

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 1 of 1 facility reviewed for care and services. The facility failed to provide sufficient nursing staff on 07/04/2026, 07/05/2026, 07/08/2026, 07/11/2026, 07/12/2026, 07/14/2026, 07/16/2026, 07/19/2026, 07/25/2026, 07/26/2026, 07/27/2026. This failure placed residents at risk of inadequate supervision, an unsafe environment, and not receiving timely care. Findings included: During a confidential group interview at an undisclosed date and time, residents in the group stated that they waited up to 3 hours for their call light to be answered. Residents stated these prolonged wait times occurred most frequently on the night shift and weekends. Residents stated staff would tell them they were short staffed when explaining delays in responding to call lights or providing care. Residents stated they believed there were not enough staff members available at times to meet their needs in a timely manner. Residents reported experiencing delays with assistance with their ADLs. Residents stated the extended response times caused them to feel they needed to delay requesting assistance because they anticipated lengthy wait times. Residents stated they felt their needs were not addressed promptly due to the lack of available staff. Residents stated they had expressed their concerns to the DON and Ombudsman. During an interview on 07/27/2026 at 12:21 PM, the Ombudsman said the residents had reported to her call lights not being answered, not being provided with incontinent care and not being assisted in and out of bed in a timely manner due to not having enough staff on the night shift and on the weekends. The Ombudsman said this was an ongoing issue over the past months. During a confidential interview at an undisclosed date and time, Anonymous Staff #1 said when staff called in, they did the best they could to provide the residents' care. Anonymous Staff #1 said when they did not have enough staff it was hard to answer the call lights and provide the residents with their personal care. During a confidential interview at an undisclosed date and time, Anonymous Staff #2 said she had not received any complaints from the residents about the call lights not being answered or not getting assistance with ADLs in a timely manner. Anonymous Staff #2 said when staff did not show up to work the ADON tried to fill the position, but there were times when the ADON was unable to fill the position and they had to work without the staff. Anonymous Staff #2 said it was difficult to provide the residents' care when they were short staffed, but they did the best they could. Anonymous Staff #2 said not having sufficient staff could result in the residents not getting the same care as if they had all the staff present at work. During an interview on 07/29/2026 at 5:09 PM, the ADON said she was responsible for the staffing. She said the facility required a PPD of 3.0 for nursing staff (a calculation used by the facility to determine the nursing staff hours per day and the calculation for the facility should be equivalent to 3.0), but if they had call-ins (someone did not show up for work) they were not meeting (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: 676045	Facility ID: 676045
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the requirements for staffing. The ADON said when someone called-in she tried to find someone to replace them, but if she could not find anyone to replace them, she divided the staff available between all the halls. The ADON said none of the residents reported to her that their call lights were not answered or not receiving assistance with their ADLs in a timely manner. The ADON said if the facility did not have enough staff it could result in the staff not being able to meet the residents' needs in a timely manner and could result in weight loss or skin breakdown. During an interview on 07/29/2026 at 5:42 PM, the DON said there had been a time when the residents reported to her that their call lights were not answered in a timely manner or they were not provided care in a timely manner. The DON said the ADON was responsible for staffing, and she did not feel they were ever short staffed because if staff called in nurse management tried to help. The DON said not having sufficient nursing staff could result in the residents having to wait a little longer to have their needs met. During an interview on 07/29/2026 at 5:53 PM, the Administrator said there were always grievances about the call lights not being answered. He said he could not remember if he received any complaints about not being provided with ADL care in a timely manner. The Administrator said he did not feel like they did not have enough staff available to provide the residents' care. He said he was aware sometimes they were not meeting their required staffing PPD of 3.0 because of call-ins. The Administrator said not having sufficient nursing staff could result in the residents not being seen as quickly as they should have been. The Administrator said the facility did not have a policy on staffing. Record review of the facility's July 2026 Nursing Direct Care PPD indicated the PPD for nursing staff was less than 3.0 on 07/04/2026, 07/05/2026, 07/08/2026, 07/11/2026, 07/12/2026, 07/14/2026, 07/16/2026, 07/19/2026, 07/25/2026, 07/26/2026, 07/27/2026.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 residents (Residents #44 and #89) and one lunch meal reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 07/28/2026. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an observation and interview on 07/28/26 at 12:34 PM, the lunch tray was sampled by the Dietary Manager and 5 surveyors. The sample tray consisted of beef steak with a glaze on top, which was hot and tender; the broccoli was lukewarm, overcooked, and bland; and the baked potato was undercooked and lukewarm. The Dietary Manager said the steak with glaze was good and tender; the broccoli could have been warmer, less cooked, and more season added; and the baked potato was not cooked enough and could have been warmer. The Dietary Manager said this failure placed residents at risk of not eating and weight loss. During an observation and interview on 07/28/2026 at 1:03 PM, Resident #89 was in her room sitting on the side of her bed with her lunch tray on her bedside table. Resident #89 had only eaten her steak, and said the food was not good and the potatoes were too hard. During an observation and interview on 07/28/2026 at 1:07 PM, Resident #44 was sitting up in her bed with her lunch tray on her bedside table sitting over her. Resident #44 said her broccoli was overcooked, the potato was not soft enough to eat, and the potato not being well cooked made it difficult to put the fixings on them. Resident #44 said she did not like overcooked food at all. During an interview on 07/29/2026 at 5:48 PM, the DON said she had received complaints about the food from residents at times. The DON said the residents had complaints that included the residents did not like what was on the menu on some days, but the facility had an alternative menu the residents could choose from. The DON said there were times residents complained about taste. The DON said she had a test tray from the kitchen before and it was okay. The DON said her expectation was for the communication to be made to the Dietary Manager and she expected the potatoes and the broccoli to have the correct texture when served to the residents. The DON said the failure placed a risk for wasting food and could potentially cause weight loss. During an interview on 07/29/2026 at 7:04 PM, the Administrator said the food at the facility should be good and spiced according to the taste of the residents. The Administrator said the responsibility was the Dietary Manager's. The Administrator said the failure placed a risk for weight loss. During an interview on 07/29/2026 at 6:46 PM the Administrator said the facility did not have a policy for palatable meals.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet for 1 of 3 residents (Resident #56) reviewed for nutrition. The facility failed to ensure Resident #56 received her physician ordered supplement (magic cup) on 07/28/26 for her lunch meal. This failure could place residents at risk for weight loss or protein deficits Findings included: Record review of Resident #56's face sheet, dated 07/29/26, reflected Resident #56 was an [AGE] year-old female, re-admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental ability that interferes with daily life), stroke, malnutrition (a health condition caused by a deficiency, excess, or imbalance in a person's intake of energy and/or nutrients), and muscle weakness. Record review of Resident #56's quarterly MDS assessment, dated 05/18/26, reflected Resident #56 rarely made herself understood, and was rarely understood by others. Resident #56 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident #56 was dependent on ADLs and required maximal assistance with eating. The MDS did not indicate any weight loss. Record review of Resident #56's physician order dated 02/23/26, revealed, Regular diet, pureed texture, nectar consistency, and magic cup twice a day. Record review of Resident #56's comprehensive care plan revised 03/25/26 indicated Resident #56 was at risk of malnutrition. The intervention was for staff to serve diet as ordered. During an observation and interview on 07/28/26 at 1:00 p.m., Resident #56 tray card read magic cup for supplements. Resident #56 did not have a magic cup on her lunch tray. CNA C was assisting Resident #56 with her lunch meal. CNA C looked at Resident #56's tray card and said she did not have a magic cup. She said magic cups were usually given for weight loss. She said the nurse checked the tray and she did not even look at the tray card before assisting Resident #56 with her meal. During an interview on 07/28/26 at 1:09 p.m., LVN D said she checked Resident #56's lunch tray and overlooked the magic cup not being on her tray. She said Resident #56's appetite was good at times and other times not so good. She said Resident #56 should have had her magic cup on her tray to prevent weight loss. During an interview on 07/28/26 at 1:12 p.m., Dietary Aide E said she was responsible for ensuring supplements were on the residents' trays who required them. She said she fixed Resident #56's lunch tray and must have missed putting the magic cup on her tray. She said they usually receive magic cups related to their diet. During a phone interview on 07/29/26 at 6:06 p.m., the dietitian reviewed Resident #56's chart and said she had an appetite stimulant ordered 04/24/26 to help with her appetite. She said Resident #56 was thin and the magic cup helped her maintain her weight. During an interview on 07/29/26 at 5:57 p.m., the DON said she expected all residents who had orders for supplements to receive them. She said the kitchen staff was supposed to place the supplement on the tray, and the nurse was responsible for ensuring it was on the tray before the tray was served to the resident. She said supplements were usually given for extra protein and failure to receive them could potentially cause weight loss. During an interview on 07/29/26 at 7:10 p.m., the Administrator said she expected all residents who had orders for supplements to receive them. She said the dietary staff should place the magic cup on the tray and the nurse should ensure it was on the tray. She said she expected the nurses to read the tray card and if the magic cup was not on the tray, to ask the dietary staff to give them one before the tray was served to the residents. She said residents usually had supplements ordered for extra protein and weight loss. Record review of the facility's policy titled, Supplements, from the Dietary Services Policy & Procedure Manual dated 2012, indicated, We will provide supplements to residents in a safe (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and sanitary manner. Physician ordered supplements will be prepared and delivered by the Food and Nutrition Department according to facility policies.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 of 6 residents reviewed (Resident #46) for special eating equipment and assistance when consuming meals. The facility failed to provide Resident #46's physician ordered sip cup on 07/27/2026 during his lunch meal. This failure could place residents at risk for dehydration, diminished independence, and self-esteem. Findings included: Record review of Resident #46's face sheet dated 07/27/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnose which included major depressive disorder (a common, serious mood disorder defined by persistent sadness, loss of interest in activities, and low energy lasting at least 2 weeks), unspecified intellectual disabilities (delayed motor and language milestones and trouble with problem-solving and logic), and autistic disorder (a lifelong developmental condition affecting social communication, behavior, and sensory processing). Record review of #46's quarterly MDS dated [DATE] indicated he sometimes understood others and sometimes made himself understood. The MDS also indicated he had a BIMS score of 1 which meant he had severely compromised cognition. The MDS also indicated he ate independently. Record review of Resident #46's order summary report dated as of 07/29/2026 indicated he had an order for: 1) Regular diet mechanical soft texture, regular consistency, sip cup with a start date of 10/18/2025 and no end date. Record review of Resident #46's comprehensive care plan revised 03/02/2026 indicated he had an ADL self-performance deficit and required supervision for eating and used a sip cup. Record review of Resident #46's meal ticket dated 07/27/2028 indicated he was supposed to have a sippy cup with his meal. During an observation on 07/27/2026 at 12:15 PM, Resident #46 was in the dining room eating his food and had a full glass of tea on his table and no sippy cup. During an observation and interview on 07/27/2026 at 12:35 PM, Resident #46 had a full glass of tea and no sip cup and he was finished eating. Resident #46 said he wanted a drink, but he did not have his sip cup, so he did not drink anything. During an interview on 07/27/2026 at 12:40 PM, the MDS Nurse said he could not remember if he served Resident #46's his lunch tray, but Resident #46 should have had a sip cup for his drink. The MDS Nurse then obtained his sip cup from the kitchen and gave Resident #46 his sip cup filled with tea. Resident #46 drank 2 full sip cups of tea. The MDS nurse said the failure could have caused Resident #46 to be thirsty. During an interview on 07/29/2026 at 6:33 PM, Dietary Aide E said she did not recall not giving Resident #46 his sip cup. Dietary Aide E said she could not even remember if she worked on 07/27/2026 or why Resident #46 was receiving the sip cup on his tray. Dietary Aide E said there was no risk for Resident #46 not having his sip cup at meals. During an interview on 07/29/2026 at 6:40 PM, the Dietary Manager said Dietary Aide E was responsible for ensuring Resident #46 had his sip cup on his tray when meals were served as well as the MDS Nurse and the nurses in the dining room passing out trays. The Dietary Manager said the failure placed Resident #46 at risk of spilling his drink or not drinking at all but she was unsure of the reason for him having the cup. During an interview on 07/29/2026 at 5:53 PM, the DON said if Resident #46 had a sip cup on his lunch ticket it should have been on his tray. The DON said the dietary and nursing staff should have ensured Resident #46 had the sip cup. The DON said the failure placed a risk for him not having anything to drink, but the DON said Resident #46 could ask for drinks. During an interview on 07/29/2026 at 7:06 PM, the Administrator said if Resident #46 needed the assistive device (sip cup) (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he should have had it on his meal tray. The Administrator said the responsibility was on dietary staff and the nurse who checked the trays. The Administrator said the failure placed a risk of dehydration. Record review of the facility policy revised February 14, 2007, Feeding, Assistive/Complete indicated: Assistive or complete feeding of meals is provided to residents who have decreased appetites or are unable to eat independently because of disabilities, confusion, weakness, or neuromuscular disorders. 10. Assist with feeding as needed: a. Place the napkin or small towel over the chest or tuck under the chin. b. Arrange the dishes on the tray to avoid spilling. c. Arrange the dishes for easy access. Remove and discard the wrappings. d. Cut meat, place straw in glass (unless contraindicated), open and pour fluids from a container into a glass cup. Open salt, sugar, pepper, and margarine and use on food or in fluids as desired or requested by the resident. e. Supply assistive devices such as swivel spoons, built up or long handled utensils, plate guards, non-slip guard on glass, large handled mugs, suction cups on the dishes.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 4 (Resident #7) reviewed for hospice services. The facility failed to obtain Resident #7's Interdisciplinary Group Meetings since the start of care. These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings Included: Record review of face sheet dated 07/29/2026 revealed Resident #7 was an [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Dementia (severe memory loss and cognitive functioning). Record review of order summary report revealed Resident #7 had an order to admit to hospice on 06/10/2026. Record review of Significant Change MDS dated [DATE] revealed Resident #7 had a change in status requiring a new assessment due to new order for hospice services. MDS assessment revealed had a BIMS score of 03 indicating severe cognitive impairment. Record review of care plan dated 06/16/2026 revealed Resident #7 required hospice services for terminal illness with the intervention for hospice staff will assist the facility in care for Resident #7. Record review of Resident #7 hospice binder on 07/29/2026 revealed Resident #7 did not have any IDG meeting notes in the tab labeled specially for Intradisciplinary Group Meetings since the start of care on 06/10/2026. Interview on 07/29/2026 at 3:37 p.m., the Hospice RN stated she does not bring the IDG meeting notes to the facility and never has been requested for them. The Hospice RN stated that she would bring the IDG meeting notes if the facility requested them. The Hospice RN stated that the IDG meetings consisted of a group of providers that collaborated to create a plan of care, orders, and goals for Resident #7. The Hospice RN stated Resident #7 was at risk of not having coordinated care and continuation of care to the nursing facility. Interview on 07/29/2026 at 4:38 p.m., RN B revealed she was unaware what documents were required to be in the hospice binder for Resident #7. RN B stated she looked in the binder for medication orders to ensure the facility and hospice have the same orders. RN B stated that the hospice binder was to ensure coordination of care, and it was important the required documents were in the binder. RN B stated Resident #7 was at risk of not having continuity of care. Interview on 07/29/2026 at 4:52 p.m., Medical Records stated she was only responsible for the 3074 Physician Certification of Terminal Illness and 3071 The current and past Texas Medicaid Hospice Recipient Election/Cancellation Form (Health and Human Services required documents) and she performed audits and uploads them to the electronic system. Medical Records stated she was unaware of what was required in the hospice binders. Medical Records stated she was not sure what the IDG meeting was or the importance of it being in the hospice binder. Interview on 07/29/2026 at 4:55 p.m., the DON revealed Resident #7 was on hospice services since 06/10/2026. The DON stated that she did not have a system for checking the hospice binders to ensure the required documents were placed in each section of Resident #7's hospice binder. The DON stated the hospice binders were used for coordination of care, care plan, orders, and team members to be able to refer to when providing care to Resident #7. The DON stated Resident #7 was at risk of not everyone knowing what the care plans consist of, who to call, medications, and continuing of care. The DON stated she expected the IDG meetings to be printed and placed in the binder every 2 weeks to ensure continuity (continued on next page)		

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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 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 1 of 4 residents (Resident#4) reviewed for infection control. 1.The facility failed to ensure CNA F did not use dirty linen and performed hand hygiene while providing incontinent care for Resident #4 on 07/28/26. This failure could place residents at risk for cross-contamination and the spread of infection. Findings included: 1.Record review of Resident #4's face sheet, dated 07/29/26, indicated he was a [AGE] year-old male re-admitted to the facility on [DATE] with diagnoses which included quadriplegia (a medical condition causing partial or total paralysis of all four limbs and the torso, usually resulting from damage to the cervical spinal cord in the neck), and muscle weakness. Record review of Resident #4's admission MDS assessment, dated 06/26/26, indicated Resident #4 usually understood and was usually understood by others. Resident #4's BIMS score was 15, indicating he was cognitively intact. The MDS indicated Resident #4 was dependent on staff's assistance with his ADLs including toileting. The MDS indicated Resident #4 was always incontinent of bowel. Record review of Resident #4's Physician order dated 02/13/24 indicated: May apply barrier cream as needed every shift. Record review of Resident #4's comprehensive care plan, last reviewed 07/20/26, indicated he was incontinent of bowel. The intervention was for staff to provide incontinence care and apply barrier cream after each incontinent episode. During an observation on 07/28/26 at 9:20 a.m., CNA F performed peri care for Resident #4. CNA F cleaned the front and then turned him to clean his buttock. She cleaned his buttock which contained feces, applied barrier cream to his buttock, and then grabbed his clean brief and applied it with the same dirty gloves on. She then grabbed the draw sheet with the same dirty gloves and allowed it to hit the floor and then applied it under Resident #4. She then changed her gloves and performed hand hygiene. CNA F pulled up his covers, gathered equipment, and left the room. During an interview on 07/28/26 at 9:49 a.m., CNA F said she should have changed her gloves after applying the barrier cream and before applying the draw sheet and should not have let the draw sheet touch the floor and then use it. She said she placed Resident #4 at risk for cross contamination. During an interview on 07/29/26 at 5:21 p.m., LVN G she said was Resident #4's nurse. She said she expected staff to wipe the correct way, change gloves, and hand hygiene between dirty to clean. She said they should not use linen that had touched the floor. She said these failures could cause infection control issues related to contamination. During an interview on 07/29/26 at 5:57 p.m., the DON said she expected staff to provide incontinent care appropriately. She said they should change their gloves from dirty to clean. She said she did not expect staff to touch clean objects with dirty gloves. She said she did not expect staff to use linen that had touched the floor. The DON said she and the ADON were the overseers of infection control and were responsible for ensuring the staff performed peri care correctly. The DON said check offs for proper incontinent care were completed yearly and as needed. She said failure to properly perform hand hygiene, and the use of dirty linen could place residents at risk of infection and cross contamination. During an interview on 07/29/26 at 7:01 p.m., the Administrator said she expected proper perineal care and hand hygiene to be completed by all staff. She said she expected staff to get new linen if it touched the floor or became contaminated in any way. The Administrator said the nursing administration (DON, ADON) was responsible for ensuring the staff provided proper linen care, perineal care, and hand hygiene. The Administrator said proficiency checks were completed yearly and as needed. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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	Administrator said these failures created a risk for infection control issues. Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, undated, indicated, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions.1. Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. Gloving: Gloves are worn for three important reasons:1. To provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin. 2.To reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to residents during invasive or other resident-care procedures that involve touching a resident's mucous membranes and nonintact skin.3.To reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite can transmit these microorganisms to another resident; in this situation, gloves must be changed between resident contacts, and hands washed after gloves are removed. Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves. Failure to change gloves between resident contacts is an infection control hazard # 7 Linen and laundry. Hygienic and common-sense storage and processing of clean and soiled linen is recommended.		