STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235139	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avista Nursing and Rehabilitation	2901 Galaxy Drive Saginaw, MI 48601

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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 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** The facility failed to provide adequate supervision, and develop, enact and evaluate interventions for repeated wandering into other residents' rooms for one resident (Resident #43). Findings include: Resident #43: A record review of the Face sheet and Minimum Data Set/MDS indicated Resident #43 was admitted to the facility on [DATE] with diagnoses: History of a stroke, history of a myocardial infarction (heart attack), weakness right lower leg, diabetes, liver disease, history of liver transplant, lung disease, dementia, depression, anxiety, chronic kidney disease, and gout. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss with a Brief Interview for Mental Status/BIMS score of 8/15, and the resident needed some assistance with care. On 6/22/2026 at 1:55 PM, Resident #43 was observed lying in another resident's bed (Resident #7) in the wrong room (across the hall from Resident #43's room). Resident #7 was very upset when he found Resident #43 lying in his bed. He told Resident #43 to get out of his bed and Resident #43 began to reach for Resident #7's cane that was leaning against the end of the bed. Resident #7 began swinging a reacher stick at Resident #43 and yelled Don't touch my cane!. A nurse aide was in the room during the incident and separated the two residents and assisted Resident #43 back across the hall to his room. The Nurse Aide told Resident #7, He can't help it Resident #43 didn't say anything and walked with the Nurse Aide back to his room. On 6/23/2026 10:47 AM, Resident #7 was observed sitting in a wheelchair in his room, when asked how he was doing that day, he said Ok now. Resident #7 said the resident across the hall (Resident #43) was in his room again the prior evening and Resident #7 was upset about it.On 6/24/2026 at 4:45 PM, Certified Nursing Assistant/CNA H was observed in the hallway near Resident #43's room. When asked about the resident, she said that he wandered in the hallway. CNA H said Resident #43 would usually sleep from early afternoon until about 5:30 PM every day. She said he would get up and start walking up and down the hall; sometimes he would ask to use the phone. The CNA was asked if she had seen him sleep in other resident's beds and she said she had seen him go into other residents' rooms. A record review of the electronic medical record for Resident #43 identified a Nursing Assessment Admission date 5/28/2026 and lock date 5/29/2026. Section P. Elopement Risk was marked Yes for Dementia and the other questions were marked No. The MDS assessment dated [DATE] Section E, question 0900 Wandering- Presence & Frequency was checked for 2. Behavior of this type occurred 4 to 6 days. A record review of the Care Plans for Resident #43 on 6/24/2026 indicated there was no mention of Resident #43 wandering into other resident's room and lying down in their beds. A record review of the progress notes for Resident #43 revealed there was no note related to the resident wandering, entering other residents' rooms or lying down in their beds. A review of a Psychosocial Evaluation dated 6/3/2026 provided, . Hospital records indicate that he has a previous diagnosis of Dementia and struck his son with his cane and was agitated and aggressive leading to his admission to the hospital.A record review of the Kardex for Resident #43, reviewed on 6/24/2026, did not mention the resident was wandering into other residents' rooms. The Safety section did not mention the resident wandering or that he could be aggressive.On 6/25/2026 at 12:35 PM, the Unit Manager EE was interviewed about the incident between Resident #7 and the (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident across the hall Resident #43. She said she had not been notified of the incident and did not know Resident #43 was wandering into other residents rooms and sleeping in their beds. She said she should have been notified of the incident; and a care plan should have been initiated. During the interview with Unit Manager EE on 6/25/2026 at 12:40 PM, she was asked how staff would be notified if a Resident had a history of wandering. She said there was an Elopement book at the front desk and Resident #43 should be listed in the book. A review of the Elopement book at the front desk revealed Resident #43 was not included.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to 1) Ensure that hand hygiene was practiced between residents while serving food in the dining room, 2) Ensure the sanitary handling of clean food plates during transporting from the kitchen to the dining room, 3) Ensure urinary catheters for 2 residents (Resident #2 and Resident #3) were not on the floor, 4) Ensure that the multi-use shower bed was cleaned and sanitized between residents' use, 5) Ensure that contact precautions were followed for 1 resident (Resident #94), 6) Ensure that a barrier was used and sanitation was done with use of a Glucometer for one resident (Resident #50), and 7) Ensure that appropriate Personal Protective Equipment (PPE) was worn during care for 1 resident (Resident #2) of 32 residents reviewed for infection control practices. Findings Include: Resident #3: On 6/22/26 at 11:55 AM, a Contact Precaution Isolation Sign was present on the outside of Resident #3's room door. The Resident was not present in their room. On 6/22/26 at 12:44 PM, Resident #3 was observed in the dining room. The Resident was sitting in a wheelchair in close (touching) proximity to two other residents. On 6/22/26 at 1:36 PM, Resident #3 was observed in their room, lying in bed. An indwelling urinary catheter drainage bag was on the side of the bed. An interview was completed at this time. When queried regarding the reason they were admitted to the facility, Resident #3 replied, UTI (Urinary Tract Infection) and kidneys. Resident #3 was asked how long the indwelling urinary catheter had been in place and replied, Over two months. When queried if they still had a UTI and if they were receiving treatment, Resident #3 replied, Getting pills for UTI but I told them it don't work. Record review revealed Resident #3 was most recently admitted on [DATE] with diagnoses which included diabetes mellites, chronic respiratory failure, bipolar disorder, anxiety, chronic kidney disease (CKD), Bardet-Biedl syndrome (BBS- rare genetic disorder characterized by obesity, kidney abnormalities, and vision loss), and urinary retention. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate assistance with toileting and bathing. The MDS further detailed the Resident had an indwelling urinary catheter and was receiving an antibiotic. Review of Resident #3's Electronic Medical Record (EMR) revealed a urine culture and sensitivity (C & S) report dated as collected on 6/17/26 with the final culture results dated 6/20/26. The (C&S) was dated as printed on 6/22/26 with handwritten documentation indicating the results were reviewed by facility staff on 6/22/26. The urine culture C &S revealed the Resident had ESBL (Extended-Spectrum Beta-Lactamase- antibiotic resistant) Escherichia coli (bacteria normally found in the intestines) and was a Multi-Drug Resistant Organism (MDRO). Review of Resident #3's EMR revealed the care plan, I have an active infection I am receiving prophylactic ABX (antibiotic) r/t (related to) frequent UTIs. I have an active UTI. (Initiated: 5/21/26; Revised: 6/25/26). The care plan included the intervention, Contact Precautions (Initiated: 6/21/26). On 6/23/26 at 2:56 PM, Resident #3 was observed sitting in the hallway, near the nurses' station and close the Therapy door, in their wheelchair. Their urinary catheter drainage bag was under their (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wheelchair and dragging on the floor. At 2:57 PM, a female staff member approached, spoke to and hugged/touched the Resident but did not address their catheter. The female staff member did not perform hand hygiene after walking away from the Resident. At 3:04 PM on 6/23/26, Resident #3 moved their wheelchair in the hall to be closer to the wall. Their urinary catheter drainage bag was observed dragging along the floor as they self-propelled themselves in their wheelchair. An interview was completed at this time. When asked how they were doing, Resident #3 verbalized they were having pain in their left kidney and had not received their pain medication at 1:00 PM. When queried, Resident #3 revealed they propelled themselves from activities in their wheelchair back to the unit to get their pain medication. Resident #3 was asked if any facility staff had adjusted or emptied their urinary catheter drainage bag and the Resident revealed that staff had not adjusted and/or emptied the drainage bag since they had been sitting in their wheelchair. After Resident #3 received their pain medication, the Resident was observed self-propelling themselves down the hallway and back to the Activity/Dining room of the facility with their urinary catheter drainage bag dragging on the floor. An interview was completed with Licensed Practical Nurse (LPN) GG on 6/23/26 at 3:29 PM. When queried why Resident #3 was placed in contact precautions, LPN GG revealed they were not sure and would need to review the Resident's EMR. LPN GG reviewed the diagnoses in Resident #3's EMR and verbalized the Resident was diagnosed with gram negative sepsis. When queried regarding the location and specific organism was related to the need for contact precautions, LPN GG replied, I don't know. LPN GG reviewed Resident #3's EMR further and stated, The only see I am thinking is that she has a wound on the pubis and buttocks. When asked if the Resident also a wound on their heel, LPN GG confirmed they did but was unable to provide the source and location of the infection. LPN GG was informed of Resident #3's urine C &S indicating the Resident had ESBL in their urine. An interview was completed with Infection Control (IC) Registered Nurse (RN) A on 6/23/26 at 3:52 PM. When queried regarding the facility policy/procedure related to residents exiting their room who are on contact precautions, IC RN A replied, Can't force them to stay in their room. When queried how the facility was protecting other residents from potential spread of infection and MRDOs, IC RN A responded they educate residents who are on contact precautions on infection prevention topics including isolation, distancing, and hand hygiene. IC RN A was asked how they educate residents and stated, I haven't had anyone to educate recently. When queried regarding Resident #3 being on contact precautions, IC RN A indicated the Resident was recently placed on contact and verbalized they had not provided infection prevention education to them. When queried regarding the source of Resident #3's infection necessitating contact precautions, IC RN A confirmed the Resident had ESBL in their urine. IC RN A was informed of observation of Resident #3 sitting in close proximity to other residents in the dining room and staff touching/hugging without Personal Protective Equipment (PPE). When queried regarding the lack of PPE and potential spread of infection, IC RN A responded that the infectious organism was contained in the Resident's urine and in their urinary catheter drainage bag. When asked if urinary drainage bags should be directly on the floor, IC RN A responded that they should not. IC RN A was then asked why Resident #3's urinary catheter drainage bag on the floor and dragging along on the floor when the Resident was propelling themselves throughout the facility and was unable to provide an explanation. When queried where and what would be considered contaminated, IC RN A replied, Wherever foley bag is touching. When asked, IC RN A confirmed understanding of the concern. Resident #50: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses which included right below knee amputation (RBKA), peripheral vascular disease, and diabetes mellitus. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required total assistance to complete all ADLs with the exception of eating. On 6/24/26 at 8:27 AM, an observation of LPN II checking Resident #50's blood glucose level was completed. LPN II removed the glucometer (device to check blood glucose level) from the medication cart along with an alcohol pad and a glucometer testing strip (strip inserted into the glucometer where blood sample is applied). LPN II entered Resident #50's room and sat the glucometer (used for multiple residents) directly on the Resident's overbed table. LPN II then donned gloves without performing hand hygiene first. LPN II wiped Resident #50's finger with an alcohol pad, allowed it to dry, and then used a lancet to poke their finger to obtain a blood sample. LPN II wiped the first drop of blood with a new alcohol pad and then immediately applied the next drop of blood to the glucometer strip in the glucometer. After the glucometer test result was obtained, LPN II exited the room and placed the glucometer directly on top of the medication cart without a barrier. An interview was completed with LPN II on 6/24/26 at 8:40 AM. When queried if barriers are supposed to be used under the glucometer, LPN II replied, Yes. An interview was conducted with the Director of Nursing (DON) on 6/25/26 at 1:50 PM. When queried regarding the procedure for glucometer use, the DON verbalized the procedure which included use of a barrier with the glucometer. The DON was informed of observations of LPN II checking Resident #50's blood glucose level and placing the glucometer directly on the Resident's over bed table without a barrier, the DON stated that was Not okay. Upon request for a policy/procedure pertaining to blood glucose monitoring and glucometer use, the facility provided a policy/procedure entitled, Blood Glucose Monitor Decontamination (Reviewed: 1/26). The provided policy/procedure did not include the procedure for using the glucometer. Observations done on 6/22/26, of Dining Room: On 6/22/26 at 12:01 p.m., observations made in the main dining room are as follows: -A total of 7 staff were passing resident's food trays out:, 5 of 7 staff did not sanitize their hands between resident's. Staff were observed setting up the resident's meals, putting clothing protectors on several resident's then going directly to the food serving line to get another resident's food without sanitizing their hands. There was a total of 3 wall hand sanitizers available. -A Nursing Assistant/CNA was observed carrying resident's food [NAME] and her long pink thumb nail was touching the food on the plates. The same CNA had long curly hair that was not pulled back, every time she bent over with the plate of food, her hair dropped down by the residents face and their food. -A housekeeper also had long hair that was not pulled back and she was delivering plates of food with her hair dropping down as she bent down to set the plate down. This same housekeeper was going table-to-table and putting clothing protectors on the resident's without sanitizing her hands between resident's or tables. -A CNA had bright pink nails that were no less then 1 inch above the tips of her fingers; she was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	serving food and did not sanitize her hands between resident's. -A kitchen food servers went into the kitchen to get more clean white plates; she carried them back to the tray line held against her right side of her clothing, contaminating the plates. -Resident #2's urinary catheter drainage bag was resting on the floor under his wheelchair as he ate his meal. Observations of Dining Room on 6/23/26: -The CNA with the long bright pink nails was serving resident's food with no gloves on, and her nails touched several food items on the plates as she carried them. -Two CNA's still had the long hair that was not pulled back, as they bent over to place the resident's plates of food their hair dropped down toward the residents face and food plate. During an interview done on 6/23/26 at approximately 9:30 a.m., the Director of Nursing/DON stated Nails can't be more then a quarter of an inch, I have looked at the policy. Review of the facility Catheter Care, Urinary policy dated 10/2025, stated Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility Hand Hygiene policy dated 9/2025, stated Use an alcohol-based hand rub before and after direct contact with residents; after contact with a residents intact skin; after removing gloves. Review of the facility Dress Code and Personal Hygiene policy dated 5/2019, stated All employees dress and groom in a manner that is appropriate to their working conditions; keeping fingernails clean and trimmed; arranging hair so that it does not interfere with work assignments or direct contact with residents. Observation of resident #2 with Enhanced Barrier Precautions/EBP: -An observation was done on 6/22/26 at 2:00 p.m., of a CNA doing peri care in resident #2's room with only purple gloves on; there was EBP signage on the outside of his door. Review of the facility Transmission-based precautions policy dated 9/2025, stated [NAME] required PPE prior to resident contact. Shower Room: Observation done on 6/23/26 at 5:00 p.m., of the main shower room revealed the following: -The blue shower mat on top of the white shower bed had an excessive amount of dirt, old dried skin, and debris on the top, sides and underneath. -The floor had papers and dirt on it; the corners were very dusty. -On the inside of the shower door was an area of dried white drippings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation done on 6/24/26 at 9:12 a.m., accompanied by Housekeeping Supervisor AA, revealed the following: -The blue shower mat on top of the shower bed was still full of dead skin, dirt-like and debris; no one had cleaned it. -The floor was dirty with dirt and papers, and also a soiled purple medical glove was on the floor by the toilet. -The inside door still had the white dried drippings on it. During an interview done on 6/24/26 at 9:37 a.m., Housekeeping Supervisor AA stated The CNA (Nursing Assistant) is supposed to clean it (the shower room, including the blue shower mat). During an interview done on 6/24/26 at 9:43 a.m., CNA Z stated (The) CNA who gave the shower, who ever uses the bed, cleans it right after. Resident #94 (R94): A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R94 was admitted to the facility on [DATE] with diagnoses that include: subacute osteomyelitis (infection in bone), Methicillin Susceptible Staphylococcus Aureus (MSSA/ infection), Proteus Mirabilis Morganii (multi-resistant drug organism – MDRO), Extended Spectrum Beta Lactamase (ESBL/ antibiotic resistant infection), peripherally inserted central catheter (PICC/ for long term IV antibiotic use), diabetes mellitis (DM), heart failure, acute respiratory failure and DM retinopathy (effecting blood vessels of the eyes). The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15. On 06/22/2026 at 11:19 AM, Observed contact precaution sign on room door of R46, after personal protective equipment (PPE) was donned, the resident was observed resting in bed and had an IV antibiotic running, a urinary catheter with light yellow urine draining, and reported that he had an infectious wound on his bottom. R94 was agreeable to observation of care as it was to occur throughout the day. Nurse M was present and said R94 was due to have IV antibiotics administered, the PICC dressing changed, wound and catheter care done on her shift. On 06/22/2026 at 1:43 PM, Nurse M said she was ready to administer IV medication, change the PICC dressing, perform wound care and urinary catheter care. After gathering supplies from the hall, Nurse M donned (applied) gown and gloves, she decided that she did not have enough or correct supplies and removed gloves and exited the room in gown to retrieve purple top wipes and reentered the room in same gown, applied a new set of gloves – no hand hygiene in between. Nurse M had a wad of gloves (not in box) that she had brought in with her and placed them on the bedside table with supplies while she cleaned the over bed table with wipes – no barrier was used. Nurse M changed gloves – no hand hygiene then transferred the supplies to the over bed table – no barrier used. During the PICC line dressing change Nurse M removed the barrier sheet from the kit and placed it to the side and then applied the sterile gloves. Nurse M changed the PICC line dressing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Focus: I am at risk for MDRO infection r/t: Hx. (history of) MDRO, Skin, Foley, PICC. Date Initiated: 06/13/2026. With Intervention: Educate on Hand hygiene; Enhanced Barrier Precautions: SKIN, FOLEY, PICC Staff will wear PPE (gown and gloves) while engaged in high contact activities. On 06/24/2026 at 9:47 AM, Observed CNA J enter the doorway of R94 room, she put on a gown then took it back off, rolled it up and stuffed it in the door (PPE holder), she walked down the hall and got the tray cart and pulled it toward R94's room. CNA J put that rolled up gown on with gloves and went in R94 room. Observed CNA J remove R94's breakfast tray and she exited the room with gloves and gown on placed the tray in the cart that was in the hallway. CNA J then re-entered the room wearing the same gloves and gown and closed the door. On 06/25/2026 at 11:52 AM, during an interview with CNA N she was asked about resident precautions. CNA N said they are trained on each type and when asked about contact she said that gown and gloves were to be donned at the resident's door before entering and removed and discarded in the room before exiting, and hand hygiene was performed. CNA N confirmed that it was not appropriate to leave the room in any PPE and/or return to the room in the same PPE. On 06/25/2026 at 11:59 AM, during an interview with the wound care nurse (WC Nurse) E was asked about contact precautions and said hand hygiene then don gown and gloves before entry to residents in contact precautions rooms. WC Nurse E said any break in contact during care with resident hand hygiene and gloves are changed at every step. WC Nurse E said always use a barrier and a wiped surface was not adequate. WC Nurse E said it was not acceptable to walk outside of a room wearing the PPE, he said PPE was disposed of in the residents room and that the process of hand hygiene, gown, gloves etc. would need to be performed before reentry to the residents room and said it was part of the infection control standards. When queried, WC Nurse E said the outside of packaging was not an appropriate or clean barrier. On 06/25/2026 at 12:17 PM, during an interview with infection control preventionist (ICP) A was advised on observations of R 94's provision of care with no hand hygiene between gloves changes, PPE that was worn in/out of room, no use of barrier with care, PPE that was donned (applied) /doffed (removed) and reused, use of bandage scissors stored in pockets / unsanitary and contamination of clothing under PPE to access them, gloves used from a wad not straight from a box. ICP A said it was not acceptable to leave and renter a room in PPE no matter the reason. ICP A said that hand hygiene should be performed before, during care when gloves were changed and after care before the resident's room was exited. ICP A agreed it was never appropriate to don doff then redon (reapply) the same PPE. When queried, ICP A said that wound wash should be dedicated to the resident in contact precaution and not placed back in stock and bandage scissors should not be stored in staff pockets and a resident in contact precautions should have dedicated equipment. ICP A said that none of the observations mentioned followed protocols and it is not the performance she expected from the staff. ICP A said she does monthly audits and training on infection control practices. According to a record review of the facilities policy titled Hand Hygiene revealed: Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of infections. And Policy interpretation and implementation: 2. All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; 9. Use an alcohol-based hand rub containing at least 62% alcohol for the following situations: Before and after direct contact with residents; Before preparing or handling medications; Before performing any non-surgical invasive procedures; Before and after handling an invasive device (e.g., urinary catheters, IV access sites); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235139	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avista Nursing and Rehabilitation	2901 Galaxy Drive Saginaw, MI 48601

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 - Many	Before donning sterile gloves; Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin; After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; After removing gloves; Before and after entering isolation precaution settings; 10. Hand hygiene is the final step after removing and disposing of personal protective equipment;11.The use of gloves does not replace hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. With Procedure: Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves; 1. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. According to a record review of the facilities policy titled Isolation- categories of transmission based precautions revealed: Policy Statement: Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. and; Contact Precautions:1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment; 2. Contact precautions are used for residents infected or colonized with MDROs in the following situations: a. When a resident has wounds, secretions, or excretions that are unable to be covered or contained .; 6. Staff and visitors wear gloves (clean, non-sterile) when entering the room; a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage); b. Gloves are removed and hand hygiene performed before leaving the room; c. Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed; 7. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.