STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Center for Skilled Care	3701 Wasson Rd Big Spring, TX 79720

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46425 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 12 of 21 confidential residents. The facility failed to ensure 12 confidential residents were provided access to the Grievance form and provided the procedure for how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: Interviews and record review during Resident Council on, 02/1/2025 at 2:00 p.m., 12 confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents attending Resident Council did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved Record review of the facility Grievance policy on 2/27/2025 at 11:07 a.m.; according to the facilities' Grievance policy a copy of the Grievance/complaint procedure should be posted on the resident bulletin board. Observation of prominent postings on 2/27/2025 at 11:30 a.m., the facility displayed the information regarding the administrator being the Grievance officer, however, the information displayed did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available and there was no access to submit a Grievance anonymously. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 2/27/2024 at 2:35 p.m., the ADM stated she was the Grievance Officer for the facility. The ADM stated she was responsible for the review of Grievances and assign them to department heads. The ADM stated the Grievance form was kept in a folder outside her office; however, she stated the forms availability was not helpful to residents if they did not know where the form is kept. The ADM stated staff completed Grievance forms for Residents, Residents do not ask for forms and complete them on their own. The ADM stated there was no procedure for Residents to submit Grievances anonymously. The ADM stated there is a box outside of her office that could be utilized for filing an anonymous Grievance; however, this procedure had never been evoked. The ADM stated the facility has 72 hours to resolve Grievances once they were submitted. The ADM stated she assigned the Grievance to the appropriate department, that department addresses the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated she will also meet with the complainant to ensure they were satisfied with the resolution, and Grievances were discussed at morning meeting. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated she was not aware the Grievance procedure was not being discussed in Resident Council. The ADM stated the potential negative outcome for the Grievance policy not being followed was Resident issues will not be resolved. Record Review of the Grievance Policy last updated in 2016. Policy Statement: Residents has the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay, the resident has the right to and the facility must make promote efforts by the facility to resolve grievances the resident may have. 1. The facility will notify residents on how to file a grievance orally, in writing, or anonymously with postings in prominent locations. 2. The grievance official of this facility is the administrator or their designee. 3. The grievance official will: oversee the grievance process, receive, and track grievances to their conclusion, lead any necessary investigations by the facility, maintain the confidentiality of all information associated with grievances, issue written grievances decisions to the resident. 4. The facility will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. 5. All grievances involving alleged allegations of neglect, abuse, including injuries of an unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. All written grievance decisions will include the date the grievance was received, a summary statement of the residents' grievances, the steps taken to investigate, a summary of findings, a statement as to whether the grievance was confirmed, any corrective action, and the date the written decision was issued. 7. The facility will take appropriate corrective action in accordance with state law if the alleged violation of the residents' rights is confirmed by the facility or outside entity having jurisdiction. 8. Maintain evidence of the grievance results for 3 years.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 5 residents (Resident #49) reviewed for PASRR Level I screenings. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #49. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnoses Post-Traumatic Stress Disorder were present upon Resident #49's admitted on 10/07/24. This failure could place residents who had a mental illness at risk of not receiving a needed assessment PASRR Evaluation, individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #49's face sheet, dated 02/27/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE], and readmitted most recently on 01/22/25. Her diagnoses included Post-Traumatic Stress Disorder, epilepsy (seizure disorder), diabetes (high blood sugar), depression (feeling of sadness and loss of interest), and anxiety (feeling of fear and worry). Record review of Resident #49's comprehensive MDS assessment, dated 11/25/24, indicated she had a BIMS score of 12, which indicated mildly impaired cognition. Section I - Active Diagnoses indicated Resident #49 had Post Traumatic Stress Disorder. Record review of Resident #49's PASRR Level 1 Screening, dated 10/07/24, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #49 did not have a mental illness. Record review of Resident #49's PASRR Level 1 Screening, dated 11/21/24, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #49 did not have a mental illness. During an interview on 02/27/25 at 9:47 AM, with the MDS nurse, she stated resident #49 had a negative PL1. She stated she was not aware that Resident #49 had diagnosis PTSD on admission. She stated no PASRR evaluation had been done. During an interview on 02/27/25 at 11:10 AM with the MDS nurse, she stated she was not the MDS nurse at the time Resident #49 was admitted to the facility. She stated she is responsible for checking the PASRR for accuracy when residents were admitted . She stated she is responsible for entering the admitting diagnosis into the EMR on admission and checks them with the PASRR received on admission. She stated the MDS nurse was responsible for PASRR corrections. She stated the potential negative outcome is the resident would not be accurately listed as PASRR positive. She stated the only available services for MI residents were only available to people within the community. She stated there were no services available for PTSD. She stated her expectation was to have a hundred percent accuracy. She stated she had been trained on PASRR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/24 at 11:30 AM with the ADM, she said the MDS Coordinator is responsible for completing PASRR evaluations. She stated she expects the PASRR to be completed properly. She stated the potential negative outcome of inaccurate PASRR evaluation could be delay of treatment and referrals for the resident. Record review of the facility policy titled, PASRR Level 1 Screen, revised date 3-6-19 indicated, Policy: It is the policy of Creative Solutions in Healthcare facilities to obtain a PL1 screening form from the RE (referring entity) prior to admission to the NF. The PL1 will be submitted via SimpleLTC timely per PASRR Regulatory timeframes. PASRR is a federally mandated program requiring all states to pre-screen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, who they live with and the training and therapy they need to live as independently as possible. PASRR Program has 3 Goals: 1. To identify individuals with MI, ID, or DD/RC (this includes adults and children); 2. To ensure appropriate placement whether in a community or in a NF; 3. To ensure individuals receive the required services for their MI, ID or DD . 3. The facility will review the PL1 screening form for completion and correctness prior to admission and submit the PL1 form per regulation. The type of admission is reviewed for correctness .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41480 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed to store and date foods stored in the refrigerator. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on [DATE] at 09:58 AM during initial observation of the kitchen: Observed the following in the walk-in refrigerator: -Plastic container with mixed fruit open with no label and no date. -Metal bowl covered with tin foil with no label and no date. -Plastic container with lid open with label Taco Bake expired date ,d+[DATE]. -Plastic container with label Pudding expired date ,d+[DATE]. -Plastic container with label Mash Potatoes no date. During an interview on [DATE] at 10:28 AM with DM, she stated all food in the refrigerator was to be sealed and dated. She stated all food should be thrown out or used by the expired date. She stated all staff are responsible for sealing and dating food placed in the refrigerator. She stated all staff have had proper training. She stated the potential negative outcome could be the food going bad and cause food poisoning. During an interview on [DATE] at 10:35 AM with [NAME] A, she stated food placed in refrigerator should be sealed and dated. She stated all food should be used or thrown out by the expired date. She stated she had been trained. She stated the potential negative outcome could be a resident getting sick from eating expired food. During an interview on [DATE] at 11:25 AM with ADM, she stated all food placed in refrigerator should be covered or sealed and dated. She stated the DM is responsible for monitoring the refrigerator along with all dietary staff. She stated everyone should be checking the refrigerator every shift. She stated the potential negative outcome could be a resident getting sick from eating expired or spoiled food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, titled Food Storage and Supplies, dated 2012 reflected the following: All facility storage areas will be maintained in an orderly manner that preserves the conditions of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Procedure: . 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened .

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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** 43150 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 2 of 3 residents (Resident #40 and Resident #51) and 3 of 6 staff (CNA E, CNA H, and CNA I) reviewed for infection control. 1. CNA E failed to follow policy and procedure for handwashing while providing incontinent care for Resident #40. 2. CNA H and CNA I failed to follow policy and procedure for handwashing while providing incontinent care for Resident #51. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #40 Record review of Resident #40s face sheet dated 02/17/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: pneumonia, acute respiratory failure, sepsis with septic shock (dramatic drop in blood pressure that can damage the lungs, kidneys, liver, and other organs), anemia (a condition in which the blood does not have enough healthy red blood cells and hemoglobin, a protein found in red blood cells), weakness, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), atherosclerosis (the buildup of fats, cholesterol, and other substances in and other substances in and on the artery walls), muscle wasting, unsteadiness on feet, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, high blood pressure, rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dysphagia, cognitive communication deficit (cognitive impairment), stroke, renal dialysis (a life-saving treatment that filters excess fluids, toxins, and solutes from the blood when the kidneys are no longer able to). Record review of Resident #40's admission MDS dated [DATE] revealed a BIMS score listed as 4 meaning moderate cognitive impairment. The MDS under functional abilities for toileting (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment), listed Resident #30 as a 3 meaning: Partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Record review of Resident #40's Care Plan dated 06/06/23, revealed that Resident #40 was listed as occasional bowel incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/26/2025 at 11:41 AM, CNA D and CNA E provided incontinent care for Resident #40. CNA D used hand sanitizer prior to gathering supplies. CNA D laid out supplies on a clean towel on the bedside table. CNA D washed hands for 23 seconds before starting incontinent care. CNA D put on clean gloves. CNA E did not wash hands prior to assisting with incontinent care. CNA E put on clean gloves. CNA E removed the front of Resident #40's brief and tucking it in between the legs. CNA D provided incontinent care to the front side of Resident #40. CNA E turned Resident #40 on right side. CNA D removed gloves, discarded them, and used hand sanitizer. CNA D put on clean gloves. Resident #40 had feces on the backside that looked dried. CNA D provided incontinent care to the backside of Resident #40. CNA D and CNA E had run out of wipes. CNA E removed gloves and discarded them in the trash. CNA E did not wash hands. CNA E went to get more wipes and returned to Resident 40's room. CNA E rinsed her hands under the water for 6 seconds but did not use soap. CNA D continued to provide incontinent care to the backside of Resident #40 until he was clean. CNA D removed gloves and discarded them in the trash. CNA D used hand sanitizer and put on clean gloves. CNA D placed a clean brief underneath Resident #40 and laid him back. CNA E gathered dirty linens and placed in bag. CNA D fastened Resident #40's clean brief and covered him up. CNA E gathered all trash in a separate bag. CNA D removed gloves and discarded them in the trash. CNA D washed hands with soap for 24 seconds before rinsing underneath the water. CNA E washed hands with soap for 12 seconds before rinsing under water. During an interview on 02/26/25 at 12:22 PM, CNA D stated that she had been trained in handwashing through Relias, monthly. CNA E stated that she did not know how long she was supposed to wash her hands. CNA E stated that she does not usually count, she just washes her hands. CNA E stated that the negative outcome for not following handwashing process would be that germs could be spread. Resident #51 Record review of Resident #51's face sheet dated 02/05/25 revealed a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: type 2 diabetes, cognitive communication deficit (cognitive impairment), muscle wasting, seizures, spondylosis (age related wear and tear of the spinal disks), [NAME] cardia (slower than expected heart rate), anxiety, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain do not work the way they should), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), high blood pressure, acid reflux. Record review of Resident #51's admission MDS dated [DATE] revealed a BIMS score of 14, which indicated the resident was cognitively intact. The MDS under functional abilities for toileting (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment), listed Resident #51 as a 3 meaning: Partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Record review of Resident #51's Care Plan dated 05/23/23, revealed that Resident #51 was listed as bowel incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/26/25 at 11:01 AM, CNA H and CNA I provided peri care for Resident #51. CNA H gathered clean peri care supplies without washing her hands or using clean gloves. Prior to providing peri care, CNA I washed her hands for 5 seconds with soap before rinsing. CNA H washed her hands for 9 seconds with soap before rinsing. CNA H and CNA put on yellow gown and gloves because Resident #51 is listed as enhanced barrier precautions. CNA I had already been by Resident #51 pulling down her blankets and positioning the resident before putting on PPE, while CNA H was washing her hands. Resident #51 had dried feces on her catheter tubing, on the bandage coving a wound on the left upper leg, on her upper right crease, and her backside. CNA H had to use the wipes to scrub Resident #51 because feces were dried on her. CNA H had run out of wipes and had to remove her gown and gloves. CNA H washed her hands for 8 seconds with soap before rinsing her hands. CNA H gathered more wipes to complete the peri care. CNA H put on yellow gown and gloves and continued to provide peri care to the backside of the resident. CNA H had to scrub the backside due to feces being dried on her and Resident #51 kept saying, Ouch, Ouch. CNA I removed dirty gloves, discarded in the trash, and washed her hands for 4 seconds with soap before rinsing her hands under water. CNA I put on clean gloves and continued to assist with the peri care by positioning Resident #51 and gathering trash. CNA H continued to wipe Resident #51's backside a few more times before removing her dirty gloves and disposing them in the trash. CNA H used hand sanitizer and put on clean gloves. CNA I fastened the clean brief on Resident #51. Dried feces were still on Resident #51's backside and on the bandage covering a wound. CNA H removed the draw sheet and replaced with a clean draw sheet. CNA I noticed that feces were on the resident's blanket, and she removed the blanket and told the resident that she would bring back a clean blanket. CNA I removed her dirty gloves and discarded in the trash. CNA I washed her hands for 7 seconds with soap before rinsing her hands with water. CNA H washed her hands with soap for 9 seconds before rinsing under water. During an interview on 02/26/25 at 3:58 PM, CNA H stated that the policy for handwashing stated to wash hands for 20 seconds before rinsing. CNA H stated that she thought she had washed for the entire happy birthday song but could not be sure because she was nervous. CNA H stated that she did realize that the resident had dried feces on her, but she could not get it off. CNA H stated that she would have normally used peri wash to clean the resident, but she did not know if she could since she was being washed. CNA H stated that she had been trained in hand washing and infection control through in-services, monthly. CNA H stated that by not providing proper hand washing techniques she could have spread germs and cross contamination. During an interview on 02/27/25 at 11:20 AM, CNA I stated that she had been trained in hand washing and infection control practices through in-services, monthly. CNA I stated that the DON had provided the training. CNA I stated that she had been in a hurry and was nervous. CNA I stated that the negative outcome of not providing proper handwashing is that it could cause the spread of infections and bacteria that could be passed. During an interview on 02/27/25 at 12:50 PM, the Administrator stated that the policy for handwashing that proper hand washing is required before, during, and after providing care for residents. The Administrator stated that she also expects staff to wash their hands with soap and water after using hand sanitizer three times in a row. The Administrator stated that all residents should be thoroughly cleaned and should not be left with urine or feces on them. The Administrator stated that the DON is responsible for over seeing the training and that all staff have completed it. The Administrator stated that if handwashing is not done then it could spread diseases and illness. The Administrator stated that if urine or feces were left on a resident it could also cause skin breakdown or skin infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility-provided policy titled, Hand Hygiene, undated, revealed: You may use alcohol-based hand cleanser or soap/water for the following: Before and after entering isolation precaution settings Before and after assisting a resident with personal care (e.g., oral care, bathing) Before and after handling peripheral vascular catheters and other invasive devices Upon and after coming into contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident) After contact with a resident's mucous membranes and body fluids or excretions After handling soiled or used linens, dressings, bedpans, catheters, and urinals. After removing gloves or aprons. You must use soap/water for the following: (alcohol-based hand cleaner is not recommended) When hands are visibly soiled. Before and after assisting a resident with toileting (hand washing with soap and water). Record review of the facility-provided policy titled, Enhanced Barrier Precautions, undated, revealed: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than one patient. EBP are indicated for residents with any of the following: Colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Record review of the facility-provided policy titled, Perineal Care, dated 04/25/2022, revealed: Introduction: An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Center for Skilled Care	3701 Wasson Rd Big Spring, TX 79720

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacture's recommendations. Skin problems associated with incontinence and moisture can range from irritation to an increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning. Procedure: 10. Perform hand hygiene 11. [NAME] gloves and all other PPE per standard precautions. 12. Soak towels in a washbasin filled with warm water and facility approved cleansing agent or remove an adequate number of pre-moistened cleansing wipes. 13. Reposition the resident on their back on their back with legs fixed and separated as able. 14. Limit resident exposure to the perineal area, provide privacy at all times. 15. If required, use a towel or extra incontinence pad to protect the mattress cover from being soiled. 16. Wipe across the pubis area 17. Gently perform perineal care, wiping from clean urethral area to dirty rectal area, to avoid contaminating the urethral area, Clean to dirty. 18. If visibly moist, pat the areas dry with a clean, dry towel or washcloth. 19. Doff gloves and PPE Back: 20. Reposition the resident to their side. 21. Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area. 22. If visibly moist, pat the areas dry with a clean, dry towel or washcloth. 23. Note skin changes and apply moisture barrier cream as directed 24. Doff gloves and PPE 25. Perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conclude: 26. Provide resident comfort and safety by re-clothing, straightening bedding, adjusting the bed and/or side rails, and placing call light within resident's reach 27. Clean and store reusable items 28. If visibly soiled or contaminated during the procedure, disinfect, or discard the barrier towel on the table 29. Return resident items on the table 30. Tie off the disposable plastic bag of trash and/or linen 31. Perform hand hygiene 32. Thank the resident for assisting in self-care. 33. Document Important Points: If heavily soiled, use an incontinence pad, brief, towel, or wipes to remove soiling, from front to back, prior to performing perineal care. Do not wipe more than once with the same surface. Doffing and discarding of gloves are required if visibly soiled. Always perform hand hygiene before and after glove use PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. For example, staff entering the resident's room to answer a call light, converse with a resident, or provide medications who do not engage in high-contact resident care activity would not need to employ EBP while interacting with the residents. Record review of the facility-provided policy titled, Infection Control Plan, dated 2019, revealed: Infection Control: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Preventing Spread of Infection: (continued on next page)

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