STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145453	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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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 - Some	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 a medication cart was locked when it was left unattended. This failure applies to residents with medications in the 500 hallway medication cart. The findings include:The facility provided list of residents whose medications were stored in the 500 hall cart showed 15 residents medications were contained in the cart. On 4/15/26 8:10 AM, the 500 hallway medication cart was near two doors in the 500 hall. The lock for the cart was extended outwards indicating the cart was not locked. The drawers were opened, and medications were in the cart. There were no staff monitoring the cart. The 500 hall nurse, V6 (Registered Nurse), then exited a resident's room. The medication cart was not visible from that resident's room. V6 then locked the cart. On 4/16/26 at 10:22 AM, V2 (Director of Nursing) stated medication carts should be locked when staff leave the cart unattended. V2 stated this is to protect medications and protect residents. The facility's Medication Storage (dated 9/2020) policy does not state medication carts need to be locked.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow a Physician order to apply compression wraps for R94 and failed to document a change in a resident's condition when sent to the emergency room for R150. This applies to two of two residents (R94, R150) reviewed for quality of care in the sample of 49.The findings include:1. On 4/14/26 at 10:30 AM, V9, (R94's wife), was observed telling the nurse that her husband's compression hose had not been applied and the staff needed to do better. R94 was observed in bed without any compression wraps to his legs. Both of R94's lower legs were observed to be swollen. V9 said her husband's legs are to be wrapped every morning and this was not being completed for him daily as ordered. The facility face sheet for R94 shows he was admitted to the facility with diagnoses to include congestive heart failure and lymphedema. The facility assessment dated [DATE] shows R94 to have severe cognitive impairment and was dependent on staff for his care. A Physician Order dated 4/4/26 shows that ace wraps (compression wraps) are to be applied daily in the morning and removed at bedtime. On 4/16/26 at 8:41 AM, V6 RN (Registered Nurse-RN) said the night shift nurses are to apply the compression wraps at 6 AM every morning. On 4/16/26 at 9:49 AM, V2 Director of Nursing said the Physician Orders for each resident are to be followed by the nursing staff. The Treatment Record for R94 for April 2026 shows compression wraps are to be applied at 6 AM and removed at bedtime. No documentation of the wraps being applied on 4/14/26 was observed on the treatment record for R94. The care plan dated 1/16/26 for R94's edema does not show any interventions for the use of compression wraps. The facility policy dated 3/2024 for hose application shows the purpose of the hose is to provide firm support, reduce pain, apply pressure and to reduce swelling. 2. R150's admission record documents he was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's Disease, Dementia and Chronic Obstructive Pulmonary Disease COPD. R150's nursing progress notes show on 12/10/25 he had congestion. His assessment shows he was afebrile and had no pain. The notes documented he was put on an antibiotic and had an Xray. The notes for 12/11/25 and 12/12/25 show monitoring of symptoms while on the antibiotic. On 12/13/25 at 11:13 PM, the notes show he was taken to the hospital by way of ambulance. He was transported and admitted to the hospital for pneumonia. The notes do not indicate any change of condition, reason for the transfer, notifications of the physician or power of attorney. The progress notes show he did not return until 12/17/25. On 4/16/26 at 10:58 AM, V2 (Director of Nursing) said there should be a nursing note of what happened. V2 would have to check for any documentation. V2 said she would have to check the policy to know what should be included in the progress note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/26, no further documentation was provided. On 4/16/26 at 9:48 AM, V16 (RN) said when a resident has a complaint and need to be sent out, there should be a progress note so everyone knows what change of condition occurred. The note should include the notification of physician, power of attorney and calling the hospital and giving the report. When a resident is sent out the DON and administrator are also notified, and all that information goes into the notes. The facility's 9/2020 policy for change of condition states the purpose is to ensure the resident's physician/physician on call/ Nurse Practitioner and responsible party is kept informed regarding the resident's change of condition. See change in conditions and signs and symptoms from AMDA clinical practice guidelines/interact 4.0. Report on why vital signs were taken, diagnostic procedures and symptoms.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review the facility failed to provide assistance with appointments for vision care in a timely manner for 1 of 2 residents (R88) reviewed for resident rights in the sample of 49.The findings include:On 4/14/2026 at 10:37 AM, R88 was sitting in a wheelchair in his room and stated he needed an appointment for his cataract in his right eye. R88 stated he couldn't see out of it and now his left eye is almost gone. R88 stated soon he would be blind. R88 stated he has needed the appointment for his cataracts for months. R88 stated they said they were waiting for a referral. R88 stated he wanted to know what was going on.On 4/15/2026 at 2:31 PM, V18 (Social Services) stated appointments are made by the nurses and transportation is arranged by the receptionist. V18 stated R88 mentioned to her a concern about his eyes and she told the (Assistant Director of Nurses-ADON).On 4/15/2026 at 2:44 PM, V15 (ADON) stated it was brought to her attention a little over a week ago that R88 needed an appointment for his cataracts with ophthalmology. V15 stated she was in contact with the nurse practitioner (NP) about the referral and had to call the NP again because one place she had contacted for R88 stated they never received the referral. V15 stated the floor nurses are to make all the appointments, and she helps when she can. V15 stated she did not know anything about this concern for R88 before when she found out a little over a week ago. V15 stated she has called two places for R88.On 4/16/26 at 11:41 AM, V10 (R88's daughter) stated R88 has been at the facility since November 2025 and when he went to the facility, they were told he needed cataract surgery. V10 stated she asked them if that was something that the facility could help with and they said they could. V10 stated nothing was done. V10 stated she has called social services a couple of times and left messages and no one has returned her calls. V10 stated she has talked to the nurse, told her R88 has cataracts and needs surgery. R88 needs to see a specialist. V10 stated she called in January 2026 and then in February 2026 she called and asked the nurse to make a note of it in his chart because it shouldn't take this long. It took a while before R88 saw an eye doctor; in March 2026 he was seen and was told he needs a referral for cataract surgery. V10 stated she hadn't heard anything about it. V10 stated R88 can't see, and it is very frustrating; he is grumpy and upset over it.The Nurses Note dated 2/6/26 at 7:01 PM for R88 showed the resident was to be placed on optometrist list and daughter be called when optometrist is seeing resident.The Optometrist Note dated 3/5/26 for R88 showed he has glasses that he does not wear, they make no difference. He had an exam two months ago, was referred to for cataract consult but never went. No history from staff.The Face Sheet dated 4/16/26 for R88 showed diagnoses including type 2 diabetes mellitus, venous insufficiency, chronic obstructive pulmonary disease, obstructive sleep apnea, atrial fibrillation, congestive heart failure, hypertensive heart disease, muscle weakness, polyosteoarthritis, weakness, lymphedema, benign prostatic hyperplasia, and localized edema.The facility's Vision policy (9/2020) showed, Policy: Ensure that residents receive proper treatment and assistive devices to maintain vision. Procedures: 1. Assist resident in making appointment; 2. Assist resident in arranging transportation to and from the office of a practitioner specializing in the treatment of vision or hearing.The facility's Residents' Rights for People in Long-term Care Facilities policy from the Illinois Long Term Care Ombudsman Program showed, your facility must provide services to keep your physical and mental health, and sense of satisfaction.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to trim the toenails of a resident. This applies to one of one resident (R33) in the sample of 49 reviewed for nail care.The findings include:The facility face sheet for R33 shows he was admitted to the facility with a diagnosis to include peripheral vascular disease and mild cognitive impairment. The facility assessment dated [DATE] shows R33 to have mild cognitive impairment and requires partial assistance with putting on footwear.On 4/14/26 at 10:15 AM, R33 said, My toenails are so long they have put holes in my slippers. R33 was wearing slippers, and a hole was observed above the great toe on both of his slippers. R33 removed his slippers, and his toes nails were observed to be long, thick and discolored. On 4/15/26 at 2:57 PM, V5 (Memory Care Director) said any staff can add a resident to the podiatry list if there is a concern about a resident's toenails.On 4/16/26 at 9:39 AM, V7 (Certified Nursing Assistant-CNA) said resident toenails are observed everyday while helping the resident get dressed. V7 said if the resident's nails are observed getting long, it should be reported to the nurse. On 4/16/26 at 12:01 PM, V17 (Podiatrist) said he sees R33 every 3-4 months to avoid complications. V17 said if R33's nails were long enough to cut through his slippers; he should have been notified of it to prevent problems.The podiatry notes for R33 show he was seen last on 11/19/25 for a nail trimming and the recommended follow-up was in 2-3 months (5 months ago).The facility policy dated 9/2020 for care of nails shows all residents will have clean, well-trimmed nails.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to ensure a resident with a history of falls had new interventions in place for 1 of 6 residents (R1) reviewed for falls in the sample of 49. The findings include:R1's face sheet printed on 4/16/26 showed diagnoses including but not limited to chronic kidney disease, spinal stenosis, polyneuropathy, bipolar disorder, and artificial knee joint. R1's facility assessment dated [DATE] showed no cognitive impairment. The same assessment showed partial/moderate staff assistance with transfers. The assessment showed substantial/maximal assistance for dressing and toilet hygiene. R1's fall risk assessment dated [DATE] showed at risk for falls. On 4/15/26 at 11:20 AM, R1 was seated in a wheelchair alone in his room. R1 said, I have a lot of medical issues and need help from the staff. I fell a couple of times since I got here. I have no patience to wait for the aides to come help me. I would wet my pants if I waited for one of them to finally show up. I just do it by myself. I can get in and out of bed alone. I fell getting out of bed alone once too. The facility provided fall log showed R1 experienced two falls since the admission date of 1/14/26. The first fall was on 2/19/26 and the second fall was on 4/11/26 (four days ago). R1's progress note dated 4/11/26 stated: This writer visually observed resident on the floor, on upright position right next his bed and wheelchair. Stated he went to washroom and went to bedside table fixing something on the phone cord then his left knee gave up. Denies hitting his head. Stated ?I fell on my butt'. R1's progress note dated 2/19/26 stated: .CNA [Certified Nursing Assistant] was coming out of another resident room, resident call light was answered and observed sitting on the floor next to bed by CNA reported to writer, resident noted sitting upright next to bed facing tv, legs extended forward even denies hitting head no redness no swelling noted no open area. Resident stated I was trying to go to bed by myself and slid down. On 4/15/26 at 2:16 PM, V3 (Restorative Nurse) stated all residents are considered a fall risk. Fall assessments are done at admission, quarterly, annually, and after each fall. V3 said, The assessments show us their abilities and help us decide where their activities of daily living levels are at. If a resident does fall, it is a team approach to decide what interventions need to be started. New interventions are important after each fall because it helps stop more falls. If a resident is having repeat falls it is clear the current interventions are not working as well as they should. Updated interventions should be started shortly after a fall. An initial intervention is started by the nurse and then updated after the team reviews why the falls are continuing. V3 said R1 does like to do things by himself and often tries to do things alone. V3 said, He has weaknesses and is at risk for more falls. There was a new intervention started back in February to encourage him to use the call light for staff assistance. But there is not anything started after the recent fall in April. A new one should have started after that fall and I don't see anything in his care plan. (R1) wheels all over the building so more frequent checks would be helpful. He should be encouraged to go to activities and ensure items are close to reach for him. He wants to be independent. There are a lot more interventions that could be trialed on him to stop him from getting up alone. R1's care plan showed a focus area related to risk of falls due to diagnoses of chronic obstructive pulmonary disease. The most recent intervention to encourage resident to use call light for staff assistance was dated 2/20/26. The care plan had no interventions following the fall on 4/11/26 in his room. The facility's Management of Falls policy dated 8/2020 states: 9. Review and/or modify the resident's plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to keep catheter tubing off the floor, the drainage bag below the level of the bladder and the drainage bag covered for 2 of 5 residents (R127 & R171) reviewed for catheters in the sample of 49.The findings include: 1. On 4/14/26 at 10:58 AM, R127 was sitting in his wheelchair in dining room at table with clothing protector on. R127's catheter tubing was on floor with cloudy yellow urine in the tubing. On 4/14/26 at 1:15 PM, R127 was sitting in his wheelchair in his room. The catheter tubing was on the floor under his chair. V12 (Certified Nursing Assistant-CNA) and V13 (CNA) had gown and gloves on and turned R127's chair around with his catheter tubing dragging under his chair. V13 took the catheter bag from the dignity bag and handed it through to V12 who put in dignity bag on lower side of bed. V12 applied the gait belt around R127 and V12 and V13 did a two person stand-pivot transfer to his bed. They turned R127 from side to side in bed to remove the gait belt. V13 removed his shoes. They turned R127 from side to side to remove his pants. V12 lifted the catheter drainage bag above the level of R127's bladder to remove the drainage bag from the resident's pant leg. V12 stated the catheter tubing should not be on the floor because there is a risk for infection. The drainage bag cannot be above the bladder because urine can flow back, be retained, and cause an infection. The Care Plan dated 2/23/26 for R127 showed he requires the use of an indwelling catheter due to diagnosis of obstructive and reflux uropathy. Position collection bag below the level of the bladder. Provide catheter care. The Minimum Data Set (MDS) dated [DATE] showed he is dependent for activities of daily living. The Face Sheet dated 4/16/26 for R127 showed diagnoses including congestive heart failure, atrial fibrillation, cerebral palsy, dysphagia, obstructive and reflux uropathy, hypertensive heart disease with heart failure, benign prostatic hyperplasia, orthostatic hypotension, retention of urine, cardiomyopathy, acute on chronic respiratory failure, anemia, ileus, gastrointestinal hemorrhage, supraventricular tachycardia, dysarthria and anarthria. The facility's Indwelling Catheter policy (9/2020) showed place drainage bag below the level of the resident's bladder to facilitate drainage and minimize stasis of urine. 2. R171's face sheet printed on 4/16/26 showed diagnoses including but not limited to chronic kidney disease, acute kidney failure, and congestive heart failure. R171's April 2026 showed an order for an indwelling urinary catheter due to status post stent removal. On 4/14/26 at 11:00 AM, R171 was lying in bed, and his catheter bag was hanging from the bed railing. The bag was visible from the doorway, and it was half full of yellow urine. A wheelchair was across the room with a blue dignity bag hanging underneath it. R171 stated he got the catheter at a recent hospital stay and wants it out as soon as possible. R171 said he does not like it hanging from him. At 11:30 AM, the urinary drainage bag was still visible from the doorway. At 12:31 PM, the bag was in the same position. On 4/16/26 at 9:44 AM, V2 (Director of Nurses) stated catheter bags should be in a dignity bag for (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	privacy. They cover the drainage bag, so others do not see the urine bag and what is in it. It should be used anytime the bag is visible to others. V2 said staff should put the urine bag inside the dignity bag whenever care is not being done. R171's care plan showed a focus area related to the use of an indwelling catheter. Interventions included: Keep drainage bag covered to promote privacy. Date Initiated: 04/13/2026.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to stop an infusion of tube feeding when it was leaking at the insertion site for 1 of 3 residents (R36) reviewed for tube feeding in the sample of 49.The findings include:On 4/15/2026 at 11:20 AM, R36 was sitting up in his chair with tube feeding infusing at 55 milliliters (ml) per hour. The front of his shirt was wet in the lower middle of his abdomen. R36 stated his feeding tube was no good and it was not working. R36 stated he had a new feeding tube put in yesterday. At 11:23 AM, V14 (Licensed Practical Nurse-LPN) stated she thinks there was something wrong with the tube feeding site and he needed his dressing and shirt changed. V14 then walked away stating she needed to talk to her (Director of Nursing-DON). At 11:29 AM, V14 came back onto the floor and stated the DON placed a call to the doctor and was waiting for the gastroenterologist to call back. V14 stated the tube feeding wasn't leaking from the tube but from the sight. V14 stated the tube feeding was still infusing at 50 ml per hour and he has water that also infuses at 45 ml per hour. At 11:33 AM V4 (Wound Care Nurse) was at R36's bedside and told the resident he was going to change the dressing around his feeding tube. V4 lifted R36's shirt and the dressing around the feeding tube was saturated. When the dressing was removed there was a milky white substance coming from the gastrostomy site.On 4/15/26 at 2:44 PM, V15 (Assistant Director of Nursing-ADON) stated if tube feeding is leaking the infusion should not be infusing. V15 stated they need to figure out why it is leaking; there is a risk for complications. V15 stated she would stop the infusion right away and notify the physician.The Care Plan dated 4/5/26 for R36 showed he requires nutritional support. R36 is on the following diet: NPO (Nothing by Mouth), NPO texture, NPO consistency. Check for placement and patency of feeding tube prior to administering meds, feedings and flushes. Assess and document on stoma site weekly and as needed. The Face Sheet dated 4/16/26 for R36 showed diagnoses including cerebral palsy, chronic respiratory failure, spastic hemiplegia, dysphagia, severe protein calorie malnutrition, atherosclerotic heart disease, hypertensive heart disease, anemia, cachexia, abdominal pain, vascular disorder, myocardial infarction, iron deficiency, obstructive and reflux uropathy, and disorders of bone density. The April 2026 Physician Orders for R36 showed tube feeding at 50 ml/hour to infuse 1000 ml day. Water flush to infuse through feeding pump at 45 ml/hour for a total of 900 ml/day while tube feeding is infusing. The Enteral Nutritional Feeding policy (9/2020) showed complications related to a feeding tube included leaking around the insertion site, erosion at the insertion site, stomach or intestine perforation, inflammation, ulceration, strictures, fistulas of the esophagus and trachea. The policy did not state what to do if there was a complication.

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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 administer insulin in accordance with manufacturer's instructions. This applies to 1 of 1 residents (R125) reviewed for insulin administration in the sample of 49. The findings include:R125's Face Sheet showed a diagnosis of diabetes type 2. R125's April 2026 Medication Administration Record showed a current order, as of 4/15/26, for rapid-acting insulin to be given at a dosage which is dependent upon R125's blood sugar value (sliding scale insulin). This sliding scale insulin is done before each meal. On 4/15/26 at 11:55 AM, V11 (Registered Nurse-RN) began preparing R125's sliding scale insulin. V11 removed R125's prefilled multi-dose insulin pen from the medication cart. V11 wiped the tip of the pen with an alcohol wipe, threaded on a new needle, dialed the pen to two units, held the pen horizontally, and punched the dose knob (plunger) with the palm of her hand then immediately released the plunger. R125's pen did have a small bubble within the insulin which remained in the pen following the priming procedure. V11 did not remove the needle cap to verify a drop of insulin. V11 then dialed R125's 2 units of insulin to be administered and entered R125's room. V11 wiped the back of R125's right arm with alcohol, inserted the needle into R125's arm, depressed the dose knob, immediately released the knob, and then continued to hold the pen against R125's skin for seven seconds. V11 did affirm that she depressed the plunger, released the plunger, then held the needle against R125's skin. At 4/16/26 at 10:22 AM, V2 (Director of Nursing-DON), stated the facility follows manufacturers instruction regarding the proper use of insulin pens. V2 stated, in general, the nursing staff should hold the insulin pen vertically during the priming process to remove any possible bubbles within the insulin. V2 stated, if the manufacturer's instructions state the plunger must be held during the priming process, she would expect her staff to follow that procedure. V2 stated the purpose of following the priming procedure is to ensure the resident receives their full dose of insulin. V2 stated when administering insulin to a resident via an insulin pen, most manufacturers recommend holding the plunger while the needle is inserted for the prescribed amount of time. V2 stated this is to ensure the resident receives the full dose of insulin. The manufacturer's instructions for R125's rapid-acting insulin (Revised July 2023) showed that during the priming process 2 units should be selected, the insulin pen should be held vertically, the pen should be tapped gently to collect air bubbles at the top (the end of the pen opposite the plunger), the needle cap removed, then the dose knob pressed and held for a 5 second count. The instructions show if a drop of insulin is not expressed the priming process should be repeated. The instruction showed that during the insulin administration process, after the needle is inserted in the skin, Push the dose know all the way in. continue to hold the dose knob in and slowly count to 5 before removing the needle.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145453	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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 ensure gloves were changed when going from a dirty to a clean area to prevent cross contamination for 2 of 6 residents (R49 & R127) reviewed for infection control in the sample of 49.The findings include:1. On 4/14/26 at 1:02 PM, V12 (Certified Nursing Assistant-CNA) and V13 (CNA) were at R49's bedside to provide incontinence care. V12 and V13 had gloves on. V12 was incontinent of urine and a small amount of bowel movement. V12 unfastened R49's incontinence brief and pulled the front down. V12 took disposable wipes and cleaned one side of his groin, discarded the wipe and did the same procedure to the other side of his groin. V12 took a wipe and cleaned under his penis and scrotum area. V12 had bowel movement under the scrotum towards his anus that she wiped off and discarded the wipe. V12 did not change her gloves. V12 tucked the mechanical lift sling under the resident and placed a clean incontinence brief under him. V12 assisted R49 resident to turn to his side and pulled the resident towards her as V13 pushed him onto his side and finished removing the sling. R49 was placed on his back, and they both fastened the brief closed. V12 tied up the trash, removed her gloves and used hand sanitizer.On 4/14/26 at 1:24 PM V12 (CNA) stated gloves are changed anytime they go from dirty to clean, after peri-care, when they come into a room, when they leave a room. done for infection control.On 4/15/26 at 2:44 PM, V15 (Assistant Director of Nursing) stated gloves are to be changed if they are soiled. V15 stated that when they go from dirty to clean, they should remove gloves, use hand sanitizer, and put on a fresh pair of gloves.The Face Sheet dated 4/16/26 for R49 showed diagnoses including hemiplegia and hemiparesis, metabolic encephalopathy, type 2 diabetes mellitus, atherosclerotic heart disease, hypertensive heart disease, hyperlipidemia, obesity, dysarthria following cerebral infarction, dysphagia, major depressive disorder, suicidal ideation, weakness, legal blindness and anxiety disorder. The Minimum Data Set (MDS) dated Care Plan dated 3/8/26 for R49 showed dependence for toileting hygiene and personal hygiene, frequently incontinent of bowel and bladder. The facility's Glove Use policy (4/2024) showed gloves will be used to prevent the spread of infection and disease to other residents, personnel, and visitors. Gloves will be used when anticipating touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin. The Incontinence Care Policy was not received.2. On 4/14/26 at 1:24 PM, R127 was transferred to bed by V12 (CNA) and V13 (CNA). R127 had an indwelling urinary catheter and an incontinence brief in place. R127 was incontinent of stool. V13 took a disposable wipe and cleaned one side of his groin and discarded the wipe. V13 did the same thing to the other side of his groin and there was bowel movement present. V13 took a disposable wipe and cleaned under his penis and scrotum and discarded the wipe. V13 did not change her gloves. V12 and V13 turned R127 onto his side. V13 cleaned bowel movement from his buttocks and anus and discarded the wipes. V13 rolled up the incontinence brief and discarded it. V13 grabbed the clean incontinence brief and put it under the resident. V12 and V13 placed R127 his back, pulled the clean brief through and fastened it closed. They removed their gloves. V12 stated gloves are changed anytime they go from dirty to clean, after peri-care, when they come into a room, and when they leave a room. V12 stated it is done for infection control.The Care Plan dated 2/23/26 For R127 showed R127 has an activity of daily living self-care performance deficit due to cerebral palsy, dysphagia, history of falls, acidosis, hypertension, obstructive and reflux uropathy. Assist with activities of daily living as needed. Provide needed level of assistance and support to complete activities of daily living. R127 is incontinent of bowel. The Face Sheet dated 4/16/26 for R127 showed diagnoses including congestive heart failure, atrial fibrillation., cerebral palsy, dysphagia, obstructive and reflux uropathy, hypertensive heart disease with heart failure, benign prostatic hyperplasia, orthostatic hypotension, retention of urine, cardiomyopathy, acute on chronic respiratory failure, anemia, ileus, gastrointestinal hemorrhage, supraventricular tachycardia, dysarthria and anarthria. The Minimum Data Set (MDS) dated [DATE] for R127 showed he is dependent for activities of daily living.