STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interviews and record review, the facility failed to ensure the right to receive written notice, including the reason for the change, of a room change before the change was made for 1 of 1 resident (Resident #92) reviewed for notification of room change. The facility failed to ensure Resident #92 received written notice prior to her room change. This failure could place residents at risk for being displaced without notice and/or reason and not allow the resident the right to see the new location and ask questions about the move. Findings included: Record review of Resident #92's Admission Record dated 12/4/24 reflected a [AGE] year-old female admitted to the facility on [DATE] and she was her own Responsible Party. The Admission Record reflected her son and daughter-in-law were listed as Contacts. Record review of Resident #92's Admission MDS assessment dated [DATE] reflected she had a BIMS score of 14 indicating she was cognitively intact. Her diagnoses included hypertension (high blood pressure); third degree burns of left lower limb, right knee and right foot burns involve all layers of the skin, acute osteomyelitis (infection in the bone); and skin transplant status. Record review of Resident #92's Progress notes reflected they included following entries: 11/14/24 at 11:39 AM: SW spoke with pt's [family member] to assist with discharge planning. Pt's [family member] stated to social worker that pt will need assisted living placement options, due to not being able to return back home. SW to provide list of facilities for pt's [family member] to review. SW to follow up and assist prn. Signed by Social Worker. 11/14/24 at 11:51 AM: SW notified pt's [family member] that pt's LCD [last covered day for insurance] is 11/17. Signed by Social Worker. (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/24/24 3:08 PM: Resident skilled for third degree burns to R leg. Alert and oriented x3. Resident stable able to make needs known. VS WNL. Resident refuses to get out of bed and or to turn on any bedroom lights or open bedroom blinds. Ate about 50% of meals today. Family visited today resident seemed encouraged. No c/o pain. Call light and personal items in reach. All staff will continue to monitor and provide care. Signed by LVN B. 11/25/24 11:15 PM: Attempted to call [family member] regarding resident moving to room . Unable to leave message secondary to voicemail being full. Successfully left message for [other family member] requesting return call regarding resident moving rooms today. Signed by LVN C. During an observation and interview on 12/3/24 at 2:05 PM, Resident #92 was observed sitting up in bed in a semi-private room. She stated she had been abruptly moved to her current room with no explanation and was just told we gotta move you. She stated her previous room had been a private room and she did not believe the room change was related to Medicare or any insurance reasons. Resident #92 stated she was never told in advance or given any explanation verbally or in writing about the move . In an interview on 12/4/24 at 1:50 PM, Unit Manager A revealed Resident #92 had been moved from her previous unit when her skilled services had ended and she was changed to long-term care. She stated she believed the change had been discussed with the resident and her family member but was unable to identify who had spoken with her or when the conversation took place. Unit Manager A stated the possibility of moving from a skilled unit to long term care unit was typically discussed with residents upon admission and again prior to any moves. She stated she had not received any complaints related to Resident #92's move to her new room. Unit Manager A stated it was important for residents to have a say as to where they were going if they were changing rooms and that any information related to a resident's room change was generally documented . In an interview on 12/4/24 at 3:58 PM, the Social Worker stated part of the process for moving a resident to a new room included checking with the resident about any preferences they may have. She stated she believed something was provided to the residents in writing but would need to check with the Administrator to be certain. The Social Worker stated she was aware Resident #92 was moving her payor source and was moved from the short stay unit. She stated she was not involved with the move and did not know whether any information had been provided to Resident #92 . In an interview on 12/4/24 at 4:12 PM, the Administrator stated he was unsure whether resident's received documentation in writing when a room change was planned and the change was usually communicated verbally with residents and their families. He stated he was unsure who had communicated the room change with Resident #92 or whether any notification had been provided in writing. The Administrator stated he was responsible for ensuring residents were notified of any room changes and he did not recall checking to determine whether Resident #92 had been properly notified in advance. He stated it was important to notify residents of any room changes because it could upset their day-to-day life by being in a different environment . (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 8:00 AM, the DON stated she had been involved in conversations with Resident #92 and her family related to the resident coming off skilled therapy and moving to a private pay arrangement. The DON stated Resident #92 had communicated she was not planning to move to another room because she had planned on going home. She was unable to say whether Resident #92 had been provided anything in writing regarding her room change and stated she would look for any documentation they may have . During an observation and interview on 12/5/24 at 8:18 AM, Resident #92 was sitting up in bed. She stated her family was still looking for other places for her to live and she was hoping to be discharged on ce something was found. She denied receiving anything in writing or being notified verbally about a room change when discussing payment arrangements with the facility. She stated no one spoke with her about moving rooms until they arrived to move her things. During a telephone interview on 12/5/24 at 9:30 AM, LVN C stated she had received a message to move Resident #92 to her unit on 11/25/24 but could not recall who had sent her the message. She stated she spoke with Resident #92 and explained they were going to move her to a new room and would be calling her family to let them know. LVN C stated resident #92 never complained about moving rooms and had only complained about them calling her family. She stated she had called and left a message for her family member letting them know about the room change. LVN C stated she never saw anything in writing about the room change and was unaware of the room change until the day of the move . An interview on 12/5/24 at 1:25 PM with the DON revealed she was unable to locate any documentation related to Resident #92's room change. She stated the risk of moving residents without prior notification was it could cause them grief and was a violation of their rights. In an interview on 12/5/24 at 1:30 PM, LVN B stated she was previously worked weekend double shifts and just changed to PRN that week. She stated she cared for Resident #92 and was her charge nurse during double shifts on 11/23/24 and 11/24/24. She stated she had been unaware Resident #92 was moving to a new room until she returned the following weekend, and she was no longer on her unit. LVN B reviewed her notes and stated she remembered Resident #92's family visiting on 11/24/24 and the subject of a room change never came up. She stated she would typically see something about a room change documented in the chart or hear about it in report. She stated she was never involved with room changes as she worked weekends and it rarely occurred on her shifts. Record review of the facility's policy titled; Room Change/Roommate Assignment, dated Revised March 2021 reflected: Policy Statement Changes in room or roommate assignment are made when the facility deems it necessary or when the resident requests a change. Policy Interpretation and Implementation 1. Resident room or roommate assignments may change if the facility deems it necessary. Resident preferences are taken into account when such changes are considered . 4. Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., resident and their representatives) are given at least a 5 day advance written notice of such change .7. Documentation of a room change is recorded in the resident's medical record. 8. Inquiries concerning room changes should be referred to the administrator.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interviews, and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for one (Resident #82) of five residents reviewed for PASARR services. The facility failed to refer Resident #82 for a PASARR level II evaluation to the State-designated authority. This failure could place residents at risk of not receiving specialized PASRR services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Findings included: Record review of Resident #82's quarterly MDS Assessment, dated 08/30/24, revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included schizophrenia. Resident #82's BIMs score of 13 indicated the resident's cognition was intact and she was able to make decisions for herself. Record review of Resident #82's PASARR Level I screening, dated 05/13/24, reflected the resident did not have a history of mental illness. An interview on 12/04/24 at 3:30 PM with Resident #82 revealed the resident did not receive PASSAR services, but she wanted to. She said she would appreciate any services she could get. An interview with LVN E on 12/04/24 at 12:51 PM revealed she was responsible for PASARR at the facility and had been for 6 years. She said Resident #82 was not receiving PASARR services because her PL-1 screening was probably negative. LVN E said she did not know the resident had a diagnosis of schizophrenia. She said she was responsible for knowing the information and she knew the information because she completed MDS assessments. LVN E said that the resident was at risk for not receiving services that she qualified for. An interview on 12/5/24 at 1:25 PM with the DON revealed she was responsible for making sure PL-1's were correct and she reviewed them. The DON said she did not know why Resident #82 did not have a new PL-1 completed for her diagnosis of schizophrenia. The DON said it was important for the PL-1 screenings to be correct so that the residents could receive the services they needed. The DON documented on 12/06/24 at 4:37 PM in an email that the facility did not have a PASSAR policy but did follow the recommendations of HHSC. 45053

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #58) of three residents observed for catheters. 1. CNA D failed to clean Resident #58's suprapubic catheter site and catheter during a bath. 2. The facility failed to ensure Resident #58 had a securement device to keep his catheter from pulling. This failure could place residents at risk of cross-contamination and development of urinary tract infections. Findings included: 1. Record review of Resident #58's admission MDS assessment, dated 10/11/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 15 indicating his cognitive status was intact. His diagnoses included bone infection of left foot/ankle, diabetes, and urinary tract infection. The resident required partial assist from one staff for bathing. The resident had an indwelling catheter and was frequently incontinent of bowel movement. Record review of Resident #58's care plans, dated 10/07/24 reflected: The resident had a suprapubic catheter. Facility interventions included monitor/document for pain/discomfort due to catheter. An observation on 12/03/24 at 10:49 AM revealed Resident #58 was in his room. He was awake and alert. CNA D was in the room and wearing gloves. CNA D undressed the resident and started bathing him. The resident had a supra-pubic catheter with crusty, brown drainage at the site and on the tubing. The catheter did not have a device to secure it on the leg to prevent it from pulling out. CNA D finished the bath but did not clean the resident's catheter site or tubing. An interview on 12/03/24 at 1:21 PM with CNA D revealed said he was supposed to clean the suprapubic catheter site and tubing and he did not know why he did not do it this time. He said he did not know how long the resident had been without a securing device for the resident's suprapubic catheter. An interview on 12/04/24 at 1:32 PM with Unit Manager A revealed CNAs were supposed to clean the catheter site and tubing for Resident #58. Unit Manager A said Resident #58 was supposed to have a securement device on his leg to ensure the resident's suprapubic catheter did not get pulled out. An interview on 12/05/24 at 1:25 PM with the DON revealed Resident #58 had a suprapubic catheter and the CNAs were supposed to clean the catheter site and tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview on 12/05/24 at 02:40 PM with the DON revealed he was supposed to have a securement device on his suprapubic catheter to prevent the resident from having urine retention and infection. Review of the facility in-service, Suprapubic Catheter Care, revised October 2010, reflected: 6. Wash around the catheter site with soap and water. (Note: If the resident has a drainage sponge around the stoma site, remove the drainage sponge before washing with soap and water.) Wash the outer part of the catheter tube with soap and water .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. 1. The facility failed to seal open items in plastic bags in the dry storage pantry and freezer according to guidelines. 2. The facility failed to ensure that expired items in the dry storage pantry and refrigerator were removed. These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other air-borne illnesses. Findings Included: Observation of the kitchen during the brief initial tour of the kitchen on [DATE] at 9:21 AM, revealed that in the dry storage area, there was one box of 1 lb. box of Monarch brand baking soda that was open, one 2 1b. bag of unsealed [NAME] brand powdered sugar, the top of the plastic container of breadcrumbs and sugar were unsealed. There three bottles of 46 fl. Oz. Hormel Thick and Easy Clear brand of thickened orange juice with an expiration date of [DATE]. There was a bag of 5 lb. curly medium egg noodles that was unsealed. The freezer contained one pack of 32 oz. chopped collard greens and a ,d+[DATE] bag of 32 oz. broccoli florets that were unsealed. The freezer also contained a lemon meringue pie that was unsealed. In an interview with [NAME] I on [DATE] at 10 AM, she stated that she had been employed at the facility for 6 years. She stated that she was unaware that there were expired and unopened items in the dry storage and freezer areas. She stated that she was not aware that there was unsealed food in the freezer. She stated that all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She stated that she had taken in-service trainings on food preparation and storage and her last in-service training was last week. She stated that if someone ingested food that had been cross-contaminated, there was a risk that someone could get salmonella poisoning (a bacterial infection that causes food poisoning) and a dented can could cause the resident to become sick and ill. In an interview with [NAME] J on [DATE] at 10:14 AM, she stated that she had been employed at the facility for 3 years. She reported that she was unaware of the findings in the kitchen. She stated that all staff were responsible for ensuring that everything in the kitchen was sealed and not expired. She stated that she had taken in-service trainings on food preparation and storage and her last in-service training was 2 weeks ago. She stated that with expired food being in the food pantry and items being unsealed, there was a possibility of cross-contamination and bacteria. She stated that the if anyone has exposed to food that is expired and unsealed, it can cause harm and for someone which will cause them to become ill and have diarrhea. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Dietician on [DATE] at 11:05 AM, she stated that the facility's Dietary Manager was not available and would not return to work until next week. She stated that she had been employed with the company for 4 years. She reported that she visited the facility at least once a week. She stated that herself and the Dietary Manager hold their staff to a high expectation. The Dietician stated that she was unaware of the expired items, unsealed items. She stated that all staff were responsible for ensuring that the food in the kitchen's dry storage area, refrigerators, and freezer were labeled, dated, and not expired. She reported that all staff had been in-serviced on food preparation, labeling, storage, and cross-contamination. She stated that all of the items mentioned to her were disposed of and discarded. She stated that if a staff member sees an expired item or something else in the kitchen that was incorrect, they were to inform herself or the Dietary Manager. She stated that she felt that there was not any risk to the residents due to the items being discarded and thrown away. She stated that there was not any cross-contamination and harm done due to the items being thrown away. On [DATE] at 3:26 PM an attempted telephone call was made to the Dietary Manager and there was no answer. In an Interview with the Administrator on [DATE] at 2:17 PM, he was informed about the findings in the kitchen during the initial tour of the kitchen. He stated that he was unaware that there were expired items, unsealed food. He stated that expired food should be thrown out and the proper protocol and procedures for food preparation, and food storage should be always used. He stated that if cross contamination occurs, the risk to anyone that eats food from the kitchen can cause them to get sick, if they were to eat any expired food from the kitchen. Record review of the facility's policy titled Food Storage, dated, [DATE] reflected, Policy: Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. Procedure: 1. Food will be stored according to the Food Storage Guidelines. 2. Dry storage rooms must be well-ventilated. All storage areas should be well lighted with humidity controls to prevent condensation of moisture and growth of molds. 3. Storage rooms must have only one access door. If the storage room has more than one door, only one door will be used. All other doors must be locked and their use prohibited. Secure locks must be installed on all other doors and windows. Key to storage rooms shall be controlled by the Dietary Services Manager. 4. Food items will be stored on shelves, with heavier and bulkier items stored on lower shelves. Glass items should always be stored on lower shelves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must legible and accurately labeled, including the date the package was opened. 6. Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area away from food. 7. Scoops must be provided for sugar, flour, dried vegetables, and spices. Scoops are not to be stored in food containers, but are kept covered in a protected area near the containers. Scoops are to be washed and sanitized on a weekly basis, or as needed. 8. Hands must be washed after unloading supplies and prior to handling food items. 9. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. a. Old stock is always used first. (First in - First out method.) b. Supervision is necessary to make sure that the person designated to put stock away is rotating it properly. 9. Food is purchased in quantities which can be stored properly. 10. Food is arranged in storage areas in food groups to make it easier to store, locate, and inventory. 11. Food is stored a minimum of 8 inches above the floor and 18 inches from the ceiling on clean racks or other clean surfaces, and is protected from splash, overhead pipes, or other contamination. 12. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables and frozen products must be refrigerated immediately to ensure nutritive value and quality. 13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within ,d+[DATE] days or discarded. 14.All refrigerator units are kept clean and in good working condition at all times. 15. Refrigeration: a. Temperatures for refrigerators should be between 40 degrees Fahrenheit or lower. Thermometers should be checked at least twice daily. (See Freezer and Refrigerator Temperature Form). b. Every refrigerator must be equipped with an internal thermometer. c. Each nursing unit with a refrigerator/freezer unit will be monitored for appropriate temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Cooked foods must be stored above raw foods to prevent contamination. e. All foods should be covered, labeled and dated. f. All foods should be stored to allow air circulation. g. Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed. 16. Frozen Foods: a. Temperatures for the freezer should be 0 degrees Fahrenheit or below and should be checked at least two times each day. b. Every freezer must be equipped with an internal thermometer c. Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing (24 hours). Thawing meat should be labeled and dated. d. Foods should be covered, labeled and dated. e. All food items should be stored upon delivery and careful rotation procedures should be followed. f. Meat, fish, and poultry should be stored on lower shelves with fruits, vegetables, juices and breads stored on upper shelves. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S , d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].

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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** 37028 Based on observation, interviews, 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 #58) of five residents observed for infection control. 1. The facility failed to ensure CNA D wore the appropriate PPE and performed hand hygiene while bathing Resident #58. These failures placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Record review of Resident #58's admission MDS assessment, dated 10/11/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 15 indicating his cognitive status was intact. His diagnoses included bone infection of left foot/ankle, diabetes, and urinary tract infection. The resident required partial assist from one staff for bathing. The resident had an indwelling catheter and was frequently incontinent of bowel movement. Record review of Resident #58's care plans, dated 10/07/24 reflected: Risk for self-care deficit with bathing. Facility interventions included to provide assistance with ADLs as needed. The resident had a suprapubic catheter. Facility interventions included monitor/document for pain/discomfort due to catheter. An observation on 12/03/24 at 10:49 AM revealed Resident #58 was on enhanced barrier precautions and there was PPE available outside the resident's door. CNA D was in the room and wearing gloves. CNA D was not wearing a gown. CNA D undressed the resident and started bathing him. The resident had a supra-pubic catheter with crusty, brown drainage at the site and on the tubing. The catheter did not have a device to secure it on the leg to prevent it from pulling out. During the bath, CNA D's clothing repeatedly touched the bed and the resident. CNA D finished the bath but did not clean the resident's catheter site or tubing. CNA D had a hole in his right glove that was exposing his skin. CNA D did not change his gloves or perform hand hygiene after bathing the resident. CNA D put a clean brief and clean clothes on the resident while using the same soiled and torn gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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	An interview on 12/03/24 at 1:21 PM with CNA D revealed he did not think Resident #58 was on enhanced barrier precautions. CNA D said if the resident was on enhanced barrier precautions, then he was supposed to wear a gown and gloves to provide care. CNA D said he was supposed to change gloves and perform hand hygiene after washing the resident and before putting on the clean brief and clothes. CNA D said he got busy and forgot. CNA D said he was supposed to change gloves if they had a hole, and he was not sure why he did not do it this time. CNA D said he was supposed to clean the suprapubic catheter site and tubing and he did not know why he did not do it this time. He said he did not know how long the resident had been without a securing device for the resident's suprapubic catheter. An interview on 12/04/24 at 01:32 PM with Unit Manager A revealed Resident #58 was supposed to be on enhanced barrier precautions. She said staff were supposed to wear a gown and gloves for bathing residents on enhanced barrier precautions. Unit Manager A also said that if the staff had a torn glove, the staff were supposed to stop, perform hand hygiene, and put on a new set of gloves. She said staff were supposed to change gloves and perform hand hygiene after cleaning a resident and before putting on the clean brief and clothes. Unit Manager A said CNAs were supposed to clean the catheter site and tubing. She said correct PPE and hand hygiene were important to prevent the spread of infection. An interview on 12/05/24 at 1:25 PM with the DON revealed Resident #58 was on enhanced barrier precautions. She said staff were supposed to wear a gown and gloves for bathing and incontinence care for the resident. The DON said staff were supposed to change gloves if they tore a glove during care. She also said staff had to perform hand hygiene and put on a new set of gloves. The DON said staff were supposed to change gloves and perform hand hygiene after cleaning a resident and before putting on the clean brief and clothes. The DON said CNAs were supposed to clean the catheter site and tubing. The DON said correct PPE and hand hygiene were important to prevent the spread of infection. Review of the facility in-service, Infection Control, dated November 2017, reflected: 1. The facility must establish an infection prevention and control program (IPCP) that must include: a. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all Patients, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment .