STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676060	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambrosio Guillen Texas State Veterans Home	9650 Kenworthy St El Paso, TX 79924

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 4 of 9 residents (Resident #1 Resident #2, Resident #3, and Resident #4) reviewed for dignity.-The facility failed on 3/18/2026 to provide glucose reading for Resident #1, Resident #2, Resident #3, and Resident #4 in a private setting.-The facility failed on 3/18/2026 to provide insulin injection for Resident #1, Resident #2, Resident #3, and Resident #4 in a private setting.The deficient practice could affect residents by contributing to poor self-esteem, dignity issues, diminished quality of life, and leaking of protected health information.The findings include:Record review of Resident #1's face sheet dated 3/18/2026 revealed a [AGE] year-old male with an original admission date of 12/05/2025.Record review of Resident #1's MDS dated [DATE] revealed under section C, a BIMS score of 3 the significance meaning he had severe cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production). Under section N revealed the resident required insulin injections every day.Record review of Resident #1's care plan dated 12/16/2025 revealed the resident had focus area related to disorientation from dementia. Interventions in place included to provide choices for the resident and assist with decision making. Record review of Resident #1's physical and health dated 12/11/2025 revealed the resident was diagnosed with Alzheimer's dementia and diabetes type 2.Record review of Resident #2 face sheet dated 3/19/2026 revealed a [AGE] year-old male with an original admission date of 5/3/2022 and readmission date of 5/8/2023.Record review of Resident #2's MDS dated [DATE] revealed under section C, a BIMS score of 6 the significance meaning he had severe cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production).Record review of Resident #2's care plan dated 12/5/2025 revealed the resident had a focus area related to impaired communication with interventions to allow adequate time for the resident to respond and evaluate resident's ability to comprehend.Record review of Resident #2's physical and health dated 2/10/2026 revealed the resident was diagnosed with diabetes type 2, dementia and bipolar disorder (a psychiatric mood disorder characterized by episodes of depression and manic behavior).Record review of Resident #3's face sheet dated 3/19/2026 revealed an [AGE] year-old male with an admission date of 6/21/2024.Record review of Resident #3's MDS dated [DATE] revealed under section C, a BIMS score of 4 the significance meaning he had severe cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production). Under section N revealed the resident required insulin injections every day.Record review of Resident #3's care plan dated 1/26/2026 revealed the resident had a focus area for diabetes mellitus concerns with interventions of observe for signs and symptoms of hyper/hypoglycemia (symptoms related to low and high blood sugar), rotate injection sites, and monitor food intake.Record review of Resident #3's physical and health dated 6/6/2025 revealed the resident was diagnosed with dementia and diabetes type 2.Record review of Resident #4 face sheet dated 3/19/2026 revealed a [AGE] year-old male (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: 676060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with an original admission date of 10/22/2025 and a readmission date of 2/11/2026.Record review of Resident #4 MDS dated [DATE] revealed under section C, a BIMS score of 11 the significance meaning he had moderate cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production). Under section N revealed the resident required insulin injections every day.Record review of Resident #4's care plan dated 11/11/2025 revealed the resident had a focus area for at risk weight loss related to diagnosis. The resident's care plan addressed a care area of cognition with interventions of ask simple questions, do not rush the resident, and explain procedures to the resident. Record review of Resident #4's physical and health dated 10/27/2025 revealed the resident had a diagnosis of hearing loss, diabetes type 2, and dementiaDuring an observation on 3/18/2026 at 11:05 AM, it was observed that RN A completed a glucose check and an insulin injection in the TV room area for Resident #1. At 11:116 AM, RN A completed a glucose check and an insulin injection in the TV room area for Resident #2. At 11:29 AM, RN A completed a glucose check and an insulin injection in the TV room area for Resident #3. At 11:42 AM, RN A completed a glucose check and an insulin injection in the TV room area for Resident #4. There were more than 15 other residents in close proximity present while Resident #1, Resident #2, Resident #3, and Resident #4 received treatment.During an interview on 3/19/2026 at 11:55 AM with the Supervisor RN, she stated that when checking a resident's glucose staff had to ensure the resident was in their room and not in the open. She stated that needed to be done to uphold a resident's dignity. She stated a resident's blood sugar, insulin brand, and number of units could be overheard by residents nearby if it was completed out in the open. She stated a resident could feel embarrassed if they received care in the open for others to see. She stated that herself, nursing leadership, and the Administrator were the individuals responsible for ensuring staff provided care to the resident inside their bedroom. She stated that she would have instructed RN A to take the residents back to their room when checking glucose levels and injecting insulin. She stated the last in-service for resident rights was last week.During an interview on 3/19/2026 at 12:53 PM with the Unit Manager, she stated a blood sugar level reading and insulin injection were a treatment that needed to be completed in a resident's room to protect their privacy. Sh stated she did observe RN A conduct glucose readings and administer insulin in the common area on 3/18/2026. She stated that after the observation she instructed RN A she could not provide care in the open and needed to administer it in the resident's bedroom. She stated all patient related care should be completed in the residents' rooms. She stated it affected residents because it took away a factor of privacy, and a resident could feel embarrassed. She added that the residents' dignity needed to be upheld by staff even if the resident was in the memory unit. She stated the last in-service for resident rights was a week ago.During an interview on 3/19/2026 at 2:34 PM with the ADON, she stated that the residents needed to be in their rooms to receive care for a glucose reading and insulin injection because skin would be exposed. She stated it was a dignity and HIPAA concern if staff provided care in the open for other residents to see. She stated by conducting treatment for diabetes out in the open the residents' glucose readings, skin, diagnosis, dosage, and type of insulin would be disclosed for others to see and hear. She stated that all staff were responsible for protecting residents' information. She stated it affected a resident because they could feel embarrassed and humiliated if they received care in a common area. During an interview on 3/19/2026 at 4:15 PM with the Administrator, he stated the facility upheld residents' dignity by ensuring the residents felt heard, following up on grievances, and provided privacy when receiving care. He stated that it was a privacy concern and added it was essential residents received care in a private setting when appropriate. He stated if staff provided treatment or care in the open it could disrupt the resident's activity or be disruptive to other residents. He stated that a diagnosis, medications, glucose levels, vitals, and residents' stomachs would be exposed to other residents due to recieving diabetic related treatment in the open. He stated that everyone in the building was responsible for upholding a resident's dignity. He stated it affected a resident because they would feel unappreciated or person-centered in th care they received.Record (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility's policy titled Resident's Rights dated 10/2022 revealed in part, Purpose: To ensure the facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility 3. Planning and implementing care: b. the right to participate in the development and implementation of his or her person-centered plan of care 5. Respect and dignity: the resident has a right to be treated with respect and dignity including 8. Privacy and confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment

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(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. **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 program designed to provide safe, sanitary, and prevent the development and transmission of communicable diseases and infections for 5 of 12 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for transmission-based precautions.-LVN G failed to perform hand hygiene and change gloves after disposing the dirty wound dressings, disposing his PPE gown, and before cleaning the wound, and applying the new wound dressing on 03/14/2026.-LVN G failed to secure his PPE gown before wound care and disposed of it without putting on a new one while providing wound care on 03/14/2026.-RN A failed on 3/18/2026 to practice proper hand hygiene during glucose measuring and insulin injection.The failures placed residents at risk for developing a preventable infection during patient care.The findings include:Record review of Resident #1's face sheet dated 3/18/2026 revealed a [AGE] year-old male with an original admission date of 12/05/2025.Record review of Resident #1's MDS dated [DATE] revealed under section C, a BIMS score of 3 the significance meaning he had severe cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production). Under section N revealed the resident required insulin injections every day.Record review of Resident #1's care plan dated 12/16/2025 revealed the resident had focus area related to disorientation from dementia. Interventions in place include to provide choices for the resident and assist with decision making. Further interventions related to diet included: provide snacks, offer alternate meals if refused, and encourage food related activities.Record review of Resident #1's physical and health dated 12/11/2025 revealed the resident was diagnosed with Alzheimer's dementia, chronic kidney disease (long-term loss of kidney function preventing the filtration of blood and waste), and diabetes type 2.Record review of Resident #2 face sheet dated 3/19/2026 revealed a [AGE] year-old male with an original admission date of 5/3/2022 and readmission date of 5/8/2023.Record review of Resident #2's MDS dated [DATE] revealed under section C, a BIMS score of 6 the significance meaning he had severe cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production).Record review of Resident #2's care plan dated 12/5/2025 revealed the resident had a focus area related to impaired communication with interventions of allow adequate time for the resident to respond and evaluate resident's ability to comprehend. A focus area for risk for skin integrity due to dementia and g tube site with an intervention to observe the resident for signs and symptoms of infections.Record review of Resident #2's physical and health dated 2/10/2026 revealed the resident was diagnosed with diabetes type 2, dementia and bipolar disorder (a psychiatric mood disorder characterized by episodes of depression and manic behavior).Record review of Resident #3's face sheet dated 3/19/2026 revealed an [AGE] year-old male with an admission date of 6/21/2024.Record review of Resident #3's MDS dated [DATE] revealed under section C, a BIMS score of 4 the significance meaning he had severe cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production). Under section N revealed the resident required insulin injections every day.Record review of Resident #3's care plan dated 1/26/2026 revealed the resident had a focus area for diabetes mellitus concerns with interventions of observe for signs and symptoms of hyper/hypoglycemia (symptoms related to low and high blood sugar), rotate injection sites, and monitor food intake. A focus area for risk for skin integrity due to fragile skin with an intervention to observe the resident for signs and symptoms of infections. Wound management was a focus area with concerns for ulcer development and infection.Record review of Resident #3's physical and health dated 6/6/2025 revealed the resident was diagnosed with dementia, recurrent pneumonias (a serious lung infection caused by bacterias, viruses or fungi) and diabetes type 2.Record review of Resident #4 face sheet (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 3/19/2026 revealed a [AGE] year-old male with an original admission date of 10/22/2025 and a readmission date of 2/11/2026.Record review of Resident #4 MDS dated [DATE] revealed under section C, a BIMS score of 11 the significance meaning he had moderate cognitive impairment. Under Section I, the resident had an active diagnosis of diabetes mellitus (a condition of high blood sugar from inadequate insulin production). Under section N revealed the resident required insulin injections every day.Record review of Resident #4's care plan dated 11/11/2025 revealed the resident had a focus area for at risk weight loss related to diagnosis. Interventions in place included to allow the resident time to finish meals, offer resident food alternatives. An additional care area focus for communication with interventions of allow resident time to prepare/finish thoughts. The resident's care plan addressed a care area of cognition with interventions to ask simple questions, do not rush the resident, and explain procedures to the resident.Record review of Resident #4's physical and health dated 10/27/2025 revealed the resident had a diagnosis of hearing loss, diabetes type 2, chronic kidney disease (long-term loss of kidney function preventing the filtration of blood and waste) and dementia.Record review of Resident #5's admission record dated 03/14/2026 revealed an [AGE] year-old male with admission date 10/13/2022.Record review of Resident #5's Nursing Home Discharge MDS dated [DATE] revealed resident was unable to participate and score a BIMS score as he was rarely/never understood per MDS. Section M-Skin Conditions notated Resident #5 had 1 unstageable pressure ulcer.Record review of Resident #5's care plan revised on 01/23/2025 revealed Resident #5 had a Stage 4 pressure injury to the Sacrum (lower part of the spine). The staff intervention included to administer treatments as ordered and monitor for effectiveness, and to monitor as needed any changes in skin status.Record review of Resident #5's Wound Care progress note dated 02/12/2026 revealed the resident had a wound to his sacrum (lower part of the spine). It also noted the following wound care orders: 1) Primary Dressing- Alginate calcium apply once daily and as needed: if saturated, soiled or dislodged. 2) Secondary Dressing- Gauze island with bdr apply once daily and as needed: if soiled or dislodged.In an observation and interview on 03/14/2026 at 3:30 PM revealed wound care was provided to Resident #5's sacrum by LVN G. LVN G was observed putting on a PPE gown but did not secure the back or neck ties. LVN G was observed disposing of Resident #5's soiled wound dressing and continued to clean the wound without performing hand hygiene and changing gloves. LVN G removed his PPE gown after cleaning the wound and stated it was getting in his way. LVN G disposed the PPE gown into the trash and continued to clean the wound on the sacrum. LVN G was observed opening the new dressing to apply on Resident #5's sacrum wound, when stopped by the State Surveyor and was asked about hand hygiene. LVN G stated he was to perform hand hygiene before placing the new dressing and performed hand hygiene and changed gloves. He was observed completing wound care without a PPE gown. After wound care was performed, LVN G stated he forgot to wash his hands and change his gloves after disposing the dirty dressing and cleaning the wound. He stated he was also expected to wash his hands after cleaning the wound and before applying the new dressing on Resident #5. He stated he forgot to wash his hands as he did not typically provide wound care and had not done so in some time as the facility had a designated Wound Care Nurse providing wound care. He stated nurses were able and expected to provide wound care when the Wound Care Nurse was unable to. He stated he removed his PPE gown because it was not secured and kept getting in his way while he provided wound care. He stated it was not secured because it was too small for him. He stated he required a larger size which the facility had provided approximately 1 month ago but had run out recently. He stated he was to notify the Nurse Supervisor when the staff were low on PPE. He stated the purpose of wearing PPE was infection control and not having a PPE gown on during wound care, or performing hand hygiene, put the resident at potential risk for infection.During an observation on 3/18/2026 at 11:05 AM, revealed RN A was providing glucose measuring and insulin administration to Resident #1. RN A did not utilize hand hygiene sanitization between completing glucose measuring and filing the syringe with insulin. RN A failed to sanitize after administering insulin, disposing of sharps and gloves and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	touched the medication cart drawer and a residents door handle. At 11:16 AM, RN A proceeded to complete glucose measuring and insulin administration on Resident #2. After completing glucose measuring RN A failed to utilize hand hygiene sanitization before filling the syringe with insulin. RN A continued to put on gloves without practicing hand hygiene and administered insulin into Resident #2's stomach and sanitized at the conclusion of discarding the sharp and glove removal. At 11:29 AM, RN A conducted glucose measuring and insulin administration on Resident #3. RN A did not utilize hand hygiene sanitization between completing glucose measuring and filing the syringe with insulin. RN A applied new gloves without practicing hand hygiene and administered medication to Resident #3. RN A failed to sanitize her hands after removing her gloves following Resident #3's treatment. At 11:42 AM, RN A proceeded to provide glucose measuring for Resident #4 without hand sanitizing after Resident #3. RN A did not utilize hand hygiene sanitization following the glucose reading for Resident #4. During an interview on 3/18/2026 at 3:20 PM with RN A, she stated she did not use the sanitizer solution on her cart and opted for the wall mounted sanitizers instead. She stated she should sanitize before and after every glove application and added she did not think she adhered to that standard. She stated she did not know why she did not sanitize her hands between glucose measuring and insulin administration and attributed it to not having hand sanitizer readily accessible on her cart. She stated that there was potential for contaminants in the blood to be exposed and needed to practice hand hygiene between care and for every glove change. She stated it affected residents because if they had an infection it could spread because staff were not sanitizing properly. She stated she was responsible for practicing infection control during patient care. She identified the Infection Preventionist as the individual responsible for ensuring all nurses were adhering to infection control practices. She stated glucose measuring and injections were considered an invasive procedure because they exposed blood. She asked for clarification if she had to sanitize multiple times if she was still working with the same resident.During an interview on 3/19/2026 at 10:50 AM with LVN C, she stated the procedure to checking glucose levels and administering insulin while adhering to infection control was to: wash hands, apply gloves, disinfect the glucose meter, sterilize the resident's finger, remove gloves, practice hand hygiene, reapply gloves, clean the insertion site, sterilize the injection site, discard sharps and gloves, and practice hand hygiene. She stated there should be 3 to 4 opportunities for nurses to practice hand hygiene during the process. She stated that needed to be completed for infection prevention practices while handling blood. She stated it was the charge nurse's responsibility to ensure that was being completed. She stated there was potential to infect the resident by not adhering to hand hygiene practices. She stated staff needed to practice hand hygiene before proceeding to another resident to prevent cross contamination between residents. She stated sometimes the nursing supervisors conducted observations on skills randomly and had an annual test for all nursing skills and with return demonstrations.During an interview on 3/19/2026 at 12:10 PM with the Supervisor RN, she stated staff needed to sanitize the glucose meter before beginning services with the resident. She stated they needed to apply gloves, sanitize the prick site, remove gloves, practice hand hygiene, prepare the insulin, practice hand hygiene, apply gloves, administer the insulin, discard the sharp, remove gloves and practice hand hygiene. She stated they needed to sanitize 3 to 4 times during glucose measuring. She stated that needed to be done to prevent an infection between residents. She stated that all staff members were responsible for practicing good infection control practices to prevent infections. She stated it affected the residents because they could be exposed to an infection by staff members. She stated as resident with an infection could present symptoms in the form of skin rash, fever, pain, discomfort, coughing. She stated that nursing administration was responsible for ensuring nurses were using proper practices.During an interview on 3/19/2026 at 1:20 PM with the Unit Manager, she stated the Infection Preventionist was the individual who oversaw infection control and added it was a shared responsibility amongst all staff to uphold the standards. She stated clinical supervisors educated nurses around the year on topics like infection prevention. She stated some examples of staff using (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection prevention procedures during glucose measuring and insulin administration were to practice hand hygiene and change gloves when providing care. She stated when a nurse provided glucose monitoring care they should wash or sanitize their hands, disinfect the glucose meter, change gloves after checking the glucose levels, sanitize their hands, clean the lid to the insulin vial, sanitize their hands, apply gloves, administer insulin, discard the sharp, discard the gloves, sanitize their hands and wipe their work area. She stated they should sanitize 3 to 4 times for the duration of the process. She stated it was for cleanliness reasons and to prevent the transfer of bodily fluids. She stated there could be a transfer of bodily fluids if hand hygiene was not conducted. She stated residents could be contaminated and affected them by resulting in an infection. She stated they could experience symptoms like fever, rash, swelling, warm to touch, discomfort. She identified the nursing supervisors were responsible for ensuring that staff was adhering to infection control practices. She stated the last in-service and training for infection control was during the skills fair hosted in October/November of 2025.During an interview on 3/19/2026 at 2:45 PM with the ADON, she stated everybody was responsible for infection prevention of practices. She stated examples would include hand hygiene, standard precautions, wearing gloves, sanitizing between residents, washing hands if physically soiled, wearing the proper PPE, ensuring residents on isolation precautions remain isolated. She stated that if the process involved blood and inserting into the skin infection prevention needed to be adhered to. She stated that the resident could be exposed to blood-borne pathogens and bacterial infections if not followed. She stated a resident could experience fevers, become hospitalized , chills, altered mental status, spread to organs, or could become septic or potentially spread to other residents. She stated that the Infection Preventionist oversaw the infection control efficacy of the facility. She stated the last in-service for infection control was a couple weeks ago facility wide. She stated there were 3 to 4 instances of potential hand hygiene applications during glucose measuring and insulin administration. She stated staff were expected to sanitize before the next resident.During an interview on 3/19/2026 at 4:25 PM with the Administrator, he stated that staff should be always sanitizing and preventing infections. He stated this included sanitizing equipment and following the facility hand hygiene procedure. He stated if staff were not following hand hygiene procedures it could lead to infections. He tated that a resident who contracted an infection could experience symptoms of fever, cough, sneezing, and discomfort. He stated it was all of staff's responsibility to adhere to infection preventions. He stated that the facility had multiple supervisors who oversaw the nursing department and provided coaching as needed for infection prevention. He identified unit managers, ADON, DON, and clinical RNs, and the Infection Preventionist that provided coaching.During an interview on 3/18/2026 at 9:08 AM with the DON, she stated she had been the DON for 10 months and RN 14 years. She added she had previous experience as a DON. She stated PPE was to ensure nothing was introduced into the resident's wound when performing wound care and to protect staff. She stated staff were to don the gown and gloves at minimum when providing the wound care. She stated it was appropriate to switch gloves during the wound care procedure; however, it was not appropriate to remove the gown during wound care. She stated if the gown was removed, it needed to be reapplied by the nurse. She stated she was not aware of any staff member requiring a larger sized gown. She stated the facility used the one size fits all and had not heard any complaints about staff not fitting into the appropriate PPE. She stated it was nursing administration and central supply's responsibility to ensure the facility had enough PPE. She stated all staff were responsible for reporting any shortages of PPE and nursing supervisors oversaw the operation and reviewed with central supply weekly for PPE orders. She stated that was a daily practice that all staff and supervisors participated in. She stated staff needed to practice hand hygiene before applying PPE, before beginning wound care, when changing gloves during wound care, and before applying the new wound dressing. She stated hand hygiene needed to be practiced during ever gloves change which would be 3 to 4 times. She stated hand hygiene needed to be practiced usually with hand sanitizer, unless their hands were visibly soiled then it required soap and water. She stated anytime staff didn't (continued on next page)

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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	adhere to hand hygiene or PPE standards there was a risk for infection or systemic infection. She stated nursing administration and wound LVN D and LVN E were responsible for ensuring nursing staff was providing wound care per protocol. She stated that return demonstration for wound care was during orientation, as needed, with annuals, or if issues identified. She added that there was a skills fair which was hosted in October/November 2025 in the facility. She stated LVN F was the staff development coordinator who provided service to all RN supervisors. She stated that the last in-service for infection control was in the evening on 3/14/2026 to ensure they were confident to teach other fellow nurses on how to complete wound care.Record review of the facility's policy titled Hand Hygiene dated 02/2020 revealed in part, it is the policy of this facility that staff will perform hand hygiene to aide in the prevention of the transmission of infections Hand hygiene with waterless hand sanitizer may be used when hands are not visibly soiled and is the preferred method per CDC guidelines Record review of the facility's policy titled Infection Prevention and Control dated 04/2025 revealed in part, It is the policy of the facility to comply with all OSHA and CDC guidelines related to infection prevention and control practices. The facility has established and maintains an infection prevention and control program designed to provide safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections 4. Standard Precautions Hand hygiene shall be performed in accordance with facility's established hand hygiene procedures. Staff shall use personal protective equipment (PPE) according to established facility governing use of (PPE) when providing resident care activities It also read: Policy Explanation and Compliance Guidelines: 4. Standard Precautions: Hand hygiene shall be performed in accordance with facility's established hand hygiene procedures. Staff shall use personal protective equipment (PPE) according to established facility governing use of PPE when providing resident care activities.