STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345433	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/23/23 through 10/26/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# ZIPH11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/23/23 through 10/26/23. Event ID# ZIPH11. The following intakes were investigated: NC00194930, NC00194978, NC00204678, NC00205538 and NC00205639. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		11/21/23

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

Electronically Signed | 11/15/2023

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F 756	Continued From page 1 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and the Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 4 residents reviewed for diabetes management (Resident #39). The findings included: Resident #39 was admitted to the facility on 06/04/20 with diagnosis including diabetes mellitus. Review of physician's orders dated 07/05/23 revealed Resident #39 had an order to receive 10 units of Humalog insulin subcutaneously 3 times daily before meals for diabetes. The order specified holding the insulin when Resident #39's capillary blood glucose (CBG) was lower than 120 milligrams per deciliter (mg/dL).	F 756	Resident #39 was reviewed by the physician on Tuesday, November 24, 2023 during the survey and changes were made to the insulin orders. The scheduled fast acting insulin was discontinued by the physician. It was Humalog 100. There was no harm to the resident. The pharmacist completed a quality review of all current diabetic residents on November 9, 2023. The medical director will review the pharmacist report on 11/13/23. He will document his review in the medical record. The administrator and the director of nursing will educate the pharmacist on identifying and recommending changes to the physician. The pharmacist will	

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F 756	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 09/15/23 coded Resident #39 with intact cognition and indicated that she was receiving insulin daily in the 7-day assessment periods. A review of medication administration records (MARs) on 10/24/23 indicated Resident #39 had received 10 unit of Humalog insulin subcutaneously erroneously 2 times when her CBGs were below 120 mg/dl, and her insulin was held against the parameter 17 times when her CBGs were above 120 mg/dl within 112 days (from 07/05/23 through 10/24/23) on the following dates and times with the charted codes: - 07/05/23 noon when CBG = 130 mg/dL - Held per parameter. - 07/08/23 noon when CBG = 167 mg/dL - Held per parameter. - 07/11/23 evening when CBG = 146 mg/dL - Insulin not required. - 07/25/23 evening when CBG = 146 mg/dL - Insulin not required. - 08/07/23 morning when CBG = 127 mg/dL - Insulin not required. - 08/21/23 morning when CBG = 111 mg/dL - Insulin was administered - 08/29/23 morning when CBG = 139 mg/dL - Insulin not required. - 09/01/23 noon when CBG = 128 mg/dL - Held per parameter. - 09/04/23 morning when CBG = 154 mg/dL - Insulin not required. - 09.05/23 morning when CBG = 121 mg/dL - Insulin not required. - 09/11//23 morning when CBG = 98 mg/dL - Insulin was administered	F 756	document the recommendations in the electronic record. The director of nursing, the assistant director of nursing and or designee will educate the staff to review the recommendations and notify he physician if there are changes recommended. This will be completed by 11/17/23. The director of nursing and or designee ill ensure that the pharmacist will review all diabetic residents monthly. All new admits and or readmissions will be reviewed. The report will be communicated to the director of nursing and then to the physician. The results will be reported to the Quality Assurance Performance Improvement (QAPI) committee on a monthly basis. The committee will evaluate the effectiveness and amend as needed. completitin date 11-21-23	

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F 756	Continued From page 3	F 756		

- 09/16/23 morning when CBG = 126 mg/dL - Insulin not required.
- 09/26/23 noon when CBG = 140 mg/dL - Held per parameter.
- 09/26/23 evening when CBG = 191 mg/dL - Held per parameter.
- 09/28/23 morning when CBG = 140 mg/dL - Insulin not required.
- 10/03/23 morning when CBG = 145 mg/dL - Insulin not required.
- 10/10/23 noon when CBG = 203 mg/dL - Held per parameter.
- 10/19/23 noon when CBG = 140 mg/dl - Held per parameter.
- 10/24/23 morning when CBG = 170 mg/dl - Insulin not required.

Review of medical records revealed Resident #39's CBGs were stable at the baselines ranged from 79 to 359 mg/dl, mostly in the high 100s or low 200s mg/dl in the past 3.5 months.

Review of medical record revealed the Consultant Pharmacist had conducted monthly medication regimen reviews for Resident #39 in the past 12 months on 11/16/22, 12/27/22, 01/25/23, 02/14/23, 03/20/23, 04/15/23, 05/20/23, 06/15/23, 07/14/23, 08/09/23, 09/03/23, and 10/12/23. However, he did not identify any drug irregularities related to insulin and did not make any specified recommendations to the physician or nursing staff to correct the error.

An interview was conducted with the Unit Manager (UM) on 10/24/23 at 12:09 PM. She stated that she was not aware of the incident and was shocked to learn that it had occurred numerous times in the past 3.5 months. She indicated that failure to follow the parameters set

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F 756	Continued From page 4	F 756		

by the physician could compromise the effectiveness of diabetes management. She expected all the nurses to consult the physician before making any clinical decisions related to insulin. It was her expectation for the Consultant Pharmacist to identify the drug irregularities and notify the MD and the facility in a timely manner.

A phone interview was conducted with the Consultant Pharmacist on 10/25/23 at 12:56 PM. He confirmed he had performed medication regimen reviews for Resident #39 in the past 12 months and acknowledged that he did not notice that the parameter for Resident #39's Humalog was not followed by numerous nurses repeatedly in the past 3.5 months. He added the failure of nurses to follow the parameter of Humalog order could elevate the level of hemoglobin A1C (A1C is a simple blood test that measures patient's average blood sugar levels over the past 3 months. A normal A1C level was below 5.7%, a level of 5.7% to 6.4% indicated prediabetes, and a level of 6.5% or more indicated diabetes).

A subsequent phone interview was conducted with the Consultant Pharmacist on 10/25/23 at 4:45 PM. He stated that Resident #39's hemoglobin A1C was not affected by the incident. In fact, he indicated that Resident #39's hemoglobin A1C had improved from 6.6% on 07/20/23 to 6.3% on 10/18/23. He stated that he could not predict what might happen if nurses failed to follow the parameter of Resident #35's Humalog order repeatedly.

During a phone interview conducted on 10/25/23 at 1:54 PM, the MD stated that the failure of nurses to follow the parameter of Resident #39's Humalog order could elevate her CBGs but not to

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F 756	Continued From page 5 a harmful level. He expected nurses to consult him before holding or administering the insulin outside of the set parameter. He expected the Consultant Pharmacist to identify the medication error and notify him in a timely manner as he had access to the MARs. An interview was conducted with the Director of Nursing (DON) on 10/26/23 at 10:49 AM. She stated that the above incident was a medication error. She expected nursing staff to follow physician's order and parameter when performing medication pass and contact the physician before making any changes to the order. She stated that the Consultant Pharmacist reviewed Resident #39's medications monthly and had access to all her medication records. It was her expectation for the Consultant Pharmacist to identify the medication error and notify her and the MD in a timely manner. During an interview conducted with the Administrator on 10/26/23 at 11:16 AM, he expected the Consultant Pharmacist to identify the issues and notify the MD and DON in a timely manner.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and the Medical Director (MD), the facility failed to prevent significant medication errors when 5 nurses failed	F 760	Resident #39 was reviewed on 10/24/23 by the physician. New orders noted on 10/24/23 for the resident #39. The physician discontinued the fast acting	11/21/23

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F 760	Continued From page 6 to follow the physician's parameter as ordered during insulin administration. As a result, Resident #39 had received 2 doses or unnecessary Humalog insulin and her insulin had been held against the parameter 17 times within 112 days. This affected 1 of 4 residents reviewed for diabetes management (Resident #39). The findings included: Resident #39 was admitted to the facility on 06/04/20 with diagnosis including diabetes mellitus. The care plan initiated on 06/15/20 indicated Resident #39 had diagnosis of diabetes mellitus. The goal was to remain free of complications related to diabetes through the next review date. Intervention included administering medications as ordered. Review of physician's orders dated 07/05/23 revealed Resident #39 had an order to receive 10 units of Humalog insulin subcutaneously 3 times daily before meals for diabetes. The order specified holding the insulin when Resident #39's capillary blood glucose (CBG) was lower than 120 milligrams per deciliter (mg/dL). The quarterly Minimum Data Set (MDS) assessment dated 09/15/23 coded Resident #39 with intact cognition and indicated that she was receiving insulin daily in the 7-day assessment periods. A review of medication administration records (MARs) on 10/24/23 indicated Resident #39 had received 10 unit of Humalog insulin subcutaneously erroneously 2 times when her	F 760	insulin, Humalog 100. Starting on 10/24/23 the director of nursing and the assistant director of nursing reviewed current resident diabetic orders with parameters that required physician notification. There were no orders found that did not have proper notification tot he physician. Starting on 10/24/23 the licensed nurses will be educated by the director of nursing and/or designee on following physician orders to include parameters for holding and/or providing insulin. This will be completed by 11/17/23 Starting on 10/24/23 to 11/17/23 the director of nursing and the assistant director of nursing began educating the licensed staff on following physician orders to include notifying the physician if any order is not followed, either due to resident condition and or by parameters set by the physician order. Newly hired licensed nurses will receive this education up hire. Starting on 11/27/23 the director of nursing and assistant director of nursing will complete a random audit on 5 diabetic residents 3 times a week for 4 weeks, then 1 time a week for 8 weeks to review diabetic orders and ensure licensed nursing staff are following physician orders to include notifying the physician if any order is not followed, either due to resident condition and or by parameters set by the physician order. The director of nursing introduced the POC to the Quality	

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F 760	Continued From page 7 CBGs were below 120 mg/dl, and her insulin was held against the parameter 17 times when her CBGs were above 120 mg/dl within 112 days (from 07/05/23 through 10/24/23) on the following dates and times with the charted codes: - 07/05/23 noon when CBG = 130 mg/dL - Held per parameter. - 07/08/23 noon when CBG = 167 mg/dL - Held per parameter. - 07/11/23 evening when CBG = 146 mg/dL - Insulin not required. - 07/25/23 evening when CBG = 146 mg/dL - Insulin not required. - 08/07/23 morning when CBG = 127 mg/dL - Insulin not required. - 08/21/23 morning when CBG = 111 mg/dL - Insulin was administered - 08/29/23 morning when CBG = 139 mg/dL - Insulin not required. - 09/01/23 noon when CBG = 128 mg/dL - Held per parameter. - 09/04/23 morning when CBG = 154 mg/dL - Insulin not required. - 09.05/23 morning when CBG = 121 mg/dL - Insulin not required. - 09/11//23 morning when CBG = 98 mg/dL - Insulin was administered - 09/16/23 morning when CBG = 126 mg/dL - Insulin not required. - 09/26/23 noon when CBG = 140 mg/dL - Held per parameter. - 09/26/23 evening when CBG = 191 mg/dL - Held per parameter. - 09/28/23 morning when CBG = 140 mg/dL - Insulin not required. - 10/03/23 morning when CBG = 145 mg/dL - Insulin not required. - 10/10/23 noon when CBG = 203 mg/dL - Held	F 760	Assurance Performance Improvement (QAPI) committee on 11/17/23. The director of nursing is responsible for implementing this plan. The Quality Assurance performance Improvement (QAPI) members consist of but are not limited to the administrator, director of nursing, unit manager, social services, medical director, housekeeping, dietary manager, and MDS nurse. the director of nursing will report findings to the QAPI committee monthly for 3 months. completition date 11-21-23	

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F 760	Continued From page 8	F 760		

per parameter.
- 10/19/23 noon when CBG = 140 mg/dl - Held per parameter.
- 10/24/23 morning when CBG = 170 mg/dl - Insulin not required.

Review of medical records revealed Resident #39's CBGs were stable at the baselines ranged from 79 to 359 mg/dl, mostly in the high 100s or low 200s mg/dl in the past 3.5 months.

During an interview conducted on 10/24/23 at 11:58 AM, Nurse #2 confirmed that he had held Resident #39's Humalog several times when her CBGs were higher than 120 mg/dl and acknowledged that it was an error. He explained that those doses were held when Resident #39 was either being lethargic or not having a good meal intake before the insulin was due. He stated that he did not consult the physician before making those clinical decisions.

During a phone interview conducted on 10/25/23 at 7:26 PM, Nurse #3 confirmed that he had failed to follow the parameter set by the physician for Resident #39's Humalog order numerous times and acknowledged that it was an error. He explained that the parameter for Resident #39's Humalog was previously set at 150 mg/dl and later had changed to 120 mg/dl. He added it was his oversight for failure to follow the parameter set by the physician when performing medication pass for Resident #39's Humalog order.

An interview was conducted with the Unit Manager (UM) on 10/24/23 at 12:09 PM. She stated that she was not aware of the incident and was shocked to learn that it had occurred numerous times in the past 3.5 months. She

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F 760	Continued From page 9	F 760		

indicated that failure to follow the parameters set by the physician could compromise the effectiveness of diabetes management. She expected all the nurses to consult the physician before making any clinical decisions related to insulin. She added it was a significant medication error as it involved insulin with 5 nurses for 19 times in approximately 3.5 months.

During an interview conducted on 10/25/23 at 11:48 AM, Resident #39 did not know that the physician had set a parameter for her Humalog. She stated that she had received insulin as ordered in a timely manner and added her CBGs were stable in the past 3 months.

A phone interview was conducted with the Consultant Pharmacist on 10/25/23 at 12:56 PM. He stated the failure of nurse to follow the parameter of Humalog order could elevate the level of hemoglobin A1C (A1C is a simple blood test that measures patient's average blood sugar levels over the past 3 months. A normal A1C level was below 5.7%, a level of 5.7% to 6.4% indicated prediabetes, and a level of 6.5% or more indicated diabetes).

A subsequent phone interview was conducted with the Consultant Pharmacist on 10/25/23 at 4:45 PM. He stated that Resident #39's hemoglobin A1C was not affected by the incident. In fact, he indicated that Resident #39's hemoglobin A1C had improved from 6.6% on 07/20/23 to 6.3% on 10/18/23. He refused to comment if the above incident would be considered as a significant medication error and added he could not predict what might happen if nurses failed to follow the parameter of Resident #35's Humalog order repeatedly.

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F 760	Continued From page 10 During a phone interview conducted on 10/25/23 at 1:54 PM, the MD stated that the failure of nurses to follow the parameter of Resident #39's Humalog order could elevate her CBGs but not to a harmful level. He expected nurses to consult him before holding or administering the insulin outside of the set parameter. He stated it was a significant medication error as it involved insulin with 5 different nurses for 19 times within 3.5 months. An interview was conducted with the Director of Nursing (DON) on 10/26/23 at 10:49 AM. She stated that the above incident was a medication error but was not sure it was a significant medication error. She expected nursing staff to follow physician's order and parameter when performing medication pass and contact the physician before making any changes to the order. During an interview conducted with the Administrator on 10/26/23 at 11:16 AM, he denied it was a medication error. He expected the nurse to work for the best interest of the residents to hold the insulin when Resident #39 was not eating well or being lethargic. On the other hand, he expected nurses to follow the order and parameter, and consult the physician before holding or administering the Humalog outside of the parameter.	F 760		
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	F 880		11/21/23

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F 880	Continued From page 11	F 880		

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;

§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

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	345433	A. BUILDING _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

(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
F 880	Continued From page 12 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. 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 record reviews, observations and staff interviews, the facility failed to implement their infection control policy when Nurse #1 did not perform hand hygiene after removing soiled dressings with drainage and before donning new gloves to cleanse the wound for 3 of 5 wound care observations on 2 of 3 residents reviewed (Resident #53 and Resident #33). The findings included: The facility's policy entitled "Dressings, Dry/Clean" revised on September 2013 under Steps in the Procedure indicated the following: 6. Put on clean gloves. Loosen tape and remove	F 880	Eemployee #1 was educated on 10/25/23 by the director of nursing regarding proper hand hygiene. Employee #1 completed a hand hygiene competency while being supervised by the directo0r of nursing. This was completed on October 25, 2023. All staff will be educated in hand hygiene starting 10/25/23 to 11/17/23 by the director of nursing and or designee utilizing the handwashing/hand hygiene policy. All staff will complete handwashing	

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F 880	Continued From page 13 soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. The facility's policy entitled "Handwashing/Hand Hygiene" which is part of their Infection Control Policies and Procedures last revised on August 2019 under Policy Interpretation and Implementation indicated the following: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; k. After handling used dressings, contaminated equipment, etc.; m. After removing gloves; 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. a. An observation of wound care by Nurse #1 was made on 10/25/23 at 9:40 AM. Nurse #1 washed both hands and put on gloves. She removed the old dressing on Resident #53's wound to the back of his left leg. The old dressing had moderate amount of serosanguinous (contains or relates to both blood and the liquid part of blood) drainage. She proceeded to clean the wound with normal saline-soaked gauze and while being cleaned, the	F 880	education by 11/17/23. The director of nursing and or designee will observe 5 staff members weekly for 1 month and then 5 staff members weekly for 1 month for 3 months. The director of nursing introduced he POC to the Qualiity Assurance Performance Improvement (QAPI) committee on 11/17/23. Tthe director of nursing is responsible for implementing this plan. The Qua;lity Performance Improvement (QAPI) committee memebers include but are no limited to the administrator, director of nursing, the assistant director of nursing, unit manager, social worker, maintenance director, housekeeping services, dietarty manger, and MDSD nurse. Nursing will report findings to the QAPI committee monthly for 3 months. completition date 11-21-23	

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wound started to bleed. Nurse #1 removed her gloves and without doing hand hygiene, she put on a new pair of gloves to both hands. Nurse #1 applied an antiseptic solution-soaked gauze onto the wound and let it soak for about ten seconds. After ten seconds, she removed it and placed a petrolatum-based mesh gauze onto the wound bed, covered it with an abdominal gauze pad and wrapped it with a rolled gauze. Nurse #1 secured it with tape and then removed her gloves, gathered any unused supplies and washed both hands.

Another observation of wound care was made for Resident #53 on 10/25/23 at 10:00 AM. Nurse #1 put gloves on after washing both hands. She removed the dressing to Resident #53's left knee which had moderate amount of clear drainage. She sprayed the wound with normal saline and patted it dry with a dry gauze. Nurse #1 removed her gloves and without performing hand hygiene, put on a new pair of gloves. She covered the wound with an adhesive border gauze, removed her gloves and washed her hands.

b. An observation of wound care was made for Resident #33 on 10/25/23 at 10:07 AM. Nurse #1 washed both hands and put on gloves. Nurse #1 tried to remove the old dressing to Resident #33's right heel but it adhered to Resident #33's skin so she sprayed normal saline around the dressing edges until it came off. The old dressing was soaked with povidone iodine solution and the wound had small amount of serosanguinous drainage. Nurse #1 removed her gloves and without doing hand hygiene, put new gloves on. Nurse #1 cleaned the wound with normal saline-soaked gauze, poured povidone iodine solution onto a stack of gauze and applied it onto

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F 880	Continued From page 15	F 880		

Resident #33's right heel. She covered it with an abdominal gauze pad, wrapped it with rolled gauze and secured it with tape. Nurse #1 repositioned Resident #33's heels, discarded unused supplies in a trash bag, removed her gloves and washed both hands.

An interview with Nurse #1 on 10/25/23 at 10:37 AM revealed she was educated to wash her hands when going into the room, between dirty and clean dressings and before leaving the room after performing wound care. Nurse #1 stated she was supposed to wash her hands after removing her gloves and prior to donning another pair of gloves but she got nervous while being observed doing wound care and she forgot to do so.

An interview with the Infection Preventionist (IP) on 10/25/23 at 10:57 AM revealed she recommended washing hands in between dressing changes and whenever gloves were removed during wound care. The IP stated that she had not done education specifically on hand hygiene during wound care with Nurse #1 because the old treatment nurse and the wound care provider had worked with Nurse #1 on how to do the treatments. The IP stated Nurse #1 should have performed hand hygiene whenever she removed her gloves after cleaning the wounds and prior to putting on new gloves.

An interview with the Interim Director of Nursing (DON) on 10/26/23 at 11:32 AM revealed she was aware that Nurse #1 was nervous when she was observed doing wound care, but she needed to do more education with her. The Interim DON stated that she was not sure if Nurse #1 understood to perform hand hygiene after

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F 880	Continued From page 16 removing her gloves and prior to cleaning the wounds.	F 880		