards, and support infection prevention and sanitation standards. Responsibilities: dietary staff; conduct routine inspections and report deficiencies. Dietary Manager: [NAME] compliance and ensure corrective actions are taken. 2. Observation on 6/11/2026 at 11:07AM in the Hair Salon room, with the Activity Director, revealed in the sink drain a glob of hair in the sink filter. Also, 3 brushes in a cabinet had hair and a box of hair curlers with hair on them. Interview on 6/11/2026 at 11:07AM in the Hair Salon room, the Activity Director confirmed the sink drain had a glob of hair in the sink filter and the 3 brushes in a cabinet that had hair and a box of hair curlers with hair on them. The Activity Director (AD) stated the Housekeeping Department was in charge of cleaning the Hair Salon sink. The AD stated the beautician came to visit on Tuesday, 6/9/2026.Interview on 6/11/2026 at 11:10 AM in the Hair Salon room, with the Housekeeping Supervisor (HS) confirmed the sink drain had a glob of hair in the sink filter. The HS stated she might have forgotten to clean the Hair Salon after the beautician visited this week. Interview on 6/11/2026 at 11:30 AM with the ADM, discussed the Hair Salon and kitchen drain findings and she did not have any comments. Record review of the policy, dated August 2019 revealed Cleaning and disinfection of environmental surfaces. Policy statement, Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of health care facilities and the OSHA bloodborne pathogen standard. Policy interpretation and implementation. 9. Housekeeping surfaces will be cleaned on a regular basis, the spills occur, and when these surfaces are visibly soiled.Record review of the policy, Beauty shop cleaning policy, (no date) revealed, Purpose, To ensure the hair salon within the facility is maintained in a clean, safe, and sanitary condition to protect residents, staff, and visitors from infection, injury, and environmental hazards. Policy statement, The facility shall maintain the hair salon in a clean and sanitary condition at all times. Cleaning and disinfection practices will be performed routinely and between resident appointments in accordance with infection prevention standards and applicable regulations. Procedure, General Housekeeping, the salon should be kept clean, organized, and free of clutter. Hair flipping shall be removed promptly from floors, chairs, countertops and equipment. 2. Cleaning and Disinfection of Equipment, Combs, brushes, clips, rollers, and other reusable equipment shall be (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaned and disinfected after each use. Responsibilities, Environmental Services: Provide routine housekeeping support as assigned. Department Manager: Monitor compliance and address deficiencies.