STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to notify residents or their representatives on how to file a grievance in an anonymous manner, and the information of who the facility named as the Grievance Official for 2 residents (Resident #27 and Resident #43) out of 7 residents interviewed for grievances.1.The facility failed to notify Residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner. 2.The facility failed to follow their grievance policy by providing the correct information as to who the facility identified as the Grievance Official for Resident #27 and Resident #43. These failures could affect resident's ability to file a grievance without the fear of discrimination, reprisal, retribution, and their right to request a written decision regarding the resolution of their grievance. Findings Included:Review of Resident #27's MDS admission assessment, dated 08/07/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 15. Her cognitive status was intact. Her diagnoses included Chronic Obstructive Pulmonary Disease (ongoing lung condition caused by damage to the lungs), GERD (a chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach), Hypertension (a condition in which the force of the blood against the artery wall is too high), Major Depression Disorder (depressed mood or loss of interest in activities, causing significant impairment in daily live), Bipolar Disorder (mental condition marked by alternating periods of elation and depression) and Epilepsy (is a brain condition that causes recurring seizures).Review of Resident #43's MDS admission assessment, dated 08/07/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 13. Her cognitive status was intact.In an interview with Resident #27 on 08/07/25 at 9:11 AM, she met with the Surveyor in the hallway, and she stated that she needed to speak with the Surveyor. Resident #27 reported that she had some issues with staff not assisting another resident (Resident #43) with her daily ADL's. Resident #27 stated that she did not know what a Grievance was and had not filed a grievance at the facility. Resident #27 stated that she did not know who the Grievance Official was at the facility. Resident #27 stated that she had never filed a grievance at the facility regarding any of her concerns because she did not know anything about filing grievances at the facility. In an interview with Resident #43 on 08/07/25 at 9:32 AM, she stated that there was an occasion when she had been left in her brief for about 10 hours. Resident #43 stated that she did not file a grievance with the facility because she was bedbound and unable to file leave her room to file a grievance. Resident #43 stated that she did not know who the Grievance Official was at the facility. Resident #43 stated that she had never filed a grievance at the facility regarding any of her concerns because she did not know how to file grievances at the facility.In an interview with the SW/GO 08/07/25 at 11:58 AM, she stated that the Grievance Forms were not available to residents, on the floor, but they were available at the Nurses Station. She stated that there was not any way for residents to complete a Grievance Form anonymously. She stated that she understood that residents needed a way to complete a Grievance Form anonymously. The SW stated that there was a risk of residents feeling concerned about retaliation if they go to the Nurses Station to fill out a Grievance Form. The SW stated that if someone completes a Grievance Form and it was turned into Management, they can feel like they were being retaliated against.In an interview with the ADON on 08/07/25 at 12:13 PM, she stated that the Grievance Forms were in a folder behind the Nurses Station. She stated that the Grievance Forms were also located inside of the Administrators Office. She stated that there was not any way for residents to complete a Grievance Form anonymously. She stated that there was a risk for residents not to feel safe, if they fill out a Grievance Form Observation on 08/07/25 at 12:20 PM, revealed that the Grievance Forms were in a folder behind the Nurses Station. Observation on 08/07/25 at 12:22 PM, revealed that the Grievance Forms were located on a side wall in front of the Administrator's Office. The Grievance Forms were on a wall with 2 wall pockets. There was not a sign indicating the location of the Grievances. Record Review of the facility's Grievance Log for January 2025 - July 2025 revealed that there were no grievances filed for Residents #27 and #43.Review of the facility's policy titled, Resident and Family Grievances dated February 2025 reflected: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to complete a discharge summary that included but was not limited to, (i) A recapitulation of the resident's stay that includes, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; (ii) A final summary of the resident's status; (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) for one (Resident #58) of four residents reviewed for discharge planning. 1. The facility failed to complete a discharge summary and a reconciliation of medications for Resident #58 for her unplanned discharge to the hospital on [DATE]. This could place residents at risk of a recapitulation of the stay being unavailable to help ensure continuity of care once they went back home and/or discharged from the facility. Findings included: Record Review of Resident #58's admission face sheet dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #58's active diagnoses included gastroesophageal reflux disease (GERD) without esophagitis (GERD is characterized by the backward flow of stomach acid into the esophagus, causing symptoms like heartburn and regurgitation. Esophagitis is a condition where the esophagus becomes inflamed due to this acid reflux), acute kidney failure (a sudden and rapid decrease in kidney function), dorsalgia (refers to pain in the dorsal spine, which is the mid-back region), hyperkalemia (a condition where there is a high level of potassium in the blood), hyperlipidemia (high cholesterol, is a condition where there are elevated levels of lipids (fats) in the blood), diabetes, and depression. Resident #58 was discharged from the facility to the hospital on [DATE]. Record review of Resident #58's Discharge MDS assessment dated [DATE], reflected that the BIMS assessment score was blank. Resident #58's BIMS score was not successfully completed due to being unable to complete the assessment because she had difficulty comprehending the instructions. In Section A - Identification Information - A0050. Type of Record, Section F., reflected Section F. Entry/Discharge reporting is coded 11, meaning Discharge assessment - return anticipated. In Section A0310 - Type of Assessment, Section G. Type of Discharge reflected that Resident #58 had an unplanned discharge. In Section Q - Participation in Assessment and Goal Setting section Q0400 - Discharge Plan, Question A. Is active discharge planning already occurring for the resident to return to the community? The entry code is 0, which means No. Record review of Resident #58's Care Plan dated [DATE] reflected, no information relating to her discharge from the facility. Record review of Resident #58's Clinical Records reflected no discharge summary. Record review of the facility's admission and Discharge Report for [DATE] reflected that Resident #58 was sent to the hospital and was discharged from the facility. An attempted telephone call to the facility's Ombudsman on [DATE] at 10:58 AM was unsuccessful. An attempted telephone call to Resident #58's RP on [DATE] at 1:09 PM was unsuccessful.[SP1] In an interview with the SW on [DATE] at 10:04 AM, she stated she could not locate a Discharge Summary for Resident #58. She reported that the DON was responsible for completing the Discharge Summaries for residents who discharge from the facility to the hospital. In an interview with the DON on [DATE] at 2:01 PM, she stated that she had been employed at the facility for 4 years. The DON acknowledged that discharge summaries were completed for each resident that discharges from the facility. The DON stated that she was responsible for completing the discharge summaries for residents who have discharged from the facility due to being hospitalized . She stated that there was not a discharge summary for Resident #58. She stated that the facility's Social Worker was responsible for completing the Discharge Summaries for residents. The DON stated there was a risk to residents being discharged from the facility without a discharge summary. She stated without a Discharge Summary, the discharge residents would not be able to meet with the staff to discuss their reconciliation of medications and their discharge plans such as home health and care responsibilities. The DON stated that there was not any harm to Resident #58 due to her discharging from the facility and not having a discharge summary in the clinical records. An attempted telephone call to Resident #58's RP on [DATE] at 2:14 PM was unsuccessful. [SP2] In an interview with the facility's Admissions Coordinator on [DATE] at 3:04 PM, he stated that he had been employed at the facility since [DATE]. He stated he did not make a telephone call to the hospital after Resident #58 was sent out to the hospital on [DATE]. He stated that he would only reach out to the family of the resident only after the Case Manager with the hospital reached out to him about the resident for a follow-up regarding the resident's discharge from the hospital to the facility. The Admissions Coordinator stated that he was unsure if there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (Resident #35) of four residents reviewed for ADL care. 1. The facility failed to ensure CNA A thoroughly cleaned the vaginal area and feet of Resident #35 when he provided the resident with a bath on 08/05/25. This failure could place residents at risk for a skin breakdown and infection.Findings included: 1. Review of Resident #35's Quarterly MDS Assessment, dated 05/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Her BIMs score was 8 reflecting that her cognitive skills were moderately impaired. Her diagnoses included diabetes and Non-Alzheimer's Disease. The resident was always incontinent of bowel and bladder. The resident was dependent staff.Review of Resident #35's Care Plan, dated 08/25/23, reflected: The resident had an ADL self-care performance deficit related to impaired balance and mobility.Facility Interventions included: Bathing/Showering: requires (extensive assistance) by (2) staff on schedule shower days and as necessary.An observation on 08/05/25 at 9:50 AM of Resident #35 revealed she was lying in bed. She said she was waiting to get a bath. CNA A was in the room, wearing gloves, and preparing water. CNA A put on gloves and gathered supplies. CNA A removed the resident's clothing and placed towels on the resident. CNA A removed the brief and threw it in the trash. CNA A cleaned the resident's arms, chest, abdomen, peri-area, and legs. CNA A did not clean the vaginal folds. CNA A assisted the resident to roll to her right side. He cleaned her back, buttocks, legs, and cleaned bowel movement from the buttocks. CNA A did not wash the resident's feet. An interview on 08/05/25 at 12:45 PM with CNA A revealed he had been trained/checked off to wash a resident's feet and peri-area with the vaginal folds during a bath. He said he did not do those things because the resident had wounds and things on her feet. (The resident had a very small diabetic ulcer on the left first toe.) He also said the resident's peri-area was tight and he was not able to clean her. CNA A said the risk to the resident if her feet and vaginal folds were not washed was skin breakdown. An interview on 08/06/25 at 2:30 PM with the ADON revealed staff were supposed to wash the resident's feet during a bath. The ADON said the risk to the resident was skin breakdown or fungal infections. An interview on 08/07/25 at 2:10 PM with the DON revealed staff were supposed to wash the resident's feet during a bath because staff were supposed to clean everyone's feet especially if they were diabetic. The DON said failure to clean the vagina properly could cause vaginal infection, urinary tract infections, and sores.Record review of the facility policy, Perineal Care, dated 05/01/24, reflected: Policy:It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, decrease risk of infection to the extent possible, and to decrease risk of and assess for skin breakdown.7. Females:a. Assist resident in bending her knees slightly and spreading her legs.b. Wet washcloth and apply perineal cleanser. If using prepackaged product, open package and obtain the wet cloth.c. Separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward anus).d. Repeat on opposite side using separate section of washcloth or new disposable wipe.e. Clean urethral meatus and vaginal orifice using clean portion of washcloth or new disposable wipe with each stroke.Record review of the facility policy, Resident Showers, dated 04/15/24, reflected: Policy:It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.Wash from head to toe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 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 observation, interview and record review, the facility failed to maintain medical records on each resident that are complete and accurately documented for 1 (Resident #7) of 5 residents reviewed for medical records. The facility failed to ensure Resident #7's medical records contained the results of the preadmission PASRR Level 1 screening and subsequent evaluations and determinations in accordance with accepted professional standards and practices. This failure could place the residents at risk of not achieving their person-centered plan of care objectives and goals. Findings included: Review of Resident #7's Face sheet, dated 08/07/2025, reflected he was a [AGE] year old male, who was admitted to the facility on [DATE], with diagnoses including end stage renal disease (the final stage of chronic kidney disease, characterized by the kidney's inability to filter waste and excess fluid from the blood), chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood and/or remove carbon dioxide), Type 2 Diabetes (the body does not produce enough insulin, leading to high blood sugar levels), dysphagia, oropharyngeal phase (difficulty swallowing) and chronic diastolic heart failure (a condition where the heart muscles is stiff, leading to increased pressure within the heart chambers). Review of the Resident #7's electronic medical record reflected there was not a PASRR Level 1 screening uploaded to the resident's medical record. During an interview with the MDS Coordinator on 08/07/2025 at 11:00 AM, the MDS Coordinator reviewed Resident #7's medical records and confirmed there was not a PASRR Level 1 uploaded to the resident's medical record. When asked how the PASRR Level 1 screening gets uploaded to the resident's medical record, the MDS Coordinator stated it was the responsibility of the MDS office to upload the PASRR Level 1 screening into the resident's medical record during admission, which they get from Simple, a software system used to manage the PASRR process in Texas. When asked what the risk is for the resident, the MDS Coordinator stated she did not think there was a risk in this instance because this was a discrepancy in charting. A review with the MDS Coordinator on 08/07/2025 at 11:05 AM revealed a PASRR Level 1 screening for Resident #7 had been completed on 05/19/2023 and was uploaded in Simple. The PASRR Level 1 screening was positive. Further review revealed a PASRR Level II evaluation was completed on 05/26/2023. An observation of the MDS Coordinator on 08/07/2025 at 11:10 AM reflected the MDS Coordinator uploaded the PASRR Level 1 screening and PASRR Level II evaluation to Resident #7's medical record. A review of the facility's Documentation in Medical Record policy, dated 02/01/2025, stated the following: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 - Some	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675888	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Healthcare & Rehabilitation	1401 Rice Rd Tyler, TX 75703

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #35 and Resident #25) of five residents, reviewed for infection control.1. The facility failed to ensure CNA A performed hand hygiene while bathing Resident #35. 2. The facility failed to ensure CNA B performed hand hygiene during incontinence care for Resident #25.These failures placed residents at risk for healthcare associated cross contamination and infections.Findings included: 1. Review of Resident #35's Quarterly MDS Assessment, dated 05/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Her BIMs score was 8 reflecting that her cognitive skills were moderately impaired. Her diagnoses included diabetes and Non-Alzheimer's Disease. The resident was always incontinent of bowel and bladder. The resident was dependent staff. An observation on 08/05/25 at 9:50 AM of Resident #35 revealed she was lying in bed. She said she was waiting to get a bath. CNA A put on gloves and gathered supplies. CNA A removed the resident's clothing and placed towels on the resident. CNA A removed the brief and threw it in the trash. CNA A changes his gloves but did not perform hand hygiene. CNA A cleaned the resident's arms, chest, abdomen, peri-area, and legs. CNA A changed gloves but did not perform hand hygiene. CNA A assisted the resident to roll to her right side. He cleaned her back, buttocks, legs, and cleaned bowel movement from the buttocks. CNA A grabbed a towel using the soiled gloves and dried the back of the resident's buttocks and back of thighs with the towel. CNA A removed his gloves and washed his hands. CNA A put on new gloves. CNA A did not wash the resident's feet. CNA A put a new brief on the resident and dressed her. An interview on 08/05/25 at 12:45 PM with CNA A revealed he had been trained/checked off to wash a resident's feet and peri-area with the vaginal folds during a bath. He said he also had been trained to perform hand hygiene between glove changes. He said he did not do those things because the resident had wounds and things on her feet. (The resident had a very small diabetic ulcer on the left first toe.) He also said the resident's peri-area was tight and he was not able to clean her. CNA A said the risk to the resident if her feet and vaginal folds were not washed was skin breakdown. CNA A said the risk to the resident if hand hygiene was not performed was infection.2. Review of Resident #25's Quarterly MDS Assessment, dated 07/16/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 15 reflecting that her cognitive skills were intact. The resident was always incontinent of bladder and bowel. Her diagnoses included heart disease and high blood pressure. The resident was dependent on staff for toileting/hygiene.Review of Resident #25's Care Plans reflected:11/03/24 Activities of daily living self-care performance deficit related to fatigue and limited mobility.Facility interventions included:Toilet use: incontinent of bowel and bladder. Check and change every two hours and as needed.An observation on 08/06/25 at 2:15 of Resident #25 revealed CNA B was preparing to perform incontinence care. CNA B folded the brief down and cleaned the peri-area. CNA B changed gloves but did not perform hand hygiene. The brief contained urine. The resident was assisted to turn to her right side and CNA B cleaned her buttocks. CNA B changed gloves but did not perform hand hygiene. CNA B placed the brief, applied cream, and assisted the resident to roll to her back. CNA B fastened the brief.An interview on 08/06/25 at 2:25 PM with CNA B revealed she had been trained to perform hand hygiene between glove changes. She said she did not do it this time because she was anxious. CNA B said the risk to the resident was infection.An interview on 08/06/25 at 2:30 PM with the ADON revealed staff were supposed to perform hand hygiene between glove changes during incontinence care. The ADON said the risk to the resident was urinary tract infections. The ADON said staff were supposed to wash resident's feet during a bath. The ADON said the risk to the resident was skin breakdown or fungal infections. She said it was not ok to use soiled gloves to grab a clean towel to dry a patient after cleaning them of bowel movement could cause urinary tract infections. An interview on 08/07/25 at 2:10 PM with the DON revealed staff were supposed to perform hand hygiene between glove changes and incontinence care. The DON said failure to do so could cause infection. The DON said staff were supposed to wash the resident's feet during a bath because staff were supposed to clean everyone's feet especially if they were diabetic. The DON said failure to clean the vagina properly could cause vaginal infection, urinary tract infections, and sores.Record review of the facility policy, Hand Hygiene, dated 06/13/24, reflected: All staff will perform proper hand hygiene procedures to