STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185271	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Health and Rehabilitation	1002 Glenview Drive Glasgow, KY 42141

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44396 Based on interview, record review, and review of facility policy, it was determined the facility failed to include the resident and/or the resident's representative in the care planning process. The facility failed to either invite the resident and/or their representative or include an explanation in the resident's medical record as to why their participation in the development of the resident's care plan was not practicable. This failure affected five (Resident (R) 45, R15, R10, R43, and R48) of twenty-five (25) sampled residents. The findings include: Review of the facility policy titled, Care Planning-Resident Participation, dated 03/20/2023, revealed that the facility would discuss the plan of care with the resident and or representative at regularly scheduled care plan conferences and allow them to see the care plan initially, at routine intervals, and after significant changes. The facility would make an effort to schedule the conference at the best time of day for the resident or the resident representative. Additionally, the facility would obtain a signature from the resident and or resident representative after discussion or reviewing of the care plan. If the participation of the resident and or resident representative is determined not practicable for the development of the resident care plan, an explanation would be documented in the resident's medical record. 1. Review of R45's Facesheet in the medical record revealed the resident was admitted on [DATE], and had a durable Power of Attorney (POA) Review of most recent Minimum Data Set (MDS), a quarterly assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 1/15, indicating the resident was severely cognitively impaired. Review of the Care Plan section of R45's medical record revealed no care conference notes, nor dates documenting when a care conference occurred. Consistent with R45's admitted , an admission care conference would have been expected to have occurred no later than 12/2023 and a quarterly care plan conference no later than March 2024. Further review of the Care Plan section revealed a baseline care plan was initiated on 11/21/2023, with and initial comprehensive care plan established within the first 14 days. Continued review of the care plan revealed subsequent problems and goals were identified in 12/2023 and in 03/2024. (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R45's progress notes revealed no documentation of that the facility extended an invitation to the resident's POA to attend his care conference and participate in his care decisions. In addition, there was no documentation to explain why the resident and/or their representative was not included in the care planning process. During interview with R45's POA on 04/09/2024 at 3:24 PM, he stated he could not recall being invited to a care plan conference. The POA questioned R45's diagnoses and was unaware of possible care areas related to the resident, such as wound care. 50153 2. Review of the Admission Record revealed R15 was a long-term resident of the facility. Review of the Quarterly MDS, dated , 03/08/2024, revealed a BIMS score of 9/15, indicating R15 had moderate cognitive impairment. Progress notes review of the previous 120 days prior to 04/12/2024 revealed no evidence that the resident and/or their responsible party had been invited to attend the care plan meeting. Upon attempting to interview R15 on 04/08/2024 at 9:00 AM, the resident was in bed. The resident made eye contact but did not reply to questions when asked. 3, Record review of R48 revealed an initial admitted [DATE]. The 03/16/2024 Quarterly MDS revealed a BIMS score of 4/15, indicating severe cognitive impairment. Progress notes review of the previous 120 days prior to 04/12/2024 for R48 revealed no evidence that the resident's responsible party was invited to attend a care plan meeting. In a telephone interview with R48's Guardian on 04/09/2024 at 11:10 AM, the Guardian stated that he does not recall receiving an invitation to attend a care plan meeting. 4. Record review of R43 revealed an initial admitted [DATE]. The MDS Quarterly assessment dated [DATE] indicated a BIMS score of 3/15, indicating severe cognitive impairment. Review of the progress notes of the previous 120 days prior to 04/12/2024 revealed no evidence that the resident's responsible party was invited to attend a care plan meeting. In a telephone interview on 04/09/2024 at 11:29 AM, R43's Guardian stated that he has not received an invitation to attend a care plan meeting. 5. Record review of R10 revealed the initial admitted [DATE], The MDS Quarterly assessment dated [DATE] indicated a BIMS score of 14/15, indicating the resident is cognitively intact. Progress notes review of the previous 120 days prior to 04/12/2024 revealed no evidence that the resident and/or their representative were invited to attend a care plan meeting. In an interview with R10 on 04/11/2024 at 10:45 AM, R10 stated she did not recall being invited to a care plan meeting and has not attended any meetings. In a telephone interview with the Durable POA for R10 on 04/09/2024 at 9:05 AM, the DPOA stated that she has not received an invitation to attend a care plan meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the MDS Coordinator on 04/12/2024 at 5:25 PM, she stated she helps with the baseline care plan and is responsible to ensure a care plan is in place for every area triggered on the Care Area Assessments (CAA) so that staff know how to take care of the resident. The MDS Coordinator stated she is responsible to send out Primetime (facility notice) weekly for residents who are due the following week for care plan review and conference and notify staff of the planned meeting. The MDS Coordinator stated she updated care plans in real time during care plan conferences but has not documented the conference notes in the dedicated section of the record for this before. She further stated the Social Services Director (SSD) is responsible for inviting families and to document who was present, including families, in the care plan conference notes. During interview with the SSD on 04/12/2024 at 5:41 PM, she stated that normally care conferences would be documented in the medical record in the Care Conference section of the care plan. The SSD stated that she uses the BIMS score of the resident, along with the resident's actual cognitive ability, to determine who to invite to the care plan meeting. The SSD explained that residents who have a BIMS score greater than 8/15 and are cognitively intact can determine who can be invited or not from their family. She stated for residents whose BIMS score is less than 8/15, she is responsible to notify families of the date of care plan conference. The SSD indicated that if the family cannot make the typical day, she is to ask what was convenient for them, call families to invite them to the care conference, and document in a progress note if she left a message or talked to them. However, she stated, she has not been doing that. She stated it was important for families to be aware of concerns of residents' everyday wellbeing and they might have insight into things such as behavior management. Interview with the interim Director of Nursing on 04/12/2024 at 5:50 PM revealed the SSD had received education on documenting care plan conferences that day, after the survey was initiated. She stated the expectation is that care conferences are documented, and the care conference note should have documented who was present, including family. She further stated the expectation is family or POA is invited to care conferences. During interview with the Administrator on 04/12/2024 at 4:51 PM, she stated care plan conferences occurred at admission, quarterly and with significant change in a resident's condition. She indicated staff were to notify families or responsible parties, (whether by call, email, or text), of scheduled care plan conferences. She stated if family or responsible parties were not able to attend a scheduled care plan conference, then an alternate date or time was offered. When asked if there needed to be documentation in the record if attendance at the meeting was declined, the Administrator stated, It doesn't have to be, even though both the regulation and facility's own policy called for an explanation to be documented if the attendance of the resident/responsible party was not practicable.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50153 Based on observation, interview, and review of the facility's policy, the facility failed to ensure all drugs and biological agents were properly labeled, stored, and/or secured in accordance with accepted professional principles. Medication was not kept under lock as required. Expired medication was not discarded per policy. Medication was not completely labeled so as to identify the resident to whom it was prescribed and/or dated as required. Temperatures for medication storage were not monitored and/or maintained at a level to protect the safety/efficacy of the drugs. These failures involved two (2) of two medications rooms, two of five medication carts, and one treatment cart. The findings include: 1.Unlocked Medications: Review of the facility policy, titled Medication Storage in the Facility, dated 05/2022, revealed medications must be stored safely, securely, and properly. a. Observation on 04/08/2024 at 8:15 AM on the 200 Hall revealed Certified Medication Technician (CMT) 5 left the medication cart unlocked and unattended as the survey team entered the building for the first time. The CMT 5 was not in the line of sight of the unlocked medication cart. During interview with CMT5 on 04/08/2024 at approximately 12:15 PM, she stated she should have locked the cart before walking away. She stated it was important to lock the cart because someone could get into the cart and take out a medication that was not prescribed for them which could cause a problem. b. Observation on 04/11/2024 at 11:42 AM revealed CMT14 left the medication cart on the [NAME] Wing unattended, unlocked, and out of line of sight in the hallway. No other staff were present to provide visual supervision of the unlocked cart. During interview with CMT14 on 04/11/2024 at 11:44 AM, she stated the medication cart should be locked if she cannot see it. She stated that if the cart was not locked, someone could get into it, and it could be very bad. c. Observation on the 300 Hall on 04/08/2024 at 09:32 AM revealed an unlocked treatment cart. At this time, Licensed Practical Nurse (LPN) 1 was observed leaving a resident bathroom and returning to the unsecured cart. Interview with LPN1 at this time revealed the treatment cart was left unlocked when a resident was going to the bathroom and the LPN went in to assist. LPN1 confirmed the treatment cart was unlocked, and she should have locked it before walking off. Observation of the contents of the cart revealed that it contained creams, ointments, insulins, nebulizer treatment medications, and wound care supplies. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview regarding securing medications with the Administrator on 04/05/2024 at 5:15 PM, she stated Generally, they [staff] are good about it. They may get distracted and lay something down but then go back to it. She stated it was her expectation that a medication cart be locked if it was not in line of sight of staff. 2. Expired Medications/Labeling Review of the facility policy, Medication Storage in the Facility, dated 05/2022, revealed medications must be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Further review of the policy revealed all medications dispensed by the pharmacy are stored in the container with the pharmacy label. The policy stated that no expired medication will be administered to a resident and all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. a. Observation of the east side medication cart on 04/10/2024 at 4:27 PM revealed benzonatate capsule 100 milligrams (mg), labeled for Resident (R) 7 that expired 01/27/2024. Further observation revealed acetaminophen 500 mg for R40 that expired 4/07/2024. b. Observation of the west side medication cart on 04/10/24 at 4:42 PM revealed ondansetron 4 mg, labeled for R19, expired on 03/03/2024. c. Observation of the west medication storage room on 04/10/2024 at 2:08 PM revealed an opened vial of Tubersol, with an open date of 03/06/2024 (more than 30 days prior). d. Observation of the east medication storage room on 04/10/2024 at approximately 2:35 PM, revealed a vial of Arexvy, RSVPreF3 vaccine, labeled for R21, 120 micrograms (mcg), dispensed 03/22/2024. The vaccine was not open, still stored in a prescription bottle. The unsealed normal saline vial to be used for reconstitution of the vaccine was not dated. Further observation revealed Amicasin 1340 mg/250 ml bag intravenous piggyback, expired 02/23/2024. A portion of the label was no longer attached, and the resident for whom it was prescribed could not be identified. During an interview with LPN2 on 04/08/2024 at 02:08 PM, LPN2 indicated the opened vial of Tubersol should be discarded because it can only be used for up to 30 days after the open date. When asked about the use of an expired medication, LPN 2 stated that a medication could increase or decrease in strength depending on the medicine and it might not be as effective. During interview with LPN1 on 04/10/2024 at 4:27 PM, she stated that discontinued intravenous medication in the refrigerator just needs to go back to pharmacy. LPN1 stated she understood the Director of Nursing (DON) went through the refrigerator to discard expired medications. In further interview, she stated, You don't give medications that are expired because they may not be as effective. She stated that everyone who has hands in the cart should probably be looking at expiration dates. However, she added, she had not particularly been trained to do that. During interview with the Interim Director of Nursing (IDON) on 04/12/2024 at 4:06 PM, the IDON stated that it was her expectation that the nurses and CMT's dispose of expired medications. She stated she expected staff to look for expired medications if they are assigned to that cart. She stated she feels recently expired medications probably would not affect resident's health but added, We do like to keep meds in date. Expiration dates are recommendations, we would follow those as a facility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview regarding expired medications with the Administrator on 04/05/2024 at 5:15 PM, she stated that it was her expectation that medications are not expired on the medication carts and that weekly cart checks are completed. In continued interview, she stated medications are pulled if it's really close or the day of if there's a chance it won't be used. She indicated this was a nursing obligation to check the medications, remove expired medications from the cart, and discard the expired medications. In additional interview, she stated the floor nurses are responsible for these tasks, as well as the unit managers and Director of Nursing. 3. Storage Temperatures: Review of the facility policy, titled Medication Storage in the Facility, dated 05/2022, revealed medications must be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Per the policy, medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC). To wit, the refrigerated temperature range specified in the policy was 36 degrees Fahrenheit (F) to 46 degrees with a thermometer to allow temperature monitoring. Additional review of the policy revealed the facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day per CDC guidelines. Observation of the west medication storage room on 04/10/2024 at 2:08 PM revealed a combined refrigerator (in which medications were stored)/freezer unit. Both the refrigerator and freezer units contained thermometers. There was no temperature log labeled for recording of refrigerator temperatures. A log, labeled for the freezer, did document temperatures for the month of April 2024. However, the daily temperatures on the freezer log ranged between 23 - 28 degrees F and were not acceptable for a freezer or refrigerator. Review of the temperature log revealed it did not reflect the accepted temperature range for staff to use as a reference to determine if the unit was properly functioning. During interview on 04/10/2024 at 02:08 PM, LPN2 stated that if the refrigerator temperature was out of range, she would have to discard the medications and notify maintenance to repair the refrigerator. LPN2 stated if medications were stored out of range, medications might not be appropriate to give if the medication was too cold or too warm and it would not be safe to administer them. LPN2 stated she was not sure of the correct temperature range of the refrigerator but thought it was 32-42 degrees. Observation on 04/10/2024 at 4:05 PM revealed LPN2 was on the telephone with the Pharmacy. During interview immediately after this call, she stated the pharmacist had recommended discarding the entire stock in the west side refrigerator due to lack of confirmation of correct temperatures. During interview with the IDON on 04/12/2024 at 4:06 PM, she stated she did not know if she would be able to produce the previous three months of temperature logs requested by the survey team to verify that staff were monitoring the temperature for both compartments of the refrigerator/freezer. No such logs were provided prior to exit from the facility. The IDON further stated that upon entry of the survey team, she was asked for a blank of the temperature log for the refrigerator and there was none in place at that time. The IDON stated that it was her expectation of staff to obtain an accurate temperature of the medication storage refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview regarding storage temperatures with the Administrator on 04/05/2024 at 5:15 PM, she stated it depends on medications and temperatures for it. The Administrator stated that whatever the medication, it should be maintained in the proper temperature. The Administrator stated that the night shift staff was responsible to check and document the refrigerator temperature every shift. She further stated if a refrigerator temperature was out of range, it would need to be addressed, which may include maintenance, and the medications in the refrigerator would need to be determined if still in the safe range. If not, the medications would need to be discarded. She also stated the reason for the temperature not being in range would have to be addressed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview, record review, review of grievance logs, and review of the Kentucky Food Guide 2013 Food Code guidance, the facility failed to provide food that was at a palatable temperature and flavorful. Hot foods were below the acceptable levels for the point of service temperatures, while the cold food/beverages were above the acceptable temperatures for the point of service. In addition, food was bland and in need of seasoning/condiments. This failure affected three (Resident (R) 47, R62, and R36) of twenty-five (25) sampled residents out of a total census of 59 resident. In addition, this failure had the potential to affect any of the 34 residents who live on the two of three halls (200 Hall and 300 Hall) who prefer to eat in their rooms (rather than the main dining room). The findings include: 1. Review of the Admission Record revealed Resident (R) 47's Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. In an interview with R47 on 04/09/2024 at 11:53 AM, she stated the food was not good. R47, who eats in her room, stated the food was bland with no flavor and sometimes cold. She further stated she received no condiments on the meal tray. She stated you have to ask for salt and pepper and most of the time they do not bring it. 2. Review of R62's Admission MDS, dated [DATE], revealed a BIMS score of 15/15, indicating the resident was cognitively intact. In an interview with R62 on 04/08/2024 at 11:22 AM, he stated, he ate meals in his room and the food was awful and most of the time it was cold. 3. A group meeting was conducted on 04/09/2024 at 2:30 PM with 18 residents the facility identified as reliable historians. During the meeting, residents voiced concerns about the food not being seasoned and hot foods being served cold. 4. a. Review of grievance logs for 01/2024 revealed R36 filed a grievance on 01/30/2024 about food being cold when it was served in the resident's room. The grievance was marked as Resolved, stating that the resident was invited to eat in the dining room and noting that the resident did not ask for her plate to be warmed. On the following day, 01/31/2024, R36 filed another grievance that the food on the tray was cold. In response, R36 was again invited to come to the dining room where, The food comes straight off the steam table and is good and hot. b. Review of the grievance log for 03/2024 revealed that six residents were listed as complaining that meals were cold when they were served in the resident's room. The response to this grievance was only addressed to one resident (R36), who was again invited to eat in the dining room (rather than her own room) and told that she that she could ask to have her plate warmed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the Kentucky Food Guide, 2013 Food Code guidance, revealed that at point of service, hot foods should be 135 degrees Fahrenheit (F), or greater and cold food/beverage products should be 41 F degrees or less. Observation during tray line on 04/08/2024 at 12:17 PM, revealed temperature reading obtained by the cook were as follows: turkey with orange glaze at 192 degrees F; green beans at 192 degrees F; herbed rice 188 degrees F; and egg noodles 161 degrees F. Continued observation revealed the meal was being plated on room temperature plates and no plate warmer or other device to keep food warm was observed. They food trays were then put in the 200-300 Hall cart, which was not temperature controlled. A test tray for the lunch meal was conducted on 04/08/2024 at 12:40 PM, the time that the last tray on the 200/300 Hall cart was served to a resident. A test of the food revealed the egg noodles and green beans were bland and tasted as if there was no seasoning, The turkey, noodles, green beans and rice (food to be served hot) were only warm to the taste. Temperature readings taken by dietary staff at the point of service included turkey -121 degrees F, herbed rice -124 degrees F, egg noodles - 119 degrees F; and green beans at 124 degrees F. A prepackaged cup of strawberry yogurt was at 60 degrees F; and a glass of sweet tea, with no ice in it, was 54 degrees F. The cook, who was present during the test tray process, confirmed the temperatures and stated that the food needed to be hotter. In an interview with the Interim Director of Nursing on 04/12/2024 at 5:49 PM, she stated she expected the kitchen to follow guidelines for maintaining food temperature on the tray line and at point of service. She stated regulatory requirements should always be met. In an interview with the Administrator on 04/12/2024 at 4:50 PM, she stated there were currently some concerns regarding the kitchen and food services. She stated dietary was working on things to take care of issues and residents were encouraged to come to the dining room to eat (rather than eating in their rooms).

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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. 44370 Based on observation, interview, record review, and review of facility policy and competency documentation, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of infection for one (1) (Resident (R) 47) of six (6) residents reviewed for wounds out of a sample of twenty-five (25) residents. During wound care, one Licensed Practical Nurse (LPN) failed to utilize a barrier to lay out wound supplies and failed to change gloves and/or perform hand hygiene when indicated. The findings include: Review of the facility policy titled, Infection Prevention and Control Program, revised on 02/21/2024, revealed that the facility would 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. Review of the facility skills review (competency check-off form) for wound care, titled Clean Wound Dressing Change, revealed staff were to implement the following steps: organize the work area by protecting linens or other surfaces with a plastic bag under the affected body part, open a disposable bag to collect soiled dressing, wash hands and don gloves, remove the soiled dressing, discard the soiled dressing and gloves in the plastic bag. The nurse would then wash her hands, set up supplies on a clean field, and don gloves, apply any medications and dressings. Finally, the nurse would place all used supplies in a plastic bag, remove gloves and dispose of them in the soiled utility room, and wash hands. Review of the Admission Record revealed the facility admitted R47 on 08/24/2023 with diagnoses including peripheral vascular disease and paresthesia of the skin. (pins and needles sensation), and skin breakdown. Review of a Wound Care note, dated 04/10/2024, revealed the current treatment order for the right heel wound was to cleanse the wound with normal saline, apply Polymem Pink to the right heel, cover the wound with a dry dressing and change daily. Observation on 04/10/2024 at 2:26 PM revealed LPN1 entered R47's room. The nurse, who was not wearing gloves at the time, proceeded to pull back the sheet from the resident's lower legs/feet to see if a dressing was in place to the resident's right heel. A dressing was not secured to R47s wound and was under the resident's right heel. LPN1 then left the room and went to get wound care supplies. LPN1 reentered the room, carrying the supplies in her bare hands. LPN1 then placed the treatment supplies on R47's bed without using a barrier of any kind. Prior to starting wound care, LPN1 donned gloves without first performing hand hygiene. She then removed the soiled dressing and disposed of it in the trash. LPN1 then, without changing the soiled gloves or performing hand hygiene, cleansed the wound to the right heel, applied the ordered treatment, and covered it with a bordered gauze dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Glenview Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Glenview Drive Glasgow, KY 42141	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN1 on 04/10/2024 at 2:38 PM, she stated she should have used a barrier and not used R47's bed to place the wound supplies. She confirmed she did not change her gloves after removing the soiled dressing from the right foot. She stated she should have changed her gloves and performed hand hygiene after she removed the soiled dressing. In an interview with the Interim Director of Nursing/Infection Preventionist on 04/12/2024 at 5:50 PM, she stated she expected the nurses to follow infection control policies and procedures. She stated the nurse should have changed her gloves and washed her hands before applying the clean dressing.