STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676398	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Hollow Post Acute	310 America Drive Brownsville, TX 78526

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview, and record review the facility failed to ensure at the time a resident is admitted , the facility had physician orders for the resident's immediate care and needs for 1 of 8 residents (Resident #79) reviewed for complete and accurate medical records. The facility failed to obtain orders for oxygen for Resident #79. This failure placed the resident at risk for not receiving the appropriate physician ordered care. The findings included: Record review of Resident #79's face sheet dated 10/29/24 reflected the resident was a 73 -year-old female admitted to the facility on [DATE]. Resident #79 had diagnoses which included the following: morbid obesity (chronic disease in which the body mass index was 40 or higher or 35 or higher and experiencing obesity-related health conditions), muscle wasting and atrophy (wasting of an organ or tissue), muscle weakness, and hypertension (the pressure in blood vessels was too high). Record review of Resident #79's Comprehensive MDS assessment, dated 10/2/24, reflected the resident had a BIMS score of 14 which suggests intact cognition. Self-care assessment reflected she was dependent on staff for all self-care except eating and oral hygiene which required partial/moderate assistance from staff. Special treatments, procedures, and programs reflected the resident received continuous oxygen therapy. Record review of the Care Plan completed on 9/27/24 for Resident #79 did not reflect the resident required the use of oxygen therapy. Record review of the most recent Care Plan on 10/15/24 for Resident #79 reflected the resident was at risk for complications with the respiratory system due to shortness of breath. Date initiated: 10/29/24 with intervention to administer medications as ordered. Monitor for side effects/adverse reactions and effectiveness. Date initiated 10/29/24. Record review of the Doctor's Order Summary reflected Resident #79 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator. Start Date 10/28/2024 at 4:30 pm. End Date 10/28/24 and O2 at 2 LPM via nasal cannula per concentrator PRN. Start Date 10/28/24 at 4:32 pm. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR for September 2024 reflected the medication reconciliation had been performed for Resident #79 with review of the prior care setting discharge medications one time only for medication reconciliation for 1 day. -Start Date- 09/26/2024. The MAR did not reflect oxygen therapy was administered. Record review of the MAR for October 2024 reflected Resident #79 was prescribed O2 @2 LPM via nasal cannula continuous per concentrator as needed for SOB. Start Date: 10/28/2024 at 4:30 pm DC Date: 10/28/2024 at 4:33 pm and O2 @2LPM via nasal cannula per concentrator PRN as needed for SOB Start Date: 10/28/2024 at 4:32 pm. Record review of Medication Reconciliation Report for Discharge for Resident #79 dated 9/26/24 reflected no orders for oxygen. Record review of O2 saturation log documented Resident #79 with oxygen via nasal cannula since 9/26/24. Record review of progress note dated 10/20/24 reflected Resident #79 continues oxygen via NC. Record review of progress note dated 10/28/24 at 4:29 pm for Resident #79 reflected new order received from MD for oxygen PRN at 2 LPM via nasal canula due to SOB. Observation and interview on 10/28/24 at 11:45 am revealed Resident #79 in bed with head of bed elevated. Resident #79 received O2 2LPM via NC. Resident stated she was on O2 because she becomes short of breath due to her edema (swelling caused by fluid buildup in the body's tissues and organs). Resident said that she had received oxygen since the first day she arrived at the facility. In an interview on 10/29/24 at 1:50 PM with CNA J, she said Resident #79 had always had O2 since she worked with her. She said sometimes the resident will not have it on because she took it off. She said the resident called the nurse to help get it back on. She said she had noted resident #79 with O2 on and off since she was admitted . In an interview on 10/29/24 at 02:10 pm with LVN K, she said Resident #79 came to facility from hospital via ambulance with O2. She said they immediately took her off the oxygen, once orders were verified, because the resident's oxygen saturations were fine. She said yesterday MD gave orders for chest x-ray, PRN O2, and a nebulizer treatment after he completed his rounds with resident due to noted edema and shortness of breath. LVN K said a nurse may use her judgement to provide O2 without an order if signs or symptoms of respiratory distress were noted. She said there were no progress notes showing Resident #79 was under respiratory distress prior to receiving orders for PRN O2 on 10/28/24. In an interview on 10/29/24 at 4:24 pm with ADON/LVN H, she said she does not recall how long Resident #79 has been receiving oxygen. She said there should be an order for O2 if a resident was receiving oxygen, unless the resident was under respiratory distress, then the nurse uses her judgement to start the resident on oxygen then receive orders from the MD. She said they have no standing orders for O2 used for PRN. ADON said that there were no progress notes showing Resident #79 with respiratory distress. (continued on next page)

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/30/24 at 4:12 pm with ADON/LVN B, she said If a resident was receiving O2, there should be orders prior to resident receiving the O2. She said a nurse can give oxygen to a resident if needed, but they must have a PRN order. She said O2 was considered a medication, so it must be given as ordered to prevent respiratory complications. In an interview on 10/30/24 at 5:16 pm with DON, she said if a resident was receiving oxygen, they must have an order. She said if a resident was in respiratory distress, nursing intervention will apply, they will complete a change in condition, and must follow up with the order, otherwise they should not be on O2. She said if oxygen was received on admission, they should have orders in PCC (a cloud-based healthcare software platform that long-term care providers use for clinical documentation) or on progress notes. She said if nothing was on PCC or progress notes, then they should not be administering O2. The DON said when Resident #79 arrived on admission, the nurse should have verified the O2 order. She said once everything was reviewed, they will need to re-educate staff. Record review of the Oxygen Administration policy, revised October 2010, reflected: Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Record review of the Medication Orders policy, revised November 2014, reflected: Purpose The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Supervision by a Physician 1. Each resident must be under the care of a Licensed Physician authorized to practice medicine in this state and must be seen by the Physician at least every sixty (60) days. 2. A current list of orders must be maintained in the clinical record of each resident. Recording Orders 1. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. A placebo is considered a medication and must also have specific orders. Example: Dilantin 100mg by mouth three times per day. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. PRN Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration. Example: Tylenol 500mg by mouth every 4 hours as needed for mild pain or temp greater than l01 F. 3. Oxygen Orders - When recording orders for oxygen, specify the rate of flow, route and rationale. Example: oxygen 3L/min per nasal cannula as needed for shortness of breath.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 8 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1's Discharge MDS reflected resident's falls. These failures could place residents at risk for improper care due to inaccurate records. The findings included: Record review of Resident #1's face sheet dated 10/30/24 reflected the resident was an 83 -year-old female admitted to the facility on [DATE] and discharged on [DATE] to home with family. Resident #1 had diagnoses which included the following: Alzheimer's (brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform even the simplest tasks), dementia (a loss of brain function that affects a person's ability to think, remember, and reason), muscle wasting and atrophy (a decrease in size of an organ or tissue), muscle weakness, difficulty in walking, lack of coordination and age-related osteoporosis (condition in which there was decrease in amount and thickness of bone tissue). Record review of Resident #1's Discharge MDS assessment, dated 1/30/24, reflected the resident had a BIMS score of 3 which suggests severe cognitive impairment. Self-care assessment reflected she was independent for all self-care except for the shower/bathe self which required setup or clean-up assistance from staff. Section J1800 reflected resident did not have any falls since admission or reentry or the prior assessment. Record review of the most recent Care Plan for Resident #1 reflected the resident had a fall while self-transferring from restroom back to bed, resulting in a laceration below chin on 1/8/24, and 1/23/24 resident noted with discoloration to eyebrow, resident stating she fell in restroom did not let anyone know, resident unable to recall date and time of incident. Date Initiated: 01/09/2024. In an interview on 10/30/24 at 4:45 pm with MDS/LVN D Coordinator. She said she was responsible for diagnosis codes, medications and any updates or changes for long term residents. She said the MDS assessments are done quarterly and if there are changes. She said a fall would be required to be captured on the following MDS assessment. She said that it would need to be in care plan. She said that Resident #1's fall should have been captured on the Discharge MDS dated [DATE]. She said she cannot think of a reason why it was not. In an interview on 10/30/24 at 5:16 pm with DON, she said Resident #1 was found with injuries and it was identified that she sustained a fall. She said the fall for Resident #1 should have been captured on the discharge MDS dated [DATE] if it fell within their look back period. Record review of the facility's Resident Assessments policy dated 2001 reflected, Policy Statement (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. Policy Interpretation and Implementation Definitions OBRA-Required Assessments - are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents in the facility: . (7) Discharge Assessment (return anticipated and return not anticipated). 8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on Observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 residents (Resident #79 and Resident #100) of 8 residents, reviewed for care plans, in that: 1. The facility failed to ensure Resident #79's care plan completed on 9/27/2024 and 10/15/24 reflected resident received oxygen therapy. 2. The facility failed to develop a comprehensive person-centered care plan for Resident #100's diagnosis of Alzheimer's disease once the MDS assessment was completed. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: 1. Record review of Resident #79's face sheet dated 10/29/24 reflected the resident was a 73 -year-old female admitted to the facility on [DATE]. Resident #79 had diagnoses which included the following: morbid obesity (chronic disease in which the body mass index was 40 or higher or 35 or higher and experiencing obesity-related health conditions), muscle wasting and atrophy (wasting of an organ or tissue), muscle weakness, and hypertension (the pressure in blood vessels was too high). Record review of Resident #79's Comprehensive MDS assessment, dated 10/2/24, reflected the resident had a BIMS score of 14 which suggests intact cognitions. Self-care assessment reflected she was dependent on staff for all self-care except for the eating task which required supervision and touching assistance from staff and the oral hygiene task which required partial/moderate assistance from staff. Special treatments, procedures, and programs reflected the resident did not receive oxygen therapy. Record review of the Care Plan completed on 9/27/24 for Resident #79 did not reflect the resident required the use of oxygen therapy. Record review of the most recent Care Plan on 10/15/24 for Resident #79 reflected the resident was at risk for complications with the respiratory system due to shortness of breath. Date initiated: 10/29/24 with intervention to administer medications as ordered. Monitor for side effects/adverse reactions and effectiveness. Date initiated 10/29/24. The care plan did not reflect resident required the use of oxygen therapy. Record review of the Doctor's Order Summary reflected Resident #79 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator. Start Date 10/28/2024 at 4:30 pm. End Date 10/28/24 and O2 at 2 LPM via nasal cannula per concentrator PRN. Start Date 10/28/24 at 4:32 pm. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Medication Reconciliation Report for Discharge for Resident #79 dated 9/26/24 reflected no orders for oxygen. Record review of the MAR for September 2024 reflected the medication reconciliation had been performed for Resident #79 with review of the prior care setting discharge medications one time only for medication reconciliation for 1 day. -Start Date- 09/26/2024. The MAR did not reflect oxygen therapy was administered. Record review of O2 saturation log documented Resident #79 with oxygen via nasal cannula since 9/26/24. Record review of the MAR for October 2024 reflected Resident #79 was prescribed O2 @2 LPM via nasal cannula continuous per concentrator as needed for SOB. Start Date: 10/28/2024 at 4:30 pm DC Date: 10/28/2024 at 4:33 pm and O2 @2LPM via nasal cannula per concentrator PRN as needed for SOB Start Date: 10/28/2024 at 4:32 pm. Record review of progress note dated 10/20/24 reflected Resident #79 continues oxygen via NC. Record review of progress note dated 10/28/24 at 4:29 pm for Resident #79 reflected new order received from MD for oxygen PRN at 2 LPM via nasal canula due to SOB. Observation and interview on 10/28/24 at 11:45 am revealed Resident #79 in bed with head of bed elevated. Resident #79 received O2 2LPM via NC. Resident stated she was on O2 because she becomes short of breath due to her edema (swelling caused by fluid buildup in spaces around body's tissue or organs). Resident #79 said that she had received oxygen since the first day she arrived at the facility. In an interview on 10/29/24 at 1:50 PM with CNA J, she said Resident #79 had always had O2 since she worked with her. She said sometimes the resident would not have it on because she took it off, but the resident called the nurse to help get it back on. She said she noticed Resident #79 with O2 on and off since she was admitted . She said care plans were used to see what the resident needs and what process or steps would be taken towards the patient. She said if there was no care plan, they receive report from the previous CNA. In an interview on 10/30/24 at 4:12 pm with ADON/LVN B, she said the MDS department completed most of the sections of the care plans, especially on admission. She said the nurses had the ability to see the care plans in PCC (a cloud-based healthcare software platform that long-term care providers use for clinical documentation), but the ADONs also let them know so they are not caught off guard. She said if a resident was receiving O2, it should be care planned. She said the MDS department was responsible for that. She said the adverse effects of not having something care planned could include bad documentation and the nurses and CNAs not knowing what interventions would need to be implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/30/24 at 4:45 pm with MDS Nurse/LVN D. She said she was responsible for diagnosis codes, medications and any updates and changes for long term residents. She said if a resident was admitted to the facility with oxygen, it would need to be placed on the Care Plan and MDS. She said if there was no order received for that oxygen, the MDS Nurse would not know if a resident was receiving O2. She said if oxygen was not in use during the 7- day look back period, then it would not be updated on the MDS. She said the floor nurses must place those orders in PCC. She said Resident #79 would not show on the care plan or MDS because there were no orders and can only place what was documented on the order. In an interview on 10/30/24 at 5:16 pm with DON. She said on admission, orders should be placed on PCC or on progress notes. She said if nothing was on PCC or progress notes, and it would not be care planned. She said if a resident was receiving O2 and there was an order, then they would care plan the oxygen. The DON said when Resident #79 was admitted to the facility, the nurse should have verified the O2 orders, so oxygen would be care planned. She said once everything was reviewed, they would need to re-educate staff. Record review of facility's Care Plans, Comprehensive Person-Centered policy dated revised March 2022 reflected: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 2. Record review of Resident #100's Face Sheet indicated Resident #100 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with early onset cognitive communication deficit, muscle weakness and other reduced mobility. Record review of Resident #100's Physician's Orders for October 2024 indicated Resident #100 had order for Memantine HCl oral tablet 15 mg, give one tablet by mouth one time a day for dementia, start date 09/24/24. Record review of Resident #100's Admission MDS assessment dated [DATE] revealed Resident #100, did not have speech, was unable to complete a Brief Interview for Mental Status, had short-term memory problem, had long-term memory problem, never/rarely made decisions and had a diagnosis of Alzheimer's Disease. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #100's care plan dated 10/22/24 did not reveal a care plan for Resident #100's diagnosis of Alzheimer's dementia or the medication memantine. Observation on 10/27/24 at 12:43 p.m. Resident #100 was sitting in the dining room. Resident was sitting at a table with two other female residents. Resident was not interacting with other residents at her table. In an interview on 10/30/24 at 3:19 p.m., LVN C said the nurse would inform the CNAs on the type of care the resident would need. The care plan informs them what the patient was here for, what needs they had, and the care plan was tailored to their needs to better care for the residents. If they did not have the care plan, they would not be able to care for the resident adequately. In an interview on 10/30/24 at 04:12 p.m., ADON/LVN B said the MDS nurses do their section on the care plan and the ADONs do their section on the care plan. The ADON/LVN B said she lets the nurses know about the care plan and the interventions for a resident and the nurse will inform the CNAs what type of care the resident requires. The adverse effect of no care plan would be that they do not have documentation so the nurses would not know what to do for the resident. In an interview on 10/30/24 at 04:45 p.m., MDS Nurse/LVN D said she was responsible for the diagnosis and medication care plans and assisted the other nurses to update the care plans and she did the MDS assessments. MDS Nurse/LVN D said if there were no orders in the chart, she had no way to know if the resident requires specific care or if there were any changes. The nurses put the orders into PCC. MDS Nurse/LVN said they have 21 days in which to complete the comprehensive care plan after admission. MDS Nurse/LVN D said Resident #100's care plan was completed within the 21 days. In an interview on 10/30/24 at 05:19 p.m., the DON said the MDS Nurse/LVN D had said she had completed the care plan for Resident #100. The DON reviewed Resident 100's care plan date agreed that the care plan had not been completed until Surveyor had requested a copy of the care plan. In an interview on 10/28/24 at 6:56 p.m., the Administrator said staff should follow their policy and procedures. Record review of the facility's policy revised on March of 2022 revealed: Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49301

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 3 of 5 residents (Resident #79, Resident #260, and Resident #261) reviewed for respiratory care. 1. The facility failed to ensure Resident #260, and Resident #261 received oxygen at the prescribed rate. 2. The facility failed to ensure Resident #79 had appropriate orders to receive oxygen. These failures could place residents at risk for respiratory distress. The findings included: 1. Record review of Resident #260's face sheet dated 10/29/24 reflected the resident was a 75 -year-old female admitted to the facility on [DATE]. Resident #260 had diagnoses which included the following: chronic (long-standing) congestive heart failure (a long-term condition in which the heart weakens and causes fluid buildup in the feet, arms, lungs, and other organs), respiratory disorders, acute (severe and sudden in onset) respiratory failure with hypoxia (decrease in oxygen supply to the tissues), and dyspnea (shortness of breath). Record review of Resident #260's 5-Day scheduled MDS assessment, dated 10/15/24, reflected the resident had a BIMS score of 5 which suggests severe cognitive impairment. Self-care assessment reflected she was dependent on staff for all self-care except eating and oral hygiene which required partial/moderate assistance from staff. Special treatments, procedures, and programs reflected the resident received continuous oxygen therapy. Record review of the most recent Care Plan for Resident #260 reflected the resident required the use of continuous oxygen related to acute respiratory failure, congestive heart failure, and dyspnea. Interventions included administering oxygen at 2 LPM via nasal cannula continuous per concentrator. Date Initiated: 10/17/2024. Record review of the Doctor's Order Summary reflected Resident #260 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator. Start Date 10/15/2024. Record review of the MAR for October 2024 reflected Resident #260 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator every shift for SOB. Start Date 10/15/2024. Observation on 10/27/24 at 2:31 pm of Resident #260 revealed resident in bed with head of bed elevated. Resident #260 received O2 at 2.5 LPM via NC. (continued on next page)

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	676398	A. Building B. Wing	10/30/2024

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Fox Hollow Post Acute	310 America Drive Brownsville, TX 78526

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/27/24 at 2:38 pm with LVN I, she said she was the nurse assigned to Resident #260. She said she was responsible for ensuring the O2 rate was set accurately for Resident #260. She said that she checked the O2 rate every morning when she arrived on shift. The State Surveyor requested the LVN check the O2 rate, and she said the rate was at 2 LPM. She said that the concentrator must be looked at slanted because the machines are slanted and that the line was supposed to be in the middle of the ball. The State Surveyor asked Resident #260 how she was feeling, and she denied SOB, difficulty breathing, heart racing or dizziness. LVN checked Resident #260's O2 saturation, and it was at 98% with a heart rate of 72 bpm. LVN I said If a resident received more O2 than prescribed, they can experience hyperoxia or too much oxygen in the blood. Record review of Resident #261's face sheet dated 10/29/24 reflected the resident was an 82 -year-old female admitted to the facility on [DATE]. Resident #261 had diagnoses which included the following: acute (severe and sudden in onset) on chronic (long-standing) congestive heart failure (a long-term condition in which the heart weakens and causes fluid buildup in the feet, arms, lungs, and other organs) and acute (severe and sudden in onset) respiratory failure. Record review of Resident #261's Physician's Order Sheet/Routine Transfer Orders Summary, dated 10/9/24, reflected the resident had oxygen at 2 L via NC. Record review of the most recent Care Plan for Resident #261 reflected the resident required the use of continuous oxygen related to acute respiratory failure, congestive heart failure, and shortness of breath when lying flat. Interventions included administering oxygen at 2 LPM via nasal cannula. Date Initiated: 10/24/2024. Record review of the Doctor's Order Summary reflected Resident #261 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator. Start Date 10/23/2024. Record review of the MAR for October 2024 reflected Resident #261 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator every shift. Start Date 10/23/2024. Observation on 10/27/24 at 2:34 pm of Resident #261 revealed resident in bed with head of bed elevated. Resident #261 received O2 at 1.5 LPM via NC. In an interview on 10/27/24 at 2:38 pm with LVN I, she said she was the nurse assigned to Resident #261. She said she was responsible for ensuring the O2 rate was set accurately for Resident #261. She said that she checked the O2 rate every morning when she arrived on shift. The State Surveyor requested the LVN check the O2 rate, and she said the rate was at 2 LPM. She said that the concentrator must be looked at slanted because the machine was slanted and that the line was supposed to be in the middle of the ball. The State Surveyor asked Resident #261 how she was feeling, and she denied SOB, difficulty breathing, heart racing or dizziness. LVN checked Resident #261's O2 saturation, and it was at 96% with a heart rate of 88 bpm. LVN said If a resident received less O2 than prescribed, they can become short of breath, hypoxic (decreased perfusion of oxygen to tissues), or experience respiratory distress. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 4:12 pm ADON/LVN B said that the floor nurses assigned to the residents were responsible for ensuring oxygen concentrators were at the appropriate settings. She said the nurses should ensure the settings are correct when doing their rounds and when they first come on shift after getting report. She said when reading the O2 flow rate, the nurse must be at eye level to ensure the line was in the center of the ball. She said if it was looked at above or below eye level, the rate will appear to be at a higher or lower rate than it was. She said she was not aware of an oxygen concentrator that was not read at eye level. She said O2 was considered a medication, so must be given as ordered to prevent respiratory complications. In an interview on 10/30/24 at 5:16 pm DON said the floor nurse that worked with a resident who received O2 was responsible for ensuring the O2 was at the correct rate. She said the nurse should check the O2 rate settings throughout their shift and periodically when they go in to see their resident on O2. She said oxygen must be given as ordered to prevent respiratory distress. She said once they reviewed the situation, she would conduct further education with staff. 2. Record review of Resident #79's face sheet dated 10/29/24 reflected the resident was a 73 -year-old female admitted to the facility on [DATE]. Resident #79 had diagnoses which included the following: morbid obesity (chronic disease in which the body mass index was 40 or higher or 35 or higher and experiencing obesity-related health conditions), muscle wasting and atrophy (wasting of an organ or tissue), muscle weakness, and hypertension (the pressure in blood vessels was too high). Record review of Resident #79's Comprehensive MDS assessment, dated 10/2/24, reflected the resident had a BIMS score of 14 which suggests intact cognition. Self-care assessment reflected she was dependent on staff for all self-care except eating and oral hygiene which required partial/moderate assistance from staff. Special treatments, procedures, and programs reflected the resident received continuous oxygen therapy. Record review of the Care Plan completed on 9/27/24 for Resident #79 did not reflect the resident required the use of oxygen therapy. Record review of the most recent Care Plan on 10/15/24 for Resident #79 reflected the resident was at risk for complications with the respiratory system due to shortness of breath. Date initiated: 10/29/24 with intervention to administer medications as ordered. Monitor for side effects/adverse reactions and effectiveness. Date initiated 10/29/24. Record review of the Doctor's Order Summary reflected Resident #79 was prescribed O2 at 2 LPM via nasal cannula continuous per concentrator. Start Date 10/28/2024 at 4:30 pm. End Date 10/28/24 and O2 at 2 LPM via nasal cannula per concentrator PRN. Start Date 10/28/24 at 4:32 pm. Record review of the MAR for September 2024 reflected the medication reconciliation had been performed for Resident #79 with review of the prior care setting discharge medications one time only for medication reconciliation for 1 day. -Start Date- 09/26/2024. The MAR did not reflect oxygen therapy was administered. Record review of the MAR for October 2024 reflected Resident #79 was prescribed O2 @2 LPM via nasal cannula continuous per concentrator as needed for SOB. Start Date: 10/28/2024 at 4:30 pm DC Date: 10/28/2024 at 4:33 pm and O2 @2LPM via nasal cannula per concentrator PRN as needed for SOB Start Date: 10/28/2024 at 4:32 pm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Medication Reconciliation Report for Discharge for Resident #79 dated 9/26/24 reflected no orders for oxygen. Record review of O2 saturation log documented Resident #79 with oxygen via nasal cannula since 9/26/24. Record review of progress note dated 10/20/24 reflected Resident #79 continues oxygen via NC. Record review of progress note dated 10/28/24 at 4:29 pm for Resident #79 reflected new order received from MD for oxygen PRN at 2 LPM via nasal canula due to SOB. Observation and interview on 10/28/24 at 11:45 am revealed Resident #79 in bed with head of bed elevated. Resident #79 received O2 2LPM via NC. Resident stated she was on O2 because she becomes short of breath due to her edema (swelling caused by fluid buildup in the body's tissues and organs). Resident said that she had received oxygen since the first day she arrived at the facility. In an interview on 10/29/24 at 1:50 PM with CNA J, she said Resident #79 had always had O2 since she worked with her. She said sometimes the resident will not have it on because she took it off. She said the resident called the nurse to help get it back on. She said she had noted resident #79 with O2 on and off since she was admitted . In an interview on 10/29/24 at 02:10 pm with LVN K, she said Resident #79 came to facility from hospital via ambulance with O2. She said they immediately took her off the oxygen, once orders were verified, because the resident's oxygen saturations were fine. She said yesterday MD gave orders for chest x-ray, PRN O2, and a nebulizer treatment after he completed his rounds with resident due to noted edema and shortness of breath. LVN K said a nurse may use her judgement to provide O2 without an order if signs or symptoms of respiratory distress were noted. She said there were no progress notes showing Resident #79 was under respiratory distress prior to receiving orders for PRN O2 on 10/28/24. In an interview on 10/29/24 at 4:24 pm with ADON/LVN H, she said she does not recall how long Resident #79 has been receiving oxygen. She said there should be an order for O2 if a resident was receiving oxygen, unless the resident was under respiratory distress, then the nurse uses her judgement to start the resident on oxygen then receive orders from the MD. She said they have no standing orders for O2 used for PRN. ADON said that there were no progress notes showing Resident #79 with respiratory distress. In an interview on 10/30/24 at 4:12 pm with ADON/LVN B, she said If a resident was receiving O2, there should be orders prior to resident receiving the O2. She said a nurse can give oxygen to a resident if needed, but they must have a PRN order. She said O2 was considered a medication, so it must be given as ordered to prevent respiratory complications. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 5:16 pm with DON, she said if a resident was receiving oxygen, they must have an order. She said if a resident was in respiratory distress, nursing intervention will apply, they will complete a change in condition, and must follow up with the order, otherwise they should not be on O2. She said if oxygen was received on admission, they should have orders in PCC (a cloud-based healthcare software platform that long-term care providers use for clinical documentation) or on progress notes. She said if nothing was on PCC or progress notes, then they should not be administering O2. The DON said when Resident #79 arrived on admission, the nurse should have verified the O2 order. She said once everything was reviewed, they will need to re-educate staff. Record review of the Oxygen Administration policy, revised October 2010, reflected: Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Steps in the Procedure . 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. 9. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40872 Based on observation, interview and record review, the facility failed to store, prepare and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation. 1. The facility failed to properly store raw meat in refrigerator. This failure could place residents at risk for foodborne illnesses. Finding included: An observation of the kitchen on 10/27/24 at 10:20 a.m., revealed lettuce stock next to raw beef on a shelf inside the walk-in refrigerator. Also observed was raw meat being thawed in a 3-compartment sink. In an interview on 10/27/24 at 10:20 a.m., [NAME] A said that the raw meat should have been stored at the bottom shelf in the refrigerator. She said she was rushing and did not notice she put it next to the lettuce. In an interview on 10/28/24 at 3:56 p.m., the DM said that meat should be stored at the bottom of the shelf and should not be stored next to vegetables. She said there could be a risk of cross-contamination. In an interview on 10/28/24 at 6:56 p.m., the Administrator said that policy should have been followed when storing and preparing food. Record review of facility policy titled Food Receiving and Storage, revision date 11/2022 states; Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerated/Frozen Storage 9. Uncooked and raw animal products and fish are stored separately in drip-proof containers and below fruits and vegetables and other ready-to-eat foods to prevent meat juices from dripping onto these foods. Record review of facility policy titled, Food Preparation and Service, not dated states; Policy Statement: Food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Record review of U.S. Food And Drug Administration Food Code revised 01/18/23 states; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3-302 Preventing food and ingredient contamination 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below or when combined as ingredients, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO EAT FOOD such as fruits and vegetables,P (b) Cooked READY-TO-EAT FOOD, P and (c) Fruits and vegetables before they are washed; (2) Except when combined as ingredients, separating types of raw animal FOODS from each other such as beef, FISH, lamb, pork, and POULTRY during storage, preparation, holding, and display.

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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** 26141 49301 Based on observation, interview, and record review, the facility failed to establish 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 8 residents (Resident #79) observed for infection control issues in that: 1. Wound care LVN M did not put on PPE when she entered Resident #79's room who was on contact precautions. 2. The AD did not change gloves while handling food and then touched the handles of a resident's wheelchair before returning to the task of handling food again. This deficient practice could place residents at-risk for infection due to improper infection control practices. The findings included: 1. 1. Record review of Resident #79's face sheet dated 10/29/24 reflected the resident was a 73 -year-old female admitted to the facility on [DATE]. Resident #79 had diagnoses which included the following: morbid obesity (chronic disease in which the body mass index was40 or higher or 35 or higher and experiencing obesity-related health conditions), muscle wasting and atrophy (wasting of an organ or tissue), muscle weakness, and hypertension (the pressure in blood vessels was too high) and sebaceous cyst (nodules filled with keratin (a protein found in the body)). Record review of Resident #79's Comprehensive MDS assessment, dated 10/2/24, reflected the resident had a BIMS score of 14 which suggests intact cognition. Self-care assessment reflected she was dependent on staff for all self-care except eating and oral hygiene which required partial/moderate assistance from staff. Record review of the most recent Care Plan on 10/15/24 for Resident #79 reflected the resident had infection of the (UTI/ESBL) Date Initiated: 10/18/2024 Revision on: 10/24/2024. The resident was on antibiotic therapy (MACROBID 100MG BID X 10 DAYS) r/t infection (UTI/ESBL) Date Initiated: 10/18/2024 Revision on: 10/24/2024. Record review of the Doctor's Order Summary reflected Resident #79 had all services and meals to be rendered in single room due to contact isolation and single room Contact Isolation in Place: DX: Escherichia Coli (a gram-negative bacteria that can cause a variety of illnesses, such as UTI and diarrhea)/ ESBL Q shift. Start Date: 10/21/24. Observation on 10/29/24 at 1:40 pm revealed wound care LVN M entered Resident #79's room without donning gown and gloves. A red contact precaution sign was observed above the room number with the following instructions: All Healthcare Personnel must: wear gloves when entering room and remove before leaving room. Wear a gown when entering the room and remove before leaving room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/29/24 at 1:45 pm with wound care LVN M, she said she only needed to use PPE if she provided care with actual contact with the resident, such as doing wound care. She said contact precautions required staff to wear a gown whenever they were having any type of contact with patients. She said if they did not follow the instructions on the precaution signs located outside of resident's rooms, they could spread infection. She said the last infection control in-service she attended was this morning. In an interview on 10/29/24 at 01:50 PM with CNA J, she said the last infection control in-service she attended was at hire approximately 4 months ago. She said they went over hand hygiene before entering rooms and when exiting rooms. She said when there was a contact precaution sign up, they cannot go into that room without applying the PPE required, which are gowns and gloves. In an interview on 10/29/24 at 1:58 PM with CNA L, she said the last infection control in-service she attended was upon hire approximately 4 weeks ago. She said they go over signs posted. She said if a resident had a yellow enhanced barrier protection sign, they must wear gowns and gloves while providing care and the resident had an indwelling device, such as a shunt for dialysis. If a resident had a red sign posted for contact precautions, they must wear gown and gloves when ever entering the room. She said they must sanitize their hands before and after entering and exiting all rooms. She said they must remove PPE before coming out of any room and wash their hands or sanitize. In an interview on 10/29/24 at 2:10 pm with LVN K, she said the last infection control in-service she attended was approximately a month or less ago. She said they go over types of PPE they must wear, and the signs posted on resident's rooms. She said for signs up showing EBP, they gown up if providing care and the resident had a foley catheter, IV, PEG tube, or was receiving dialysis. She said when a resident was on contact precautions, they must be careful with infection control and wear a gown and gloves anytime they enter the room. She said they must perform hand hygiene before entering the room and when exiting the room. She said they must doff PPE after care was completed and wash hands before exiting the room. In an interview on 10/30/24 at 4:12 pm with ADON/LVN B, she said staff had an in-service on infection control approximately every 1-2 weeks. She said the IP was responsible for those trainings. She said they went over all protocols for contact precautions, EBP, hand hygiene and how to don and doff PPE. She said if a resident was in contact isolation, staff must go in with gown and gloves to render care to the resident any time they enter the resident's room because they cannot be sure what the resident had touched. In an interview on 10/30/24 at 5:16 pm DON said that the IP usually trained on infection control, but she helped. She said in the training, they go over EBP and contact precautions. She said EBP had made things a little confusing, but they keep reminding staff of the differences because of it. She said if a resident was on contact precautions, staff must wear a gown and gloves prior to entering the resident's room. She said when wound care LVN M entered the resident's room without the appropriate PPE, it was not done intentionally. She said the LVN was very nervous. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 6:32 pm with the Administrator, he said for infection control, they have the IP and DON involved with training. He said they do admit residents with an array of infections and follow protocols for them. He said they are trained once a week. He said that he does not go to any of the trainings, but he was aware that for residents on precautions they must use appropriate PPE when providing care and remove PPE before exiting the rooms. He said for residents on EBP, they must gown up and wear gloves while providing direct care. He said for residents on contact precautions, they did not have a choice but to gown up before entering the room. Record review of the facility ' s Isolation - Categories of Transmission-Based Precautions, revised September 2022, revealed: Policy Statement Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact Precautions 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment. 7. Staff and visitors wear gloves (clean, non-sterile) when entering the room. b. Gloves are removed, and hand hygiene performed before leaving the room. c. Staff avoid touching potentially contaminated environmental surfaces or items in the resident ' s room after gloves are removed. 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. 2.Observation on 10/27/24 at 3:01 p.m. of the AD passing out cupcakes and coffee for residents during an activity. The AD had gloves on and was getting a napkin and picking up the cupcake a fork and placing it on the napkin. Surveyor observed the AD turn around and repositioned a female resident's wheelchair closer to the table. The AD then turned and resumed handing out the cupcakes without changing her gloves. In an interview on 10/27/24 at 03:05 p.m., the AD said she was not a CNA but did know that if she touches a resident or a chair, she needed to change gloves. Surveyor asked the AD if she should just put her gloves on, the AD said no she needs to wash her hands and then put on a pair of clean gloves before handling the food. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/27/24 at 03:10 p.m., Housekeeper E said they have in-services on infection control and hand hygiene often. Housekeeper E said if she is doing a task and then has to change tasks, she needs to change gloves. Housekeeper said she must wash her hands before she dons a clean pair of gloves. Housekeeper E said they must wash their hands for 30 seconds. Housekeeper E said they had an in-service on hand washing this month. In an interview on 10/28/24 at 9:30 a.m., the AD said the in-services on infection control were necessary so that they do not spread germs. The AD said if they touched a surface and then go in and touch a resident, they may spread germs and some residents do not have healthy immune systems. The AD said it is important to wash their hands before donning gloves to handle food and if they touch a surface such as a table or chair, they need to change gloves, they must wash or sanitize before donning a clean pair of gloves. In an interview on 10/28/24 at 10:52 a.m., CNA F said they have in-services every Monday and Thursday. CNA F said they had an in-service last Monday on abuse and neglect. The CNA said they also have in-services on infection control. CNA F said they would need to don PPE if a resident was on isolation, and they must wash their hands. CNA F said washing their hands was the best way to prevent transmission of germs. CNA F said if she was providing care and her gloves were dirty, she needed to doff the dirty gloves, wash her hands and don clean gloves. If she was feeding a resident in isolation, she needed to don gloves and then when she takes off the gloves, she needed to wash her hands before she left the room. In an interview on 10/28/24 at 4:15 p.m., LVN G said they get in-services on hand hygiene weekly. LVN G said the CNAs are in-serviced often by the Lead CNA. LVN G said the nurses are on the floor and can observe the CNAs to check if they are using hand sanitizer and washing their hands as needed. LVN G said they also check the non-nursing staff and family. They educated the family on the importance of hand hygiene. LVN G said that in-services on hand hygiene are for all staff because all staff are hands on. They do in-services with demand demonstration. LVN G said they do spot checks for CNAs, Housekeeping staff and the Activity Department. Interview on 10/29/24 at 10:59 a.m., ADON/LVN H said she did rounds daily. She made sure the staff are gowning up when going into an isolation room. ADON H said she did spot checks on staff and would go into a room to make sure they are washing their hands and checking the CNAs are cleaning the resident correctly. ADON/LVN H said she has not used the audit but would start soon. ADON/LVN H said she did hand hygiene in-services for the whole facility staff. ADON/LVN H said the reason they have infection control procedures is to prevent the spread of infection. In an interview on 10/30/24 at 4:35 p.m., the DON said they just had an in-service on hand hygiene last week. The DON said the AD was present for the in-service and she did well during the demand demonstration. The DON said hand hygiene is important to prevent transmission of infection. The DON said she would conduct another in-service for hand hygiene procedures with all staff immediately. Record review of policy for Handwashing/Hand Hygiene revised on October 2023 reflected: Policy Interpretation and Implementation Administrative Practices to Promote Hand Hygiene (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676398	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Hollow Post Acute	310 America Drive Brownsville, TX 78526

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	1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol- based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. Indications for Hand Hygiene 1. Hand hygiene is indicated: 1. immediately before touching a resident; 2. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); 3. after contact with blood, body fluids, or contaminated surfaces; 4. after touching a resident; 5. after touching the resident's environment; 6. before moving from work on a soiled body site to a clean body site on the same resident; and 7. immediately after glove removal. 8. before aseptic procedures; 9. when anticipating contact with blood or body fluids; and 10. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. 2. The use of gloves does not replace hand washing/hand hygiene. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves.