STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675560	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Nursing and Rehabilitation Center	169 Lake Park Rd Lewisville, TX 75057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information, for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specification established by CMS. The facility failed to submit staffing data to CMS for FY Quarter 1 2026 (October 1 - December 31). This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included:Review of the CMS PBJ report for CMS for FY Quarter 1 2026 (October 1 - December 31) indicated the facility had failed to submit data for the quarter triggered. During an interview on 05/05/26 at 11:25 AM, HR stated been HR at this facility for 3.5 years. HR stated the workflow process was to create a contingent worker profile, followed by keying in the work hours. HR stated the SC is our Home Office. Upon our submission of the time record(s); the SC then obtains the hours from the documents submitted to them. They in turn submit them to CMS for PBJ requirements. During an interview on 05/05/26 at 11:38 AM, the DON stated part of her duties would be to review the staff hours, and make sure the times accurate before submitting them to HR. HR, would then submit them to the SC. The SC submits them to CMS. This instance it was submitted on 2/13/26. It was not until the following date we found out there was a software glitch. The DON stated it was added to our QAPI meeting to be reviewed quarterly, to ensure it is accurate to provide the SC the correct information in a timely manner.During an interview on 05/05/26 at 1:15 PM, ADMIN stated he has been ADMIN here for 5 years. He stated staff goes by the guidelines that CMS provides regarding PBJ submission. ADMIN stated the facility compiles the information and data, and submit to the SC, and they in turn submit it to CMS. The ADMIN stated that it would affect the facility's star rating and cause the facility to default to a 1 star for 4 quarters. ADMIN said it would affect the facility's quality measures by causing the facility to lose stars. When asked how late or omitted PBJ submissions could affect the facility residents, the Administrator said that it created the potential for the facility to be inadequately or inappropriately staffed, but should not if monitoring staffing appropriately, and it can affect the residents negatively. The ADMIN stated, since that time, no staffing issues were reported. He stated the information is compiled and data submitted to the SC and they in turn submit it to CMS.Record review of the Facility's Q4 PBJ submission internal investigation revealed. The PBJ data submitted to CMS 2/13/26 at approximately 4:30 PST by facility payroll Vendor.- At 12:26 am 2/14/26 CMS loaded the [NAME] report showed failed submission (Top right of [NAME] report)- Submitted PBJ data for 256 employees. 1 of those employees didn't match due to new software that went live 1/1/26. This caused submission failure. (see page 2 of the [NAME] report 4016/Fatal)- On 2/16/26 realized the report didn't submit and initiated internal root cause analysis while also enlisting Simple LTC to aid in research. - Root Cause Analysis PBJ submission in the correct format occurred prior to the deadline but was rejected due to a coding error attached to employee positions contained within the file. Facility payroll vendor system was upgraded in January and February of 2026, resulting in an unanticipated increased length of time for the Facility to review (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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and validate data to be submitted and facility was not notified of this increased time requirement. The coding issue was not identified or recognized prior to the contracted service submission of the PBJ file. The contracted service did not discover the issue until the submission error occurred and extensive investigation identified the coding error several days past the submission deadline, preventing resubmission. Upgrades to payroll vendors and contracted service providers occurred too close and overlapping with data validation process of the PBJ reporting submission date preventing opportunity for the Facility to complete thorough review and validate submission.- After finding the root cause to be software change issues, on 2/23/26 an appeal was filed with CMS to try and resubmit data. Software issues are one of the few reasons they list for possible appeal.- 2/23/26 AHCA also contacted CMS on 's behalf.- 2/24/26 CMS denied the Appeal- Plan of Correction was created by the Facility leaders in conjunction with. (please see doc Process Improvement Plan: F851 - Payroll-Based Journal (PBJ) Staffing Data Submission)- Plan of Corrections run through QAPI in anticipation of May 15, Q1, deadline. Record review of the facility's Email correspondence with CMS dated 02/24/26 revealed. CMS Nursing Home Staffing RE: Appeal for late PBJ Submissions. Stated the following: Unfortunately, it is not possible to submit or correct PBJ data once a submission deadline has passed. There are no exceptions. To post staffing measures and ratings for all facilities on a set schedule, it is critical that the submission deadline is met. We calculate the measures for all ~15,600 facilities at once {not individual facility's measures one-by-one). We hope you can understand that to maintain a complex system that collects and processes millions of pieces of data effectively, we cannot easily deviate from set processes. Also, in order to maintain fairness and objectivity for all facilities, we need to hold all facilities accountable to the same standards {which have been public for quite some time). All providers should be running the staffing reports that are available in CASPER to check the accuracy and completeness of their final submissions before the submission deadline has passed. Providers are given 45 days from the end of the quarter, and we have cautioned providers that they should not be waiting until the last few days before the deadline to be making their final submissions as they must allow time to deal with any issues that may occur. Providers using a third-party vendor are still ultimately responsible for their PBJ submissions. This Appeal and Request for Reconsideration is being filed on behalf of 45 individual facilities, by their contracted service provider and authorized agent, [NAME] Services, Inc. (ESI). ESI performs certain administrative services for and on behalf of approximately 357 skilled nursing facilities, including but not limited to the processing and submission of PBJ data.This Request seeks approval for the 45 affected facilities to resubmit their PBJ data for the quarter ending December 31, 2025. It is based on the PBJ Technical Manual and related authority which expressly grants CMS the discretion to rescind, modify or otherwise respond to a submission failure resulting from unexpected circumstances. Each of the 45 facilities that experienced a fatal error relative to their PBJ submission were impacted by the same technical data migration issue which prevented the submission from being successful. We have attached the following documentation in support of this request:1. Separate appeal documents for each of the facilities with appropriate identifying information (e.g., name, CCN, etc.) as well as a detailed description of the issue and the basis for the appeal. (PBJ Appeal detaLl.s_.zip)2. CMS confirmation report letters for each of the affected facilities. (PBJ Confirmation Reports.zip). Record request from the ADMIN on 05/05/26 at 12:26 PM, for their PBJ policy, the ADMIN stated, We don't have a policy other than following CMS guidelines for PBJ reporting. Record review of the CMS, Electronic Staffing Data Submission Payroll-Based Journal, Long-Term Care Facility Policy Manual, Version 2.7, June 2025, section 1.2 Submission Timeliness and Accuracy, reflected Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. Further review revealed Report Quarter 1 date range as October 1-December 31. Policy manual reflected, Deadline: Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure all food items in the facility's kitchen were dated and discarded prior to their use-by date and were properly sealed. These failures could place residents at risk for food contamination and food-borne illness. Finding included: An observation on 05/03/26 between 9:10 AM and 9:45 AM in the facility's kitchen revealed:One gallon bag containing yellow cake mix dated 04/23/26 with no visible expiration date.One gallon bag containing corn flakes dated 02/04/26 with no visible expiration date. One 5 lb. bag of muffin mix dated 05/29/26 with no visible expiration date, not properly sealed and exposed to air contaminants.One gallon bag containing corn flakes date 01/22/26 with no visible expiration date. One gallon bag containing Lime gelatin mix dated 03/04/26 with no expiration date. One gallon bag containing Lime gelatin mix dated 02/01/26 with no expiration date.One 10 lb. bag of spaghetti pasta noodles dated 04/30/26 with no expiration date. One gallon bag containing powdered sugar dated 12/26 with no visible expiration date. One gallon bag containing mashed potatoes with no visible dates. One gallon bag containing pinto beans with no visible use by date or expiration date. One gallon bag of chicken gravy dated 04/27/26 with no visible expiration date. One 32-quart bin containing creamer mix not properly sealed and exposed to air contaminants. One gallon bag of chocolate syrup dated 04/28/26 with no visible expiration date was observed. One gallon bag of vegetable mix dated 04/29/26, with no visible expiration date was observed.One bag of pork chops with freezer burn that had visible freezer burn. One gallon bag containing hot dogs was undated and revealed no expiration date. One gallon bag containing chicken nuggets dated 04/27/26 with no visible expiration date. One gallon bag containing battered corn nuggets dated 02/09/26 with no visible expiration date was observed.During an interview on 05/05/26 at 10:14 AM, the DM stated she was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. DM confirmed the surveyor observations and stated the listed items would be corrected. DM stated once items were opened, they should be properly sealed and dated. DM stated he was responsible for ensuring policy was followed. DM stated he and the kitchen aides were responsible for labeling and making sure that the items were labeled properly. The DM stated the risk to residents if policy was not followed was a health risk to the residents. DM stated the items should be labeled, and the risk of the concerns not being addressed could result in food-borne illnesses. DM stated if food items were not dated when opened, then they would not know how long the item would last. DM stated a full in-service completed in reference to food rotation and storage pertaining to what the proper procedures were dealing with food rotation and storage. The DM stated the risk of serving foods that were past the use-by date, or serving food that was not labeled or dated, could cause food borne illness. During an interview on 05/05/2026 at 10:45 AM, the ADMIN stated he oversaw all departments, and ensured residents were taken care of. ADMIN stated the DM made him aware of the concerns observed in the kitchen, and he had spoken with the DM. He stated the issues could cause food contamination, and that matter would be resolved. He stated if items were expired, they should not serve them to residents. The ADMIN stated the risk of all those concerns observed in the kitchen could result in residents getting sick. The ADMIN said the policy or procedure for storing food was, everything needed to be dated, and if opened, it needed to have an open date and an expiration date. He said the risk to residents if policy was not followed, was they could get sick from food borne illnesses. The ADMIN stated he would expect the DM to ensure that the kitchen followed all guidelines, including ensuring the food items were labeled properly in the kitchen. The ADMIN stated he expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. Record review of the facility's Food and Nutrition (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services Policy, dated January 2022, indicated 3. All foods shall be labeled and dated prior to being stored. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 1 kitchen reviewed for environmental conditions. The facility failed to provide an effective pest control program treat the kitchen for cockroaches. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. Findings included: Observation tour of the kitchen on 05/03/26 at 9:10 AM, revealed a dead roach in the kitchen area. During an interview on 05/05/26 at 11:58 AM, MS stated has been in Maintenance at this facility for approximately 24 years. MS stated an ac unit was installed in the window and had to cover the space around the window. It has been scheduled two times a month to correspond with laundry department to clean the area, which included the exhaust vent, ac window area, and to add a disinfectant when needed. The kitchen staff check these areas bout two times a week. The MS stated recently there have not been any issues with roaches and gnats. MS if there was an issue it would be coordinated the pest control company. When the Pest Control services would come out set up bait and traps. MS stated when they receive reports, pest control is contacted. This is followed up with a deep clean at the floor level. During an interview on 05/05/26 at 12:05 PM, the DON stated food service areas create serious risks including contamination with bacteria (Salmonella, E. coli, Staphylococcus), spread of disease to immunocompromised residents, and allergen exposure.During an interview on 05/05/26 at 12:15 PM, DM confirmed state surveyor observations over the issue of pests in the kitchen. DM stated a while back went through the kitchen with the MS, during the tour of the kitchen area observed an area around the AC window unit where they observed water. The condensation looked like it was coming down into the kitchen area. MS sealed the area up, and since then we have had no more issues, other than when it rains, we have had a few every now and then.During an interview on 05/05/26 at 12:30 PM, ADMIN stated the pest control agency did the treatment twice a month and it was up to date. The ADM said the pest control treatment might not be fully effective since there were insect activities at the facility. The ADMIN stated he was committed to have a pest-free facility as they were harmful to residents in many ways like causing insect bites or spreading various diseases. He stated, however, no one has reported to him about any insect activities at the facility. Record review of pest control records revealed the pest control agency visited the facility and did the treatment on 02/06/2026. It was also revealed they visited the facility every 15 days for treatment. Record review of the facility provided Pest Control Statements revealed the facility received pest control service on the following dates:02/06/202602/12/202603/13/2026 03/30/2026 04/07/202604/28/2026 Record review of the contracts provided by the facility revealed the facility had a contract with a pest control company and the facility was serviced for roaches and pests twice per month. The most recent visit was 6 days prior to the sighting of the rodent, on 05/03/2026. The contractor serviced every area of the facility, including exterior areas and the kitchen.Record review of Pest Control Scope of Services and Compensation dated 04/20/2023 revealed: Service: will perform regular service Monthly/Weekly/Bi-Weekly for the control of: Roaches, Rats, Mice, Ants Treatment: Treat the exterior, Bait the exterior, Inspect/Treat entry points, Inspect/Treat Common Areas, Inspect Exterior StationsProposal Specifications: will implement a twice a month service for these location covering general pests, and rodents.Record review of the facility-provided policy titled Safe/Comfortable/Homelike Environment dated February 2026 reflected, Policy Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Procedure1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. Cleanliness and order;

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the residents' environment remained free of hazards as was possible for one of eighteen residents (Resident #55) reviewed for accident hazard.The facility failed to ensure there were no unattended container of germicidal wipes (substance that destroys germs and microorganism) on a table at the lobby, where Resident #55 was on 05/03/2026.This failure could place residents at risk of having an environment that was not free from exposure toxic chemicals.Findings included:Record review of Resident #55's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and depression (persistent feeling of sadness or loss of interest). Record review of Resident #55's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 04/17/2026, reflected that the resident had severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated that the resident had dementia and depression. Record review of Resident #55's Comprehensive Care Plan, dated 02/24/2026, reflected that the resident was at risk for impaired cognitive function and had depression. The interventions were to engage in simple and structured activities and to observe confusion.During an observation on 05/03/2026 at 9:07 a.m. revealed that an unattended container of germicidal was on top of a table at the reception area. It was observed that Resident #55 was near the table with an unattended container of germicidal wipes.During an interview on 05/03/2026 at 9:56 a.m. revealed Resident #55 still sitting in the lobby. She did not reply when asked about the container of germicidal wipes on top of the table.During an observation and interview on 05/03/2026 at 11:50 a.m. revealed the Activity Director was sitting at the table in the reception area. She said she did not see the container of germicidal wipes when she stepped inside the facility. She said somebody might be cleaning the table and forgot to store the container of germicidal wipes properly. She said germicidal wipes could be harmful to the residents when ingested. She said if the container had Keep out of reach of children should not be accessible to the residents because some of them were confused.During an interview on 05/03/2026 at 12:20 p.m., LVN B said he did not notice the container of germicidal wipes when he went to the reception area. He said he did not know who left it on top of the table. He said there could be confused residents sitting in the lobby that could get hold of the wipes and use them inappropriately, like wiping their eyes and skin with them, and could cause irritations. He said whoever used it should have stored it properly after using it.During an interview on 05/03/2026 at 12:50 p.m., LVN C said she did not notice the container of germicidal wipes in the lobby left unattended. She said a confused resident might open it and pull some wipes to use on their face and body. She said the wipes had chemicals in them that could cause irritation to the eyes and skin. She said it should be stored somewhere that the resident could not reach them.During an interview on 05/04/2026 at 9:57 a.m., HK G said she was in the facility the day before; she said she was not the one who left the container of germicidal wipes on top of the table in the reception area and did not know who did. She said the wipes had chemicals that could be harmful to the residents.During an interview on 05/05/2026 at 6:30 a.m., ADON A said they normally keep the containers of germicidal wipes in the carts or somewhere that withing reach of the residents. She said if the containers of germicidal wipes were left unattended, the resident might easily open it, pull some wipes, and use them. She said the wipes could be harmful when used to wipe the face and skin. She said the expectation was for the staff to be vigilant and leave containers of germicidal wipes accessible to the residents. She said they would re-educate the staff about germicidal wipes. She said they already started an in-service about not leaving germicidal wipes within reach of the residents. During an interview on 05/05/2026 at 7:09 a.m., the DON said the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	container of germicidal wipes should not be within reach of the residents because they might be able to get some wipes and use them to clean their eyes, nose, ears, and skin. She said contact with the wipes might result to irritations and chemical burns. She said the germicidal wipes should be stored inside the last drawer of the cart for safe keeping. She said anything that had Keep out of reach of children as an instruction should be considered harmful because the facility had confused residents that may not know germicidal wipes from ordinary wipes. She said the expectation was for the staff not to leave germicidal wipes or anything with chemicals unattended. She said she already started an in-service about not leaving the germicidal wipes unattended as soon as she heard about the issue.During an interview on 05/05/2026 at 7:47 a.m., the Administrator said the container of germicidal wipes should have been stored properly after using it because the facility had confused residents that could use the wipes inappropriately. He said the expectation was for the staff to store the germicidal wipes properly, not left unattended, and not within reach of the residents. He said the DON had already started an in-service about the germicidal wipes, and they would continue to re-educate them. He said they would also monitor closely that the staff understood what the in-service was all about.Record review of the facility's policy Safety, Resident Policy/Procedure revised April 2026 reflected POLICY: It is the policy of this facility to create a safe environment for the resident . PROCEDURES . 5. Ensure all medications, chemicals, cleaning supplies, and any other potential hazardous materials are kept locked/ secured when staff has completed their use.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for two of four residents (Resident #43 and Resident #91) reviewed for incontinent care. 1. The facility failed to ensure that CNA F did not use the wipes that she used to clean Resident #43's inguinal area (lower portion of the abdomen) to clean the perineal area (area between the legs) on 05/04/2026.2. The facility failed to ensure that CNA E did not place Resident #91's catheter bag on top of the resident's bed rendering the catheter to be not below the bladder while the resident's linen was being changed on 05/03/2026. These failures could place the residents at risk for urinary tract infection.Findings included: 1. Record review of Resident #43's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting (loss of muscle leading to its shrinking and weakening) and atrophy (decrease in size of a body part).Record review of Resident #43's Comprehensive MDS Assessment, dated 03/23/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated that the resident was incontinent (uncontrolled) for bladder and bowel. Record review of Resident #43's Comprehensive Care Plan, dated 04/07/2026, reflected that the resident had bowel and bladder incontinence and one of the interventions was to check as required for incontinence.During an observation on 05/04/2026 at 6:51 a.m. revealed CNA F was about to do Resident #43's incontinent care. She washed her hands, put on a pair of gloves, and proceeded with incontinent care. She pulled some wipes and cleaned the sides of the perineal area (area between the legs); after cleaning the sides, she cleaned the vulva (external female genitals) of the resident using the wipes she used to clean the sides.During an interview on 05/04/2026 at 7:17 a.m., CNA F said she should have pulled some new wipes to clean the middle portion of Resident #43's perineal area because the wipes she used to clean the sides were already soiled. She said her actions could cause UTI.2. Record review of Resident #91's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive reflux uropathy (a blockage in the urinary tract).Record review of Resident #91's Comprehensive MDS Assessment, dated 05/01/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter bag). Record review of Resident #91's Comprehensive Care Plan, dated 04/29/2026, reflected that the resident had an indwelling Foley catheter (device used to help drain urine from bladder) r/t obstructive and reflux uropathy and one of the interventions was to secure the catheter to facilitate flow of urine.Record review of Resident #91's Physician Order, dated 04/28/2026, CATHETER CARE EVERY SHIFT. MONITOR URETHRAL SITE (a tube where urine exits the body) FOR S/S OF SKIN BREAKDOWN, PAIN/DISCOMFORTS, UNUSUAL ODOR, URINE CHARACTERESTIC OR SECRETIONS, CATHETER PULLING CAUSING TENSION every shift.During an observation and interview on 05/03/2026 at 9:14 a.m. revealed Resident #91 was in his bed, awake. It was observed that the resident had a catheter with its bag hanging at the side of the bed. The resident said he had the catheter for months, but he did not know what the exact date was.During an observation on 05/03/2026 at 9:16 a.m. revealed CNA E was about to change Resident #91's bed linens. She went inside the resident's room carrying with her a fitted sheet and a blanket. She went out of the room to ask somebody to assist her in turning the resident. Before she went out of the room, she placed the resident's catheter bag on top of his bed. It was observed that there were urine and streaks of blood in the catheter tubing.During an observation on 05/03/2026 at 9:21 a.m. revealed CNA E returned to Resident #91's room with LVN B. LVN B noticed that there was blood in the catheter tubing but did ask CNA E why the catheter bag (continued on next page)

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	675560	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Nursing and Rehabilitation Center	169 Lake Park Rd Lewisville, TX 75057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was on top of the bed nor hang it on the bed's railing.During an interview on 05/03/2026 at 12:20 p.m., LVN B said it did not occur to him that the catheter bag should not be on top of the bed and should always be below the bladder to prevent urine from flowing back to the bladder that could result to infection. He said for Resident #91, it was not only urine that could go back to the bladder but also some blood that was in the tubing.During an interview on 05/03/2026 at 12:28 p.m., CNA E said she knew the catheter bag should always be below the bladder so that urine will not go back to the inside the Resident #91's body. She said she was not sure if the urine from the catheter bag went back inside the body. She said she put it on the bed because it might be pulled when the resident was turned. She said the catheter bag could be hung to the other side once the resident was turned instead of putting it on top of the bed.During an interview on 05/05/2026 at 6:30 a.m., ADON A said the catheter bag should always be below the bladder to prevent urine from going back to the bladder that could eventually cause urinary tract infection. She said the staff could hang the catheter bag on the other side if they needed to turn the resident. She said the staff should have changed her wipes after she cleaned the sides of the perineal area because they were already dirty. She said the right procedure was to discard the wipes with every stroke. She said the expectation was that catheter bags would always be below the bladder and that the staff would perform the right procedure in doing incontinent care. She said the DON had already started an in-service about placement of the catheter bag and perineal care.During an interview on 05/05/2026 at 7:09 a.m., the DON said the catheter bag should always be below the bladder to prevent backflow of urine from the catheter bag to the bladder. She said if there was a backflow, it could result to urinary tract infection. She said the staff could always hang the catheter bag to the other side of the bed if they needed to turn the resident. She said the right procedure in cleaning a female resident was to clean the sides first and then the middle portion, but the staff could not use the same wipes because it could cause urinary tract infection. She said the expectation was for the staff to keep the catheter bag below the bladder and to do the right procedure in performing incontinent care. She said she already started an in-service about catheter care and incontinent care.During an interview on 05/05/2026 at 7:47 a.m., the Administrator said the expectation was that the catheter bag should be below the bladder at all times to prevent the urine from returning into the bladder. He said soiled wipes could not be used to clean the middle part of the female's perineal area. He said both issues could result to urinary tract infection. He said the expectation was for the catheter bags to be below the bladder and that the right procedures for incontinent care were followed. He said the DON already started an in-service about the issue, and they would continually re-educate the staff about the issues. He said they would closely monitor that the staff understood what the in-service was all about. He said they would also do random checking and check off for incontinent care.Record review of the facility's policy Indwelling Urinary Catheter Care Policy & Procedure revised April 2026 reflected Policy: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection . Procedure . 13. Maintain the drainage tubing below the level of the bladder.Record review of the facility's Perineal Care Checklist, undated, reflected Perineal Care Procedure . I. Female Procedure . Cleaning downward from front to back using a clean part of cloth/wipe with each stroke.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of ten residents (Resident #91) reviewed for respiratory care.The facility failed to ensure Resident #91's nasal cannula was stored properly when not in use on 05/03/2026.This failure could place residents at risk of respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #91's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and pulmonary edema (accumulation of fluid in the lungs).Record review of Resident #91's Comprehensive MDS Assessment, dated 05/01/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #91's Comprehensive Care Plan, dated 04/29/2026, reflected that the resident had oxygen therapy and one of the interventions was to provide oxygen therapy as ordered. Record review of Resident #91's Physician's Order, dated 04/29/2025, reflected O2 at 2 L/MIN via NASAL CANNULA (flexible tube used to deliver oxygen to the nose through two prongs) as needed for SOB, RESPIRATORY DISTRESS (person struggles to get enough air), CYANOSIS (low levels of oxygen in the blood), LABORED BREATHING, related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) WITH (ACUTE) EXACERBATION; ACUTE PULMONARY EDEMA.During an observation and interview on 05/03/2026 at 9:14 a.m. revealed that Resident #91 was in his bed, awake. It was observed that a nasal canula, connected to an oxygen concentrator, was on top of the resident's side table. The nasal cannula was not bagged. The resident said he did not use the oxygen always and the last time he had the oxygen was the day before. He said the nurse put it on, but he was not sure who took it off. He said he was not the one who took it off, and there would be no way that he could reach his side table. During an observation on 05/03/2026 at 9:20 a.m. revealed CNA E and LVN B changed Resident #91's linen. After they were done with the linen changed, both staff left the room. Neither staff addressed the unbagged nasal cannula. During an interview on 05/03/2026 at 12:20 p.m., LVN B said he saw the unbagged nasal cannula, and it did not occur to him to change it, bag it, or even notify his nurse about it. He said the nasal cannula should be bagged to prevent cross contamination and any kind of respiratory infection because the table might adhere to the nasal cannula and could eventually go inside the lungs.During an interview on 05/03/2026 at 12:50 p.m., LVN C said she saw the nasal cannula on top of the Resident #91's side table when she hung the resident's antibiotics. She said she had already changed it and put it in a plastic bag. She said she did not notice it being unbagged when she did her morning round, nor did she know who took it off. She said the nasal canula should be bagged to prevent cross contamination and respiratory infection.During an interview on 05/05/2026 at 6:30 a.m., ADON A said the nasal canula should be bagged when not in use to prevent any respiratory infection. She said the staff were responsible for bagging the nasal cannula. She said if they saw the nasal cannula was not bagged, then they should throw it and change them. She said there should always be a plastic bag for the nasal cannula. She said the expectation was that the nasal cannula would be bagged after it was taken off. She said they already started an in-service about bagging the nasal cannula.During an interview on 05/05/2026 at 7:09 a.m., the DON said the staff were responsible in making sure the nasal cannula was bagged when not in use to keep it clean and prevent respiratory infection. She said the expectation was for the staff not to forget to bag the nasal cannula when not in use. She said she already started an in-service about bagging the nasal cannula when not in use as soon as she heard about the issue.During an interview on 05/05/2026 at 7:47 a.m., the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator said the expectation was for the staff to bag the nasal cannula when not in use to prevent respiratory issues. He said the DON had already started an in-service about bagging the nasal cannula, and they would continue to re-educate them. He said they would also monitor closely if the staff understood what the in-service was all about. He said they would also do random checking if the staff were bagging the nasal cannulas of the residents.Record review of the facility's policy Respiratory Policy & Procedures revised April 2026 reflected PURPOSE: To provide guidelines for exceptional infection control within all respiratory related practices and care of equipment . PROCEDURE . 4. When not in use, all tubing should be stored in plastic bags or other approved storage bag method.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for two of twenty residents (Residents #8 and Resident #34) reviewed for medication storage. 1. The facility failed to ensure that Resident #8 did not have a pain reliever gel inside her room on 05/03/2026. 2. The facility failed to ensure that Resident #34 did not have a tube of hydrocortisone cream (used to treat inflammation and itching) inside her room on 05/03/2026.These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1. Record review of Resident #8's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia and aphasia (an impairment that affects an individual's comprehension or formulation of language). Record review of Resident #8's Comprehensive MDS Assessment, dated 04/08/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident had dementia aphasia. Record review of Resident #8's Comprehensive Care Plan, dated 04/20/2026, reflected that the resident was at risk for impaired cognitive function related to dementia and aphasia one of the interventions was to provide consistent care to decrease confusion.Record review on 05/03/2026 of Resident #8's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage her own medications.During an observation and interview on 05/03/2026 at 11:24 a.m. revealed Resident #8 was sitting at the side of her bed. It was observed that a tube of pain reliever gel, which was almost empty, was on top of the resident's side table and was in plain view. The resident pointed to her hip and then did a rubbing motion when asked what the gel was for. 2. Record review of Resident #34's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia. Record review of Resident #34's Comprehensive MDS Assessment, dated 04/06/2026, reflected that the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had dementia. Record review of Resident #34's Comprehensive Care Plan, dated 04/03/2026, reflected that the resident had an impairment to the skin integrity and one of the interventions was to administer treatments as ordered.Record review on 05/04/2026 of Resident #34's Physician Order reflected that the resident did not have an order for hydrocortisone cream.Record review on 05/04/2026 of Resident #34's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage her own medications. During an observation and interview on 05/03/2026 at 9:18 a.m. revealed that Resident #34 was in her bed, awake. It was observed that a tube of hydrocortisone was on top of the resident's side table and was on plain view. The resident said it was for bottom that was usually itchy. She said the cream had always been on her side table, and she was not sure if the staff saw them or not.During an observation and interview on 05/03/2026 at 6:09 a.m., LVN C said she did not notice that Resident #34 had a tube of hydrocortisone inside her room. She said she would talk to the resident and explain to her that she should not have any medications inside her room. She went inside Resident #34's room, talked to the resident, and took the medication with her when she left the room. She said she knew Resident #34 did not have an assessment that she could administer her own medication. She said Resident #34 also did not have an order for hydrocortisone. She said she would request an order, but the staff would be the one administering it when the resident needed it. She then went to Resident #8's room and did the same. She said the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents could not have medications inside the room because the staff would not know how often and how much the residents were applying the topical medications. She said too many topical medications could cause skin irritation. She said some confused residents might go inside Resident #8 and Resident #34's rooms, take the medications, and consume them causing adverse effects. She said she would also call the family members to remind them that they need to inform the staff if they were bringing any medications. She said medications should be inside the carts.During an interview on 05/05/2026 at 6:30 a.m., ADON A said medications should not be inside the rooms of the residents because some residents were confused and might ingest them or might thought that the topical medications were just ordinary lotions and apply them all over their body. She said the expectation was for the staff to be vigilant in scanning the rooms of the residents if they have any medications. She said the staff could not open the drawers of the residents but if the medications were in plain view, then the staff should talk to the residents about the medications. She said they had already started an in-service about medication at bedside. She said they would also remind the family members about letting the staff know that they were supposed to give the staff any medications that they would be bringing.During an interview on 05/05/2026 at 7:09 a.m., the DON said medications, in whatever form, should not be inside the residents' rooms because the residents might use them inappropriately that could result in adverse reactions, such as overdosing, irritations, and upset stomach. She said confused residents might get hold of the topical medications and consume them. She said the expectation was for the staff to be observant if there were medications inside the room of the residents. She said she had already started an in-service about medication at bedside, and the in-service was for all the staff going inside the residents' rooms.During an interview on 05/05/2026 at 7:47 a.m., the Administrator said that there should be no medications inside the rooms of the residents to make sure that they were not taking any medications that were not prescribed. He said confused residents could grab them and consume them. He said they already started an in-service, and they would go around to check if there were medications inside the rooms of the residents.Record review of the facility's policy Safety, Resident Policy/Procedure revised April 2026 reflected POLICY: It is the policy of this facility to create a safe environment for the resident . PROCEDURES . 5. Ensure all medications . are kept locked/ secured . 7. Conduct room checks routinely by staff members . to ensure safety of residents residing in the facility. Room checks include but not limited to resident observation (wearing appropriate clothing, oral hygiene, assistive devices, etc.) and bedside observation (call lights within reach, no unauthorized medications, ointments, lotions at bedside, infection control, etc.).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 two of twenty residents (Resident #43 and Resident #91) reviewed for infection control. 1. The facility failed to ensure CNA F performed hand hygiene during Resident #43's incontinent care on 05/04/2026. 2. The facility failed to ensure CNA E did not put Resident #91's catheter bag on top of the resident's bed on 05/03/2026. 3. The facility failed to ensure LVN B and CNA E wore gowns when they changed Resident #91's linen, who had a catheter on 05/03/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #43's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting and atrophy.Record review of Resident #43's Comprehensive MDS Assessment, dated 03/23/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated that the resident was incontinent for bladder and bowel. Record review of Resident #43's Comprehensive Care Plan, dated 04/07/2026, reflected that the resident had bowel and bladder incontinence and one of the interventions was to check as required for incontinence.An observation on 05/04/2026 at 6:51 a.m. revealed CNA F was about to do Resident #43's incontinent care. She washed her hands, put on a pair of gloves, and proceeded with incontinent care. She took a brief from the resident's overbed table, opened it, and placed it at the side of the resident's head. She took off her gloves and put on a new pair of gloves. She did not sanitize her hands before putting on a pair of gloves. She unfastened the brief and tucked it between the residents' legs. She took off her gloves and put on a new pair. She did not sanitize her hands before putting on the new pair of gloves. She then cleaned the resident's perineal area. She took off her gloves and put on a new pair. She did not sanitize her hands before putting on the new pair of gloves. She rolled the resident and cleaned the resident's bottom. It was observed that the resident had a bowel movement. After cleaning the resident's bottom, she took off her gloves and put on a new pair. She did not sanitize her hands before putting on the new pair of gloves. She took the brief from the resident's side, placed it under the resident, and fixed it.During an interview on 05/04/2026 at 7:17 a.m., CNA F said she knew she messed up because she did not sanitize her hands when she changed her gloves. She said she had a bottle of sanitizer in her pocket, but forgot to use it. She said hands should be sanitized before putting on a new pair of gloves to prevent cross contamination and infection. She said she did have an in-service about hand hygiene.2. Record review of Resident #91's Face Sheet, dated 05/04/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive reflux uropathy and urinary tract infection.Record review of Resident #91's Comprehensive MDS Assessment, dated 05/01/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter.Record review of Resident #91's Comprehensive Care Plan, dated 04/29/2026, reflected that the resident had an indwelling Foley catheter r/t obstructive and reflux uropathy, and one of the interventions was to provide catheter care.Record review of Resident #91's Physician Order, dated 04/28/2026, CATHETER CARE EVERY SHIFT. MONITOR URETHRAL SITE FOR S/S OF SKIN BREAKDOWN, PAIN/DISCOMFORTS, UNUSUAL ODOR, URINE CHARACTERESTIC OR SECRETIONS, CATHETER PULLING CAUSING TENSION every shift.An observation and interview on 05/03/2026 at 9:14 a.m. revealed Resident #91 was in his bed, awake. The resident had a catheter with the bag hanging at the side of the bed. The resident said he had the catheter for months, but he did not know what the exact date was.An observation on 05/03/2026 at 9:16 a.m. revealed CNA E was about to change Resident #91's bed linens. She went inside the resident's room, bringing with her a fitted sheet, a blanket, and (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	some pillowcases. She went out of the room to ask somebody to assist her in turning the resident. Before she went out of the room, she placed the resident's catheter bag on top of the resident's bed. 3. Record review of Resident #91's Comprehensive Care Plan, dated 04/29/2026, reflected that the resident had an indwelling Foley catheter r/t obstructive and reflux uropathy and was on antibiotic therapy r/t UTI present on admission. Intervention for both was to use enhanced barrier precautions.Record review of Resident #91's Physician Order, dated 04/29/2026, Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication:Indwelling Catheter & IV access every shift.Record review of Resident #91's Physician Order, dated 04/28/2026, reflected PICC LINE (long, flexible tube inserted into the vein used for administering intravenous medications) FLUSHING: FLUSH WITH 10 CC 0.9 % NS IV SOLUTION Q SHIFT every shift.An observation and interview on 05/03/2026 at 9:14 a.m. revealed Resident #91 was in his bed, awake. It was observed that the resident had a catheter and had a PICC line. The resident said he was receiving antibiotics because he had a UTI. It was also observed that there was a sign on the resident's door that the resident was on EBP. The sign indicated that staff needed to wear gloves and gowns when changing linens.An observation on 05/03/2026 at 9:22 a.m. revealed CNA E returned to Resident #91's room with LVN B. Both staff started to change the resident's linen. They rolled the resident towards LVN B while CNA E was making half of the bed. It was observed that LVN B was in contact with the resident's torso while he was assisting the resident not to roll back. Both LVN B and CNA E were not wearing a gown. An interview on 05/03/2026 at 12:20 p.m., LVN B said it did not occur to him that the catheter bag should not be on top of the bed, because it was dirty. He said since Resident #91 had a catheter and a PICC line, they should have worn gowns in addition to the gloves because the resident was on EBP. He said he did not know why he forgot to wear a gown when CNA E called him to assist her in changing the resident's linens. He said he saw that CNA E did not have a gown and did not occur to him as well to tell her to wear a gown because the resident was on EBP. He said, even though they changed the linens, the catheter had contact with the foot board, and could indirectly cause infection. He said gowns were required to make sure the staff would not transfer any microorganisms to residents with indwelling medical devices.Aan interview on 05/03/2026 at 12:28 p.m., CNA E said she knew the catheter bag was dirty and putting it on top of the bed made the bed dirty also. She said she did not notice that there was a sign outside Resident #91's door that indicated that the resident was on EBP. She said they had an in-service before that would say PPE was needed for residents with catheter and with IV. She said putting something dirty on the bed and not wearing a gown when needed could cause infection.An interview on 05/05/2026 at 6:30 a.m., ADON A said they were in-servicing the staff about infection control almost on a weekly basis to remind them to sanitize their hands before putting on a new pair of gloves and to wear PPE when required. She said they needed to re-educate the staff about the importance of hand hygiene and wearing a gown during provision of care. She said putting the catheter bag on top of the bed was also an infection control issue because something dirty had contact with the bed and foot board. She said the expectation was that the staff would understand the in-service about infection control and put them in practice. She said they already started an in-service about hand hygiene, EBP, and infection control.An interview on 05/05/2026 at 7:09 a.m., the DON said if a resident was on EBP, then the staff doing care should wear a gown every time they had contact with the resident to prevent cross contamination and spread of infection. She said for a resident with a catheter and a PICC line, a gown was needed to change the resident's linens. She said residents who were on EBP and required PPE to prevent the spread of infection from one resident to another. She said hands should be sanitized first before putting on a new pair of gloves. She said the catheter bag should not have been placed on top of the bed because it was dirty. She said the concerns discussed were all infection control issues. She said the expectation was for the staff to not introduce any cause of infection that could affect the health of the residents. She said she already started an in-service about hand hygiene, EBP, and infection control. She said they would keep on re-educating the staff about infection control.An interview on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675560	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Nursing and Rehabilitation Center	169 Lake Park Rd Lewisville, TX 75057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/05/2026 at 7:47 a.m., the Administrator said the expectation was for the staff to wear gowns in addition to the gloves if the residents were on EBP, sanitize between changing of gloves, not to put something dirty on the bed. He said the DON already started an in-service, but they would monitor the staff if they understood the in-service and if they were compliant to the policy. He said they would also do some spot checks and check offs. He said there was no specific policy about not putting the catheter bag on top of the bed, but it was given that the protocol was from clean to dirty and not dirty to clean.Record review of the facility's policy, IPCP Standard and Transmission-Based Precautions Infection Control revised April 2026 reflected Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . 3. Enhanced Barrier Protection (EBP}: expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (Multi-Drug Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident . c. Examples of high-contact resident care activities requiring gown and glove . v. Changing linens . vii. Device care or use: central vascular line (flexible tube inserted into a large vein in the neck, chest, or arm) . urinary catheter.Record review of the facility's policy Hand Hygiene Infection Control revised April 2026 reflected Policy: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards . Purpose: Hand hygiene is one of the most effective measures to prevent the spread of infection . 2. Use an alcohol-based hand rub . h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids . m. After removing gloves.