STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676466	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interview and record review the facility failed to ensure the resident had the right to be treated with respect and dignity for 1 of 4 residents (Resident #67) reviewed for dignity. The facility failed to ensure staff properly fed Resident #1 breakfast, while he was in bed. This deficient practice could place the resident at risk of not feeling as if they were being treated with dignity and respect. Findings include: Record review of Resident #67's face sheet, dated 05/05/25, revealed a 38 -year-old male who was admitted to the facility on [DATE]. Resident #67's relevant diagnoses included Multiple Sclerosis (nerve deterioration), and Idiopathic Peripheral Autonomic Neuropathy (nerve damage). Record review of Resident #67's Minimum Data Set, dated dated [DATE] revealed he had a BIMS score of 9 (severe cognitive impairment) and for ADL care it stated, Helper does all of the effort. Resident does none of the effort to complete the activity. Record review of Resident #67's Care plan, dated 12/30/24, revealed Provide and serve diet as ordered. In an interview and observation on 05/05/25 at 8:15 AM, CNA M was observed feeding Resident #67 breakfast while she was standing over the resident as he was in bed. She stated they were required to be sitting down at eye level with the resident while feeding them. She stated the reason for doing so was a dignity concern. In an interview on 05/05/25 at 8:20 AM, RN T stated she was the hall nurse for Resident #67. She stated staff was required to be sitting at eye level while feeding residents. She stated the reason for doing so was to ensure the resident was not eating too quicky and you could observe if the resident was choking. She stated it was also a dignity concern. (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/06/25 at 8:53 AM, the DON stated she had been at the facility more than 4 years. She stated she was made aware of staff feeding Resident #67 while standing over him. She stated she expected the staff to provide general care to the resident and ensure they got the nutrition and hydration they needed in a private setting. She stated policy stated staff should provide one on one interaction at eye level. She stated the risk of not following protocol when feeding residents could impact the engagement of the resident. Review of the facility's policy on Feeding the Resident, undated, revealed Staff member should position themselves so that the resident is at eye level with the staff member for better communication with the resident and to provide feeding in a dignified manner.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #42 and Resident #93) of eighteen residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Resident #42 and #93's rooms were in a position that was accessible to the resident on 05/04/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #42 Record review of Resident #42's Face Sheet, dated 05/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with lack of coordination and gait abnormalities. Record review of Resident #42's Quarterly MDS Assessment, dated 03/26/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11 (resident may need additional support and monitoring). The Quarterly MDS Assessment indicated the resident required extensive assistance for bed mobility and transfer. Record review of Resident #42's Comprehensive Care Plan, dated 04/18/2025, reflected the resident had a history of falling and one of the interventions was to be sure the resident's call light was within reach. In an interview and observation on 05/04/2025 at 9:22 AM revealed Resident #42 was sitting in his wheelchair inside his room. It was observed that the resident's call light was between the mattress and the bed frame. When asked where his call light was, the resident just shrugged his shoulders and shook his head. In an observation and interview on 05/04/2025 at 9:49 AM, CNA D stated call lights should be with the residents so they could call the staff if they needed something. She said if the residents were already in their wheelchairs, the call lights should be on top of the bed, or secured on the repositioning bar, or anywhere that could be easily accessed by the residents. CNA D went inside Resident #42's room and observed that the resident's call light was between the mattress and the bed frame. She tried to pull the call light and then said she needed to raise the mattress so she could pull the call light. She raised the mattress, pulled the call light, and placed it on top of the bed. She said staff should make sure the call lights were within reach of the residents before they leave the room so that the needs of the residents could be addressed and also to prevent falls. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/05/2025 at 12:19 PM, ADON A stated the call lights should always be with the residents in case they needed assistance with something like a refill of water or the resident needed a pain medication. She said when a resident was already in the wheelchair, the call light should be on top of the bed so the resident could still call the staff if needed. She said the staff should make sure that the call lights were with the residents before they left the room. She said she would coordinate with the DON to do an in-service about call light placement. In an interview on 05/05/2025 at 2:20 PM, the DON stated call lights were inside the residents' rooms so they can call the staff for assistance, for pain medication, or because they wanted to get up. The DON said if the call lights were not within reach, their needs would not be met and the residents might get upset because there was no way to call the staff. The DON said all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the residents' room when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. The DON said she would educate the staff about the importance of call lights for the residents. In an interview on 05/06/2025 at 8:52 AM, the Administrator stated call lights should be with the residents all the time in case they need help. He said the call lights were for all the residents whether dependent or independent. He said the aides where primarily responsible for the call lights but everybody was responsible in making sure the call lights were with the residents to prevent any falls. He said he would coordinate with the DON about the issue regarding call lights. Resident #93 Record review of Resident #93's Face Sheet, dated 05/05/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #93's diagnoses included history of falling, need for assistance with personal care, and dementia (loss of cognitive function that interferes with daily life and activities). Record review of Resident #93's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 02/25/2025, reflected severe cognitive impairment with a BIMS (screening tool to assess cognition) score of 04. Section GG (functional abilities) indicated Resident #93 used a walker to ambulate and required supervision or touch assistance with transfers and walking. Record review of Resident #93's Comprehensive Care Plan, dated 04/24/2025, reflected Resident has a history of falling or other identified risk factors that result in increased risk of falling. One intervention was Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. During an observation and interview on 05/04/2025 at 11:15 AM, Resident #93 was lying in bed awake. Resident #93's call light was on the floor by the resident's bed. When Resident #93 was asked about her call light, she did not answer. She pointed at her roommate sleeping and then at the door, indicating for the surveyor to leave the room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/04/25 at 11:29 AM, CNA I stated Resident used the call light at times. She stated it was important to ensure the resident's call light was in reach so staff could be notified when she needed assistance. She stated there were many reasons a resident might need to use their call light. She stated residents needed a way to notify staff in case something happened, or if the resident needed water, pain medication, or needed to go to the restroom. CNA I went to the Resident #93's room and placed the call light on the bed next to the resident and told her to call if she needed anything. During an interview on 05/05/25 at 10:15 AM, ADON J stated the residents' call lights should always be in reach. She stated the call light cord had a clip on it to secure it. She stated whether the resident was in bed or sitting up in a chair, the call light should be placed within reach of the resident. She stated it was important that residents always have access to their call light and be able to reach staff when they need assistance. During an interview on 05/05/25 at 07:50 AM, the DON stated the expectation was to ensure call lights were in reach for residents who were not very mobile. She stated all staff members should ensure the call light is in reach before leaving a resident's room. She stated the call light cords had a clip attached to ensure the call lights were secured and stayed within the resident's reach. She stated it was important for the resident to be able to call staff for assistance. Record review of the facility's policy Resident Call System undated, revealed The nurses' station is equipped to receive resident calls through a communication system from resident rooms at each resident's bedside and at toilet, shower and bathing facilities. The call system shall be accessible to a resident lying on the floor. The call system in resident rooms will be accessible to alert, confined residents and confused residents and the residents will be instructed as to its' availability and location.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for three (Resident #1, Resident #11, and Resident #42) of eight residents reviewed for Care Plans. 1. The facility failed to ensure Resident #1 was care planned for hospice on 05/04/2025. 2. The facility failed to ensure Resident #11's was care planned for Parkinson's Disease (a movement disorder). 3. The facility failed to ensure Resident #42's was care planned for Parkinson's Disease. These failures could place the residents at risk of not receiving the necessary care and services needed. Findings included: 1. Record review of Resident #1's Face Sheet, dated 05/04/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with encephalopathy (a condition that caused brain dysfunction), respiratory failure, kidney disease, and cerebrovascular disease (stroke). Record review of Resident #1's Quarterly MDS Assessment, dated 04/17/2025, reflected the resident had severe impairment in cognition with a BIMS score of 07 (resident required significant assistance and support in daily life). The Quarterly MDS Assessment indicated the resident was receiving hospice care. Record review of Resident #1's Comprehensive Care Plan, dated 04/18/2025, reflected the resident did not have a care plan for hospice care. Record review of Resident #1's Physician Order, dated 04/07/2025, reflected HOSPICE - ADMIT . HOSPICE for DX: Sequalae (complications resulting from previous disease or injury) of unspecified cerebrovascular disease. In an interview and observation on 05/04/2025 at 9:17 AM revealed the resident was in his bed with eyes closed. A family member was at bedside and said she was notified that Resident #1 had a change of condition and was declining. In an interview on 05/04/2025 at 10:42, Hospice Nurse M stated Resident #1 was actively dying and she was there to give additional orders to keep the resident comfortable. She said she already gave RN F the new orders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #11's Face Sheet, dated 05/04/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with Parkinson's Disease (movement disorder). Record review of Resident #11's Quarterly MDS Assessment, dated 04/03/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated that Parkinson's disease was one of the resident's primary medical conditions. Record review of Resident #11's Comprehensive Care Plan, dated 03/23/2025, reflected the resident did not have a care plan for Parkinson's disease. Record review of Resident #11's Physician Order, dated 01/30/2025, reflected Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day related to PARKINSON'S DISEASE WITHOUT DYSKINESIA (difficulty in controlling movements), WITHOUT MENTION OF FLUCTUATIONS (changes in the ability to move). 3. Record review of Resident #42's Face Sheet, dated 05/04/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with Parkinson's Disease. Record review of Resident #42's Quarterly MDS Assessment, dated 03/26/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 11 (resident may need additional support and monitoring). The Quarterly MDS Assessment indicated that Parkinson's disease was one of the resident's primary medical conditions. Record review of Resident #42's Comprehensive Care Plan, dated 04/18/2025, reflected the resident did not have a care plan for Parkinson's disease. Record review of Resident #42's Physician Order, dated 01/01/2025, reflected Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day related to PARKINSONISM. In an interview and observation on 05/05/2025 at 10:55 AM, the MDS Nurse stated a care plan is a reflection of a resident's care and services being provided by the staff. She said it indicated the observations done by the staff to be able to provide the best care possible. She said if there was no care plan, the staff might miss something and the residents' needs will not be addressed. She said if a resident was admitted in hospice, there should be a care plan for hospice to make sure the resident was comfortable and given a proper end of life care. She said if a resident had a diagnosis of Parkinson's, there should be a care plan for Parkinson's just like there was a care plan for hypertension, diabetes, and heart failure. She logged on to her computer and saw that Resident #1 was on hospice, had an order for hospice admission, and was coded for hospice. She said she missed it and started adding the care plan for hospice. She then checked Resident #11 and Resident #42's profile and saw both residents had Parkinson's disease as a diagnosis, were taking carbidopa, and were coded for Parkinson's as one of their primary medical conditions. She said she would also add a care plan for Parkinson's for Residents #11 and #42. She said she would also check the MDS of the other residents to check if she missed something. She said care plan were done quarterly, annually, and when there was a change in condition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/05/2025 at 12:19 PM, ADON A stated everything about the resident should be care planned to make sure the residents were being taken care for and so that the staff were in sync with the care being provided to the residents. She said without the care plan, needed interventions might not be provided. She said the expectation was all the issues of the residents were care planned. She said she would coordinate with the DON and the MDS Nurse on how to make sure the residents were care planned accordingly. In an interview on 05/05/2025 at 2:20 PM, the DON stated every resident needed a comprehensive care plan to ensure the residents received the care needed and appropriate to their current conditions and functionality. She said the care plans reflect the resident's problem lists, the goals, and the interventions. She said care plans should be in place so all the staff providing care would be on the same page. She said without the care plan, there could be confusion with the care needed by the residents. she said if a resident had a change in condition and was admitted to hospice, the care plan for hospice should be added. She said if residents had Parkinson's, then there should be a care plan for their Parkinson's disease. She said the expectation was every resident had detailed care plans and they should be reflected on their profile. She said she would coordinate with the MDS Nurse to audit the care plans of the residents. In an interview on 05/06/2025 at 8:52 AM, the Administrator stated all the care, services, and treatment done for the residents should be reflected in their care plans to make sure the staff would not know and understand what kind of care to provide. He said he was not a clinician and would let the DON take the lead in making sure the residents had their care plans in place. Record review of the facility's policy, Comprehensive Person-Centered Resident Care Planning, undated, Operational/Resident Care Policies revealed A comprehensive person-centered care plan is developed and implemented for each resident . will incorporate resident-centered goals . to meet a resident's medical, nursing, and mental and psychosocial needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 3 of 8 residents (Residents #49, #55, and #61) reviewed for accident prevention. 1. The facility failed to ensure Resident #49, #55, and #61 had physician orders for the for the scoop mattress on their bed. 2. The facility failed to ensure CNA E used a gait belt when transferring Resident #55 from bed to wheelchair on 05/05/2025. These failures could prevent the residents from having an environment that was free and clear of accidents and hazards. Findings include: 1. Record review of Resident #49's Face Sheet, dated 05/04/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included history of falls and need for assistance of personal care. Record review of Resident #49's Quarterly Minimum Data Set (MDS) assessment, dated 04/15/25, reflected she had a BIMS score of 7 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance. For active diagnosis, it reflected unstadiness on his feet. Record review of Resident #49's Comprehensive Care Plan, dated 04/07/25, revealed the resident had a history of fall and there was no mentioning of using a scoop mattress as an intervention. Record review of Resident #49's physician orders, dated 05/04/25, reflected no physician orders for the scoop mattress. An Observation on 05/04/25 at 11:58 AM, revealed Resident #49 had a scoop mattress on her bed. Record review of Resident #55's Face Sheet, dated 05/05/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with multiple fracture of the pelvis, and unsteadiness on her feet. Record review of Resident #55's Quarterly MDS Assessment, dated 04/01/2025, reflected resident had a severe impairment in cognition with a BIMS score of 07. The Quarterly MDS Assessment also indicated the resident needed substantial assistance for transfer. For active diagnosis, it reflected unstadiness on his feet. Record review of Resident #55's Comprehensive Care Plan, dated 03/20/2025, reflected the resident required assistance with activities of daily living and one of the interventions was to provide assistance with transfers, and she had a history of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's Progress Notes, dated 05/04/2025, reflected the resident was dependent for transfer. Record review of Resident #55's physician orders, dated 04/16/25, reflected no physician orders for a scoop mattress. An observation on 05/04/25 at 12:56 PM, revealed Resident #55 had a scoop mattress on her bed. Record review of Resident #61's Face Sheet, dated 05/04/25, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included history of falls and lack of coordination. Record review of Resident #61's Quarterly Minimum Data Set (MDS) assessment, dated 04/27/25, reflected she had a BIMS score of 3 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance. For active diagnosis, it reflected unspecified fall. Record review of Resident #61's physician orders, dated 05/04/25, reflected no physician orders for the scoop mattress. An Observation on 05/04/25 at 12:35 PM, revealed Resident #61 had a scoop mattress on her bed. In an interview on 05/05/25 at 11:20 AM, ADON A stated Resident #61 was care planned for the scoop mattress, but she did not have physician orders for it. He stated the resident had a history of fall, which was why she was provided the scoop mattress, but he was unaware physician orders were required. He stated the risk of not having physician orders for the resident could result in the resident having an accident as a result of the scoop mattress. In an interview on 05/05/25 at 11:23 AM, ADON K stated Resident #49 did not have physician orders for usage of the scoop mattress. She stated the resident had a history of falls, which was why she was provided the scoop mattress, and she was unsure why the resident had no physician orders. She stated the risk of not having physician orders for the resident could result in the resident having an accident as as result of the scoop mattress and physician orders were required for all specialty equipment. In an interview and observation on 05/05/25 at 12:00 PM, LVN G stated she was the hall nurse for Resident #55. She observed the resident having a scoop mattress on her bed and she stated she was unsure if the resident had physician orders for the mattress. She stated the resident was a fall risk and required the scoop mattress to assist with fall prevention. She stated she was unsure of the risk of the resident not having physician orders for the scoop mattress. In an interview on 05/06/25 at 8:53 AM, the DON stated she had been at the facility more than 4 years. She stated Residents #49, #55, and #61 had assessments and the scoop mattress was not a risk to them. She stated she was not aware that physician orders or a physician assessment was needed for the equipment. She was advised that other residents' record reviews did have physician orders for the scoop mattress. She stated they were working on securing physician orders for the residents to have scoop mattresses. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. In an observation and interview on 05/05/2025 at 8:17 AM, CNA E stated she would change Resident #55's clothes and then transfer her to her wheelchair because the resident would usually eat better when she was sitting in her wheelchair. CNA E pulled a blouse and pants from Resident #55's cabinet and placed them beside the resident. She washed her hands, put on a pair of gloves, and started to change the resident's clothes. She put on the pants and said she would transfer the resident to her wheelchair and then would put on her blouse. She lowered the bed, placed the resident's wheelchair parallel to the bed, and then assisted the resident to sit at the side of the bed. She told the resident that she was about to transfer her to her wheelchair and the resident started to scoot forward. CNA E then placed her arms under the resident's armpits and lifted the resident to the wheelchair parallel to the bed. CNA E then took off the hospital gown and put on the resident's blouse. CNA E did not use a gait belt during transfer. In an interview on 05/05/2025 at 8:40 AM, CNA E stated she transferred Resident #55 using a stand and pivot technique. She said the resident provided little assistance during the transfer. She said a gait belt was required if a resident was transferred manually and she knew she needed a gait belt to transfer Resident #55 but did not find one inside the room. She said she should had looked for a gait belt first before proceeding with the transfer. She said a gait belt was required during transfer to ensure the safety of the resident. In an interview on 05/05/2025 at 8:49 AM, LVN G stated staff should use a gait belt when a resident was being transferred to a wheelchair to protect the resident and the back of the staff as well. She said if there was no gait belt inside the resident's room, the staff should have asked or looked for one before transferring the resident. Observation on 05/05/2025 at 9:35 AM revealed LVN G was distributing gait belts to some of the resident's room. In an interview on 05/05/2025 at 12:19 PM, ADON A stated a gait belt was needed when transferring a resident to a wheelchair to avoid injury to the resident and the staff. She said the purpose of a gait belt was to prevent falls of weak residents or those who were high risk for fall. She said the expectation was for the staff to transfer the residents using a gait belt. She said they should use the gait belt when transferring a resident from bed to wheelchair and wheelchair to bed. She said she would coordinate with the DON in educating the staff with regards to proper transfer. In an interview on 05/05/2025 at 2:20 PM, the DON stated the staff must use a gait belt if they were transferring a resident from bed to wheelchair and wheelchair to bed. She said the gait belt was used to maintain stability and support during manual transfer. She said the staff would place the gait belt around a resident's waist snugly so they would have a secure grip to prevent slips and falls. She said the expectation was for the staff to transfer the residents using a gait belt to ensure a safe transfer and that she would monitor the issue closely to avert any accidents during transfer. In an interview on 05/06/2025 at 8:52 AM, the Administrator said the staff must use a gait belt during transfer because if a resident fell during the process of transfer, the staff will not have anything to grab. He said the expectation was for the staff to make sure there were gait belts inside the residents' room who needed gait belt during transfer and to use the gait belt to ensure the residents were safe during transfer. He said he would coordinate with the DON to in-service the staff pertaining to transfer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy, Transfer of Patient undated, revealed Purpose: To safely move resident from one place to another . Equipment: 1. Gait belt . Procedure . 5. Help resident to sit on edge of the bed with legs and feet hanging over the edge . 6. Stand in front of the resident with a firm grasp on gait belt that has been secured around resident waist. The facility's policy Restraint Free Facility Initiative (undated) reflected It is the policy of this facility to not restrain residents, chemically or physically, except for their own safety or to prevent harm to other residents. The facility recognizes that restraints may constitute an accident hazard.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one (Resident #1) of five residents reviewed for Pharmaceutical Services. The facility failed to ensure RN F disposed of Resident #1's Lorazepam (medication for anxiety) properly on 05/04/2025. This failure could place residents at risk of not receiving medications as ordered by the physician. Findings included: Record review of Resident #1's Face Sheet, dated 05/04/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with encephalopathy, respiratory failure, chronic kidney disease, and cerebrovascular disease. Record review of Resident #1's Quarterly MDS Assessment, dated 04/17/2025, reflected the resident had severe impairment in cognition with a BIMS score of 07 (resident required significant assistance and support in daily life). The Quarterly MDS Assessment indicated the resident was receiving hospice care. Record review of Resident #1's Comprehensive Care Plan, dated 04/18/2025, reflected the resident did not have a care plan for hospice care. Record review of Resident #1's Physician Order, dated 05/04/2025, reflected Lorazepam Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 1 tablet via G Tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) every 2 hours as needed for Anxiety for 14 Days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 05/04/2025 at 10:36 AM revealed RN F was receiving orders from Hospice Nurse M and one of them was to administer Lorazepam via g-tube. She said she would put the order in the system and then would give the medication because the Resident #1 was observed being restless. After transcribing the order, she placed one tablet of Lorazepam 0.5 mg in a small plastic cup but eventually the tablet fell on the floor. She said she would prepare another one and would dispose the one that fell . She placed another Lorazepam 0.5 mg tablet in a small plastic cup, crushed it, and returned it to the small plastic cup. She then prepared the water that she needed to flush the g-tube and to incorporate on the crushed medication. She went inside the room, took the resident's overbed table, sanitized it, placed the things she prepared for medication administration, and rolled it back beside the resident's bed. She sanitized her hands and the bell of the stethoscope, put on a gown and a pair of gloves, and pull the privacy curtain. The Lorazepam tablet was still on the floor and was now not within her sight because of the pulled privacy curtain. RN F proceeded to administer Resident #1 medication. After medication administration, she gathered the things used for medication administration and threw them in the trash can. She tied the plastic bag on the trash can, exited the room, and went to the utility room to throw the trash bag. The utility room was approximately five rooms away from Resident #1's room. The Lorazepam tablet was still on the floor when she went to the utility room. She went back to her cart and called ADON A to witness her dispose it and co-sign it. She picked up the tablet and put it in a pill tablet crusher. ADON A crushed it, threw it in the sharp container, and then co-signed the narcotic sheet for the resident's Lorazepam. In an interview on 05/04/2025 at 10:58 AM, RN F stated she dropped the Lorazepam on the floor when she was preparing the medication. She said she should had picked it up immediately and disposed it. She said she should have not left it on the floor because a resident might pick it up and consume it. She said the resident might be allergic to the medication, choke on it, or might have a bad stomach for consuming something from the floor. In an interview on 05/05/2025 at 12:19 PM, ADON A stated the staff should have picked it up when it fell on the floor and should not be left unattended because a resident might picked it up and ingest it. She said a resident might choke on it. She said RN F called her to assist her with the disposal but did not know that the medication was left unattended on the floor for a period of time. She said the expectation was to dispose any narcotics immediately and not leave it on the floor. She said she would coordinate with the DON to do an in-service regarding proper disposal of narcotics. In an interview on 05/05/2025 at 2:20 PM, the DON stated the Lorazepam is a narcotics and should not be left unattended on the floor. She said the staff should had picked-it up, dispose or secure it if she was in a hurry. She said the tablet should have been dispose at once and not left on the floor unattended because somebody might pick it up, swallow it, and choke. She said somebody might overdose as well. She said the narcotics were placed in a locked box inside the carts so nobody unauthorized could access them. She said the same principle applied in disposing of the narcotics. She said the expectation was for the staff to know that narcotics should be disposed immediately. She said she would educate the staff about proper and immediate disposal of narcotics. In an interview on 05/06/2025 at 8:52 AM, the Administrator stated narcotics should not be left unattended on the floor where residents could pick it up and swallow it. He said the resident might be allergic to it or might choke on it. He said the expectation was for staff to dispose of the narcotics immediately and not left unattended. He said he would coordinate with the DON to do an in-service about disposal of narcotics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Medication - Wasting Controlled Substances undated, revealed Purpose: 1. To dispose of controlled substances that has been refused or contaminated during medication pass.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the medication for one (Resident #5) of fifteen residents stored in locked compartments and only authorized personnel had access. The facility failed to ensure Resident 5's zinc oxide (cream used to treat skin irritations, diaper rash, and other skin conditions) was not left on top of the resident's left side table on 05/04/2024. This failure could place the residents at risk of not receiving medications, accidental overdose, or misuse of medications. Findings included: Record review of Resident #5's Face Sheet, dated 05/04/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with delusional disorder (brain disorder were an individual have delusional thoughts), depression (a mood disorder that cause a feeling of sadness and loss of interest), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). Record review of Resident #5's Comprehensive MDS Assessment, dated 04/26/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 10 (resident may need additional support and monitoring). The Comprehensive MDS Assessment indicated the resident had Alzheimer's, depression, and psychotic disorder. The resident was also incontinent for both bladder and bowel. Record review of Resident #5's Comprehensive Care Plan, dated 05/04/2025, reflected the resident used antidepressant, hypnotic medication, had an impaired cognitive function, and required assistance for incontinent care. Record review of Resident #5's Progress Notes on 05/04/2025 did have any documentation that the resident wanted the barrier cream on top of her table. Observation on 05/04/2025 at 9:13 AM revealed Resident #5 was in her bed with eyes closed. A container of zinc oxide was observed on top of the resident's right side table. In an interview and observation on 05/04/2025 at 9:59 AM, CNA C stated she used zinc oxide after every incontinent care to prevent redness of the bottom. She said after she used it, she should not left on the side table because the resident might be confused and mistakenly swallow the cream. CNA C went inside Resident #5's room and put the zinc oxide inside the resident's drawer. She said the resident might ingest it and might be allergic to it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/05/2025 at 12:19 PM, ADON A stated zinc oxide should be not within reach of a resident because the resident might ingest it. She said zinc oxide had chemicals that could be toxic when ingested by confused residents. she said the expectation was for the staff to put the zinc oxide where the resident could not reach it. She said she would coordinate with the DON about making sure there were no treatment cream within reach of the residents. In an interview on 05/05/2025 at 2:20 PM, the DON stated the zinc oxide, used during incontinent care, should be placed inside the drawer of the side tables after using it. She said if the resident or a visitor ingested it, there could be adverse reactions especially if somebody who accidentally ingested the medications were allergic to the medications. She said the expectation was the treatment cream used for incontinent care be placed inside the drawer to secure it. She said she would do an in-service making sure no treatment creams were accessible to the residents. In an interview on 05/05/2025 at 2:43 PM, Resident #5 said nobody told her that the zinc oxide should not be on top of the table. She said she would not mind if the barrier cream was placed inside her drawer. In an interview on 05/06/2025 at 8:52 AM, the Administrator stated the barrier cream should not be within reach of the residents because they might ingest it. He said if it was not for ingestion and was ingested, it might cause adverse reactions like allergy. He said he would coordinate with the DON to educate the staff about the matter. Record review of the facility policy, Storage of Drugs, Operational/Resident Care Policies, undated revealed, All drugs and biologicals are stored . Drug Security . All drugs used externally will be stored separately.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interview, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure the ice machine and ice scoop holder in the facility kitchen was thoroughly cleaned. 2. The facility failed to ensure kitchen cooking equipment was cleaned. 3. The facility failed to place a cover on top of the tea dispenser to avoid air borne contaminants. 4. The facility failed to ensure prepared food in the refrigerator was labeled and dated when stored. 5. The facility failed to ensure expired food in the refrigerator was discarded. 6. The facility failed to ensure kitchen and dining room equipment was cleaned and sanitized. 7. The facility failed to ensure foods stored in the freezer was sealed from air-borne contaminants. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations on [DATE] from 9:05 AM to 9:15 AM in the facility's only kitchen revealed: The ice machine, located in the kitchen had black and white stains on the inside of the machine and along the opening of the machine. The ice scoop holder, hanging on a wall near the ice machine, had gritty stains inside the bottom of the holder. One ice machine, located in the dining area, had built up dark brown dirt along the area where a black tray was positioned. One ice cream machine, located in the dining area, had white and brownish stains plastered all over the outside of it. One bowl of chef salad, located in a refrigerator, was not labeled with the date it was stored. One large container of fruit cocktail, located in the refrigerator, had a use by date of [DATE], and was not discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Three large bags of pre-scrambled eggs, located in the refrigerator, was not labeled with the date the items were stored. One pack of cheese wrapped in a clear wrap, located in the refrigerator, was not labeled with the date the item was stored. One large cooking container of soup, located in the refrigerator, was not labeled with the date the item was stored. One large tea dispenser, located in the dining area, had tea filled to the top of it and it did not have a lid placed on the top of the dispenser to avoid air-borne contaminants. One large tray of frozen beef patties, located in the freezer, had a sheet of foil laying on top of the tray and it was not sealed from air-borne contaminants. One plate containing fruits, cottage cheese, lettuce, and crackers, located in a refrigerator, was not labeled with the date it was stored. In an interview on [DATE] at 1:05 PM, the Dietary Manager was shown pictures of the concerns observed in the kitchen area on [DATE]. She stated the tea dispenser should have been covered once it was done. She stated the ice machine, ice cream machine, and ice scoop holder was cleaned at night at the end of the day and she checked for cleanliness when she arrived in the morning. She stated the items not dated should have been dated once stored, and items should have been discarded once it had passed the use by date. She stated the frozen beef patties should have been sealed properly when stored. She stated all the concerns observed could result in cross contamination and air-borne contaminates. In an interview on [DATE] at 9:53 AM, the Administrator was shown pictures of the concerns observed in the kitchen and dining area. He stated he expected these areas to comply and meet all expectations. He stated the risk of the concerns not being addressed could result in food contamination. Record review of the facility's policy on Operational/Resident Care Policies(undated), revealed Food is store, prepared, distributes, and served to residents in accordance with professional standards for food safety. Leftovers should be discarded after 72 hours. Freshness dates on refrigerated products should be checked and discarded if warranted.

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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** 47743 Based observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Resident #39, Resident #50 and Resident #219) of fifteen residents reviewed for Infection Control. 1. The facility failed to ensure the Wound Care Nurse performed hand hygiene when changing gloves during wound care for Resident #39 on 05/05/2025. 2. The facility failed to ensure CNA K did not take a bedside table from Resident #50's room into the hall with contaminated linens on the bedside table on 05/05/2025. 3. The facility failed to ensure CNA B performed hand hygiene, changed gloves, and wore a gown while performing Resident #219's incontinent care on 05/05/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #39's Face Sheet, dated 05/06/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included local infection of the skin and subcutaneous tissue (deepest layer of the skin), hypertension (high blood pressure), and chronic kidney disease (gradual loss of kidney function). Record review of Resident #39's Quarterly MDS Assessment, dated 04/22/2025, reflected moderately impaired cognition with a BIMS score of 10. The MDS Assessment reflected Resident #39 was administered an antibiotic for a wound infection. Record review of Resident #39's Comprehensive Care Plan, dated 04/17/2025, reflected Resident has skin INJURY to ABDOMEN. One intervention was to Follow house protocol/regime for treating breaks in skin integrity/pressure ulcers. Record Review of Resident #39's Physician Order, dated 04/21/2025, reflected to clean the wound bed on the abdomen with wound cleanser or normal saline and pat dry. Apply Santyl (medicated ointment) to the wound bed, silver alginate (antimicrobial wound dressing), and cover with a dry dressing one time a day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/05/2025 at 11:05 AM, the Wound Care Nurse stated Resident #39 was admitted with a left abdominal wound. There was a disposable barrier pad placed on top of the bedside table and the wound care supplies were on the barrier pad. The Wound Care Nurse told Resident #39 she was going to change the wound dressing and asked if the resident had any pain. The Wound Care Nurse pulled the privacy curtain around the resident's bed and washed her hands in the resident's restroom. The Wound Care Nurse cleaned the wound with saline and dropped the gauze into a bag. The Wound Care Nurse removed her gloves and did not use hand sanitizer before putting on clean gloves. She used a q tip to remove the Santyl ointment from a small plastic container and applied it to the wound bed. She applied the silver alginate to the wound bed and covered it with a bandage. The Wound Care Nurse tied up the bag of trash, cleaned the table, and washer her hands in the resident's restroom. She stated she should have used hand sanitizer when she changed her gloves. She stated she had a bottle of hand sanitizer in her treatment cart but forgot to take it into the room with her. She stated it was important to use hand sanitizer after removing soiled gloves to prevent the spread of infection. During an interview on 05/05/2025 at 1:50 PM, the DON stated the Wound Care Nurse should have sanitized her hands between glove changes. She stated it was important to avoid transmission of any type of bacteria or infectious disease. 2. Record review of Resident #50's Face Sheet, dated 05/06/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included hypertension (high blood pressure), hyperlipidemia (high cholesterol), and cerebral infarction (interruption of blood flow to the brain). Record review of Resident #50's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 02/01/2025, reflected moderately impaired cognition with a BIMS (screening tool used to assess cognitive status) score of 10. Section G (functional status) indicated Resident #50 required extensive assistance with acts of daily living. Section I (active diagnoses) indicated Resident #50 was treated for pneumonia (lung infection). Record review of Resident #50's Comprehensive Care Plan, dated 02/17/2025, reflected the resident was incontinent of bladder related to physical and mental decline. One intervention was to monitor for signs and symptoms of a urinary tract infection which included an elevated temperature, difficulty urinating, and blood in the urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/05/2025 at 8:40 AM, CNA I and CNA K provided incontinence care for Resident #50. Incontinence care items were on a bedside table in Resident #50's room. The bedside table was brought into the room and did not belong to Resident #50. A towel was draped over the top of the bedside table and incontinence care supplies were on the towel. Resident #50's curtain was pulled around her bed for privacy. CNA I and CNA K washed their hands in the resident's restroom. CNA I pulled down the front of the brief and cleaned the resident using a single wipe for each pass. CNA I removed her gloves and used hand sanitizer before putting on clean gloves. CNA K assisted CNA I to turn Resident #50 to her left side. CNA I removed her gloves and used hand sanitizer before putting on clean gloves. CNA I wiped Resident #50's bottom using a single wipe for each pass. CNA I removed her gloves and used hand sanitizer before putting on clean gloves. CNA I placed a clean brief under Resident #50 and secured the tabs on the brief. CNA I removed her gloves and used hand sanitizer before putting on clean gloves. CNA K assisted CNA I to pull up the resident's pants. CNA I bagged the soiled items. CNA I and CNA K removed their gloves and washed their hands in the resident's restroom. CNA I took the bagged items across the hall to dispose of them. CNA K took the bedside table into the hall and placed it against the wall outside of Resident #50's room. The bedside table had the towel draped over the top and an unused towel on it. When asked about it, CNA K stated she should not have brought the bedside table into the hall with supplies on it. She stated she should have bagged the linens on the bedside table before bringing the bedside table into the hall. She stated after taking the linens into the resident's room, they were contaminated. CNA I agreed the linens should have been bagged in Resident #50's room and not brought into the hall on the bedside table. She stated it was important to avoid bringing contaminated items out of a resident's room to prevent the spread of infection. During an interview on 05/05/25 at 10:15 AM, ADON J stated the towels should have been removed from the bedside table and bagged for laundering. She stated they should not have been brought into the hall on the bedside table. She stated it was important to prevent cross-contamination. During an interview on 05/05/2025 at 11:21 AM, RN L stated the towels should have been bagged in the resident's room. RN L stated regardless of if they were used or not, they must be bagged and taken to the soiled linen room. She stated it was important to prevent contamination and the spread of infection to staff and to other residents. She stated she would follow up with the CNAs. During an interview on 05/05/25 at 1:50 PM, the DON stated her expectation was for staff to contain all soiled items before leaving a resident's room. She stated the towels were contaminated, after taking them into the resident's room, and should have been bagged before removing them. The DON stated it was important to avoid transmission of any type of bacteria. She stated staff would be in-serviced. 3. Review of Resident #219's Face Sheet, dated 05/05/2025, reflected the resident was a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with cystitis (inflammation of the urinary bladder) with hematuria (blood in the urine). Review of Resident #219's Comprehensive MDS Assessment, dated 04/11/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 09 (resident may need additional support and monitoring). The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676466	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #219's Comprehensive Care Plan, dated 04/14/2025, reflected the resident had bladder and bowel incontinence and one of the interventions was perennial care after each incontinent episode. The Comprehensive Care Plan indicated that the resident also had a skin breakdown to right buttocks. Observation on 05/05/2025 at 9:19 AM revealed CNA B went inside Resident #219's room to answer a call light. Once inside the room, he asked the resident what she needed. A family member, who was inside the room, said the resident needed to be changed. CNA B told the family member that he would go ahead and change the resident. He put on a pair of gloves and proceeded with incontinent care. He did not wash his hands before doing incontinent care. Before doing the process, he took the trash can from the other side of the bed and put it beside him. He then changed his gloves but did not sanitize his hands before putting on a new pair of gloves. He unfastened the brief on both sides and pushed it between the legs. He then pulled some wipes and cleaned the resident's perineal area (area between the thighs) using the front to back technique. He did it four times. After cleaning the perineal area, he instructed and assisted the resident to roll towards the left side, and cleaned the resident's bottom. After cleaning the resident's bottom, he pulled the soiled brief and threw it on the trash can. After throwing the soiled brief, he took the brief from the resident's side table, placed it beneath the resident, and fixed it. He instructed the resident to roll to the other side so he could fix the other half of the brief. After fixing the brief, CNA B rolled back the resident and fastened the brief on both sides. He did not change his gloves after cleaning the resident's bottom and before touching the new brief. After he was done with incontinent care, he gathered his trash and left the room to throw his trash on the utility room. He did not wash his hands after performing incontinent care. A sign outside the room indicated that the resident was on enhanced barrier precaution. CNA B did not wear a gown while providing incontinent care. In an interview and observation on 05/05/2025 at 9:26 AM, CNA B stated hand hygiene was important to prevent cross contamination and development of infection. He said he was not able to wash his hands before and after doing Resident #219's incontinent care. He said during the process, he should had sanitized his hands after he changed his gloves and should had changed his gloves after cleaning the resident's bottom. He said his actions could cause transfer of germs and possible infection. He said he would be mindful the next time he would perform incontinent care. CNA B then saw the sign outside the resident's room and realized that the resident was on enhanced barrier precaution. He said he did not notice the sign and he was used to of having the PPE cart outside the room of the resident if they were on enhanced barrier precaution. CNA B then saw the gown inside the resident's room near the resident's restroom. He said, next time, he would check if the resident was on enhanced barrier precaution before entering the resident's room. In an interview on 05/05/2025 at 12:19 PM, ADON A stated staff must wash their hands before and after incontinent care. She said staff should be mindful that when they touched something dirty, they should change their gloves before touching something clean. She also said that before putting on a new pair of gloves, staff must wash their hands or sanitize their hands depending how soiled the resident was. She said if the resident had a sign outside the door that said enhanced barrier precautions, staff must wear a gown to prevent the spread of any unwanted microorganism. She said she would coordinate with the DON to do an in-service pertaining to hand hygiene, infection control, and enhanced barrier precaution. (continued on next page)

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	676466	A. Building B. Wing	05/06/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/05/2025 at 2:20 PM, the DON stated hand hygiene was the most efficient way to avoid cross contamination and development of infection. She said staff should do hand hygiene before and after any care, should sanitize their hands when changing gloves, and change their gloves after touching anything soiled. All of these should be done to make sure that microorganisms would not transfer to the clean items. She also said that if a resident was on enhanced barrier precaution, the staff should wear a gown when caring for them. She said Resident #219 had a wound at the bottom, which was why she was on enhanced barrier protection. She said she was responsible in overseeing that the staff were following the policies and procedure for infection control. She said the expectation was for the staff to follow the protocols for infection control and hand hygiene. She said she would personally monitor the staff's adherence to the policy and procedure of infection control, enhanced barrier protection, and hand washing. In an interview on 05/06/2025 at 8:52 AM, the Administrator stated that staff must be mindful in preventing spread of germs and development of infection. He said he was not a clinician and would let the DON take the lead in educating the staff about infection control, hand washing, and enhanced barrier precaution. Record review of the facility's Incontinent Care Procedure and Proficiency Evaluation undated, revealed Perineal Care . 7. Perform hand hygiene, don gloves . 11. Remove soiled pad and clothing and place in plastic bag . 12. Remove gloves and discard .13. Preform hand hygiene, don gloves . 14. Place clean pad under resident . 22. Dispose of soiled linens, trash appropriately . 22. Preform hand hygiene. Record review of the facility's policy Hand Washing undated, revealed Policy: Hand washing is required before and after a procedure that involves direct or indirect contact with a resident. Record review of the facility's policy Enhanced Barrier Precautions (EBP) revealed EBP are indicated for residents with: . Wounds . even if resident is not known to be infected. Review of the facility's policy Linens reflected Soiled linen and clothing will be transported in accordance with procedures consistent with universal precautions. Bags or containers will not be reused to transport or store clean items. The staff should handle all used laundry as potentially contaminated. Review of the facility's policy Infection Control Program reflected All employees are required to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.