STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676007	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Rehab & Nursing	1901 Whippoorwill Kilgore, TX 75662

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 4 of 21 residents reviewed. (Resident #24, Resident #27, Resident #33, and Resident #91)1. The facility failed to securely store over the counter medications (hemorrhoid cream) for Resident #24.2.The facility failed to securely store over the counter medication, ear relief ear drops for Resident #27.3.The facility failed to securely store prescribed medication, (Nystatin Topical Cream) for Resident #33.4.The facility failed to securely store prescribed medication, Breyna (budesonide and formoterol fumarate dihydrate) inhalation aerosol for Resident #91.This failure could place residents at risk for adverse reactions.Findings included: Record review of the face sheet dated 04/02/23 indicated Resident #24 was [AGE] years old and was admitted on [DATE] with diagnoses including Cerebellar Ataxia (a neurological condition caused by damage to the cerebellum, resulting in a sudden or progressive loss of voluntary muscle coordination, balance, and gait), Peripheral Vascular Disease (a slow, progressive circulation disorder caused by narrowed, blocked, or spasmodic blood vessels outside the heart and brain, often leading to reduced blood flow to the limbs), Muscle Weakness (a reduced ability to exert force with muscles, often caused by nerve damage, muscular disorders, metabolic imbalances, or inactivity). Record review of the MDS dated [DATE] indicated Resident #24 understands and was understood by others. The MDS indicated a BIMS score of 15 indicating Resident #24 was cognitively intact. Record review of a care plan revised on 06/11/25 indicated Resident #24 had an activities of daily living Self Care Performance Deficit and was at risk for not having their needs met in a timely manner. During an observation on 3/31/26 at 2:50 p.m. it was observed that Resident #24 had a tube of hemorrhoid cream on his bedside dresser. The medication was in plain view and accessible to anyone in the facility. Resident #24 was not available for interview. During an interview on 4/1/26 at 1:10 p.m. ADON F said that all over the counter medications should be stored inside the medication cart or secured somewhere in the facility. She said that there was a potential for residents who did not need the over the counter medication to misuse the medications. She said that all staff are responsible to ensure that medications were not accessible to residents. During an interview on 4/1/26 at 1:49 p.m. the Director of Nurses stated that all nurses are responsible to ensure that medications were stored properly. She said there was a potential that residents could misuse medications that were not theirs. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/1/26 at 2:05 p.m. the Administrator stated that over the counter medications should be stored in the medication cart or medication room. He said that everyone was responsible to have those medications out of resident's rooms. He said that residents could potentially misuse the medications. 2.Record review of the face sheet dated 3/31/26 indicated Resident #27 was [AGE] years old female who was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including mild cognitive impairment of uncertain or unknown etiology, insomnia (difficulty sleeping and cognitive impairment). Record review of the MDS dated [DATE] indicated Resident #27 understands and was understood by others. The MDS indicated a BIMS score of 8 indicating Resident #27 was moderately cognitively impaired. Resident #27 had highly impaired hearing. Record review of a care plan revised on 2/16/26 indicated Resident #27 had impaired cognition and was at risk of further decline in cognitive and functional abilities related to: mild cognitive impairment. Record review of order summary report dated 3/31/26 indicated Resident #27 had no order for Rexall ear relief ear drops. During observation on 3/30/26 at 9:42 AM, Resident #27 was lying in bed asleep. Resident #27 had ear drops on her bedside table. During observation and interview on 3/31/26 at 9:15 AM, Resident #27 was lying in bed. Resident had ear drops at bedside. Resident #27 said she used ear drops at times. During observation on 3/31/26 at 11:56 AM, Resident #27 was lying in bed asleep with ear drops at bedside. 3.Record review of the face sheet dated 3/31/26 indicated Resident #33 was [AGE] years old female who was admitted on [DATE] with diagnoses including unspecified dementia (memory loss and confusion), unspecified dementia, mild, with generalized anxiety disorder and muscle weakness (generalized). Record review of the MDS dated [DATE] indicated Resident #33 understands and was understood by others. The MDS indicated a BIMS score of 14 indicating Resident #33 was cognitively intact. Record review of a care plan revised on 1/13/26 indicated Resident #33 had impaired cognition and was at risk of further decline in cognitive and functional abilities related to: dementia. Interventions included administering medications per physician's orders and monitoring for unusual adverse reactions and effectiveness. Record review of order summary report dated 3/31/26 indicated Resident #33 had no order for Nystatin Cream 100,000 unit/gm. During observation on 3/30/26 at 9:34 AM, Resident #33 was lying in bed watching television. Resident #33 had nystatin cream in a bucket on her nightstand. During observation and interview on 3/31/26 at 9:13 AM, Resident #33 had nystatin cream in a bucket (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on her nightstand. Resident # 33 said staff used the cream on her buttocks. During observation on 3/31/26 at 11:57 AM, Resident #33 was lying in bed watching television with nystatin cream in a bucket on her nightstand. 4.Record review of the face sheet dated 3/31/26 indicated Resident #91 was [AGE] years old male who was initially admitted on [DATE] and readmitted [DATE] with diagnoses including cerebral infarction (ischemic stroke caused by a blockage in an artery supplying the brain, leading to oxygen deprivation and tissue death), muscle weakness (generalized). Record review of the MDS dated [DATE] indicated Resident #91 understands and was understood by others. The MDS indicated a BIMS score of 15, indicating Resident #91was cognitively intact. Record review of a care plan revised on 10/06/25 indicated Resident #91 had impaired cognition and was at risk of further decline in cognitive and functional abilities related to: mild cognitive impairment. Record review of order summary report dated 3/31/26 indicated Resident #91 had no order for Breyna (budesonide and formoterol fumarate dihydrate) inhalation aerosol 160 mcg/ 4.5 mcg. During observation and interview on 3/30/26 at 10:28 AM, Resident #91 was lying in bed resting. Resident #91 said the staff treated him okay in the facility. Resident #91 had an inhaler on the nightstand. During observation on 3/31/26 at 9:22 AM, Resident #91was lying in bed resting. Resident #91 had an inhaler on his nightstand. During observation on 3/31/26 at 11:50 AM, Resident #91 was lying in bed resting with oxygen in place. Resident #91 had an inhaler on his nightstand. During an interview on 4/1/26 at 10:39 AM, LVN G stated residents should not have medications in their rooms. She stated nursing staff were responsible for ensuring that medications were not in residents' rooms. She stated nurses had informed housekeeping and they had been trained to let nursing staff know if they see medications in resident's rooms while cleaning. She stated the risk was confused residents getting the medications and the residents not taking the medications correctly. During an interview on 4/1/26 at 12:57 PM, ADON F stated she expected a resident to have an order and be able to administer the medication if in their room. She stated if a resident has not had education and been checked off on administering the medication themselves, they should not have the medication in their room. She stated all staff were responsible for prohibiting medications in residents' rooms. She stated the risk was a resident could misuse prescribed over the counter medication. During an interview on 4/1/26 at 1:39 PM, the Director of Nursing stated she does not expect residents to have medications in their rooms. She stated the families bring medications for the residents. She stated all staff were responsible for ensuring the medications were not in the residents' rooms. She stated the risk was that the residents could take the medications inappropriately. The Director of Nursing stated the facility did not have a policy on Medication Storage. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/1/26 at 1:51 PM, the Administrator stated he expected no one in the nursing home was able to self-medicate. He stated if family brought medications from home, it needed to be checked in with the nurse and there needed to be an order for it. He stated the facility does its best by using rounds for medications throughout the facility. He stated the risk was a resident taking a medication that was discontinued and having an interaction with current medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 20 (Resident #73) residents reviewed for call lights. The facility failed to ensure Resident #73 had a call light with reach. This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.Findings included: Record review of Resident #73's face sheet dated 3/31/26 indicated the resident was [AGE] years old male and originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #73 had diagnoses which included type II diabetes mellitus, lack of coordination, unsteadiness on feet, muscle weakness, epilepsy (unprovoked seizures), other fatigue, age related physical debility (a state of general physical weakness), legal blindness, angina pectoris (chest pain), unspecified convulsions, dysphagia (difficulty swallowing), muscle wasting and atrophy, other abnormalities of gait and mobility and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #73's quarterly MDS assessment dated [DATE] indicated the resident understands and understood by others. Resident #73 had a BIMS score of 9, which indicated moderate impairment in cognition. The MDS indicated Resident #73 required maximal assistance with ADLs. Record review of Resident #73's care plan last revised 10/6/23 indicated Resident #73 had impaired visual function and was at risk for falls, injury and a decline in function debility (legally blind). Intervention included anticipate needs and meet them as able and keep call light in reach when in room or bathroom. During observation on 3/30/26 at 10:21 AM, Resident #73 was lying in bed resting. Resident call light was on the floor under the bed and not within reach. During observation on 3/30/26 at 12:05 PM, Resident #73 continued to lay in bed with the call light under the bed and out of reach. During observation on 3/30/26 at 2:14 PM, Resident #73 continued to lay in bed with the call light under the bed and out of reach. During an interview on 3/31/26 at 3:04 PM, CNA J stated he did not witness Resident #73's call light under his bed. The call light might have fallen under the bed. The aides are responsible for ensuring the residents' call lights are within reach. The risk was the resident could fall and not be able to call for help. During an interview on 3/31/26 at 3:17 PM, CNA H stated that she did not witness Resident #73's call light on the floor, but it probably fell and they did not see it. The aides were mostly responsible for ensuring the residents' call lights were within reach. She stated the risk was anything could happen. During an interview on 4/01/26 at 10:39 AM, LVN G stated she expected for the Residents #73s call lights to be within reach. She stated all the staff were responsible for ensuring the residents' call lights were within reach. She stated the risk was if there was an emergency the resident could not reach staff and the resident could get injured trying to get the call light from the floor. During an interview on 4/1/26 at 12:57 PM, ADON F stated she expects the Resident #73's call light to be within reach. She stated everyone was responsible for ensuring the residents' call lights were within reach. She said the call light is for safety and for residents' needs. During an interview on 4/1/26 at 1:35 PM, the Director of Nursing stated she expects the residents' call lights to be within reach. She stated all staff were responsible for ensuring the call lights were within reach. She stated the risk was the resident not being able to get the help he needed. She stated staff rounded every two hours and as needed, so the staff would be able to address the residents' needs. During an interview on 4/1/26 at 1:51 PM, the Administrator stated he expects residents' call lights to be within reach. He stated the aides do rounds and maintenance were responsible for ensuring the call lights were working. He stated the risk was the resident's inability to be able to call for assistance or help. Record review of the facility Call Light Response policy dated 2/10/21 indicated, .5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed.

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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 that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 19 residents (Resident #31) reviewed for accidents and supervision. The facility failed to ensure an oxygen cylinder found in Resident #31?s room was properly stored. This deficient practice could place residents at risk of injury. Findings included:Record review of Resident #31's face sheet, dated 04/01/26, reflected that Resident #31 was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included paraplegia (impairment of motor or sensory function in the lower extremities) and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Record review of Resident #31's quarterly MDS assessment, dated 03/06/26, reflected that he had a BIMS score of 15, which indicated intact cognition. During an observation on 03/30/2026 at 10:59 AM, Resident #31 was sitting in his motorized wheelchair. There was a freestanding oxygen tank in his room that was not in a caddy. During an observation on 03/30/2026 at 11:57 AM, the freestanding oxygen container was still in Resident #31's room, without a caddy. During an interview on 04/01/2026 at 1:21 PM, ADON F said the oxygen container should have been in a caddy. She said it could cause a hazard and potentially hurt a resident. She said all staff were responsible for ensuring that the oxygen containers were in a caddy. During an interview on 04/01/2026 at 1:55 PM, the DON said the oxygen tank should have been in a caddy. She said it could have fallen over and caused a hazard to the residents. She said the nursing staff was responsible for ensuring that the oxygen container was in a caddy. She said the housekeeping staff were also responsible. During an interview on 04/01/2026 at 2:16 PM, the Administrator said the expectation was that there should not have been any unsecured tanks in the resident's room. He said it could have fallen over and caused a hazard. Record review of the facility's policy, Oxygen Safety, dated 02/11/22, reflected: .It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment.1. Safety is the responsibility of all staff, residents, visitors, and the general public.4. Oxygen Storage -- .c. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 20 residents reviewed for respiratory care. (Resident #37) The facility failed to ensure Resident #37's oxygen concentrator had a clean filter. This failure could place residents at risk of respiratory complications or respiratory infection. Findings included:1. Record review of a face sheet dated 3/31/26 indicated Resident #37 was [AGE] years old female and initially admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), chronic respiratory failure and morbid (severe) obesity. Record review of a physician's Order Summary Report dated 3/31/26 for Resident #37 indicated an order to change 02 tubing every Sunday night with a start date of 2/23/26. Record review of a physician's Order Summary Report dated 3/31/26 for Resident #37 indicated an order 02 at 2 liters via nasal cannula continuously every shift with a start date of 2/23/26.Record review of a quarterly MDS dated [DATE] indicated Resident #37 understands and was understood by others. The MDS indicated a BIMS of 15 indicating she was cognitively intact. Resident #37 was dependent on ADLs. The MDS indicated Resident #37 received oxygen therapy while she was a resident in the facility. Record review of a care plan last revised on 3/4/26 indicated Resident #37 uses oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. During an interview and observation on 3/30/26 at 10:49 AM, Resident #37 sat up in a chair resting. Resident said they treated her fine. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator. During an observation on 3/31/26 at 9:23 AM, Resident #37 was in room sitting up in a wheelchair. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator. During an observation on 3/31/26 at 11:52 AM, Resident #37 sat up in a wheelchair in her room watching television. She had on a nasal cannula that was connected to a running oxygen concentrator. There was a gray fuzzy substance on the filter on the concentrator. During an interview on 4/01/26 at 10:39 AM, LVN G stated she expected the resident concentrator air filters to be cleaned. She stated the nursing staff were responsible every Sunday night for checking and cleaning the air filters on the concentrators. She stated the risk was infection and allergens getting into the filtration system of the concentrator. During an interview on 4/01/26 at 12:57 PM, ADON F stated she expected for the resident air filters on concentrators to be cleaned. She stated the nursing staff were responsible for cleaning and replacing the air filters. She stated the risk was a potential for respiratory infection. During an interview on 4/1/26 at 1:39 PM, the Director of Nursing stated that she expected the air filters on the concentrators to be clean. She stated all staff were responsible for ensuring the filters were clean. She stated the risk was infection. The surveyor requested an Oxygen Administration policy. The DON stated the facility did not have a policy on Oxygen Administration. During an interview on 4/1/26 at 1:51 PM, the Administrator stated that he expected the air filters to be cleaned on the concentrators. He stated he was not sure who cleaned the filters. He stated he thought restorative and maintenance were responsible for the air filters. He stated the risk was respiratory issues.

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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 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 for 1 of 20 residents reviewed for infection control practices (Resident #9). The facility failed to ensure CNA A changed her gloves and performed hand hygiene appropriately after taking Resident #9's pants off and before performing indwelling catheter care. CNA A also failed to change her gloves and perform hand hygiene prior to touching disposable bags, some containing clean wipes. CNA A placed the dirty and clean disposable bags on Resident #9's bed side table beside his water cup while providing catheter care to Resident #9. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: Record review of the undated face sheet indicated Resident #9 was a [AGE] year-old male that admitted [DATE] with a readmission date of 3/27/26. Record review of the physician's orders dated 4/1/26 indicated Resident #9 had diagnoses that included: Multiple Sclerosis (a chronic autoimmune disease of the central nervous system where the immune system attacks the protective myelin sheath covering nerves, causing communication issues between the brain and body), and Diabetes type 2 (the body resists insulin or fails to produce enough, causing high blood sugar), and muscle weakness. The physician's orders indicated he had a Suprapubic catheter (a hollow tube inserted into the bladder through a small abdominal incision, usually just above the pubic bone, to drain urine.) Record review of the undated care plan indicated Resident #9 had Multiple Sclerosis, was dependent with personal hygiene, and had a Suprapubic catheter related to obstructive uropathy (blockage in the urinary tract that prevented urine from flowing) with urine retention (inability to fully empty the bladder.) Record review of the quarterly MDS dated [DATE] indicated Resident #9 had clear speech, understood others , and was understood by others. He had a BIMS score of 14, indicating he was cognitively intact. The MDS indicated he had an indwelling catheter. During an observation on 4/01/2026 at 9:55 AM, CNA A performed catheter care and CNA B assisted. Both washed their hands and donned PPE for EBP precautions. Clear disposable bags were on Resident #9's bedside table with his water cup. CNA A pulled Resident #9's pants down. She then began SP catheter care without changing her gloves or sanitizing her hands. She cleaned the part of the catheter closest to the resident, using both hands, then with the same gloves touched all the disposable bags looking for the dirty bag to discard her used wipe. She took off her gloves and sanitized her hands, donning clean gloves and continued with catheter care. During an interview on 4/1/26 at 10:10 AM CNA A said she should have changed her gloves and sanitized her hands after pulling down Resident #9's pants and before touching the catheter. She said she should have changed gloves before going from dirty to clean. She said these mistakes were a cross contamination and infection control issue. She said she should not have touched all of the bags with her dirty gloves because that was also a cross contamination and infection control issue. CNA A said she should have put the bags on the foot of Resident #9's bed and not on his bed side table especially by his drinking cup. She said doing that was also an infection control problem which could spread infection to staff and residents. She said she was very nervous. During an interview on 4/1/26 at 10:04 AM, CNA B said she realized CNA A had not changed her gloves or sanitized her hands after touching Resident #9's pants and before touching his catheter and she should not have because her gloves were considered dirty. She said CNA A should not have put the dirty bag on the bed side table or touched the bags with her dirty gloves. The dirty bag should not have been on Resident #9's bed side table, or by his water cup. She said these things were an infection control problem and cross contamination. She said she did not know why she did not say anything to CNA A or remind her to change her gloves or wash her hands. During an interview on 4/1/26 at 12:19 PM, LVN E said staff should sanitize their hands and change gloves after touching a (continued on next page)

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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	resident's clothes and before touching a resident's catheter to prevent infection. She said a dirty bag should not be placed on a resident's bed side table and especially by a resident's water cup. She said touching bags with dirty gloves would contaminate all the bags. LVN E said all these things were infection control and cross contamination issues that could cause illness for staff and residents. During an interview on 4/1/26 at 12:23 PM, CNA C said after touching a resident's clothing, gloves were considered dirty. A staff would have to wash their hands and don clean gloves before touching a resident's catheter, otherwise it would be an infection control problem. She said staff should never put a bag for dirty items on a resident's bed side table. She said cross contamination could cause illness to residents and staff. During an interview on 4/1/26 at 12:30 PM, ADON D said staff should not put a bag for dirty items on a bed side table. She said that was a risk of infection to residents and staff. She said after touching a residents' clothing staff should wash their hands and don clean gloves before touching a resident's catheter. ADON D said if a staff touched disposable bags with gloves that were considered dirty they would all be contaminated. She said all these things were infection control problems that could transmit illness. During an interview on 4/1/26 at 1:20 PM, the DON said after a staff had touched a resident's clothing, they would need to wash their hands and change their gloves before beginning catheter care, because the gloves would be contaminated from the resident's clothing. She said a disposable bag that was for dirty items should never be put on a resident's bed side table. She said if a staff touched disposable bags with gloves they had been using for catheter care and had not changed them, the bags would be considered contaminated. She said that was an infection control and cross contamination issue that could cause illness to staff and residents. The DON said she thought the CNAs were nervous. During an interview on 4/1/26 at 1:37 PM, the ADM said if staff had washed their hands and donned clean gloves it was okay to touch a resident's clothing (remove their pants) then proceed with catheter care. He said if staff were performing catheter care and had not changed their gloves or washed their hands and touched disposable bags with the gloves, the bags would be considered contaminated. The ADM said it was not okay to put disposal bags for dirty items on a resident's bed side table, especially by the resident's drinking cup. He said it was an infection control/cross contamination issue which could cause illness to residents and staff. Record review of a Nursing Peri-Care competency dated 1/16/26 indicated CNA A was proficient in perineal care and catheter care. Record review of a Nursing Peri-Care competency dated 11/19/25 indicated CNA B was proficient in perineal care and catheter care. Record review of an Indwelling Foley Catheter Guidelines Policy dated 5/23/14 with a review date of 2/10/2020 indicated: Anticipated outcome The facility should identify and assess patients with an indwelling catheter or at risk for catheterization, provide appropriate treatment and services to prevent urinary tract infections. Record review of an Infection Prevention and Control Program Policy dated 10/24/22 with a reviewed date of 11/6/24 indicated: Policy: The facility has established and maintains 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 as per accepted national standards and guidelines. 4. Standard Precautionsa.All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted while providing resident care services. 16. Staff Educationa.All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b.All staff are expected to provide care consistent with infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility. d.The Infection control Preventionist implements/monitors/validate that staff are trained in infection control practices.