STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676419	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Hacienda DE Paz Rehabilitation and Care Center	3333 Bob Rogers Dr Eagle Pass, TX 78852

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 of 12 residents (Resident #75) reviewed for advanced directives. Resident #75's OOH-DNR was missing a physician's signature and was therefore invalid. This deficient practice could place residents at-risk of having their end of life wishes dishonored and of having CPR performed against their will. The findings included: Record review of Resident #75's face sheet dated [DATE] revealed an [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] and [DATE] with diagnoses that included acute kidney failure (sudden loss of the kidneys' ability to filter waste products), dependence on renal dialysis (medical treatment that performs the job of the kidneys when they are not working properly), hypertension (medical condition where the force of blood against the walls of the arteries is consistently too high), hyperlipidemia (medical condition in which there are abnormally high levels of fats in the flood), and heart failure. Record review of Resident #75's most recent significant change MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required renal dialysis treatments. Record review of Resident #75's Order Summary Report dated [DATE] revealed the following:- DNR, with order date [DATE] and no end date. Record review of Resident #75's comprehensive care plan with date of initiation [DATE] reflected the resident had an order for DNR with the goal to honor the resident/responsible party's decision for DNR and interventions that included for the SW to consult with the resident and RP regarding their decision to continue DNR. Record review of Resident #75's Request for Do Not Resuscitate (DNR) document dated [DATE] reflected the request for DNR was requested by the resident representative on [DATE] and the attending physician was informed of the request for DNR on [DATE]. Record review of Resident #75's OOH DNR revealed the resident's representative signed the form but did not include the date the document was signed. Resident #75's OOH DNR revealed two witness signatures signed the form on [DATE]. Resident #75's OOH DNR revealed the physician failed to sign the upper portion and lower portion of the form. During an interview on [DATE] at 11:28 a.m., LVN B stated she was uncertain if Resident #75 had a DNR code status, but if she needed to find out it was in the profile section of the electronic record. LVN B confirmed Resident #75 was identified in the profile section of the electronic record as having a DNR code status. LVN B stated, code status was determined at the time of admission, and the admitting charge nurse was responsible for inputting the DNR/Full Code information in the computer with the help of the ADON's, after an order from the physician was obtained. LVN B stated there was somebody in the front office that obtained the paperwork to initiate the DNR. During an interview on [DATE] at 11:34 a.m., ADON D stated the nursing staff could obtain a resident's code status from the profile section in the electronic record and code status information could also be obtained from a binder on the crash cart that listed the resident's code status. ADON D stated the code status resident list on the crash cart was updated every night at midnight in case there were any new admissions. ADON D stated, Resident #75 had a DNR code status and reviewed Resident #75's OOH DNR and stated the form was missing the physician's signature and therefore was considered invalid. ADON D stated, since the OOH DNR form for Resident #75 was missing the physician's signature, the resident would have to be considered full code status. ADON D stated, if Resident #75 had suffered cardiac arrest (heart attack) and the OOH DNR form was not valid, then the resident would receive CPR, and that would not be following their wishes because they wanted the DNR status. During an interview on [DATE] at 11:54 a.m., the SW stated code status was discussed at the time of admission and if the resident or representative chose OOH DNR status, the admission office would initiate the OHH DNR form and would only refer to the SW if the resident or representative had any questions. The SW stated she was responsible for auditing OOH DNR forms every two weeks. The SW confirmed Resident #75's OOH DNR filed in the electronic record was not signed by the attending physician and they were still waiting for the doctor to sign it. The SW stated, If the resident should have a cardiac arrest, the staff would not initiate CPR because the family signed the Request for Do Not Resuscitate (DNR) document. The SW stated sometimes the doctors were really fast and sometimes they take a while to get documents signed. The SW reiterated, The staff would not initiate CPR because that would be going against the family's wishes, and we have proof that was their wish because they signed the Request for DNR status. During an interview on [DATE] at 2:31 p.m., the DON stated, Resident #75's code status changed from full code status to DNR

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #7) of 7 residents reviewed for resident rights. The facility failed to notify Resident #7's physician of her change of condition when LVN G documented on 9/1/25, 9/15/25, and 9/22/25 the resident had bruising to multiple areas and did not notify the physician. This failure could affect residents by placing them at risk for a delay in medical treatment, decline in health, and death. The findings included: Record review of the admission Record, dated 9/26/25, reflected Resident #7 was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included sepsis (the body's extreme response to an infection), age related cognitive decline, atherosclerotic (a buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with mood disturbance. Record review of Resident #7's quarterly MDS assessment, dated 9/2/25, revealed her memory was severely impaired for daily decision making. Section N revealed she was taking an anticoagulant (medication that stops your blood from clotting too easily). Record review of the Resident #7's Care Plan, dated 4/7/25, revealed she was on aspirin therapy and anticoagulant therapy with interventions to report immediately to the charge nurse if bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV, or surgical sites, blood in urine/feces/vomit, coughing up blood and monitor/document/report to MD PRN s/sx of aspirin complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (lack of energy), bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Another care area reflected the resident received antiplatelet medication related to PVD (peripheral vascular disease is a progressive disorder that affects blood flow to arms, legs, or other body parts due to narrowed or blocked blood vessels). Record review of Resident #7's physician's orders, dated 9/26/25, revealed orders for:-apixban (blood thinner that prevents blood clots and to prevent strokes) oral 2.5 mg tablet, give 1 tablet by mouth two times a day related to atherosclerotic heart disease of native coronary artery without angina pectoris. Monitor for signs and symptoms of anticoagulant use: bruising, bleeding, sore gums, sore joints, nose bleeds, petechiae (tiny red, purple, or brown spots on the skin caused by bleeding from small blood vessels that have broken), rectal bleeding, hematemesis (vomiting of blood) or hematuria (blood in urine). If noted notify MD. The order had a start date of 11/22/24, and no end date.-Aspirin (a nonsteroidal anti-inflammatory drug (NSAID) and a salicylate, commonly used for pain relief, inflammation reduction, and cardiovascular protection) 81 mg tablet, give 1 tablet by mouth one time a day related to atherosclerotic heart disease of native coronary artery without angina pectoris. Monitor for signs and symptoms of anticoagulant use: bruising, bleeding, sore gums, sore joints, nose bleeds, petechiae (tiny red, purple, or brown spots on the skin caused by bleeding from small blood vessels that have broken), rectal bleeding, hematemesis (vomiting of blood) or hematuria (blood in urine). If noted notify MD. The order had a start date of 11/22/24, and no end date.-Cilostazol (vasodilator that improves blood flow by relaxing blood vessels) tablet 50 mg give 1 by mouth one time a day related to peripheral vascular disease. Monitor for signs or symptoms of antiplatelet use: bruising, bleeding, sore gums, sore joints, nose bleeds, petechiae (tiny red, purple, or brown spots on the skin caused by bleeding from small blood vessels that have broken), rectal bleeding, hematemesis (vomiting of blood) or hematuria (blood in urine). If noted notify MD. The order had a start date of 6/28/25, and no end date.-May use geri sleeves (protective garments designed to shield the arms from damage caused by friction and shearing) on both arms, one time a day for fragile skin, with a start date of 7/12/25, and no end date. Record review of Resident #7's progress notes, dated 9/26/25, revealed notes written by LVN G-9/1/25 Weekly skin assessment.bruise present: Yes. Location, measurement of bruising: multiple arms.-9/15/25 weekly skin assessment. Bruise present: Yes. Location, measurements of bruising: BIL (bilateral-both) UPPER AND LOWER EXT (extremity) . -9/22/25 weekly skin assessment. Bruise present: Yes. Location, measurements of bruising: multiple bruising to upper and lower extremities. During an observation and interview on 9/24/25 at 8:44 a.m. revealed Resident #7 was lying in bed. She had dark purplish discoloration on both arms from

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Record review of the admission Record, dated 9/26/25, reflected Resident #7 was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included sepsis (the body's extreme response to an infection), age related cognitive decline, atherosclerotic (A buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with mood disturbance. Record review of Resident #7's quarterly MDS assessment, dated 9/2/25, revealed her memory was severely impaired for daily decision making. Section N revealed she was taking an anticoagulant (medication that stops your blood from clotting easily). Record review of the Resident #7's Care Plan, dated 4/7/25, revealed she was on aspirin therapy and anticoagulant therapy with interventions to report immediately to the charge nurse if bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV, or surgical sites, blood in urine/feces/vomit, coughing up blood and monitor/document/report to MD PRN s/sx of aspirin complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (lack of energy), bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Another care area reflected the resident received antiplatelet medication related [NAME] PVD (peripheral vascular disease is a progressive disorder that affects blood flow to arms, legs, or other body parts due to narrowed or blocked blood vessels). Record review of Resident #7's physician orders, dated 9/26/25, revealed orders for:-May use geri sleeves (protective garments designed to shield the arms from damage caused by friction and shearing) on both arms, one time a day for fragile skin, with a start date of 7/12/25, and no end date. Record review of Resident #7's progress notes, dated 9/26/25, revealed notes written by LVN G-9/1/25 Weekly skin assessment.bruise present: Yes. Location, measurement of bruising: multiple arms.-9/15/25 weekly skin assessment. Bruise present: Yes. Location, measurements of bruising: BIL (bilateral) UPPER AND LOWER EXT (extremity) .-9/22/25 weekly skin assessment. Bruise present: Yes. Location, measurements of bruising: multiple bruising to upper and lower extremities. During an observation and interview on 9/24/25 at 8:44 a.m. revealed Resident #7 was lying in bed. She had dark purplish discoloration on both arms from about her knuckles to midway up to her upper arms. The resident stated she had the bruises for about 15 days and was unsure why or where they came from. She stated they were not painful, and she had no issues with staff. She stated she had just come from showering and needed her arm covers because she was cold. During an interview on 9/24/25 at 8:45 a.m. NA H stated Resident #7 had confusion at times. NA H stated Resident #7 bruised easily and they had to be careful when they transferred the resident. NA H stated they had recently showered the resident and needed to place her arm sleeves on. During an interview on 9/26/25 at 8:55 a.m. LVN G stated the resident was known to bruise and that was why they used the geri sleeves. LVN G stated Resident #7's bruises would come and go. When asked by this surveyor if she reported the bruises to anyone LVN G stated the provider was aware, but she had not recently reported them to anyone. During an interview on 9/26/25 at 9:35 a.m. the DON stated LVN G should have completed an incident report for the bruises the resident had, notified her, and notified her doctor. The DON stated she spoke with the resident's doctor on 9/26/25 and he gave directions to discontinue her apixaban and cilostazol. The DON stated the resident had no recent known incidents in the past month that could have caused the bruising, and they were most likely from her anticoagulant medications, transferring her, and self-inflicted because she was known to scratch herself. The DON stated if staff did not report bruises to the doctor the resident could continue to bruise easily or have internal bleeding. Record review of the facility's policy titled Abuse/Neglect, no date, stated The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.12. Injury of Unknown Source any injury to a t resident observed where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.D. Identification The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for 1 of 7 residents (Resident #7) reviewed for abuse and neglect. The facility failed to investigate when Resident #7 had bruising to both her arms and could not state how they happened. This deficient practice placed all residents at risk of harm from neglect due to not having a thorough investigation. The findings Include: Record review of the admission Record, dated 9/26/25, reflected Resident #7 was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included sepsis (the body's extreme response to an infection), age related cognitive decline, atherosclerotic (a buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with mood disturbance. Record review of Resident #7's quarterly MDS assessment, dated 9/2/25, revealed her memory was severely impaired for daily decision making. Section N revealed she was taking an anticoagulant (medication that stops your blood from clotting easily). Record review of the Resident #7's Care Plan, dated 4/7/25, revealed she was on aspirin therapy and anticoagulant therapy with interventions to report immediately to the charge nurse if bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV, or surgical sites, blood in urine/feces/vomit, coughing up blood and monitor/document/report to MD PRN s/sx of aspirin complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (lack of energy), bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Another care area reflected the resident received antiplatelet medication related to PVD (peripheral vascular disease is a progressive disorder that affects blood flow to arms, legs, or other body parts due to narrowed or blocked blood vessels). Record review of Resident #7's physician orders, dated 9/26/25, revealed orders for:-May use geri sleeves (protective garments designed to shield the arms from damage caused by friction and shearing) on both arms, one time a day for fragile skin, with a start date of 7/12/25, and no end date. Record review of Resident #7's progress notes, dated 9/26/25, revealed notes written by LVN G-9/1/25 Weekly skin assessment.bruise present: Yes. Location, measurement of bruising: multiple arms.-9/15/25 weekly skin assessment. Bruise present: Yes. Location, measurements of bruising: BIL (bilateral) UPPER AND LOWER EXT (extremity) .-9/22/25 weekly skin assessment. Bruise present: Yes. Location, measurements of bruising: multiple bruising to upper and lower extremities. During an observation and interview on 9/24/25 at 8:44 a.m. revealed Resident #7 was lying in bed. She had dark purplish discoloration on both arms from about her knuckles to midway up to her upper arms. The resident stated she had the bruises for about 15 days and was unsure why or where they came from. She stated they were not painful, and she had no issues with staff. She stated she had just come from showering and needed her arm covers because she was cold. During an interview on 9/24/25 at 9:45 a.m. NA H stated Resident #7 had confusion at times. NA H stated Resident #7 bruised easily and they had to be careful when they transferred the resident. NA H stated they had recently showered the resident and needed to place her arm sleeves on. During an interview on 9/26/25 at 8:55 a.m. LVN G stated the resident was known to bruise and that was why they used the geri sleeves. LVN G stated Resident #7's bruises would come and go. LVN G stated she had not had a recent conversation with Resident #7's doctor about the bruising she documented but the doctor was aware of her bruising. During an interview on 9/26/25 at 8:55 a.m. LVN G stated the resident was known to bruise and that is why they used the geri sleeves. LVN G stated Resident #7's bruises would come and go. LVN G stated she had not had a recent conversation with Resident #7's doctor about bruising she documented but the doctor was aware of her bruising. During an interview on 9/26/25 at 9:35 a.m. the DON stated LVN G should have completed an incident report for the bruises the resident had, notified her, and notified her doctor. The DON stated she spoke with the resident's doctor on 9/26/25 and he gave directions to discontinue her apixaban and cilostazol. The DON stated the resident had no recent known incidents in the past month that could have caused the bruising, and they were most likely from her anticoagulant medications, transferring her, and self-inflicted because she was known to scratch herself. The DON stated if staff did not report

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 5of 7 residents (Resident #1, Resident #20, Resident #32, Resident #100, and Resident #10) who were reviewed for resident assessments. 1. The facility failed to accurately documents Resident #1's skin conditions on his significant change MDS. 2.The facility failed to document Resident #20's use of pain medication and antiplatelet medication on the quarterly MDS assessment. 3. The facility failed to document Resident #32's use of antidepressant medication and antiplatelet medication on the quarterly MDS assessment. 4. The facility failed to document Resident #100's use of antidepressant medication on the quarterly MDS assessment. 5. The MDS Case Manager incorrectly coded Resident #10 with a primary diagnosis of dementia and with no mental illness. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of the admission Record, dated 9/26/25, reflected Resident #1 was a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included unspecified protein-calorie malnutrition (deficient protein and calorie intake that can lead to muscle loss and fat loss) and atherosclerotic (A buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris. Record review of Resident #1's significant MDS assessment, dated 9/15/25, showed his memory was severely impaired for daily decision making. Section M showed he had unhealed pressure ulcers and then showed 0 number of current unhealed pressure ulcers. Record review of Resident #1's care plan, dated 5/26/25, revised 9/25/25, stated the resident had potential for pressure ulcers development with interventions to Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings as needed, notify nurse immediately of any new areas of skin breakdown: open area, redness, Blisters, Bruises, discoloration noted during bath or daily care, the resident needs assistance to turn/reposition at least every 2 hours. Record review of Resident #1's physician orders, dated 9/26/25, revealed an order to apply hydrocolloid dressing to buttocks for preventative as needed for preventative previous injury site, with a start date of 9/11/25, and no end date. During an interview on 9/25/25 at 2:50 p.m. with the MDS Case Manager and MDS I stated Resident #1 used to have a pressure ulcer, but it was resolved. The MDS case Manager stated that MDS I should have entered no pressure ulcers on the significant changed MDS from 9/15/25. The MDS Case Manager stated when MDS I entered 0 pressure ulcers she should have been given an error. The MDS Case Manager stated the residents' MDS helps to determine their level of care and should be accurate to the residents. 2. Record review of Resident #20's admission sheet dated 9/01/2020 with an original date of 5/15/2020 documented an [AGE] year-old female resident with diagnoses including dementia, chronic kidney disease, anxiety, depression, hyperlipidemia (high cholesterol), heart disease, and diabetes mellitus. Record review of Resident #20's MDS dated [DATE] documented a BIMS of 3 indicating severe cognitive impairment and recorded the use of anticonvulsant and hypoglycemic medications. Further review of Resident #20's MDS revealed the assessment did not include the use of pain medication or antiplatelet medication, despite the resident receiving Acetaminophen (a non-opioid analgesic medication) and Aspirin (an antiplatelet medication). Record review of Resident #20's order summary documented active orders for the analgesic medication Acetaminophen with an order date of 8/25/25 and the antiplatelet medication Aspirin with an order date of 6/27/23. Record review of Resident #20's August 2025 and September 2025 MARs documented the resident had been receiving Acetaminophen and Aspirin as prescribed. Further review of the August and September MARs recorded Acetaminophen was ordered as Acetaminophen 325mg, give 2 tablets by mouth two times a day for pain. Aspirin was ordered as Aspirin 81mg, give 1 tablet by mouth one time a day. Record review of Resident # 20's care plan with an initiation date of 6/9/2020 documented resident has primary osteoarthritis of right knee with interventions including Give analgesics as ordered by the physician. The care plan further documented The resident receives an aspirin medication, with the goal of The resident will be free from discomfort or adverse reactions related to antiplatelet use. 3. Record review of Resident #32's admission sheet dated 7/26/2025 with an original date of 6/5/2025 documented a [AGE] year-old female resident with diagnoses including insomnia, dementia, diabetes mellitus, hyperlipidemia, hypertension (high blood pressure), depression, and heart disease. Record review of Resident #32's MDS assessment dated [DATE] documented a BIMS of 13 indicating intact cognition and recorded the use

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Hacienda DE Paz Rehabilitation and Care Center	3333 Bob Rogers Dr Eagle Pass, TX 78852

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, meet professional standards of quality for 1 of 7 residents (Residents #7) reviewed for following physician orders. The facility failed to obtain all 3-guaiac test (also known as the fecal occult blood test (FOBT), is used to detect hidden (occult) blood in stool samples) ordered for Resident #7 on 5/13/25 and report new onset bruising to the physician as directed in the physician orders and care plan. These failures could place the residents at risk of not having their individual needs met and of not receiving adequate care and medical interventions to maintain their health and prevent worsening health conditions. Findings included: Record review of the admission Record, dated 9/26/25, reflected Resident #7 was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included sepsis (the body's extreme response to an infection), age related cognitive decline, atherosclerotic (A buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with mood disturbance. Record review of Resident #7's quarterly MDS assessment, dated 9/2/25, revealed her memory was severely impaired for daily decision making. Section N showed she was taking an anticoagulant. Record review of the Resident #7's Care Plan, dated 4/7/25, revealed she was on aspirin therapy and anticoagulant therapy with interventions to report immediately to the charge nurse if bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV, or surgical sites, blood in urine/feces/vomit, coughing up blood and monitor/document/report to MD PRN s/sx of aspirin complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (lack of energy), bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Another care area stated the resident received antiplatelet medication related [NAME] PVD (peripheral vascular disease is a progressive disorder that affects blood flow to arms, legs, or other body parts due to narrowed or blocked blood vessels). Record review of Resident #7's laboratory report, dated 4/10/25, revealed Resident #7 had low hemoglobin at 7.9 g/dL (a protein in red blood cells that carries oxygen throughout the body; normal levels are between 11.2 and 15.7 g/dL), low hematocrit at 24.5% (volume percentage of red blood cells in the blood; normal ranges are between 34.1% and 44.9%), and low red blood cell count 2.68 x10^6/uL (is a blood test that measures the number of red blood cells in your body which are essential for transporting oxygen; normal levels are between 3.93 and 5.22 x10^6/uL) levels. The doctor wrote on the lab report an order for x3 days of guaiac test and signed it on 5/13/25. Record review of Resident #7's lab test results revealed 2 stool tests were completed on 5/24/25 and 5/26/25 with negative occult blood results for both tests. No results for the 3rd test were located in the resident's medical records. During an interview on 9/26/25 at 2:41 p.m. the DON stated they only had results for 2 tests and was unsure why they did not have 3 results for the order for x3 days of guaiac testing. Record review of the facility's policy titled Notifying the Physician of Change in status, no date, stated The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. 1. The nurse will notify the physician or their delegated nurse practitioner or physician assistant with change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.3. The nurse may collect several non-emergent items and place one telephone call during the shift in order to avoid multiple calls to a physician with non-emergent questions. The nurse is responsible, however, for responding to a change of condition in a timely and effective manner. The nurse will document the time of the call to the physician in the clinical record. 4. If the physician does not return the call within a reasonable amount of time, the nurse will attempt to contact the physician a second time. If the situation is an emergency, and the physician does not call back within a reasonable amount of time, the nurse will contact the Medical Director or the nearest ambulance service for assistance. The nurse will document all attempts to contact the physician in the resident's clinical record. 5. The resident's family member or legal guardian should be notified of significant change in resident's status unless the resident has specified otherwise. 6. The nurse will monitor and reassess the resident' s status and response to interventions. Physicians should develop a working diagnosis and guide nursing staff in what to

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. (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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission for 4 of 4 residents (Resident #10, #11, #12, #91) and at least once every 60 days thereafter for 10 of 22 residents (Resident #1, #2, #3, #7,#9, #13, #20, #29, #67, #94) reviewed for physician services. 1. The facility failed to ensure Resident #10 was seen by the physician every month for the first three months since admission on [DATE].2. The facility failed to ensure Resident #11 was seen by the physician every month for the first three months since admission on [DATE].3. The facility failed to ensure Resident #12 was seen by the physician every month for the first three months since admission on [DATE].4. The facility failed to ensure Resident #91 was seen by the physician every month for the first three months since admission on [DATE].5. The facility failed to ensure Residents #1, #2, #3, #7, #9, #13, #20, #29, #67, and #94 were seen by the physician every 60 days. These failures could place residents at risk for medical conditions not being identified, care needs not being met, and a decline in health status. Findings include: Findings include: 1. Record review of Resident #10's face sheet dated 09/24/2025 revealed a [AGE] year-old female admitted to the facility with an original date of 08/20/2024 and a readmission date of 06/17/2025 with a diagnosis of pneumonia. Record review of Resident #10's MDS dated [DATE] documented a BIMS of 3 out of 15 indicating severely impaired cognition and recorded the use of antipsychotic, antidepressant, anticonvulsant, and hypoglycemic medications. Record review of Resident #10's Nursing Home Visit note dated 07/19/2025 revealed the resident was last seen by the primary care physician on 07/19/2025. 2. Record review of Resident #11's face sheet dated 9/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included diabetes, urinary tract infection, and hypothyroidism. Record review of Resident #11's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and received insulin injections. Record review of Resident #11's progress note reflected the resident was seen by the primary care physician to establish care on 4/1/25 and again on 6/27/25 since the time of admission on [DATE]. 3. Record review of Resident #12's face sheet dated 9/26/25 revealed a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included acute metabolic acidosis (sudden, serious disturbance in the body's acid-base balance where there is an excess of acid or a loss of bicarbonate in the blood), diabetes (a chronic medical condition in which the body either does not produce enough insulin or cannot use insulin effectively), dependence on renal dialysis (medical treatment that performs the job of the kidneys when they are not working properly), and heart disease. Record review of Resident #12's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills and required dialysis treatments. Record review of Resident #12's History and Physical document reflected the resident was seen by the primary care physician once on 6/13/25 since admission on [DATE]. 4. Record review of Resident #91's face sheet dated 09/24/2025 revealed a [AGE] year-old female admitted to the facility with an original date of 01/12/2021 and a readmission date of 06/24/2025 with diagnoses that included a fracture of superior rim of right pubis (right hip bone), osteoporosis, fracture of sacrum , diabetes, major depressive disorder, hyperlipidemia, hypertension, and heart disease. Record review of Resident #91's MDS dated [DATE] documented a BIMS of 3 out of 15 indicating severely impaired cognition. Record review of Resident #91's Nursing Home Visit note dated 06/24/2025 revealed the resident was last seen by the primary care physician on 06/24/2025. 5. Record review of the admission Record, dated 9/26/25, reflected Resident #1 was a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included unspecified protein-calorie malnutrition (deficient protein and calorie intake that can lead to muscle loss and fat loss) and atherosclerotic (A buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris. Record review of Resident #1's significant MDS assessment, dated 9/15/25, showed his memory was severely impaired for daily decision making. Record review of Resident #1's hospital documentation, dated 9/4/25, revealed he was admitted on [DATE] and discharged on 9/10/25. Resident #1's most recent primary care physician notes were requested and this hospital documentation was instead provided. Record review of Resident #2's admission record, dated 9/26/25, revealed a [AGE] year-old male resident, admitted on [DATE], and readmitted on [DATE], with diagnosis of diffuse traumatic brain injury with loss of consciousness of unspecified duration. Record review of Resident

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 2 of 6 carts (the 500/600 hall PO cart and the 100/200/600 hall PO cart) reviewed for pharmacy services. The facility failed to ensure the controlled substance reconciliation logs were signed for accuracy of medication quantities during shift change. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life. The findings included: During an observation of the 500/600 hall po cart on 9/25/2025 at 9:45 AM, a sample of controlled medications was inventoried for accuracy with RN A. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs, however record review of the comprehensive controlled medication reconciliation log used for cart audit during shift change revealed the log was missing two signatures. During an interview with RN A on 9/25/2025 at 9:45 AM, RN A stated it was important for the control log to be signed during shift change by the staff member taking control of the cart and the staff member relinquishing control of the cart, because the count of controlled medications could be inaccurate, and residents might not get their medication. During an observation of the 100/200/600 hall PO cart on 9/25/2025 at 10:10 AM a sample of controlled medications was inventoried for accuracy with RN A. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs, however record review of the comprehensive controlled medication reconciliation log used for cart audit during shift change revealed the log was missing one signature. During an interview with RNA on 9/25/2025 at 10:10 AM, RN A stated it is important for the reconciliation log to be signed at every shift change to make sure the count of controlled substances is accurate. During an interview with the DON on 9/25/2025 at 3:20 PM, the DON stated her expectation for the controlled substance reconciliation log was for staff to reconcile the controlled medications daily. The DON further stated everything contained in the medication carts has to be accounted for and double checked every shift to make sure it is accurate to avoid drug diversion or missing items. During an interview with the Administrator on 9/25/2025 at 3:20 PM, the Administrator stated her expectation regarding the controlled medication log was for the log to be accurate to avoid drug diversion, medication errors, and to ensure they provide proper care for residents. Record review of the facility policy titled Controlled Medications - Administration dated 2025 noted At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 2 of 6 medication carts (the 300/400 hall PO cart and the 500/600 hall PO cart) assessed for medication storage and labeling. 1. The facility failed to ensure all medications located inside the 300/400 hall PO cart were stored in labeled containers.2. The facility failed to ensure the 500/600 hall PO cart was locked and secured. These failures could place residents at risk of receiving inadequate treatments or ingesting medications for which they were not prescribed. The findings included: 1. During an observation of the 300/400 hall PO cart on 9/25/2025 at 10:00 AM, one loose pill was discovered lying in the bottom of the drawer of the of the medication cart. During an interview with LVN C on 9/25/2025 at 10:00 AM, LVN C stated if a pill is in the cart unlabeled, they would not know what medication it was or for which resident it was prescribed. During an interview with the DON on 9/25/25 at 3:25 PM, the DON stated her expectation regarding medication storage was for everything to be accurate and to be contained where it should be. The DON further stated her expectation for carts were for items to be dated, nothing to be missing, medications to be reordered timely, carts to be clean, and there should be no loose pills. During an interview with the Administrator on 9/25/25 at 3:25 PM, the Administrator stated her expectations were for there to be no medication errors, drug diversion, or any resident or staff having access to any loose pills which could lead to an incident. 2. Observation on 9/25/25 at 10:04 a.m. revealed the 500-hall medication cart was left unlocked and unattended. During an observation and interview on 9/25/25 at 10:08 a.m., LVN E confirmed the 500-hall medication cart was unlocked and unattended and stated the medication cart was assigned to two nurses, LVN C and RN F. LVN E stated, a medication cart was never supposed to be left unlocked and unattended because people who were not supposed to have access to the cart could get a medication that did not belong to them. LVN E stated the facility had residents who wandered and if unauthorized persons got into the medication cart, they could take medication that could make them sick, and they could have a serious reaction. During an interview on 9/25/25 at 10:19 a.m., LVN C stated she had used the 500-hall medication cart earlier in the morning, before breakfast, maybe between 6:30 a.m. and 7:00 a.m. LVN C stated RN F had also used the 500-hall cart the same day. LVN C stated, a medication cart was never supposed to be left unlocked and unattended because somebody could get into it when they were not supposed to. LVN C stated, the 500-hall medication cart had blood pressure medications stored in it and if a person took those medications not prescribed to them it could cause a serious reaction, such as their blood pressure dropping. LVN C stated the facility also had residents who wandered, and those residents could potentially get into the cart. During an interview on 9/25/25 at 5:51 p.m., the DON stated, medications carts should always remain unlocked when unattended for safety reasons. The DON stated, residents and other unauthorized people could get into an unlocked medication cart and consume medications that were not prescribed to them and could cause an adverse reaction. Record review of the facility policy titled Medication Storage in the Facility dated 2025 noted Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier, and the pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. The policy further noted Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review revealed the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 of 7 Residents (Resident #7) whose records were reviewed for lab services. 1. The facility failed to report to Resident #7's physician and document abnormal laboratory results on 4/11/25. This deficient practice could affect any resident and contribute to residents' decline of health condition by not providing the physician information necessary to be informed decisions. The findings were: Record review of the admission Record, dated 9/26/25, reflected Resident #7 was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnosis that included sepsis (the body's extreme response to an infection), age related cognitive decline, atherosclerotic (A buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) heart disease of native coronary artery without angina pectoris, and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with mood disturbance. Record review of Resident #7's quarterly MDS assessment, dated 9/2/25, showed her memory was severely impaired for daily decision making. Section N showed she was taking an anticoagulant. Record review of the Resident #7's Care Plan, dated 4/7/25, showed she was on aspirin therapy and anticoagulant therapy with interventions to report immediately to the charge nurse if bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV, or surgical sites, blood in urine/feces/vomit, coughing up blood and monitor/document/report to MD PRN s/sx of aspirin complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy (lack of energy), bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Another care area stated the resident received antiplatelet medication related [NAME] PVD (peripheral vascular disease is a progressive disorder that affects blood flow to arms, legs, or other body parts due to narrowed or blocked blood vessels). Record review of Resident #7's laboratory report, dated 4/10/25, revealed Resident #7 had low hemoglobin at 7.9 g/dL (a protein in red blood cells that carries oxygen throughout the body; normal levels are between 11.2 and 15.7 g/dL), low hematocrit at 24.5% (volume percentage of red blood cells in the blood; normal ranges are between 34.1% and 44.9%), and low red blood cell count 2.68 x10^6/uL (is a blood test that measures the number of red blood cells in your body which are essential for transporting oxygen; normal levels are between 3.93 and 5.22 x10^6/uL) levels. The doctor wrote on the lab report an order for x3 days of guaiac test (also known as the fecal occult blood test (FOBT), is used to detect hidden (occult) blood in stool samples) and signed and dated it on 5/13/25. Record review of Resident #7's nursing progress notes, dated 9/26/25, revealed between 4/10/25 and 4/25/25 there were no progress notes referencing Resident #7's abnormal lab results from 4/10/25. Record review of Resident #7'd lab test results revealed 2 stool tests were completed on 5/24/25 and 5/26/25 with negative occult blood results for both tests. The facility collected 2 of the 3 samples ordered for testing over 3 days. During an interview on 9/26/25 at 2:41 p. m. the DON stated staff should notify the doctor immediately of any abnormal labs or critical labs and it should be documented in a progress note. The DON stated she was unsure why the labs were not reviewed by the physician until 5/13/25 and the additional labs ordered were not collected until 5/24/25. Record review of the facility's policy titled Notifying the Physician of Change in status, no date, stated The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. 1. The nurse will notify the physician or their delegated nurse practitioner or physician assistant with change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record. 11. Abnormal lab, x-ray and other diagnostic reports require physician notification.

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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. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 nourishment room fridges. The nourishment room had undated opened items in the fridge. This deficient practice could place residents who ate food from the nourishment room fridge at risk for foodborne illness. The findings include: During observation on 09/23/2025 at 11:13 a.m., the following containers of food looked to have previously been opened with no date to include, a bottle of chocolate milk, a clear container with soup-like substance, a to go box, an item in foil, a soup-like substance in a clear container with a blue lid, a plastic wrapping with cheese slices in it, and a container of meat. During an interview on 09/23/2025 at 11:15 a.m., the Dietary Manager stated they are only responsible for the snacks they put in the fridge for the residents. When asked about the other items in the fridge the dietary manager stated she did not know what they were or where they came from. The Dietary Manager stated they change out their snacks every day and that they are labeled and dated with the residents' names and what the snack is. The Dietary Manager stated they label items with dates to know when they need to be out by so residents aren't eating bad food. During an interview on 09/24/2025 at 7:18 a.m., the Administrator stated anything pertaining to the residents goes in the nourishment room and that everyone has access to it which includes staff and families. The Administrator stated the nourishment room has no code, and the fridge is for residents only. The Administrator stated the nourishment room falls under the kitchen and follows the same polices as the kitchen. The Administrator stated items in the fridge should follow the kitchen policies in order to be safe for residents to consume. Record review of facility document titled Food Storage and Supplies reveals:4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676419	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Hacienda DE Paz Rehabilitation and Care Center	3333 Bob Rogers Dr Eagle Pass, TX 78852

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 7 residents (Resident #90) reviewed for infection control: The facility failed to ensure staff maintained proper hand hygiene during wound care on Resident #90. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #90's admission record, dated 9/26/25, revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pressure ulcer of sacral region stage 4 (A stage 4 pressure ulcer is characterized by significant tissue loss and damage. These ulcers penetrate deep into the skin and underlying tissues, affecting muscles, tendons, and even bones.). Record review of Resident #90's quarterly MDS assessment, dated 8/12/25, revealed the resident cognition was severely impaired for daily decision-making skills, and section M revealed he had 2 stage 4 pressure injuries. Record review of Resident #90's care plan, initiated 5/30/22, revised 7/10/23, revealed the resident had pressure injuries: stage IV to right buttocks and stage IV to sacrum with interventions to follow facility policies/protocols for the prevention/treatment of skin breakdown. Record review of Resident #90's Physician Order, dated 9/26/25, revealed the following:- Stage 4 to right buttock: cleanse site with wound cleanser, pat dry, apply silver alginate, cover with dry dressing, secure with tape one time a day, with a start date of 9/24/25. During an observation on 9/25/25 at 9:57 a.m. LVN G provided wound care to Resident #90's pressure wounds. LVN G left the bedside to wash her hands in the resident's bathroom. LVN G returned and touched the privacy curtain with her barehand, put on gloves, and returned to cleaning the resident's 1st wound bed. LVN G removed the old dressing from the 2nd wound and again went to wash her hands. LVN G left the bathroom and touched the door handle with her bare hand, opened and touched the privacy curtain with her bare hand, put on gloves, and began to clean the 2nd wound bed. During an interview on 9/25/25 at 10:18 a.m. LVN G stated she did not touch the door with her bare hand or the privacy curtain. LVN G stated if she had touched the door handle or curtain with her bare hand, then directly put on gloves, germs from the door handle would be transferred to the resident. During an interview on 9/25/25 at 4:59 p.m., the DON stated LVN G should have used hand sanitizer if she touched something on the way back from washing her hands. The DON stated if not possible cross contamination of the wound could happen. Record review of the facility policy titled Fundamentals of Infection Control Precautions, dated 3/2024, stated A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions.1. Hand Hygiene, Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. Before and after assisting a resident with personal care.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 handling soiled equipment or utensils.After removing gloves or aprons.