

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Rose Haven Retreat		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Live Oak St Atlanta, TX 75551	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all essential mechanical and electrical equipment in safe operating condition, for 1 of 1 commercial gas range and oven in the kitchen reviewed for food service in that: The facility did not ensure the commercial gas range and oven were in proper working order: Two of ten gas stove burners (far right front and back) did not light automatically, when the knobs were turned on. Eight of ten gas burners had carbon buildup. One (right oven) of two ovens did not heat properly. These failures could place residents who ate food from the kitchen at risk for under-cooked food and foodborne illness. Findings included: During an observation and interview on 6/15/26 beginning at 9:07 AM, initial tour of the kitchen revealed there was carbon buildup on eight of the ten burners on the commercial gas range. DA E said all of their equipment was in good working order except for the right-side oven. DA E said it often did not cook at the proper temperature, and it had been going on for quite a while. DA E said they would work on it to fix it, and it would maybe work right for two weeks and then it would go back to not heating correctly. During an observation and interview on 6/16/26 beginning at 10:00 AM to observe preparation of purees (smooth, lump-free food with a pudding consistency) followed by food temperatures, at 10:35 AM, [NAME] F removed a pan of Teriyaki chicken from the oven on the right side of the stove and placed a thermometer in the chicken. The thermometer read 140 degrees. The right-side oven was set at 350 degrees. During observation, [NAME] F did not open the right side of the oven between 10:00 AM and 10:35 AM. [NAME] F said the chicken had been in the oven since before 9:00 AM and it still was not hot enough. [NAME] F placed the pan of chicken over two burners on the top of the stove. [NAME] F said the right-side oven had issues and she often had to take food out and place it on the stove burners to heat the food to the right temperatures. [NAME] F said it was a frequent occurrence that the food was not cooked in the right-side oven. [NAME] F said often she would think the food would be done because it had been in the oven for the required amount of time or more, but then when she pulled the food out of the oven, it would not be done. [NAME] F had to frequently stir the chicken as the liquid in the pan was boiling. [NAME] F said she had to watch it closely to not burn or scorch it while trying to cook the chicken to the appropriate temperature to serve to the residents. [NAME] F said it would often put her behind and she had to rush to heat the food on the stove top to get the residents' meals served on time. There continued to be carbon build up to eight of ten burners on top of stove. During an interview on 6/17/26 at 9:15 AM, DA E said she had worked at the facility for over thirteen years, and the stove was there long before she came to work there. DA E said the burners on the right side of the stove had not worked since the last time the vent-a-hood cleaning service came around the end of May 2026. DA E said they reported the burners not working to the Maintenance Supervisor verbally, about two weeks ago. During an observation and interview on 6/17/26 at 9:30 AM, [NAME] F said she had worked at the facility for four years this time. [NAME] F said she had come in around 5:15 AM and turned the right oven on at 350 degrees. [NAME] F said she was cooking hamburger patties in both ovens for the lunch meal and started them early to ensure she had time, if they were not cooked all the way. [NAME] F said she was going to check the hamburger patties at that time. Using an infrared thermometer, the right-side oven temperature was 230 degrees when the oven door was opened, and the oven was set at 350 degrees. (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Maintenance Director and there were no work orders related to the stove/oven or burners not working. On 6/17/26 at 1:50 PM, the Maintenance Director provided documentation of the last time a technician came to work on the stove/oven, it was dated 11/13/25 and said they came out and adjusted the thermometer on the right-side oven. Record review of the facility's policy titled Maintenance Service dated revised December 2009 revealed . Maintenance Service shall be provided to all areas of the building, grounds, and equipment . the Maintenance Department was responsible for maintaining the building, grounds and equipment in a safe and operable manner at all times . the Maintenance Director was responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment were maintained in a safe and operable manner .		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide notice to residents when changes in coverage were made to items and services covered by Medicare as soon as is reasonably possible to 2 of 3 residents (Resident #6 and Resident #10) who were provided skilled Medicare services, were discharged from services, and remained in the facility in that: 1. The facility failed to notify Resident #6 and Resident #10 at least 2 days before the end of Medicare Part A coverage. 2. The facility failed to notify Resident #6 and Resident #10 with a complete Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) form before the end of Medicare Part A coverage. These failure could affect residents who use skilled services and could place them at risk of not being aware of changes to provided services. The findings were: 1. Record review of a face sheet, dated 06/16/26, revealed Resident #6 was admitted on [DATE] with diagnoses including dementia, diabetes, and anxiety disorder. Record review of a quarterly MDS dated [DATE], revealed Resident #6 had a BIMS of 7 which indicated severely impaired cognition. The MDS indicated Resident #6 required supervision or touch assistance with ADLs. Record review of a SNF (skilled nursing facility) Beneficiary Notification Review form indicated Resident #6's last day of coverage of Part A Service was 01/04/26. The form indicated Resident #6 had been provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form and Notice of Medicare Non-Coverage form. Record review of a Notice of Medicare Non-Coverage form revealed Part A (Skilled) coverage for Resident #6 ended on 01/05/26. The form was signed by Resident #6 on 01/05/26. Record review of a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form for Resident #6 reflected it was incomplete. There was no date indicating the date coverage would end and care the resident had received during the Inpatient Skilled Nursing Facility stay was not completed. The estimated cost of services per day/item was completed. The form was signed by the resident on 01/04/26. 2. Record Review of a face sheet, dated 06/16/26, revealed Resident #10 was initially admitted on [DATE] with diagnoses including chronic obstructive pulmonary diseases (chronic lung disease), nasal congestion, and pain. Record Review of a quarterly MDS for Resident #10, dated 04/13/26, revealed a BIMS of 12 indicating moderate cognitive impairment. The MDS indicated Resident #10 required supervision to touching assistance with ADLs. Record review of a SNF (skilled nursing facility) Beneficiary Notification Review form indicated Resident #10's last day of coverage of Part A Service was 02/04/26. The form indicated Resident #10 had refused to sign a Beneficiary Notice task did not reveal a Notice of Medicare Non-Coverage form. Record review of documentation provided by the facility between 06/15/26 - 06/17/26 for the Beneficiary Notice task did not reveal a Notice of Medicare Non-Coverage form for Resident #10. Record review of a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form for Resident #10 reflected it was incomplete. There was no date indicating the date coverage would end and care the resident had received during the Inpatient Skilled Nursing Facility stay was not completed. The estimated cost of services per day/item was completed. The form was signed by the resident on 02/05/26. During an interview on 06/17/26 at 10:16 a.m., the Social Worker said the Beneficiary Notices were her responsibility, but she was not very familiar with the process. She said the Business Office Manager helped her. She said not being familiar with the process said was the reason the forms were not complete and the residents were not being notified in a timely manner. During an interview on 06/17/26 at 10:20 a.m., the Business Office Manager said the Social Worker was new to the Beneficiary Notice process, and she had been helping her. She said she did not know that the residents had to be notified at least 2 days before the last day of Part A Service coverage. She said Resident #10 had refused to sign a Notice of Medicare Non-Coverage form. She said she was not very familiar with the forms and that was why they were not completed accurately. During an interview on 06/17/26 at 12:17 p.m., the DON said Beneficiary notices were supposed to be given at least 48 hours in advance. She said she (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected the notices to be complete and in the correct time frame. She said it was important for residents to be aware of the changes, if they want to appeal, and have their needs met. During an interview on 06/17/26 at 12:40 p.m., the Administrator said she expected for Beneficiary Notices to be done properly, completely, and timely. She said this was important because they do not want to surprise bill someone. She said residents need notice in case they need to make other arrangements and so they know what to expect. Record review of a Medicare Advanced Beneficiary Notice facility policy dated April 2021 indicated, .Residents are informed in advance when changes will occur in their bills. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered not medically reasonable and necessary, or custodial. The resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility. If the resident's Medicare P A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons).		

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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 observation, interview, and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and provide the resident and their representative with a summary of the baseline care plan for 2 of 4 (Resident #27 and Resident #61) residents reviewed for baseline care plans. 1. The facility did not ensure Resident #27 and Resident #61's baseline care plan was developed within 48 hours of admitting to the facility. 2. The facility did not ensure Resident #27, Resident #61, or their representatives were provided with a summary of the baseline care plan. These failures could place residents at risk of not receiving care and services to meet their needs. The findings included: 1. Record review of the face sheet, dated 06/17/26, reflected Resident #27 was a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia without behaviors (decline in cognitive abilities severe enough to interfere with daily life). Record review of the admission MDS assessment, dated 06/04/26, reflected Resident #27 had clear speech, was understood by others, and was able to understand others. Resident #27 had a BIMS score of 6, which indicated severe cognitive impairment. She had no behaviors or refusal of care. Record review of Resident #27's baseline care plan reflected there was no date to indicate the day the baseline care plan was completed. The section titled Written Summary of Baseline Care Plan was not filled out. Another resident's family member was written in the blank as being informed and delivered in person, with no date. During an observation and interview on 06/15/26 at 10:04 a.m., Resident #27 was walking down the hallway using her rolling walker. The conversation with Resident #27 was confused and she was unable to remember admitting to the facility. 2. Record review of the face sheet, dated 06/17/26, reflected Resident #61 was an [AGE] year-old male who admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, with agitation-sundowner syndrome (a person with dementia whose specific type is not clearly identified, but who exhibits agitation and sundowning - a pattern of mood or behavioral that worsen in the late afternoon, evening, or night). Record review of the MDS assessment list, accessed on 06/17/26, reflected Resident #61's MDS assessment was In progress. It had not been completed. Record review of Resident #61's baseline care plan reflected there was no date to indicate the day the baseline care plan was completed. The section titled Written Summary of Baseline Care Plan was not filled out. There was no indication that the resident or resident representative was informed. During an observation and interview on 06/15/26 at 11:25 a.m., Resident #61 was wheeling himself around in his wheelchair. The conversation with Resident #61 was confused. Resident #61 stated he needed to call his wife to come pick him up. He believed he was at a diner for free coffee. During an attempted telephone interview on 06/15/26 at 2:33 p.m., Resident #61's family member did not answer the phone. A brief message was left with a call back number that was not returned upon exit from the facility. During an attempted telephone interview on 06/15/26 at 2:41 p.m., Resident #27's family member did not answer the phone. A brief message was left with a call back number that was not returned upon exit from the facility. During an interview on 06/16/26 at 3:44 p.m., LVN D stated the admitting nurse was responsible for completing the baseline care plan. She stated the baseline care plan was a form that was included in the admission packet that was provided by the management team. LVN D stated the admitting nurse was the one who initiated the baseline care plan. LVN D stated the baseline care plan was usually checked off but she did not go over the baseline care plan with the families. She stated the DON brought her the baseline care plan for Resident #27 earlier in the day (06/16/26) and asked her to fill it out because the state surveyor was asking for it. LVN D stated she was not the admitting nurse for Resident #27 but knew the resident pretty well because she had been at the facility for a few weeks. LVN D stated she was the admitting (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse for Resident #61 and believed she had mistaken the baseline care plan for the elopement care plan. LVN D stated she did not complete Resident #61's baseline care plan. LVN D stated it was important to ensure baseline care plans were completed within 48 hours, so residents received accurate and consistent care. During an interview on 06/17/26 at 9:58 a.m., the DON stated baseline care plans were part of the admission packet. The DON stated the charge nurse was responsible for completing them on admission, then they were placed in the chart. She stated the interdisciplinary team reviewed the baseline care plans at the first care plan meeting after admission. The DON stated she was unable to find Resident #27 and Resident #61's baseline care plans so both baseline care plans were completed on 06/16/26 when the state surveyor asked for them. She stated the facility staff went over the care provided to each resident with the representatives, but they did not go over the baseline care plan form specifically. She said it was important to ensure the baseline care plans were completed timely and discussed with the family to ensure the correct care was being provided to the resident. During an interview on 06/17/26 at 10:12 a.m., the Administrator stated she expected baseline care plans to have been completed upon admission or at least within 24 hours after admission. The Administrator stated the nurse was responsible for completing the baseline care plans and going over them with the resident and their family. The Administrator stated it was important to ensure baseline care plans were completed timely and discussed with the family to ensure the correct care was being provided to the resident. Record review of the Care Plans - Baseline policy, dated December 2016, reflected 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.the resident and their representative will be provided a summary of the baseline care plan.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were maintained in accordance with accepted professional standards and practices on each resident that were complete and accurately documented for 2 of 4 residents (Resident #27 and Resident #61) reviewed for accuracy of medical records. 1. The facility failed to ensure Resident #27 and Resident #61's baseline care plans were dated. 2. The facility failed to ensure Resident #27's baseline care plan had the accurate family member listed as informed and delivered. 3. The facility failed to ensure LVN D's signature on Resident #27's baseline care plan was valid and accurate. These failures could place residents at risk of not receiving care and services to meet their needs. The findings included: 1. Record review of the face sheet, dated 06/17/26, reflected Resident #27 was a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia without behaviors (decline in cognitive abilities severe enough to interfere with daily life). Record review of the admission MDS assessment, dated 06/04/26, reflected Resident #27 had clear speech, was understood by others, and was able to understand others. Resident #27 had a BIMS score of 6, which indicated severe cognitive impairment. She had no behaviors or refusal of care. Record review of Resident #27's baseline care plan reflected there was no date to indicate the day the baseline care plan was completed. The section titled Written Summary of Baseline Care Plan was not filled out. Another resident's family member was written in the blank as being informed and delivered in person, with no date. LVN D's signature of her last name was misspelled. 2. Record review of the face sheet, dated 06/17/26, reflected Resident #61 was an [AGE] year-old male who admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia, with agitation-sundowner syndrome (a person with dementia whose specific type is not clearly identified, but who exhibits agitation and sundowning - a pattern of mood and behavioral symptoms that worsen in the late afternoon, evening, or night). Record review of the MDS assessment list, accessed on 06/17/26, reflected Resident #61's MDS assessment was In progress. It had not been completed. Record review of Resident #61's baseline care plan reflected there was no date to indicate the day the baseline care plan was completed. The section titled Written Summary of Baseline Care Plan was not filled out. During an interview on 06/16/26 at 3:44 p.m., LVN D stated the DON brought her the baseline care plan for Resident #27 earlier in the day (06/16/26) and asked her to fill it out because the state surveyor was asking for it. LVN D stated she was not the admitting nurse for Resident #27 but knew the resident pretty well because she had been at the facility for a few weeks. LVN D stated she checked off the boxes for Resident #27's baseline care plan but did not sign the document. LVN D was shown the paper copy of the baseline care plan and stated that it was not her signature. She stated the last name was spelled wrong. She stated she did not complete Resident #61's baseline care plan. During an interview on 06/17/26 at 9:58 a.m., Tthe DON stated she expected the baseline care plans to be completed fully and accurately. The DON stated she was unable to find Resident #27 and Resident #61's baseline care plans so both baseline care plans were completed on 06/16/26 when the state surveyor asked for them. The date was not filled out. She stated Resident #27's family member was not the one listed on the baseline care plan. She stated that it was inaccurate documentation. The DON said she was unsure who signed LVN D's name on Resident #27's baseline care plan. She said she was unsure why anyone would sign someone else's signature. She said it was important to ensure the baseline care plan documentation was completed fully and accurately to ensure each residents received the appropriate care and services. During an interview on 06/17/26 at 10:12 a.m., the Administrator stated she expected baseline care plans to have been completed accurately and completely. The Administrator stated the nurse was responsible for completing the baseline care plans accurately and fully. The Administrator stated she was unsure who would have signed LVN D's (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signature. The Administrator stated it was important to ensure records were completed accurately and fully so the facility staff had the information they needed and access to the care needed for each resident. Record review of the Charting and Documentation policy, dated July 2017, reflected .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 7. Documentation of procedures and treatments will include care-specific details, including: .a. the date and time of the procedure/treatment was provided; the name and title of the individual who provided the care. the signature and title of the individual documenting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Rose Haven Retreat		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Live Oak St Atlanta, TX 75551	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents reviewed for incontinent care. (Resident #7)The facility failed to ensure CNA A changed her gloves and sanitized her hands after providing incontinent care to Resident #7 prior to touching Resident #7's clean fabric incontinent pad, her bare leg and shoulder, and her bedding.This failure could place residents and staff at risk for cross-contamination and the spread of infection.Findings included:Record review of Resident #7's face sheet dated 6/16/26 indicated she was an [AGE] year-old female and she admitted to the facility initially on 11/13/19 and re-admitted on [DATE]. Resident #7 had diagnoses including dementia (decline in mental ability), diarrhea (loose, watery stools) and hypertension (high blood pressure).Record review of Resident #7's quarterly MDS assessment dated [DATE] indicated she was understood and understood others. The MDS indicated she had a BIMS score of 6 which indicated she had severe cognitive impairment. The MDS indicated Resident #7 required substantial assistance of staff in performing most activities of daily living. The MDS indicated Resident #7 was always incontinent of bowel and bladder.Record review of Resident #7's undated care plan indicated she had the potential for urinary tract infections related to a history of urinary tract infections with interventions to ensure meticulous personal hygiene, especially after elimination, to provide perineal (private areas) care as soon as possible after an incontinent episode per the facility policy and use principles of infection control.During an observation on 6/16/26 beginning at 1:10 PM, CNA A assisted by CNA B provided incontinent care for Resident #7. CNA A and CNA B washed their hands and put on clean gloves. CNA A and CNA B positioned themselves one on each side of Resident #7's bed. CNA B assisted with turning Resident #7 and CNA A performed the incontinent care. CNA A and CNA B positioned Resident #7's covers to expose her front perineal area. CNA A removed her gloves, sanitized her hands, and put on clean gloves. CNA A used a multi-folded washcloth to cleanse Resident #7's front perineal area appropriately and then discarded the washcloth. CNA A removed her soiled gloves, sanitized her hands and put on a clean pair of gloves. CNA A and CNA B rolled Resident #7 toward the wall and CNA B held the resident on her side. CNA A then used a clean multi-folded washcloth to cleanse bowel movement off Resident #7's back perineal area appropriately and then she took a towel and dried the resident's back perineal area. CNA A then got a clean fabric incontinent pad from a bag on the bedside table, rolled it 1/2 way and pushed it under the resident's bottom half of her body wearing the same gloves she used to clean bowel movement off of Resident #7's back perineal area. CNA A assisted Resident #7 onto her back. CNA A then put the same gloved hands used to clean bowel movement off Resident #7's back perineal area, onto Resident #7's bare left leg and shoulder and pulled the resident toward herself. CNA B pulled the other 1/2 of the fabric incontinent pad from under the resident and smoothed it out on the bed, and then the resident was allowed to roll back onto her back. CNA A and CNA B pulled the covers up over resident. CNA A then removed her gloves that were used to cleanse bowel movement from Resident #7's back perineal area and sanitized her hands. CNA A and CNA B then pulled Resident #7 up in bed and positioned her for comfort.During an interview on 6/16/26 at 1:25 PM, CNA A said she had worked at the facility since February 2026. CNA A said she was nervous during the incontinent care on Resident #7, and she should have changed her gloves and sanitized her hands after she cleaned the bowel movement off the resident and before she handled Resident #7's clean linens, bedding, or Resident #7. CNA A said she cross-contaminated and whatever was on her gloves could have gotten on anything she touched with those gloves. CNA A said the resident could get an infection and could get sick from her not changing her gloves or sanitizing her hands after cleaning bowel movement during incontinent care and then touching clean items on the resident's bed. CNA A said she had been (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trained to change her gloves and sanitize her hands after cleaning bowel movement from the resident and prior to touching clean items, but she was nervous and must have forgotten to. During an interview on 6/16/26 at 1:28 PM, CNA B said she had worked at the facility for about 2 years as a CNA. CNA B said staff should change their gloves after cleaning the front perineal area and after cleaning the back perineal area. CNA B said staff should change their gloves before touching anything clean such as the resident's bedding or the resident. CNA B said CNA A did not change her gloves or sanitize her hands after cleaning bowel movement off Resident #7's back perineal area and before touching her clean pad, turning her, or touching Resident #7's bedding. CNA B said staff were not supposed to touch anything clean after providing incontinent care because it was dirty and cross-contaminated anything that was touched with the soiled gloves. CNA B said the resident could get sick from the cross-contamination. During an interview on 6/17/26 at 10:01 AM, CNA C said he was the CNA Supervisor. CNA C said staff should change their gloves and sanitize their hands after performing incontinent care to the resident's front perineal area. CNA C said then they would do the back perineal area. CNA C said staff should then change their gloves and sanitize their hands and remove the privacy blanket and then pull the resident's covers up. CNA C said by CNA A not changing her gloves after cleaning bowel movement off the resident's back perineal area and touching the incontinent pad and her covers was cross-contamination. CNA C said not changing her gloves after cleaning bowel movement off the resident's back perineal area, could spread infection and germs. During an interview on 6/17/26 at 12:52 PM, the DON said staff should be removing their gloves and sanitizing their hands after providing incontinent care to the resident. The DON said staff should not be touching any of the resident's clean linens, bedding, call lights or anything clean wearing the same gloves that were used to clean bowel movement or provide incontinent care to the resident. The DON said the staff know what they should do, but they get nervous and forget what they are doing. The DON said she would expect the staff to change gloves before touching other items in the resident's room after performing incontinent care. The DON said by not changing gloves after incontinent care and touching items on the resident's bed, it placed the resident at risk for the spread of infection. During an interview on 6/17/26 at 1:06 PM, the ADM said staff contaminated whatever the CNA touched, when she did not change her gloves after cleaning bowel movement from the resident while performing incontinent care. The ADM said the resident could get an infection from the CNA not changing her gloves and not performing hand hygiene after cleaning bowel movement from the resident and then touching clean linen and the resident, and it was just nasty and could be a dignity issue. The ADM said she would expect staff to follow the facility policies while performing incontinent care. Record review of the facility's policy titled Perineal Care dated revised October 2010 revealed . the purpose of this procedure is to provide cleanliness and comfort to the resident, preventing infections and skin irritation . Steps in the Procedure . 2. Wash and dry your hands . 7. put on gloves . 9. For female resident . 9b. wash perineal area, wiping from front to back . 9c. Instruct or assist the resident to turn on her side . 9e. Wash rectal area thoroughly . g. Dry area thoroughly . 11. Discard disposable items into designated containers . 12. Remove gloves and discard into designated container. Wash and dry hands thoroughly . 13. Reposition bed covers. Make resident comfortable . Record review of the facility's policy titled Infection Control Guidelines for All Nursing Procedures dated revised August 2012 revealed . Purpose . To provide guidelines for general infection control while caring for residents . 3. Employees must wash their hands for ten to fifteen seconds using . soap and water under the following conditions . c. after contact with blood, body fluids, secretions, mucous membranes . d. After removing gloves . e. After handling items potentially contaminated with blood, body fluids, or secretions . 4. In most situations, the preferred method of hand hygiene was with an alcohol-based hand rub . for all the following situations . a. Before and after direct contact with residents . f. Before moving from a contaminated body site to a clean body site during resident care . j. After removing gloves .		