

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Collinwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 S Rigsbee Rd Plano, TX 75074	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 10 of 15 resident rooms on the 500 - hall (Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10). Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 10 of 15 resident rooms on the 500 - hall (Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10). The facility failed to ensure Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10, were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings include: An observation on 08/05/25 at 10:42 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark dirt stains between the vents. The bathroom floor had white and grayish stains on it. A wall near an assist rail in the bathroom had a brown stain going down the wall. An observation on 08/05/25 at 10:47 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains on and between the vents. The toilet in the bathroom had brownish stains on a visible plastic bolt attached to the toilet seat, and the bolt attaching the toilet to the floor. A mini fridge in the room had red stains and dark dried up food particles inside. An observation on 08/05/25 at 10:59 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains on and between the vents. The bathroom floor had white paste around the toilet. A piece of tissue was used to determine if it was able to be cleaned and the substance came up. The top of the cover of the toilet seat had brownish spot stains. The faucet on the sink had thick blue and green soap scum build up. An observation on 08/05/25 at 11:04 AM of resident room [ROOM NUMBER] reflected the air condition vents had dark stains on and between the vents. The faucet on the sink had thick blue and green soap scum build up and the faucet had cracks. The toilet in the bathroom had brownish stains on a visible bolt attaching the toilet to the floor. An observation on 08/05/25 at 11:12 AM of resident room [ROOM NUMBER] reflected the air condition vents had [NAME] stains on and between the vents. The toilet in the bathroom had brownish stains on the base of the toilet. An observation on 08/05/25 at 11:17 AM of resident room [ROOM NUMBER] reflected the faucet on the sink had thick blue and green soap scum build up. The bathroom floor had white and grayish stains around the toilet and corners of the floor. An observation on 08/05/25 at 11:20 AM of resident room [ROOM NUMBER] reflected the toilet in the bathroom had brownish stains on the base of the toilet. An observation on 08/05/25 at 11:23 AM of resident room [ROOM NUMBER] reflected the toilet in the bathroom had brownish stains near the top of the toilet seat cover. The faucet on the sink had thick blue and green soap scum build up. An observation on 08/05/25 at 11:28 AM of resident room [ROOM NUMBER] reflected the bathroom sink had light and dark stains on the inside of the sink. An observation on 08/05/25 at 11:30 AM of resident room [ROOM NUMBER] reflected the faucet on the sink had thick blue and green soap scum build up. The bathroom floor had white and grayish stains around the toilet and corners of the floor. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The air condition vents had [NAME] stains on and between the vents. In an interview on 08/07/2025 at 9:23 AM, Housekeeping P stated she was responsible for cleaning the rooms on the 500-hall. She was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10. She stated housekeeping was responsible for cleaning those areas identified. She stated she tried to clean the faucets, but they could not get the dirt build up off. She stated the dried-up soap scum was hard to clean. She stated not cleaning the resident rooms thoroughly could result in residents getting sick. In an interview on 08/07/2025 at 9:33 AM, the Housekeeping Director stated she had been at the facility for 36 years. She stated the cleaning staff were to clean all areas of the resident rooms and bathrooms. She was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10. She stated the areas identified should have been cleaned by her cleaning staff. She stated they had tried to clean the faucets, but they had not been successful. She stated not cleaning resident rooms thoroughly could result in some residents having respiratory problems. In an interview on 08/07/2025 at 10:00 AM, the Administrator was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10. He stated his expectation was for housekeeping to clean resident rooms thoroughly every day. He stated the leadership had to do a better job inspecting what they expect. He stated the concerns with the faucets was that it could cause leaks and be a fall risk for the resident. He stated he really did not see any other risk for the residents. He stated the air condition vents not being thoroughly cleaned could impact the resident's air quality. Record review of the facility's policy on Cleaning and Disinfection of Environmental Surfaces dated June 2009, reflected Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #7) reviewed for ADL care provided to dependent residents. Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #7) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #7 received any of her scheduled showers based on records reviewed for July 2025. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Included: Record review of Resident #7's face sheet, dated 08/06/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included rash and other non-specific skin eruption. Record review of Resident #7's Comprehensive MDS Assessment, dated 07/29/25, reflected the resident was unable to complete the interview for a BIMS score. The Comprehensive MDS Assessment reflected the resident required extensive assistance with ADL care. Record review of Resident #7's Comprehensive Care Plan dated 06/10/25, reflected the resident refused showers and had skin tears in multiple areas. Interventions included encouraging showers and keeping the resident's skin clean and dry. Record review of Resident #7's Comprehensive Care Plan, dated 07/16/25, reflected the resident was incontinent of urine and bowel. One of the approaches was for hygiene as needed after every incontinent episode to maintain dignity. Record review of Resident #7's Bath/Shower Sheets for the month of July 2025, reflected the resident had one shower sheet on file dated 07/24/25, which indicated the resident had refused a shower. Record review of Resident #7's progress notes for the month of July 2025, reflected no notes indicating the resident refusing showers nor were there any notes indicating any attempts to contact the resident's responsible party regarding the resident's refusal to take a shower. In an interview on 08/05/2025 at 10:29 AM, Resident #7 was asked if she was receiving her showers and she stated she wanted a shower. The resident was asked if she refused showers or received bed baths but did not respond. In an interview on 08/06/25 at 10:45 AM the ADON stated the CNAs were to complete a shower sheet for all residents, whether they received a shower or refused a shower. She stated if a resident refused a shower, the CNA was to notify the hall nurse and advise them of the refusal so the nurse could attempt to persuade the resident to shower, and if they were unsuccessful, the nurse was to contact the responsible party to see if they could convince the resident to take a shower. She was advised that Resident #7 had only 1 shower sheet on file for the month of July 2025, which indicated the resident had refused a shower. She stated the resident was scheduled to receive her showers during the 2 PM to 10 PM shift on Tuesday, Thursday, and Saturday. She stated the resident had a history of refusing showers and it was care planned. She stated a shower sheet indicating a refusal to shower should have been completed each time she was scheduled for a shower. She stated not providing the resident her scheduled showers could result in skin break down. In an interview on 08/06/25 at 1:32 PM with Resident #7, the ADON, and the Receptionist, Resident was asked if she wanted a shower in Spanish by the Receptionist and she said yes and she was taken to get a shower. In an interview on 08/06/25 at 2:20 PM CNA A, stated she had been at the facility for 9 months. She stated most of the times she provided Resident #7 bed baths. She stated they were supposed to complete a shower sheet for all residents, even if they refused a shower. She stated she did provide the residents bed baths but did not complete the shower sheets for the resident. She stated she did not always work the 500- hall and only worked with the resident a few times. She stated they were to document the refusal and notify the hall nurse. She stated she did notify the hall nurse but failed to document it. She stated if the resident did not (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive their scheduled showers, she could get sick. In an interview on 08/06/25 at 2:29 PM, LVN D stated he had been at the facility more than 4 years. He stated he was the nurse for the 500-hall. She stated Resident #7 sometimes refused showers, so they tried to give her bed baths. He stated CNAs were required to complete shower sheets for the resident, whether she received a shower or refused. He stated if the resident refused a shower, the CNA was to notify him, and he would attempt to persuade the resident and notify family to assist. He was made aware that Resident #7 only had one shower sheet in the binder, and he stated she should have had a shower sheet for all scheduled days. He stated the resident was scheduled for showers on Tuesday, Thursday, and Saturday during the 2 PM-10 pm shift. He stated if the resident did not receive showers she could have a skin impairment. In an interview on 08/07/25 at 9:02 AM, the DON stated he had just started with the facility on 08/04/25. He stated the ADON had made him aware of Resident #7 not receiving her scheduled showers. He stated his expectation was for all residents to receive their scheduled showers by the CNA and if the resident refused, they were to notify the floor nurse, and the floor nurse would try to persuade the resident to take a shower. He stated if the resident still refused to take a shower, they were to contact the Responsible party to try and get them to take a shower. The DON stated that staff had to complete a shower sheet whether the resident took a shower or refused, and the refusal should be documented in the progress notes. He stated the risk of the resident not getting her scheduled showers could result in skin breakdown. He stated he completed an in-service on showers with his staff on 08/06/25. Record review of the facility's policy on Shower/Tub bath, dated December 2024, revealed The purposes of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The following information should be recorded on the resident's ADL record and/or in the resident's medical record: The date and time the shower/tub bath was performed. The name and title of the individual(s) who assisted the resident with the shower/tub bath. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. Notify the supervisor if the resident refuses the shower/tub bath.		

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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** Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that included measurable objectives and time frames to meet the resident's medical, nursing, and psychosocial needs identified in the comprehensive assessment for 1 (Resident #10) of 4 residents reviewed for care plan review and revision. The facility failed to review and revise Resident #10's care plan interventions after he fell on [DATE] and sustained injuries that did not require transfer to the hospital for treatment. This failure could affect all residents and contribute to residents not receiving the care and services they needed to prevent falls. The findings included: Record review of Resident #10's Face Sheet, dated 08/07/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #10 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), cognitive communication deficit (impacts how a person processes and conveys information), and unsteadiness on feet. Record review of Resident #10's Quarterly MDS (tool used to measure health status) Assessment, dated 07/13/2025, reflected moderately impaired cognition with a BIMS (tool used to assess cognition) score of 08. Section G (functional status) indicated Resident #10 required limited assistance of one staff member for activities of daily living. Record review of Resident #10's Comprehensive Care Plan, dated 05/12/2025, reflected the resident was at risk for falls related to generalized weakness and indicated the resident had a fall on 3/31/25 with no injury and a fall on 06/22/25 which caused an abrasion to the left elbow and a laceration on the face. This focus was initiated on 02/22/2025 and revised on 06/25/2025. An intervention to prevent a future fall was not added to the care plan after the resident fell on [DATE]. Record review of Resident #10's Incident Report, dated 06/22/2025, reflected The resident had a witnessed fall near to nurse station while ambulating to his room. Staff nurse observed while resident walking suddenly lost balance and fell forward. Resident hit his head and on assessment abrasion to right side eyebrow observed. The incident report reflected a head to toe assessment was completed, vital signs obtained, and neuro checks initiated. Record review of Resident #10's Fall Risk Evaluation, dated 06/22/2025, reflected his fall risk score was 16. The Fall Risk Evaluation reflected If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. The clinical suggestion included on the fall risk evaluation, dated 06/22/2025, reflected rubber-soled shoes or nonskid slippers worn for ambulation. This intervention was not reflected in the resident's care plan. During an interview on 08/07/2025 at 10:03 AM, the ADON looked at the resident's medical record and stated the fall date was added to the focus of the resident's fall risk care plan but an intervention to prevent a future fall was not added. She stated it was important to update the care plan to help prevent another fall. She stated if the interventions the resident had before did not work, it was important to find a new intervention. During an observation and interview on 08/07/2025 at 10:47 AM, Resident #10 was lying in bed on top of the blanket. He was dressed and wearing shoes with rubber soles. Resident #10 stated he did not remember falling. During an interview on 08/07/2025 at 10:50 AM, the DON stated an intervention should have been added to the care plan after Resident #10 fell on [DATE]. He stated it was important to update the care plan and interventions after a resident fell. He stated most likely the interventions in place did not work and it was important to update the care plan and interventions to try to avoid a future fall. During an interview with the Administrator on 08/08/2025 at 2:40 PM, he stated Resident #10's fall risk care plan should have been updated with an intervention to help prevent a future fall. He stated the DON and ADON were responsible for ensuring any acute change was added or updated in the resident's care plan. Record review of the facility's policy Care Plan, Comprehensive reviewed December 2024, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected the policy statement A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.		

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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 observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #37) of five residents reviewed for infection control. The facility failed to ensure that CNA B changed her gloves and performed hand hygiene when providing incontinence care to Resident #37 on 08/05/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: Record Review of Resident #37's Face Sheet, dated 08/05/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #37 had diagnoses which included dysarthria (slow or slurred speech that can be hard to understand), personal history of traumatic brain injury, hypertension (high blood pressure), and type 2 diabetes (the body does not use insulin effectively). Record review of Resident #37's Quarterly MDS Assessment, dated 05/29/2025, reflected the resident had severely impaired cognition with a BIMS score of 03. Section G (functional status) reflected Resident #37 required the assistance of one staff member with toileting needs. Record review of Resident #37's Comprehensive Care Plan, dated 06/30/2025, reflected bladder incontinence related to immobility. The goal reflected to remain free from skin breakdown due to incontinence and brief use. One intervention was to change the resident every two hours and as needed. During an observation and interview on 08/05/2025 at 1:25 PM, CNA B was providing incontinence care to Resident #37. Resident #37 was lying in bed on her left side. CNA B stated she had just finished cleaning Resident #37. CNA B removed the soiled brief and barrier pad from under Resident #37 and dropped the items in a bag on the floor. CNA B did not change gloves or use hand sanitizer. CNA B placed a clean brief and barrier pad under Resident #37 and assisted Resident #37 to lie flat. CNA B pressed buttons on the resident's bed controller to adjust the bed. CNA B moved to the opposite side of the bed, assisted Resident #37 to turn to her right side, and straightened the barrier pad and brief under the resident. CNA B assisted Resident #37 to lie flat and secured the tabs on each side of her brief. CNA B covered up the resident with a sheet. CNA B removed her gloves but did not use hand sanitizer or wash her hands before leaving the room. CNA B took the bag of soiled items to another room in the hall to dispose of, and after exiting the room, CNA B used hand sanitizer from a pump on the wall in the hall to sanitize her hands. When asked about hand hygiene, CNA B stated she should have removed the gloves and washed her hands or used sanitizer after removing the soiled brief. CNA B stated she should not have touched the clean brief and the resident's bed controller with soiled gloves. CNA B stated she should have cleaned her hands before exiting the resident's room. CNA B stated she normally put on three pair of gloves at the beginning of incontinence care and removed a pair after they became soiled. CNA B stated it was important to prevent cross-contamination when providing incontinence care. During an interview on 08/05/2025 at 1:30 PM, RN A stated it was important to use proper hand hygiene for infection control. She stated when CNA B's hands or gloves were dirty, and touching other items, she was spreading germs to other surfaces. She stated she would talk to CNA B to ensure she understood the importance of infection control measures when providing resident care. During an interview on 08/05/2025 at 1:55 PM, the DON stated it was important to change gloves and use hand sanitizer appropriately during incontinence care and avoid touching the resident or surfaces with soiled gloves. He stated it was important to prevent cross contamination and potentially spreading infection. He stated staff should wash their hands before leaving the residents' room and going to the next resident. He stated staff would be provided in-service about infection control. Review of the facility's policy Handwashing/Hand Hygiene, revised August 2015, reflected the policy statement This facility considers hand hygiene the primary means to prevent the spread of infection. 9. The use of gloves does not replace use hand washing/hand hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.		