STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted on-site from 11/29/21 through 12/2/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID PE6711.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation were conducted on-site from 11/29/21 through 12/2/21. The facility is in compliance with the requirement of 42 CFR Part 483, subpart B for Long Term Care Facilities. There were a total of 18 allegations investigated and 1 was substantiated without citation. Event #PE6711.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		12/24/21

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

Electronically Signed | 12/24/2021

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an anticoagulant and diabetes care plan for 1 of 5 residents (Resident #28) reviewed for unnecessary medications. The findings included: Resident #28 was admitted to the facility on 4/1/2019 with a diagnosis of Diabetes Mellitis. Resident #28 was diagnosed with a Deep Vein Thrombosis (DVT) in the left lower extremity (LLE) on 11/22/2019. A quarterly Minimum Data Set (MDS) dated 10/15/2021 revealed Resident #28 was severely	F 656	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it	

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F 656	Continued From page 2 cognitively impaired. Care plan review revealed there was no care plan in place for diabetes or for the anticoagulant medication. Physician order review revealed orders for the following medications: * Eliquis Tablet 5 MG (Apixaban) -Give 1 tablet by mouth two times a day for DVT LLE q12hr. Order dated 11/25/2019 * Insulin Glargine Solution 100 UNIT/ML -Inject 45 unit subcutaneously in the morning for diabetes. Order dated 1/17/2020 * NovoLog Solution 100 UNIT/ML (Insulin Aspart) -Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 11; 401+ = 13 401 or Greater give 13u, subcutaneously four times a day for Diabetes Before meals and at bedtime. Call the provider if blood glucose is less than 70 or more than 350 two times in a row or at the same time each day for 3 days in a row. Order dated 5/13/2020 * Insulin Glargine Solution 100 UNIT/ML -Inject 15 unit subcutaneously one time a day for diabetes. Order dated 11/25/2020 * NovoLog Solution 100 UNIT/ML (Insulin Aspart) -Inject 14 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) HOLD IF GLUCOSE IS < 90. Order dated 11/29/2020 During an interview with the MDS coordinator on	F 656	constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 656 On 12/01/2021, the Minimum Data Set Coordinator updated Resident #28's care plan to include diabetes and anticoagulant medication for the resident. On 12/01/2021 the Minimum Data Set Coordinator performed an audit of every resident's Medication Administration Record and care plan for accuracy. Any negative findings noted were corrected on 12/01/2021. On 12/01/2021, the Minimum Data Set Coordinator was in-serviced by the Administrator to develop, implement, and update residents comprehensive person-centered care plans for each resident according to the needs that are identified in the comprehensive assessment. On 12/01/2021, the Staff Development Coordinator initiated an in-service for all facility nurses that each resident must have a comprehensive person-centered care plan that is developed, implemented, and updated according to the needs that are identified in the comprehensive assessment. This in-service was completed on 12/24/21 for	

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F 656	Continued From page 3 12/1/2021 at 9:50 AM, the MDS coordinator revealed she was the one responsible for ensuring the appropriate care plans were in place for the residents. The MDS coordinator further revealed there was no care plan in place for diabetes or the anticoagulant medication for Resident #28. The MDS coordinator indicated that Resident #28 should have a care plan in place for diabetes and the anticoagulant medication. An interview with the Director of Nursing (DON) on 12/1/2021 at 10:02 AM revealed Resident #28 should have had a care plan in place for diabetes and for the anticoagulant medication. An interview with the Administrator on 12/1/2021 at 10:08 AM revealed Resident #28 should have had a care plan in place for diabetes and for the anticoagulant medication.	F 656	all staff including agency by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one education by the Staff Development Coordinator prior to next scheduled shift. All newly hired nurses and contract nurses will be educated and trained regarding developing, implementing, and updating residents comprehensive person-centered care plans during new employee orientation. On 12/24/21, the in-service regarding the development, implementation, and updating of residents comprehensive person-centered care plans for each resident according to their needs that are identified in the comprehensive assessment, was completed by all facility nurses including agency. This was completed by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one education by the Staff Development Coordinator prior to next scheduled shift. All newly hired nurses and contract nurses will be educated and trained regarding developing, implementing, and updating residents comprehensive person-centered care plans during new employee orientation. Beginning 12/03/2021, the Administrator or Director of Nursing will audit all resident's comprehensive person-centered care plans who are receiving anticoagulants and antidiabetic medication by using Framework	

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F 656	Continued From page 4	F 656	Pharmacy Link and Care Plan Audit Tool to ensure care plan accuracy five days per week for one week, three times per week for two weeks, weekly for two weeks and then monthly for one month. All findings will be presented to the Quality Assurance and Performance Improvement team by the Administrator or Director of Nursing, for review and recommendations for three months and as needed.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		12/24/21

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F 880	Continued From page 5 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 6 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and the Centers for Disease Control (CDC) COVID-19 Tracker for Rowan county transmission rate, the facility failed to follow CDC guidance regarding Personal Protective Equipment (PPE) for counties of high county transmission rates when 3 of 3 staff members (Infection Preventionist, Nurse #3 and Nurse Aide (NA) #3) failed to wear eye protection while providing care to 3 of 3 residents (Resident #3 Resident # 28 and Resident #51), the facility failed to implement their infection control policies and procedures when 2 of 2 staff members (Housekeeper #1 and NA #3) failed to wear the appropriate PPE for 1 of 1 resident (Resident #352) on enhanced droplet precautions and when 1 of 1 staff members (Wound care nurse) failed to perform hand hygiene in between glove changes while performing wound care for 1 of 1 resident (Resident # 49) reviewed for infection control. These practices had the potential to affect all residents who receive care from the facility staff. These failures occurred during a COVID-19 pandemic. The findings included: 1. On 11/29/2021 and 11/30/2021 the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker was reviewed. The CDC Covid-19 Data Tracker revealed that the county where the facility was located had a high level of community transmission for COVID-19. CDC guidance entitled, "Interim Infection	F 880	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes this plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Graham Healthcare & Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Graham Healthcare & Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 880 On 11/30/2021, the Facility Administrator and Director of Nursing, reviewed the Centers For Medicare and Medicaid Services Coronavirus 19 guidelines regarding eye protection in counties with high transmission rates. On 11/30/2021, the Administrator and Director of Nursing provided education to the Infection Preventionist, Nurse #3 and Nurse Aide	

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F 880	Continued From page 7 Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on 9/10/2021 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP): * If SARS- CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), Healthcare Personnel (HCP) working in facilities working in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. A facility policy entitled "Guidelines on Latest Approach to PPE Use During COVID-19 Pandemic dated June 2021 read in part the following information under the section "Eye Protection": * Staff working in the General Population should follow standard precautions with respect to eye protection UNLESS: -The facility is in a community with moderate to substantial COVID-19 transmission a. During an observation on 11/29/2021 at 11:42 AM, Nurse #3 was observed to administer medications to Resident #28 without eye protection in place. Nurse #3 was within 6 feet of Resident #28. An observation on 11/29/2021 at 11:45 AM	F 880	#3 that all staff that have direct resident care encounters are to wear eye protection due to the county's high transmission rate. On 11/30/2021, the Director of Nursing initiated education to all staff in the facility at the time of guideline review and eye protection was handed out to all staff on shift. All staff that have direct resident care encounters were educated and given eye protection, beginning 11/30/21 by the Director of Nursing. Eye Protection will be readily available for all staff at all times. All newly hired staff and contract staff will be educated and trained regarding eye protection during new employee orientation. On 12/01/2021 the Facility Administrator and Director of Nursing provided one on one education to Nurse Aide #3 regarding the facility policy and procedure for wearing Personal Protective Equipment in resident rooms that are suspected to be infected with microorganisms transmitted by droplets. On 12/02/2021 the Facility Director of Nursing and the Housekeeping Supervisor provided one on one education to Housekeeper #1 regarding the facility policy and procedure for wearing Personal Protective Equipment in resident rooms that are suspected to be infected with microorganisms transmitted by droplets. On 11/30/2021, the Director of Nursing initiated education for all staff on the proper use of Personal Protective Equipment while in resident room on quarantine and that all quarantine rooms will have proper signage on the room door	

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F 880	Continued From page 8 revealed Nurse Aide (NA) #3 passing meal trays to Resident #3 and Resident #28 without eye protection in place. NA #3 was within 6 feet of both residents. An interview with NA #3 on 11/29/2021 at 3:05 PM revealed the NAs had attended a recent in-service regarding PPE but was not sure when the in-service was conducted. NA #3 further revealed she was not aware of what the Covid-19 community transmission rate was for the county the facility was in and had not recently been instructed to wear eye protection during patient care encounters. An interview with Nurse #3 on 11/29/2021 at 3:15 PM revealed Nurse #3 had attended a recent in-service regarding PPE but was not sure when the in-service was conducted. Nurse #3 further revealed she was not aware of what the Covid-19 community transmission rate was for the county the facility was in and there had been no recommendation to wear eye protection during patient care encounters. An interview with the Infection Preventionist on 11/29/2021 at 3:20 PM revealed the Infection Preventionist was not aware of the Covid-19 community transmission rate for the county in which the facility was located. The Infection Preventionist indicated she thought the staff were supposed to just wear surgical masks at that time. An observation on 11/30/2021 at 8:20 AM revealed the Infection Preventionist assisted Resident #51 to eat breakfast with no eye protection in place. The Infection Preventionist was within 6 feet of Resident #51.	F 880	for use of Personal Protective Equipment and Personal Protective Equipment items available at all times per facility guidelines. On 11/29/2021, a Polymerase Chain Reaction Coronavirus 19 test was obtained for resident #352, Nurse Aide #3 and Housekeeper #1 and all Polymerase Chain Reaction test results were negative. All newly hired staff and contract staff will be educated and trained regarding Personal Protective Equipment while in resident's rooms on enhanced precautions/quarantine during new employee orientation. On 12/01/2021, the Facility Administrator and Director of Nursing provided one on one education to Wound Nurse regarding the facility policy and procedure for hand hygiene during wound care. On 12/01/2021, Director of Nursing began additional in-servicing of all departments including nursing, dietary, housekeeping, therapy, maintenance, and administrative staff on proper PPE usage on the Quarantine halls, proper hand hygiene, and the use of eye protection in resident care areas. This in-service was completed on 12/24/21 for all staff including agency by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one education by the Staff Development Coordinator prior to next scheduled shift. All newly hired nurses and contract nurses will be educated during orientation and trained by the Staff Development Coordinator regarding proper use of PPE while in Quarantine rooms, proper hand hygiene	

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F 880	Continued From page 9 An interview with the Infection Preventionist on 11/30/2021 at 3:31 PM revealed the Infection Preventionist did not have eye protection in place during patient care encounters because she had asked the Administrator about it and reported she was told by the Administrator the community transmission rate was not what the facility used to decide if they wore eye protection during patient care encounters. The Infection Preventionist was not able to provide information on what policy or guidelines that were currently being followed. An interview with the Administrator on 11/30/2021 at 4:15 PM revealed she did look at the Covid-19 community transmission rate to determine whether the staff needed to wear eye protection. The Administrator further revealed she also looked at the case rate and it was suppressed. The Administrator indicated the facility policy dated June 2021 did state the staff should wear eye protection when their community transmission rate was high. The Administrator requested to research their facility policies at that time. A follow up interview with the Administrator on 11/30/2021 at 5:20 PM revealed per CDC guidelines and their facility policy dated June 2021, staff should have worn eye protection while the Covid-19 community transmission rate was high. b. A facility policy entitled "Isolation Precautions" dated 3/10/2020 read in part the following information: * Droplet precautions in addition to standard precautions should be used for residents known	F 880	and use of eye protection while in resident care areas. Signage is posted through-out the facility for proper handwashing, PPE usage in the Quarantine Area and for use of eye protection in resident care areas. The Administrator and Director of Nursing will monitor periodically the signage to ensure it is in place. If signage needs replaced or updated the Administrator or Director of Nursing will be responsible for replacement or updating the signage. On 12/24/21, the in-services for proper PPE usage on the Quarantine halls, proper hand hygiene, and the use of eye protection in resident care areas was completed for all staff members including agency by in-person in-servicing or by mail. If the in-service was mailed, the staff members must complete one on one education by the Staff Development Coordinator prior to next scheduled shift. All newly hired nurses and contract nurses will be educated during orientation and trained by the Staff Development Coordinator regarding proper use of PPE while in Quarantine rooms, proper hand hygiene and use of eye protection while in resident care areas. Beginning 12/03/2021, the Facility Administrator, Director of Nursing or Registered Nurse Supervisor will observe staff providing direct resident care encounters by using the Eye Protection Audit Tool to ensure they are wearing appropriate eye protection daily for one week, weekly for four weeks, then monthly for one month. Beginning	

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F 880	Continued From page 10 or suspected to be infected with microorganisms transmitted by droplets. Examples include Covid-19. A physician's order dated 11/19/2021 revealed an order to admit Resident #352 to quarantine. An observation on 11/29/2021 at 2:40 PM revealed NA #3 was in Resident #352's room making his bed with only a facemask in place. No other PPE was in place. Housekeeper #1 was also observed in Resident #352's room at the same time mopping the floor with only a facemask in place. No other PPE in place. Resident #352 was a new admission on enhanced droplet precautions due to unknown Covid status. Resident #352's door did have enhanced droplet precaution signage posted and PPE equipment was available for use. An interview with NA #3 on 11/29/2021 at 3:05 PM revealed she should have worn the appropriate PPE while in Resident #352's room. An interview with Housekeeper #1 on 12/1/2021 at 6:35 PM revealed Housekeeper #1 did not wear the appropriate PPE in Resident #352's room because she did not see the enhanced droplet precaution sign or the PPE equipment on Resident #352's door. Housekeeper #1 further revealed she would have worn the appropriate PPE if she had seen the signage and PPE equipment. During an interview with the Housekeeping Supervisor on 12/2/2021 at 8:16 AM, she indicated the part of the facility where Resident #352 resided was designated as quarantine rooms. The Housekeeping supervisor further	F 880	12/03/2021, the Facility Administrator, Director of Nursing or Registered Nurse Supervisor will audit resident on enhance precautions/quarantine rooms by using the Quarantine Audit Tool daily for one week, weekly for four weeks, then monthly for one month for proper signage on resident room door, availability of Personal Protective Equipment at the quarantine rooms and staff while providing care to ensure proper use of Personal Protective Equipment. Beginning 12/03/2021, the Facility Administrator, Director of Nursing or Registered Nurse Supervisor will observe staff while performing treatments to ensure proper hand hygiene and glove usage by using the Hand Hygiene Audit Tool daily for one week, weekly for four weeks, then monthly for one month. All findings will be presented by the Administrator or Director of Nursing to the Quality Assurance and Performance Improvement team, for review and recommendations for three months and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11	F 880		

indicated Housekeeper #1 should not have been in Resident #352's room without the appropriate PPE in place.

An interview with the Director of Nursing (DON) on 12/1/2021 at 10:02 AM revealed Resident #352 was on enhanced droplet precautions at the time of the survey. The DON further revealed staff should wear the appropriate PPE when they enter an isolation/quarantine room.

During an interview with the Administrator on 12/1/2021 at 10:08 AM, she indicated Resident #352 was on enhanced droplet precautions at the time of the survey. The Administrator further revealed staff should wear the appropriate PPE when they enter an isolation/quarantine room.

An interview with the Administrator on 12/2/2021 at 8:56 AM revealed the part of the facility where Resident #352 resided was designated as quarantine rooms. The Administrator further revealed she expected staff to follow facility policies and procedures for isolation/quarantine rooms which included to wear the appropriate PPE according to the posted signage on the doors.

2. Review of the facility's handwashing policy, dated 3/10/20, stated in part, "Wash hands before and after touching wounds, after touching blood, body fluids, secretions, excretions and contaminated items, whether gloves are worn or not. Wash hands immediately after gloves are removed ...An alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 12	F 880		

On 12/01/21 at 1:34 PM, the Wound Nurse (WN) was observed performing wound care on Resident #49. The WN performed hand hygiene, put on clean gloves, cleaned Resident #49's buttocks of stool using wipes. The wipes were discarded as well as the dirty gloves. WN put on a clean pair of gloves without performing hand hygiene. She removed the soiled dressing and discarded. She removed her gloves but failed to perform hand hygiene. She put on a clean pair of gloves and cleaned with sacral pressure ulcer with normal saline, applied Santyl and silver alginate. She applied skin prep around the wound and applied a hydrocolloid dressing. She removed the gloves and failed to perform hand hygiene. She put on a clean pair of gloves and pulled Resident #49 up in the bed.

On 12/01/21 at 2:01 PM, an interview was conducted with the Wound Nurse. She stated she should have used hand hygiene between glove changes. She stated she had hand sanitizer in her pocket but forgot to use it.

On 12/01/21 at 2:10 PM, an interview was conducted with the Infection Control Nurse. She stated the wound nurse should have performed hand hygiene between each glove change while performing the wound care.

On 12/2/21 at 9:30 AM, an interview was conducted with the Director of Nursing. She stated the wound nurse should have performed hand hygiene between each glove change.