STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675716	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Post Nursing & Rehab Center	605 W 7th St Post, TX 79356

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen (Kitchen A) reviewed for dietary services, in that: From 10/1/25 to 10/3/25, the facility failed to properly cover and store resident cups and drinks, exposing the rims of the glasses to the underside of serving trays. From 10/1/25 to 10/2/25, the facility failed to ensure food items (resident drinks, bread, frozen bread and frozen broccoli) in the dry pantry and freezer were labeled with received or use-by dates. On 10/1/25, the facility failed to maintain hot food items (spaghetti) at the required serving temperature of 165 F. From 10/1/25 to 10/3/25, the facility failed to separate dented cans from undamaged cans. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 10/1/25 in Kitchen A: On 10/1/25 at 11:20 AM, 38 glasses of fluid prepared for resident consumption were stored unsanitary with a serving tray placed directly on top, exposing the rims of the glasses to the underside of the serving tray. On 10/1/25 at 11:25 AM, seven resident drinks in the kitchen refrigerator were uncovered and unlabeled. Staff member DA G was observed placing a serving tray on top of the glasses, exposing the rims of the glasses to the underside of the tray. On 10/1/25 at 11:27 AM, hot food (spaghetti including ground beef) was observed with the temperature of 141.0 F being served below the required temperature of 165 F. On 10/1/25 at 11:32 AM, three loaves of bread and one package of hamburger buns were unlabeled (Did not include a manufactured used by date). At the same time, two of five dented cans (Chicken of the Sea tuna cans, dated 9/19/25) were stored with undamaged canned goods. On 10/1/25 at 11:34 AM, multiple food items in the freezer were unlabeled (no manufactured used by date observed), including 24 loaves of bread, six packages of hot dog buns, five packages of hamburger buns, and three packages of frozen broccoli. The following observations were made on 10/2/25 in Kitchen A: On 10/2/25 at 9:16 AM, 29 glasses of fluid prepared for resident consumption were stored unsanitary with a serving tray placed directly on top, exposing the rims of the glasses to the underside of the serving tray. On 10/2/25 at 9:18 AM, a dented can (Chicken of the Sea tuna can, dated 9/19/25) was observed stored with undamaged canned goods. One of the dented cans identified on 10/1/25 was observed stored on the bottom of a wire rack in the same dry pantry. On 10/2/25 at 9:20 AM, multiple food items in the freezer remained unlabeled (no manufactured used by date observed), including 24 loaves of bread, six packages of hot dog buns, five packages of hamburger buns, and three packages of frozen broccoli. On 10/2/25 at 9:21 AM, three loaves of bread and one package of hamburger buns were again observed without labels (no manufactured used by date observed). The following observations were made on 10/3/25 in Kitchen A: On 10/3/25 at 9:20 AM, a dented can (Chicken of the Sea tuna can, dated 9/19/25) was observed stored with undamaged canned goods. One of the dented cans identified on 10/1/25 was observed stored on the bottom of a wire rack in the same dry pantry. On 10/3/25 at 9:20 AM, one loaf of bread and one package of hamburger buns were observed without labels (no manufactured used by date observed). On 10/3/25 at 9:22 AM, multiple food items in the freezer remained unlabeled (no manufactured used by date (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observed), including 24 loaves of bread, six packages of hot dog buns, and five packages of hamburger buns. (The 3 frozen packages of frozen broccoli were no longer in the freezer). On 10/3/25 at 9:23 AM, 20 empty glasses prepared for resident liquids were stored unsanitary with a serving tray placed directly on top, exposing the rims of the glasses to the underside of the serving tray. Observed the [NAME] preparing to pour liquid in the cups. During an interview on 10/03/25 at 10:25 AM, the [NAME] stated that resident drinks should have been individually covered with plastic wrap. She stated that dented cans should not have been stored with undamaged cans. The [NAME] stated that she and DA H were responsible for unloading the truck on Tuesday (09/30/25). She stated she would have been responsible for labeling the frozen items, while DA H was responsible for placing dented cans in the appropriate area. The [NAME] stated that regarding food temperature, she should have removed the spaghetti from the steam table and reheated it to 165 F, then returned it to the steam table once it reached the correct temperature. She stated she was familiar with food storage and labeling requirements and had been employed at the facility for 22 years. She stated the potential negative outcome for not properly covering drinks was exposure to germs, which was unsanitary. She stated that serving food below the required temperature of 165 F could cause residents to become ill. She stated she did not know the potential negative outcome of storing dented cans with undamaged ones. The [NAME] stated she was aware of the uncovered cups observed on 10/03/25 that were exposed to the underside of serving trays. She stated she had filled those cups with liquid for breakfast service. She stated that on 10/01/25, she observed drinks that had been filled and covered with the bottom of serving trays but did not intervene because that was the way it had been done for years, and she tried not to interfere with others' work. She stated she knew the spaghetti was not at the correct temperature but did not reheat it because she was unsure whether she was allowed to do so while the HHSC investigator was present. She stated she proceeded to serve the meal as it was. The [NAME] stated she believed she had labeled the bread when it was received but noted that frozen items were difficult to label. She stated that not labeling food could negatively affect residents because old or expired food could be served, possibly leading to illness or mold growth. She stated she became aware of the dented can on 10/01/25 when the DM asked her why she had not moved or used it. She initially stated she thought the DM had told her to use the dented can of tuna but later clarified she was unsure whether the DM meant she should use the can for salmon patties or move it elsewhere. She stated the system in place to prevent such issues included not stacking serving trays on resident cups, using plastic wrap to cover individual or grouped drinks, and labeling drinks stored in the refrigerator. She stated plastic wrap was available for staff use. She stated food items, such as bread and broccoli, were to be labeled as they were received. She stated dented cans were typically reported to the DM and not placed on shelves. The [NAME] stated the procedure for food temperatures was to check the temperature 10 minutes before serving and reheat if needed. She stated she had received training when first hired and participated in refresher training as required. She stated she expected kitchen tasks to be performed the correct way, including labeling all food items and maintaining proper food temperatures. She stated everyone was responsible for ensuring food was served safely and explained that the identified failures occurred because things just slipped through the cracks, but they did the best they could.During an interview on 10/03/25 at 10:46 AM, the DM stated that DA H was unavailable because she was on break, and DA G was unavailable because she had been terminated earlier that morning for reasons unrelated to dietary deficiencies. The DM stated that DA G had been scheduled to return to work on 10/02/25 but was excused due to scheduling issues. The DM stated spaghetti could remain at 140 F on the steam table but acknowledged that milk and bread had never been labeled because they were used quickly, and it had never been an issue. She stated that after 10/01/25, she moved one dented can of tuna and later noticed another dented can after the HHSC investigator's visit. She stated that on 10/03/25, while reviewing policy, she learned of a new system for monitoring dented cans, which required taking a picture, notifying the vendor, and discarding the dented item. She stated the kitchen policy provided to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that each resident was treated with dignity and respect for 1 of 16 residents (Resident #30) reviewed for resident rights, in that: Resident #30's care plan, dated 09/18/25, which Resident #30 had access to, contained negative descriptive language (argumentative, picky and manipulative) to describe Resident #30. This failure could negatively affect residents psychologically, socially, emotionally and physically overall affecting their dignity and quality of life. The findings included:Record review of Resident #30's face sheet, dated 10/01/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include altered mental status (deviation from a person's normal level of alertness, awareness, and responsiveness to stimuli). Record review of Resident #30's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score of 12, which indicated the resident's cognition was moderately impaired.Record review of Resident #30's care plan, dated 9/18/25, revealed the following:RN I initiated a care plan dated 3/13/23 and revised 1/29/25 that read I am very manipulative; I will complain to my doctor that I am scared to be left isolated and would like to get out of bed but refused to allow staff to get me out of bed. I am very argumentative and am known to belittle staff.RN J initiated a care plan dated 5/12/25 and revised 5/12/25 that read I am very picky and usually find something wrong with staff on a daily basis. I can be very manipulative and am known to not say the truth at times.Record review of Resident #30's progress notes, dated, revealed:The SW documented on 07/22/25 at 10:54 AM that Resident Representative K told Resident #30 that she could no longer be her MPOA because Resident #30 was being manipulative by accusing her of things she had never done.During an interview on 10/03/25 at 2:35 PM, Resident #30 stated she had participated in her care plan meetings, which were usually held in her room. She stated she could not remember the date of the last care plan meeting she attended or what all the meetings entailed. She stated she did not remember going over any goals because she was on hospice and believed people on hospice did not have goals, as no improvement was expected. Resident #30 stated she had never seen her care plan before and did not know what it entailed. She stated she would never describe herself as a picky eater or picky. She explained she required a gluten-free diet, which was not her being picky. She stated she liked the staff at the facility, describing them as very nice and providing great care. She stated the staff positioned her pillows and phone the way she liked them and that all the staff were polite to her, and she was polite to them. Resident #30 told the HHSC investigator that she did not like the terms picky or manipulative because the staff were nice to her and she did not agree with those descriptive words being used. She stated the staff were efficient and knew what she liked. Resident #30 stated she would describe herself as calm, peaceful, and honest. She stated she would not describe herself as manipulative, argumentative, or picky, adding that those were not nice words and would be untrue if used to describe her. She stated she could not say how those words made her feel because they were untrue.During an interview on 10/02/25 at 3:07 PM, the SW stated she had participated in care plan meetings for Resident #30 but was unsure of the exact date of the latest meeting. She stated the most recent meeting was held to address whether Resident #30 was able to make her own decisions about what she wanted in place. The SW stated Resident #30 sometimes exhibited behaviors in which she became fixated on one issue. She stated that even after an issue was resolved, Resident #30 might approach another staff member as if it had not been addressed. The SW described Resident #30 as manipulative, clarifying that she did not say this directly to her but used the term because Resident #30 would tell one staff member one thing and another staff member something different to achieve a desired outcome. The SW provided an example, stating that Resident #30 had said her resident representative (K, MPOA) was not legitimate and later denied making that statement. The SW stated she had never heard Resident #30 describe (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ombudsman stated she had attended care plan meetings for Resident #30 in the past. She stated recent meetings were more informal and included the DON, ADM, and Resident #30, sometimes with Resident Representative K present. The Ombudsman stated she had never seen the care plan and was unaware that it contained the words picky, manipulative, and argumentative. She stated Resident #30 did not describe herself that way and would be highly upset if she knew those words were used. She stated that even if the words were true or accurate, Resident #30 would deny them because she saw herself as kind and loving. The Ombudsman stated she only reviewed care plans if an issue arose and the residents gave permission to view the care plan.Record review of the facility policy, Quality of Life-Dignity, Revised February 2020, revealed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of wellbeing, level of satisfaction with life, feeling of self-worth and self-esteem.Policy Interpretation and ImplementationResidents are treated with dignity and respect at all times.The facility culture is one that supports and encourages humanization and the individuation of residents, and honors resident choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.Staff speak respectfully to residents at all times, including addressing the resident by his or her name choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.Demeaning practices and standards of care compromise dignity are prohibited. Staff are expected to promote dignity and assist residents.Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: Not challenging or contradicting the resident's beliefs or statements.Record review of the facility policy, Resident Rights, Revised December 2016, revealed: Policy Statement: Employees shall treat all residents with kindness, respect and dignity.Policy Interpretation and Implementation:Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:A dignified existence.Be treated with respect, kindness, and dignity

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	675716	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Post Nursing & Rehab Center	605 W 7th St Post, TX 79356

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with an accurate PASRR Level I for 2 of 16 residents (Resident #2 and Resident #3) reviewed for PASRR screening, in that: 1. Resident #2 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness. 2. Resident #3 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness. These failures could place residents, with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation, at risk of not receiving care and services to meet their needs.The findings included:Resident #2 Record review of Resident #2's electronic face sheet dated 10/01/2025 revealed an [AGE] year-old male initially admitted to the facility on [DATE]. The face sheet included the following diagnoses: Parkinsonism (A group of movement symptoms found in several conditions, including Parkinson's disease. These symptoms include slow movements, stiffness, tremors, and problems with walking and balance.), Primary, with an onset date of 05/20/2025. Anxiety Disorder (excessive, ongoing worry that is hard to control), Admission, with an onset date of 05/21/2025. Major Depressive Disorder Single Episode, Severe without Psychotic Features (a mood disorder that causes a persistent feeling of sadness and loss of interest), no classification, with an onset date of 09/29/2025. Vascular Dementia, Moderate, with mood disturbance (loss of mental functions severe enough to affect daily life and activities) Secondary, with an onset date of 09/29/2025.The document did not indicate Resident #2 had a primary diagnosis of dementia. Record review of Resident #2's admission MDS dated [DATE], revealed under Section C Cognitive Patterns, Resident #2's MDS revealed a BIMS of 03, indicating the resident was significantly, cognitively impaired. There was not an option chosen on Resident #2's MDS, under section I Psychiatric/Mood Disorder, related to a Mood Disorder. Record review of Resident #2's care plan with a last Care Plan review date of 09/27/2025, under Diagnoses, indicated Resident #2 had a diagnosis of Major Depressive Disorder. Record review of Resident #2's Preadmission Screening and Resident Review (PASRR) Level One (PL1) form dated 05/19/2025 revealed under section C0090 Primary Diagnosis of Dementia an answer of YES, indicating the resident had a primary diagnosis of dementia. Additionally, under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. There were no additional PL1 screenings provided by the facility for Resident #2. There were no additional documents provided to suggest Resident #2 had a completed PASRR Level 2 Evaluation. Resident #3 Record review of Resident #3's electronic face sheet dated 10/03/2025 revealed a [AGE] year-old male initially admitted to the facility on [DATE]. The face sheet included the following diagnoses: Atherosclerotic heart disease (progressive narrowing and hardening of coronary arteries due to the deposition of atheroma (fatty deposits).) Primary, with an onset date of 01/31/2025. Cognitive Communication Deficit, Unspecified Classification, with an onset date 01/31/2025. Major Depressive Disorder Single Episode, Severe without Psychotic Features (a mood disorder that causes a persistent feeling of sadness and loss of interest), no classification, with an onset date of 02/12/2025.The document did not indicate Resident #3 had a primary diagnosis of dementia. Record review of Resident #3's Quarterly MDS dated [DATE], revealed under Section C Cognitive Patterns, Resident #3's MDS revealed a BIMS of 13, indicating the resident was cognitively intact. There was not an option chosen on Resident #3's MDS, under section I Psychiatric/Mood Disorder, related to Mood Disorder. Record review of Resident #3's care plan with a last Care Plan review date of 02/26/2025, under Diagnoses, indicated Resident #3 had a diagnosis of Major Depressive Disorder. Additionally, the care plan included a focus area that began on 02/26/2025 which stated, I require antidepressant medication (Specify Lexapro) for diagnosis of (Major) Depression, with a goal that stated, I will verbalize/communicate and understanding of the discharge (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan and describe the desired outcome by the review date., with the Interventions/Tasks that included the following: Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress; Evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits, and needs for maximum independence. Record review of Resident #3's Preadmission Screening and Resident Review (PASRR) Level One (PL1) form dated 01/31/2025 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. There were no additional PL1 screenings provided by the facility for Resident #3. There were no additional documents provided to suggest Resident #3 had a completed PASRR Level 2 Evaluation. During an interview on 10/03/2025 at 11:25 AM the DON stated she was currently responsible for entering a Resident's PASRR, upon admission. The DON stated she was also responsible for reviewing the PASRR to ensure accuracy. The DON stated the PASRR was usually completed prior to the resident admitting to the facility, and she assumed they were completed correctly. The DON verified Resident #2 and Resident #3 both had an active diagnosis of Major Depressive Disorder. The DON stated, to her knowledge, major depressive disorder should have qualified a Resident for a positive PASRR Level 1 screening. The DON stated Resident #2 and Resident #3 did not have a primary diagnosis of dementia. The DON stated if a resident received a new diagnosis of mental illness, the facility notified their Local intellectual and developmental disability authorities (LIDDAs) representative to have a new PASRR screening completed for the resident. The DON stated she was not aware Resident #2 and Resident #3 received a new diagnosis of a mental illness, Major Depressive Disorder, after admitting to the facility. The DON stated she would ensure both residents were referred for new PASRR Level 1 screening. The DON stated she did not recall receiving training pertaining to PASRR. The DON stated it was important for a Resident to have an accurate PASRR to ensure the Resident was receiving services related to their mental illness. During an interview on 10/03/2025 at 12:08 PM the ADM stated the DON was currently the person responsible for entering PASRR screenings when a resident was admitted to the facility. The ADM stated the DON was responsible for checking the PASRR screening to ensure it was accurate. The ADM stated if a new diagnosis of mental illness was received for a resident a referral was made to their Local intellectual and developmental disability authorities (LIDDAs) representative to have a new PASRR screening completed for a resident. The ADM stated she was not aware Resident #2 or Resident #3 received a new diagnosis of Major Depressive Disorder since being admitted to the facility. The ADM stated a resident could potentially miss out on services available to them if their PASRR Level 1 screening was not accurate. Record review of the facility's policy titled, Pre-admission Screening & Resident Review (PASRR),, undated, revealed the following: GuidelineIt is the intent of Post Nursing and Rehab Center to meet and abide by all State and Federal regulations that pertain to resident Preadmission and Screening Resident Review (PASRR) Rules.PurposeThe intent of this guideline is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD. P ASRR Level 1 Screen (PL1) The community Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL1 upon admission. In the event the facility is considering admission from the community (home, homeless shelter, jail, group home, off the street etc.) and if the facility Interdisciplinary Team (IDT) suspects any MI, ID or DD the community Admissions Coordinator prior to admission will contact the LIDDA and follow the preadmission process: 1. When it is determined that an individual's diagnosis was changed and/or a state surveyor determines the PL1 was incorrect, the social worker or designee will complete and submit a form 1012 (MI) or new PLI (ID/DD). A subsequent positive PLI will be entered according to 1012 findings.

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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 2 of 6 (Resident #17 and Resident #4) residents reviewed for infection control. 1. CNA A failed to utilize hand hygiene between glove changes during foley catheter care for Resident #4.2. CNA B failed to utilize hand hygiene between glove changes during incontinence care for Resident #17. These failures could place residents at risk for cross contamination and infection.The findings include:Record review of Resident #4's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #4 had a medical history of paraplegia (a condition characterized by paralysis or loss of movement in both legs), neuromuscular dysfunction (a group of disorders that affect the nerves and muscles, impairing their communication and function), and tubulointerstitial nephritis (a condition that affects the kidneys). Record review of Resident #4's quarterly MDS dated [DATE], Section C- Cognitive Patterns revealed a BIMS score of 11 which indicated Resident #4 had moderate cognitive impairment. Section H- Bladder and Bowel revealed Resident #4 had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine continuously) and was incontinent of bowel. Record review of Resident #4's physician orders revealed an order for Cath care every shift and PRN with a start date of 1/16/2023. Record review of Resident #4's care plan revealed a risk for catheter associated urinary tract infection or trauma with interventions for Cath care as needed, with a start date of 1/13/2022. During an observation of Resident #4's foley care on 10/1/2025 at 2:15pm, CNA A cleaned Resident #4's foley catheter and doffed (removed) contaminated gloves. CNA A failed to utilize hand hygiene between the glove change and donned (put on) clean gloves. CNA A turned Resident #4 onto his right side and cleaned Resident #4's bottom. CNA doffed contaminated gloves and donned clean gloves and placed a clean brief on Resident #4. CNA A did not utilize hand hygiene between the glove change. Record review of Resident #17's undated face sheet revealed am [AGE] year-old female originally admitted to the facility on [DATE]. Resident #17 had a medical history of dementia, chronic obstructive pulmonary disease (a group of lung diseases that cause persistent airflow obstruction and breathlessness), hypertension (high blood pressure), and muscle weakness. Record review of Resident #17's quarterly MDS dated [DATE], Section C- Cognitive Patterns revealed a BIMS score of 04 which indicated Resident #17 had severe cognitive impairment. Section H- Bladder and Bowel revealed Resident #17 was always incontinent of bowel and bladder. During an observation of Resident #17's incontinence care on 10/1/2025 at 3:07pm, CNA B cleaned Resident #17's front, doffed contaminated gloves and donned clean gloves. CNA B did not utilize hand hygiene between the glove change. CNA B turned Resident #17 onto her right left side and cleaned her bottom. CNA B doffed contaminated gloves and donned clean gloves. CNA B did not utilize hand hygiene between the glove change. During an interview on 10/02/2025 at 1:00pm with CNA A, she stated the DON was the infection preventionist. She stated she had been trained on infection control and the last training was approximately two months ago. She stated she was trained to utilize hand hygiene between glove changes. CNA A stated she did not use hand hygiene between glove changes because she forgot her hand sanitizer and she was nervous being observed. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be a chance of infection or spreading infection. During an interview on 10/02/2025 at 1:04pm with CNA B, she stated the DON was their infection preventionist. She stated she had been trained on infection control and hand hygiene last week. CNA B stated the training did cover utilizing hand hygiene between glove changes. She stated she did not utilize hand hygiene between glove changes because she was nervous and forgot. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be spreading infection or causing sepsis (condition that occurs when the body's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immune system overreacts to an infection). During an interview with the DON on 10/03/2025 at 10:15AM, she stated she is the infection preventionist. She stated she had been at this facility for a few months and had been training staff on infection control and catheter care. The DON stated there was an in-service in September 2025 on infection control. She stated she was not aware of staff not utilizing hand hygiene between glove changes. She stated compliance with infection control practices and hand hygiene are monitored through competencies, and those are done quarterly. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be spreading infection. During an interview with the ADM on 10/03/2025 at 11:15AM, she stated the DON was the infection preventionist. She stated in-services on infection control and hand hygiene are done quarterly and as needed. She stated she was not aware of staff not utilizing hand hygiene between glove changes. The ADM stated hand hygiene is covered during infection prevention training. She stated the potential negative outcome of not utilizing hand hygiene between glove changes could be spreading infection and cross contamination. She stated compliance with infection control practices is monitored through competencies where staff are visually monitored during incontinence care and are corrected as needed. Record review of facility policy titled Handwashing/ Hand Hygiene last revised 8/2015 revealed; 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. m. After removing gloves. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment.