STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675120	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodville Health and Rehabilitation Center	102 N Beech St Woodville, TX 75979

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on interview and record review, the facility failed to ensure preadmission screening for individuals identified with MI, DD, or ID were evaluated for services for 1 of 15 residents reviewed for resident assessments (Resident #6). The facility did not have a PASRR level 1 screening (PL1) for Resident #6 upon admission. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings included: Record review of a face sheet dated 06/19/24 indicated Resident #6 was a [AGE] year-old male admitted on [DATE]. His diagnoses included cerebral palsy (a congenital disorder of movement, due to abnormal development). Record review of the electronic record from 05/02/24 to 06/17/24 indicated no evidence of PL1 for Resident #6. Record review of the admission MDS assessment dated [DATE] indicated Resident #6's PL1 was completed and was PASARR positive. Record review of the PL 1 was dated 05/02/24 for Resident #6 was not completed until after surveyor intervention. Record review of the LIDDA portal for Resident #6 indicated the PL 1 was transmitted to LIDDA on 06/17/24. (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: 675120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/18/24 at 3:30 p.m., the MDS Nurse said Resident #6's PL 1 was not sent to LIDDA until yesterday (06/17/24). She said the PL 1 for Resident #6 was never completed or sent to LIDDA on 05/02/24. She said when being trained by the corporate office, she was instructed upon completing a late PL 1, to date the PL 1 with the date it should have been completed before transmitting to the LIDDA. She said the marketing staff would tell her when a resident was going to admit and might be PASARR positive. She said if LIDDA was not notified, the resident could have a delay in services, and not receive services paid for by LIDDA. She said she was trained that a cerebral palsy diagnosis was a Developmental Disability, and the resident would be considered positive for PASARR. She said she had no policy on PASARR. During an attempted phone interview on 06/18/24 and 06/19/24, there was no answer on the marketing staff's phone number, and she was not at the facility. During an interview on 06/19/24 at 2:00 p.m., the DON said her expectation was for the PL 1 to be completed and transmitted to LIDDA prior to admission. The MDS nurse had been helping this facility while the regular MDS nurse was out of the building. She said if the PL 1 is not completed timely, could delay PASARR services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 3 residents reviewed for care plans on the Secured Unit. (Resident #10) The facility did not have an Elopement care plan for Resident #10. This failure could place residents on the Secured Unit at risk of not having individual needs met and not receive needed services. Findings included: Record review of the face sheet dated 06/19/24 indicated Resident #10 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning). Record review of an Elopement Risk assessment dated [DATE] indicated Resident #10 was a moderate risk for elopement with actions including Implement Elopement Care Plan Record review of physician orders for June 2024 indicated Resident #10 had an order dated 04/15/24 to admit to the Secured Unit. Record review of the care plan dated 04/15/24 indicated Resident #10 had no care plan for Elopement. Record review of an MDS assessment dated [DATE] indicated Resident #10 had a BIMS of 05 indicating she had severely impaired cognition. During an observation and interview on 06/17/24 at 09:07 a.m., Resident #10 resided on the Secured Unit. She said she was doing good and liked it at the facility. During an interview on 06/19/24 at 01:10 p.m., the DON said a care plan should include a care plan for elopement with interventions for prevention of elopement and assessments to be done. She said ultimately it was her responsibility to ensure one was done. She said not having the care plan could result in nursing staff not being aware of care. Record review of an Accident/Incident policy dated 5/2016 indicated 6 .An Elopement Risk Care Plan must be completed for all Patients based upon the Elopement Risk Assessment

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview, and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 15 residents reviewed for care plans. (Resident #43) The facility failed to ensure Resident #43's care plan accurately addressed his diagnosis of urinary tract infection (UTI) and administration of antibiotics. This failure could place residents at risk for staff not being aware of the resident needs and not receiving the care and services to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of a face sheet dated 06/19/24 indicated Resident #43 was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of benign prostatic hyperplasia (A benign {not cancer} condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine) and retention of urine (difficulty urinating and completely emptying the bladder). Record review of an admission MDS dated [DATE] indicated Resident #43 had a BIMS score of 7 indicating he was severely cognitively impairment and had an indwelling catheter (a tube that is inserted into the bladder through the urethra and left in place to drain urine). Record review of a care plan dated 05/10/24 indicated Resident #43 had impaired urinary elimination related to obstruction of urinary flow secondary to enlarge prostate gland. Care plan indicated he was at risk for infection related to his indwelling urinary catheter but did not address his UTI. Record review of a physician order dated 06/11/24 Indicated Resident #43 was to receive Ceftriaxone (antibiotic) 1 gram solution for injection intramuscular daily for seven days for diagnosis of UTI. During an observation on 06/17/24 at 08:51 a.m., Resident #43 was sitting in a wheelchair in the common area of the secure unit with a catheter bag hung for gravity drainage (below the level of the bladder) at the bottom of his wheelchair. He was unable to answer questions about his catheter. During an interview on 06/17/24 at 02:16 p.m., Resident #43's family member said he had a catheter due to his BPH and was currently being treated for a UTI. During an interview on 06/19/24 at 08:33 a.m., the DON said there was no care plan for Resident #43's UTI and antibiotic treatment. She said the Infection Control Nurse was responsible for completing care plans related to infections. She said she was the infection Control Nurse's supervisor. The DON said not updating the care plan could result in other staff not being aware of the change in Resident #43's care. She said her expectation was for care plans to be updated to reflect changes in resident care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/24 at 08:40 a.m., the Infection Control Nurse said she was responsible for updating care plans related to infections and antibiotics. She said she was aware of Resident #43's UTI and ordered antibiotic, but she had not revised his care plan to reflect the changes in his care. She said it was just overlooked. She said not updating the care plan could result in nursing staff not being aware of changes in care. Record Review of a facility policy titled Care Plans, Comprehensive Person-Centered revised March 2022 indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents' conditions change.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 13 residents reviewed for significant medication errors. (Resident #152) The facility did not continue to hold Resident #152's Eliquis following an outpatient minimal invasive procedure. This failure could place residents at risk of harm, impairment, or death from receiving a significant medication when it should have been held. Findings included: Record review of physician orders dated June 2024 indicated Resident #152, admitted [DATE], was an [AGE] year-old female with diagnosis including atrial fibrillation (type of irregular heartbeat). Resident #152 was prescribed Eliquis 2.5 mg twice daily. (a blood thinner). Record review of the entry MDS assessment dated [DATE] indicated Resident #152 was admitted to the facility on [DATE] from a short-term general hospital. The entry MDS did not include BIMS score. Review of Resident #152's care plan dated 06/12/24 indicated the resident had a high risk for increased bleeding and/or bruising related to blood thinning agent Eliquis. The interventions included Hold medication before planned surgery as ordered by MD. Record review of Resident #152's Clinical Notes dated 06/13/24 at 13:01 p.m. indicated LVN A documented an entry to hold Eliquis tonight and tomorrow per MD. (06/13/24 at 7 p.m. and 06/14/24 at 7 a.m.) Record review of Resident #152's Clinical Notes dated 06/14/24 at 09:08 a.m. indicated LVN A documented an entry resident is having a loop recorder aka (also known as) an internal EKG (electrocardiogram - a test that measures the electrical activity of the heart to help diagnose heart problems). Resident (#152) should return to the facility today. Eliquis was held per cardiologist orders. Will remain on hold until further instructions. At 09:09 a.m., LVN A documented spoke with cardiologist office and Eliquis is to be resumed on 06/17/24. Review of the June 2024 MAR indicated on the following dates and times, Resident #152 was administered Eliquis 2.5 mg when it should have been held: *06/14/24 at 7:00 p.m.; *06/15/24 at 7:00 a.m.; *06/15/24 at 7:00 p.m.; *06/16/24 at 7:00 a.m.; and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*06/16/24 at 7:00 p.m . During an interview and record review on 06/19/24 at 10:15 a.m., the DON and the state surveyor reviewed Resident #152's June 2024 MAR which indicated Eliquis was administered on the evening of the 14th, and twice daily on the 15th and 16th when it should have been held. The DON said her expectations were for all medications to be administered or held per physician orders. She said this was a medication error and the physician would be notified of it, the cardiologist, and RP (responsible party). Staff would be re-in serviced and disciplinary action would be taken. The DON said when charge nurses obtain an order, it should be documented in the resident's clinical record immediately. She said the electronic medical record program used by the facility had an area to place medications on hold and can be seen by other staff who were responsible for administering medications. She said Resident #152's Eliquis was not documented as held in her MAR, which contributed to the medication error of Eliquis being administered when it should have been held. She added the Unit Managers were responsible for chart audits, and ultimately, she was also. This error could have placed Resident #152 at an increased risk of bleeding following the procedure. During an interview on 06/19/24 at 2:00 p.m., LVN A said she had received an order from Resident #152's cardiologist for her Eliquis to be held on 06/13/24 and to resume on 06/17/24. She said she documented in Resident #152's clinical notes but did not place the Eliquis on hold on the electronic MAR. LVN A said by not documenting to hold the medication, Resident #152 was administered 5 doses of Eliquis while it should have been withheld. She said she now realized the error of not placing Resident #152's Eliquis on hold in the Electronic MAR where the following shifts would know to hold the medication. LVN A said her interventions post incident was to monitor Resident #152 for signs of bleeding and/or bruising, monitor vital signs, and to assess skin during follow up assessments. She said she would also verify orders when receiving them and document at the time orders are taken. LVN A said she notified Resident #152's cardiologist and primary physician of the medication error. She said this error could have placed Resident #152 at an increased risk of bleeding following the procedure. A Charting and Documentation policy date July 2017 indicated the following. All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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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 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30664

Based on observation, interview, and record review, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for 2 of 3 residents on the secured unit reviewed for clinical records. (Resident #32 and #7)

The facility did not have a physician order for placement on the Secured Unit and an Elopement Assessment upon admission to the Secured Unit for Resident #32.

The facility did not have an Elopement Risk Assessment for change in condition, a physician order for placement on the Secured Unit, and a complete care plan for Resident #7.

These failures could place residents on the Secured Unit at risk of being inappropriately place and staff not being aware of needs for residents.

Findings included:

1. Record review of the face sheet dated 06/19/24 indicated Resident #32 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included vascular dementia (a type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), and amnestic disorder (a deficit in memory caused by brain damage or brain diseases).

Record review of Nurse Notes with entry dated 02/24/24 for Resident #32 indicated She walks ad lib about secure unit with steady gait and balance

Record review of a care plan dated 02/24/24 indicated Resident #32 was at risk for elopement and resided on the Secured Unit.

Record review of the MDS dated [DATE] indicated Resident #32 had a BIMS score of 06 indicating she had severely impaired cognition.

Record review of the clinical record from February 2024 through June 2024 for Resident #32 indicated the following:

* no physician order for placement on the Secured Unit; and

* no Elopement Assessment upon admission to the Secured Unit.

During an observation and interview on 06/17/24 at 09:10 a.m., Resident #32 resided on the Secured Unit. She was sitting in a chair in her room. She said she was doing fine.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/19/24 at 01:48 p.m., the DON said there was not an Elopement Risk Assessment done on Resident #32 on admission and one should have been done. She said one was done almost 2 months after admission on 04/02/24. Record review of an Accident/Incident policy dated 05/2016 indicated 6. An Elopement Risk Assessment must be completed the day of admission (including readmission) and upon any significant change in a Patient's condition 2. Record review of face sheet dated 06/19/24 indicated Resident #7 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoseis of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), mood disturbance (feelings of distress or sadness, or symptoms of depression and anxiety), and cognitive communication deficit (a communication difficulty caused by an underlying cognitive impairment). Record review of a quarterly MDS dated [DATE] indicated Resident #7 had a BIMS score of 3 indicating severe cognitive impairment, had no behaviors, and required partial/moderate assistance with most ADLs. Record review of an undated care plan indicated Resident #7 was at risk for wandering as evidenced by dementia. Interventions included reporting any attempts to exit the facility to IDT, family, and physician and record in the clinical record. Placement on secure unit was not addressed in the care plan. Record review of a progress note dated 02/04/24 indicated Resident #7 was threatening to leave the facility and was being transferred to the secure unit for her own safety. Record review of physician orders dated June 2023 did not indicate an order for Resident #7 to reside to reside on the secure unit. During an observation on 06/17/24 at 09:23 a.m., Resident #7 was in bed in her room on the secure unit. She was unable to answer questions. During an interview on 06/19/24 at 01:10 p.m., the DON said she was unsure if a physician order was required for resident admission or transfer to the secure unit. She said Resident #7 was placed on the secure unit because she required low stimulation and was exit seeking. She said an elopement assessment was included in admission, re-admission, and quarterly nursing assessments, but was not completed before transferring Resident #7 to the secure unit. She said Resident #7's care plan should include an intervention of secure unit placement. She said possible negative outcome for not obtaining a physician order and including secure unit placement on Resident #7's care plan could be staff being unaware of why the resident required placement and inconsistencies of nursing care . Record review of an Accident/Incident policy dated 05/2016 indicated 6. An Elopement Risk Assessment must be completed the day of admission (including readmission) and upon any significant change in a Patient's condition 36214

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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 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** 30664 Based on 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 for2 of 4 residents reviewed for infection control. (Residents #102 and #252) The facility did not have appropriate signage indicating Resident #102 was on Droplet Isolation. The facility did not ensure staff implemented appropriate infection control measures while providing care for Resident #252. These failures could place residents, staff, and visitors at risk of exposure to Infectious diseases, decreased health, and/or hospitalization . Findings included: 1. Record review of a face sheet dated 06/17/24 indicated Resident #102 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included MRSA (infections caused by specific bacteria that are resistant to commonly used antibiotics) of the sputum (mixture of saliva and mucus produced by the lungs as a result of viral or bacterial infections). Record review of physician orders for June 2022 indicated Resident #102 had an order dated 06/15/24 for Droplet Isolation and received Linezolid (antibiotic) twice daily ordered to treat respiratory infection. Record review of a Baseline Care Plan dated 06/15/24 indicated Resident #102 was on Droplet Precautions. During an observation on 06/17/24 at 09:20 a.m., outside Resident #102 room indicated an isolation set up cart with sign on top indicating Enhanced Barrier Precautions there was no indication of Droplet Precautions. During an observation on 06/17/24 at 12:20 p.m., outside Resident #102 room indicated an isolation set up cart with sign on top indicating Enhanced Barrier Precautions there was no indication of Droplet Precautions. During an observation on 06/17/24 at 02:10 p.m., outside of Resident #102 room indicated there was an isolation set up cart with sign on top indicating Enhanced Barrier Precautions there was no indication of Droplet Precautions. During an interview on 06/17/24 at 02:12 p.m., LVN A said Resident #102 had MRSA of the sputum and was on Droplet Precautions not on Enhanced Barrier Precautions. (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 interview on 06/17/24 at 03:25 p.m., the DON said she did not know why the signage was not indicating Droplet Precautions. She said it was the responsibility of the nurses to place the signage on the door. She said the signage missing would not let visitors know to apply a mask or face shield when entering the room and could expose them to infections. Record review of an Isolation-Categories of Transmission-Based Precautions policy revised September 2022 indicated .Policy Interpretation and Implementation: 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room 33460 2. Record review of a face sheet dated 06/17/24 indicated Resident #252 was [AGE] year-old male admitted on [DATE]. His diagnoses included pneumonia (infection in lung or lungs) due to methicillin (antibiotic) susceptible staphylococcus aureus (bacteria). Record review of the admission MDS dated [DATE] indicated Resident #252 was intact with cognition. He had diagnoses of pneumonia and methicillin susceptible staphylococcus aureus during the last seven days. Record review of care plan date 05/31/24 indicated Resident #252 required droplet isolation for methicillin susceptible staphylococcus aureus. Record review of the physician orders dated 06/17/24 indicated Resident #252 orders included cefazolin 2-gram solution for intravenous every eight hours for seven days with start date of 06/17/2024. Flush right upper arm PICC (peripherally inserted central catheter) line using the SASH (saline, administer medication, saline, heparin) Method every shift and after each use: 10 cc normal saline, administer medications/fluids, then 10 cc normal saline, and then 5 cc of heparin with start date of 06/01/24. Droplet isolation precautions (a set of precautions used to prevent spread of germs from a patient with respiratory Infection) pneumonia with methicillin susceptible staphylococcus aureus with start date of 06/02/24. During an observation on 06/18/24 at 9:50 a.m., LVN A donned her mask, gown, and gloves and went into Resident #252's room to disconnect his IV. She disconnected the tubing and cleaned the PICC line port for 30 seconds with an alcohol pad. She reached under her isolation gown and obtained a 10-cc normal saline flush and a heparin flush out of her pocket without hand hygiene or changing gloves. LVN A then flushed his PICC line with the 10-cc of normal saline and flushed with heparin without hand hygiene or changing gloves. During an interview on 06/18/24 at 9:55 a.m., LVN A said she should not have placed the normal saline flush and heparin flush in her pocket and should not have reached under her gown. She said reaching under her isolation gown and into her pocket would contaminate her pocket and her gloves. During an interview on 06/18/24 at 2:00 p.m., DON said the staff should not reach under the isolation gowns when in the rooms with droplet precautions as they could spread germs. (continued on next page)

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Woodville Health and Rehabilitation Center	102 N Beech St Woodville, TX 75979

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Droplet Precautions policy dated August 2012 indicated Droplet Precautions are designed to reduce the risk of droplet transmission of infectious. In addition to Standard Precaution and contact Precautions, use droplet precautions for a patient known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the patient during coughing, sneezing, talking or the performance of procedures. Standard Precaution Handwashing 1. Hand washing after touching blood, body fluids, secretions, and contaminated items, whether gloves were worn. Wash hands immediately after gloves are removed, between patient contacts, and otherwise indicated to avoid transfer of microorganism other patients or environment.