

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Ebony Lake Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Central Blvd Brownsville, TX 78520	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were labeled and stored appropriately for 3 of 4 medication carts (300 Hall Nurse Cart, Blue Med-Aide Cart, and 200 Hall Nurse Cart) reviewed for labeling and storage. The facility failed to ensure the 300 Hall Nurse Cart belonging to LVN-E was free from personal items. The facility failed to ensure the Blue Med-Aide Cart belonging to Medication Aide-D was free from medications without labels. The facility also failed to ensure the 200 Hall Nurse Cart belonging to LVN-C was locked and secured. These failures could place residents at risk of being administered a wrong or possibly expired medication, a medication which could have been exposed to cross-contamination, as well as a risk of residents gaining access to unlocked medications which were not prescribed to them and could cause them harm. The findings included: An observation on 01/14/2026 at 10:41 AM of the 300 Hall Nurse Cart revealed a white personalized bag which contained a toothbrush, toothpaste, dental floss, and body spray. An observation on 01/14/2026 at 11:14 AM of the Blue Med-Aide Cart revealed a brown prescription bottle approximately 3/4 of the way full of a liquid. The prescription on the label was so faded it could not be read what the medication was, when it expired, or which resident it belonged to. An observation on 01/14/2026 at 9:04 PM of the 200 Hall Nurse Cart revealed an unlocked medication cart. The lock on the cart was popped out, and all drawers except the narcotic drawer were able to be accessed. In an interview on 01/14/2026 at 10:05 PM, LVN-C stated she knew she was not supposed to leave her med-cart unlocked when she walked away. She stated she had never done this in the past, so she was not sure why it happened tonight, other than she was busy with the residents. LVN-C stated if a med-cart was left unlocked residents could have gotten into the cart and taken medications which had not belonged to them, which could have caused them harm. LVN-C stated she had been in-service on this before, but she could not recall how long ago the in-service was. In an interview on 01/14/2026 at 10:42 AM, LVN-E stated she believed the bag belonged to one of the nurses because she had seen it in the 300 Hall Nurse Cart before, but she had no idea which nurse it belonged to. LVN-E stated personal belongings did not belong in the medication carts because they could have caused cross-contamination with the medication and could have possibly caused harm to the residents. In an interview on 01/14/2026 at 11:16 AM, Medication Aide-D stated she was not sure where the bottle of liquid medication on the Blue Med-Cart came from, and she was not sure which resident it belonged to since she was unable to read the label. She stated this medication could be a risk to residents' health because if it was administered to the wrong resident, or if it had expired or gone bad, it could make the resident sick. She stated she had never given this medication before. In an interview on 01/14/2026 at 11:24 AM, ADON-B stated nurses were not supposed to leave personal belongings in the medication carts because it could have caused a cross contamination with residents' medication and caused them to be sick. She also stated nurses should have checked the medication carts each shift for expired medications and notified the ADON or DON if they had expired medications. ADON-B stated if a resident was given a medication without a legible label on it, they could have gotten the wrong medication or an expired medication which could have caused them (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675635
		If continuation sheet Page 1 of 8

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	harm. In an interview on 01/15/2025 at 9:00 AM, the DON stated nurses routinely checked their medication carts for expired medications, as well as the pharmacist typically checked them at least monthly while at the facility. She also stated nurses should not leave their medication carts unlocked because residents could have gained access to medications which did not belong to them, and this could have caused the residents harm. Record review of the facility's Medication Administration policy, dated 10/24/2022, revealed 1. Keep medication cart clean, organized, and stocked with adequate supplies. 11. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time. 12. Identify expiration date. If expired, notify nurse manager. Record review of the facility's Medication Carts and Supplies for Administering Meds policy, dated 10/01/2019, revealed 2. The medication cart is locked at all times when not in use. 3. Do not leave the medication cart unlocked or unattended in the resident care areas. 10. Equipment and supplies relating to medication administration are clean and orderly.		

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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 review, the facility failed to store, distribute and sever food in accordance with professional standards for food service safety for 1 of 2 refrigerators (1 of 2 kitchen refrigerator) and 3 of the 3 steam table wells reviewed for storage, preparation, and sanitation. -The facility failed to ensure a box of cabbage in the kitchen refrigerator was labeled and dated. -The facility failed to ensure a box of cabbage in the kitchen refrigerator was sealed properly. -The facility failed to ensure a box of cabbage in the kitchen refrigerator was not expired and spoiled. -The facility failed to ensure 3 of 3 the steam table wells were cleaned. -These failures could place residents at risk of complications from food contamination. Findings included: Observations during the initial tour of the kitchen on 01/13/26 at 9:36 a.m. revealed a box in the refrigerator with eight heads of cabbage spoiled and had black mold and did not have use by date. Observation of 3 of 3 steam table wells revealed white build up on the bottom 3 of 3 steam wells observed. In an interview on 01/14/25 at 9:15 a.m. with DA G she stated the steam table wells were cleaned every day by all staff at all shifts after every use. DA G stated she did not know why they were in the condition they were in but she cleaned it after every use during her shift. DA G stated it was important to keep the steam table well clean and working good so the food is served at the right temperature so no bacteria could be present. DA G stated she did not know of the cabbage in the refrigerator but knows all food stored in refrigerator was to be labeled dated and covered. In an interview with the DM on 01/14/26 at 9:43 a.m. stated she and the staff clean out the refrigerator daily and the cabbage in the box were not stored correctly. The DM stated they should have placed with a protective barrier with an in date of when it was placed in the refrigerator. The DM said the cabbage had not been used for cooking, and that could be why the cabbage was not noticed with no use by date and had begun to spoil. The DM stated she did not know why they did not have a date on the box with the cabbage or when the cabbage was put in the refrigerator as all other items had a date on the containers. The DM stated she will do retraining on the importance or maintaining the steam tables clean and in good working condition so the food is maintained at the correct temperature to ensure residents don't get sick from the food being contaminated bacteria and with dating items and making sure they are all covered and not exposed to the air with containers sealed correctly and throwing out all expired foods for all forms of storage. Record review of the facility's policy dated 2018, titled, Food Storage revealed to ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. FDA Food Code 2022 Ch. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. to (E) and (F) of this section, refrigerated, Ready-to eat, Time/Temperature Control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one of six residents (Resident #23) reviewed for medication errors. The facility failed to ensure Resident #23's blood pressure/pulse altering medications (Amlodipine) was not given outside of the blood pressure parameters during the month of December 2025 per the physician's orders. This failure could place residents at an increased risk for complications such as decreased blood pressure, decreased pulse, exacerbation of symptoms and disease processes, and potential hospitalization. Findings include: Record review of Resident #23's face sheet dated 01/14/26 reflected a [AGE] year-old-male with an original admission date of 10/28/24. Diagnoses included type 2 diabetes (insufficient insulin production in the body), Parkinsons disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), Alzheimer's disease (progressive mental deterioration of the brain affecting memory, thinking and behavior), hypertensive urgency (severe high blood pressure), and end stage renal (kidney) disease. Record review of Resident #23's physician's orders dated 11/25/25 reflected:Amlodipine Oral Tablet 10 MG. Give 1 tablet via G-Tube one time a day for HTN, hold for BP<100/60, HR <60. Record review of Resident #23's quarterly MDS dated [DATE] reflected a BIMS of 00 which indicated severe cognitive impairment. Record review of Resident #23's December 2025 MAR blood pressure and pulse summaries reflected the following:On 12/04/25, Resident #23's blood pressure was 130/53 with a pulse of 92. RN F documented in the MAR, the medication of Amlodipine was given. On 12/22/25, Resident #23's blood pressure was 135/51 with a pulse of 81. RN F documented in the MAR, the medication of Amlodipine was given. On 12/23/25, Resident #23's blood pressure was 131/57 with a pulse of 100. RN F documented in the MAR, the medication of Amlodipine was given. In an interview on 01/15/2026 at 8:48 AM, RN F stated according to the physician's orders, Resident #23's medication of Amlodipine should have been held since the diastolic blood pressure was less than 60. RN F stated he knew when the medication should have been held and if the medication was given, then it was a typing error. RN F stated all three entries were made in error because he has big fingers and a mistake could have been made. RN F stated if the medication was given outside of parameters, Resident #23's blood pressure could have dropped low, and the resident could have experienced dizziness or fainting. In an interview on 01/15/2026 at 9:59 AM, the DON stated Resident #23's blood pressure medication should not have been given since the blood pressure was outside of parameters per physician's orders. The DON stated if the medication was given outside of parameters, Resident #23's blood pressure could drop, and resident could have had dizziness and possible blurred vision. Record review of the facility's Medication Administration policy dated 10/24/22 reflected; Policy Explanation and Compliance Guidelines 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's parameters.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations, interviews, and record reviews, the facility failed to ensure the meals served reflected the culture and ethnic needs of the resident population in accordance with established national guidelines for all residents when the facility failed to ensure menus were accommodated for all residents for 1 of 3 meals observed. The facility failed to reflect, based on a facility's reasonable efforts, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups. This failure could place residents that eat food from the kitchen at risk of poor intake, chemical imbalance, and/or weight loss. The findings included: In observation and interview of the Resident council meeting on 01/14/26 at 2:30 pm revealed the all the residents who attended the meeting were not happy with the selection they were served daily. The attendees stated they did not like some of the items served on the menu and wanted more foods that they enjoyed from their Mexican culture. The president of the Resident Council, R #99, stated he could speak for all residents in the facility who have told him the menu did not offer them enough Mexican style foods in the menu and tended to serve food the Mexican residents were not accustomed to eating. In record review on 01/14/25 at 5:00 p.m. of the Mexican/ Hispanic menu only one day of the 4 weeks of the menu had one day that served Mexican style entrees of lunch Pork Carne Guisada (stewed pork in gravy) roasted potatoes winter vegetable mix corn tortilla, and dinner Chicken fajitas (grilled chicken with peppers) , Mexican Rice, sauteed peppers and corn tortilla. The other days the facility offered Shepherd's pie, smoked ham, chicken Dijon, tuna patty, spaghetti with meatballs, deli sandwich, sweet and sour chicken, pepperoni pizza, fried fish, BBQ pork and meatballs with buttered noodles and broccoli cheese soup or chicken salad sandwich. In an interview on 01/15/26 at 9:30 am with the Dietary Manager she stated the menus are changed every 5 weeks and she is responsible for making any changes in the menu if a certain type of food on the menu is not being eaten by the residents. The menu was on a 5-week rotation and has two menus a seasonal and a Mex/Hispanic menu. The DM stated she was given resident food preferences updated in the quarterly assessment of the resident. The DM stated it was very important the residents to receive food that was liked and healthy so there was no big or rapid weight loss or gain. The DM said she would swap out all the items she sees which are not liked and eaten by the residents for a more cultural healthy substitute. The DM stated the menus come from a distributor of food products, and that was what they followed, but will look for other types of menus and would make changes and add different kinds of Mexican food to the rotation of the menus. The DM stated breakfast was a challenge breakfast was more individualized but will see if adding salsa to the menu would make the breakfast more edible and not so bland and boring. The DM will make sure to the residents' choices are met in a healthy way, monitor which types of food come back uneaten and will make changes to all menus and snacks. In an interview 01/15/26 at 10:30AM with Dietitian he stated the DM was given the food preferences and updated quarterly in the assessment. The DM stated if the resident is identified to not eat often a shake or alternative is given to ensure the resident is having an intake of food and nutrition. Two cycle menus only change every other month and they are on a 5-week cycle menu. The dietitian would change food items if certain foods don't work and meet dietary requirements with the residents. The dietitian stated the DM will swap out items if needed if residents don't eat before he is able to make changes. The menu comes from the distributor, and the menu is either a seasonal or regular menu. The daily intake is different at every meal for protein and vegetables and fruits and is adjusted. The dietitian stated breakfast was more individual and health based so not to many changes can occur. The dietary manger is responsible for the changes in menu when the resident is assessed and changes need to be made. The dietitian stated the CNA's are responsible for meal intakes and percentage documentation for the residents. The dietitian stated he tries to make it to the facility once a week to go over any issues with resident diets and menus that need to be updated for nutritional value with any changes. Record (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of facility kitchen policies titled Food and Nutrition Services revised Policy dated 6/1/19 reveal The facility believes that nutrition is an important part of maintaining the wellbeing and health of its residents and is committed to providing a menu that is well balanced, nutritious and meets the preferences of the resident population. A standardized menu which meets the nutritional recommendations of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences will be used. Modifications for resident population and preferences may be made as appropriate.		

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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, record review, and interview, 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 one of six Residents (Resident #88) that were reviewed for infection control and transmission-based precautions policies and practices. The facility failed to ensure the WCN performed hand hygiene after removing gloves while prepping Resident #88's supplies for wound care. This failure could place residents at risk of infection through cross contamination of pathogens and infectious diseases. Findings include: Record review of Resident #88's face sheet dated 01/14/26 reflected an [AGE] year-old-female with an original admission date of 12/29/25. Diagnoses included hypotension (low blood pressure), end stage renal (kidney) disease, and type 2 diabetes (insufficient insulin production in the body). Record review of Resident #88's admissions MDS dated [DATE] reflected a BIMS score of 12 (cognition moderately impaired). Record review of Resident #88's physician's orders reflected: 1. tx to coccyx, one time a day for unstageable (severe type of wound where the depth cannot be determined due to the presence of slough or eschar) pressure ulcer (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time); cleanse with wound cleanser, pat dry, apply betadine (antiseptic solution used to promote healing to wounds) cast and cover with dry dressing qd till resolved. Dated 01/05/2026. 2. tx to right heel, pressure ulcer unstageable; cleanse with wound cleanser, pat dry, apply betadine cast and cover with dry dressing qd till resolved. Dated 01/05/2026. 3. tx to right ear, pressure ulcer stage 1 (injury of intact skin with the presence of non-blanchable redness); cleanse with wound cleanser, pat dry, apply betadine cast and cover with dry dressing qd till resolved. Dated 01/05/2026. During a wound care observation of Resident #88 on 01/14/26 at 1:15 PM, the WCN was preparing the supplies needed and disinfected the scissors. The WCN then removed her gloves and did not perform hand hygiene prior to putting on new gloves. In an interview on 01/14/26 at 1:59 PM, the WCN stated she did not realize she did not perform hand hygiene after sanitizing the scissors. The WCN stated she was nervous and just forgot. The WCN stated it was important to perform hand hygiene after glove removal to prevent cross contamination and because the scissors were dirty and had Clorox on them from the Clorox wipe used. The WCN stated if Resident #88's wounds came into contact with bacteria; the wound could become infected or worse. In an interview on 01/14/26 at 9:44 PM, the DON stated all staff should be performing hand hygiene after every glove removal to prevent the spread of infection. The DON stated if Resident #88's wound came in contact with any bacteria; the wound could become infected, worsen or delay healing. Record review of the facilities Hand Hygiene policy dated 10/24/22 reflected: Policy: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All staff will perform hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub, also known as alcohol-based hand rub. 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.		