

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Granby House		STREET ADDRESS, CITY, STATE, ZIP CODE 301 South Main Granby, MO 64844	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193</p> <p>Based on interview and record review, the facility failed to provide care per standards of practice when for all residents when staff failed to administer one resident's (Resident #1) levothyroxine (medication for a low thyroid) as ordered. The facility census was 51.</p> <p>Review of the facility policy Administering Medications, revised April 2019, showed the following:</p> <ul style="list-style-type: none"> -Medications are administered in accordance with prescriber orders, including any required time frame; -Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance and Performance Improvement) committee to inform of process changes and or the need for additional staff training. <p>Review of the facility Electronic Medical Record Admission Checklist, undated, showed the following:</p> <ul style="list-style-type: none"> -Call and verify medications with provider and be sure to add to admission note; -Progress note must include the physician was notified of admission and the medication list was reviewed; -Every admission needs a TSH (thyroid stimulating hormone level - used to test the thyroid levels) lab test yearly; -Fax face sheet, discharge summary, and medication list to provider. <p>1. Review of Resident #1's face sheet (information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included systemic lupus erythematosus (a chronic illness that occurs when the immune system attacks healthy tissues and organs and can cause fatigue and joint pain and affects many parts of the body such as joints, skin, kidneys, blood cells, brain, heart, and lungs), epilepsy (seizures), hypothyroidism (low thyroid levels which may cause symptoms of fatigue, cold sensitivity, dry skin, unexplained weight gain, and hair loss), major depression, and anxiety. <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/16/24, showed the resident's cognition was intact.</p> <p>Review of the resident's admission information provided from the transferring facility showed the following:</p> <p>-Diagnoses of hypothyroidism with onset date of 12/09/19;</p> <p>-A physician's order, dated 12/8/24, for levothyroxine sodium 88 micrograms (mcg), one tablet by mouth in the morning for hypothyroidism.</p> <p>Review of the resident's December 2024 Medication Administration Record (MAR) showed staff did not document an order for levothyroxine sodium oral tablet 88 mcg, to administer one tablet by mouth one time a day for hypothyroidism.</p> <p>Review of the resident's physician's orders showed an order, dated 01/24/25, with start date of 01/25/25, for levothyroxine sodium oral tablet 88 mcg. Staff to administer one tablet by mouth one time a day at 4:00 A.M. for hypothyroidism.</p> <p>Review of the resident's January 2025 MAR showed an order, with a start date of 01/25/25, for levothyroxine sodium oral tablet 88 mcg for staff to administer one tablet a day for hypothyroidism at 4:00 A.M. (Staff did not document administering levothyroxine prior to 01/25/25.)</p> <p>During an interview on 01/29/25, at 10:26 A.M., the resident said he/she was at another facility in December 2024 before coming to this facility. He/she was on levothyroxine 88 mcg every day, but had not been getting the levothyroxine until a week ago or so. He/she had lupus for [AGE] years and had a low thyroid since he/she was [AGE] years old.</p> <p>During an interview on 01/29/25, at 12:00 P.M., Licensed Practical Nurse (LPN) A said the resident came from another facility and did have a physician's order summary and profile sheet. The resident was on levothyroxine, but he/she was not sure if the order did not go in the electronic medical record or if there was a misunderstanding and miscommunication from the other facility about the levothyroxine.</p> <p>During an interview on 01/29/25, at 12:03 P.M., Certified Medication Technician (CMT) B said the resident came from another facility. The night nurse administers thyroid medication on night shift. The resident reported to him/her that he/she had not gotten his/her levothyroxine medication. When the resident was admitted to the facility, he/she had a medication card with three pills of levothyroxine 88 mcg. This medication card was in his/her medication cart with the regular medications, but he/she did not pay attention to this since he/she does not administer the thyroid medications. The night nurse administers the levothyroxine medications from 4:00 A.M. to 5:00 A.M.</p> <p>During interview on 01/30/25, at 4:00 A.M., the night nurse, LPN C, said another staff member pointed it out to him/her that the resident told them about the levothyroxine. When he/she went to administer a pain medication to the resident, he/she told him/her about not getting levothyroxine medication. He/she usually administered levothyroxine medication on his/her shift from 4-5:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 01/29/25, at 4:00 P.M., the Associate Director of Nurse (ADON) said when they admit a resident to the facility, they do an assessment of the resident and will take the resident's medication list from the hospital and go over this with the physician. When the resident admitted , they had a nurse in training. The nurse put the resident's medications in the electronic medical record and must have overlooked the medication levothyroxine. When the resident came to him/her and said he/she didn't think he/she was getting the levothyroxine, the ADON looked at the resident's medication orders and did not see the order for the levothyroxine. Usually the Director of Nursing (DON) and ADON look at the resident's admission check list to double check the medications, but they did not do this for the resident. The charge nurse would give any medications to the medication technician upon admission. The night nurse would administer the levothyroxine. If the medication order was in the computer, the medication would have popped up for the night nurse to administer. They should have double checked the medications within 24 hours from admission.</p> <p>During interview on 01/29/25, at 3:52 P.M., the Administrator said the nursing staff have a checklist to use on a new admission to the facility. They found they missed a routine medication for the resident who has lupus and they made a medication error report.</p> <p>MO00246993</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection control program when staff failed to practice proper hand hygiene while providing care for three residents (Residents #2, #3, and #4) and when staff failed to gown as required for two residents (Resident #4 and #5) who had enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO -microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) in place due to wounds. The facility census was 51.</p> <p>Review of the facility policy, Hand washing/Hand Hygiene, revised October 2023, showed the following:</p> <ul style="list-style-type: none"> -All personnel were expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors; -Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc) were readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-based hand-rub dispensers were placed in areas of high visibility and consistent with workflow throughout the facility; -Hand hygiene is indicated immediately before touching a resident; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the resident's environment; before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal; -The use of gloves does not replace hand washing/hand hygiene; -When applying and removing gloves, perform hand hygiene before applying non-sterile gloves and when removing gloves, perform hand hygiene. <p>Review of the facility policy Enhanced Barrier Precautions, dated March 2024, showed the following:</p> <ul style="list-style-type: none"> -It was the policy of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms; -EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities; -All staff receive training on EBP upon hire and at least annually and were expected to comply with all designated precautions; -All staff receive training in high-risk activities and common organisms that require EBP; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff were aware of which residents require the use of EBP prior to providing high-contact care activities;</p> <p>-EBP will be initiated for residents with any of the following: wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling/implanted medical devices such as central lines, ports, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident was not known to be infected or colonized with a MDRO (multi-drug resistant organism) and infection or colonization with a CDC (Centers for Disease Control) targeted MDRO when contact precautions do not otherwise apply;</p> <p>-Make gowns and gloves available immediately near or outside of the resident's room (note: face protection may also be needed if performing activity with risk of splash or spray such as wound irrigation and tracheostomy care);</p> <p>-Personal Protective Equipment (PPE) for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room;</p> <p>-Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room);</p> <p>-Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room;</p> <p>-Place a yellow sticker or magnet on the name plate of the resident's door to identify the need of EBP;</p> <p>-High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of central lines, urinary catheters, feeding tubes, and tracheostomy/ventilator tubes;</p> <p>-EBP should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility;</p> <p>-EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>Review of the Centers of Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 04/02/24, showed the following;</p> <p>-MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;</p> <p>-EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status</p> <p>Infection or colonization with an MDRO;</p> <p>-Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care;</p> <p>-Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, or tracheostomy/ventilator) and wound care (any skin opening requiring a dressing).</p> <p>1. Review of Resident #2's face sheet (information at a glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included chronic obstructive pulmonary disease (COPD - lung disease that blocks air flow and makes it difficult to breathe).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/02/24, showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-Resident dependent on staff for personal hygiene, dressing, toileting, mobility, and transfers;</p> <p>-Incontinent of bowel and bladder.</p> <p>Review of the resident's care plan, undated, in the electronic medical record (EMR), showed the following:</p> <p>-Required two staff to help transfer the resident to the wheelchair;</p> <p>-Incontinent of both bowel and bladder related to impaired mobility. Staff were to clean perineal area with each incontinence episode.</p> <p>Observation on 01/30/25, at 5:00 A.M., showed the following:</p> <p>-Certified Nurse Aide (CNA) D asked the resident, who was in bed, if he/she wanted to get up. CNA E turned on the light, did not wash his/her hands, got a pair of gloves from the box on the wall, and put on the gloves.</p> <p>-CNA D could not find the cleansing wet wipes so he/she removed his/her gloves, left the room to get a box of wipes. CNA D returned and put on gloves without washing his/her hands.</p> <p>-CNA E shut off the oxygen concentrator and both aides dressed the resident who was in bed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-CNA D and CNA E, turned the resident to his/her side, put a clean incontinence brief underneath the resident's wet brief, removed the bed pad and brief wet with urine, and pulled up the clean incontinence brief. CNA D got the cleansing wipes and performed perineal care (without performing hand hygiene or changing gloves). CNA D took a tube of barrier cream and wiped the cream on the resident's buttocks (without performing hand hygiene or changing gloves).</p> <p>-CNA D removed his/her gloves, did not wash hands, and put on a clean pair of gloves.</p> <p>-CNA D attached the clean incontinence brief.</p> <p>-Both CNA D and CNA E kept the same pair of gloves on. CNA E took a mechanical lift sling and placed it underneath the resident.</p> <p>-CNA D removed his/her gloves and did not perform hand hygiene. CNA D put the resident's eye glasses on and his/her shoes lying on the bed. CNA E removed his/her gloves, did not perform hand hygiene, and took the trash bag of linens to the soiled utility room down the hall. CNA D touched his/her own personal watch, then got the foot pedals to the wheelchair and placed the foot pedals next to the bed. Without performing hand hygiene and donning gloves, CNA E brought the mechanical lift into the room and they attached the resident in the sling to the mechanical lift.</p> <p>-CNA D and CNA E transferred the resident. Without performing hand hygiene, CNA E put on gloves and tried to put the oxygen tubing per nasal cannula back on the resident who refused. CNA E put the tubing back on the machine. CNA D put a blanket over the resident's lap and sat the resident next to his/her bed and placed the call light on the resident. CNA D did not perform hand hygiene or put on gloves as he/she touched the resident personal items on the bedside table such as snacks.</p> <p>-CNA D removed the mechanical lift from the room and put in the hall. CNA E put on a pair of gloves without performing hand hygiene and took another bag of linens down the hall.</p> <p>-CNA D used the hand sanitizer on the wall as he/she left the room.</p> <p>2. Review of Resident #3's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included acute respiratory failure, heart failure, COPD, type 2 diabetes mellitus (high blood glucose), unspecified head injury, convulsions (seizures), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), acute kidney failure, dementia (progressive impairments in memory, thinking, and behavior which negatively impacts a person's ability to function and carry out every day activities).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severely impaired cognition;</p> <p>-Dependent for toileting, personal hygiene, upper/lower body dressing, and transfers;</p> <p>-Always incontinent of bowel and bladder.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, undated, from the EMR, showed the following:</p> <ul style="list-style-type: none"> -Required assistance with activities of daily living due to weakness in lower extremities related to a stroke; -Incontinent of both bowel and bladder related to impaired mobility. Staff to clean perineal area with each incontinence episode. <p>Observation on 01/30/25, at 5:50 A.M., showed the following:</p> <ul style="list-style-type: none"> -CNA D and CNA E entered the resident's room and did not wash or sanitize hands, and put on gloves. The resident sat up on the edge of the bed. The CNAs assisted the resident to dress. The resident wore an incontinence brief. -CNA D assisted the resident to stand up and removed the wet incontinence brief. While the resident stood, CNA E took cleansing wipes and cleansed between the resident's buttocks and outer buttocks, put a clean incontinence brief on the resident and assisted the resident to sit down in the wheelchair. -CNA D then removed his/her gloves and did not did not perform hand hygiene. CNA E removed his/her gloves, did not perform hand hygiene, and took the trash bag out of the room. -CNA D picked up a brush and brushed the resident's hair and then pushed the resident in his/her wheelchair out of the room. -CNA E came back to the room, put on gloves without performing hand hygiene, and raised the resident's bed, took the trash, removed gloves, and then used the hand sanitizer on the wall before leaving the room with the trash bag. <p>3. During an interview on 01/30/25, at 6:00 A.M., CNA E and CNA D both said they were to wash hands when they walk into a resident's room, before they put on gloves, and when they remove gloves. They could wash hands in the break room because there were no paper towels in the residents' rooms right now since they were changing out the towel dispensers. Most rooms had hand sanitizer.</p> <p>Observation on 01/30/25, at 6:03 A.M., showed there were paper towels in the towel dispenser in Resident #3's room.</p> <p>4. Review of Resident #5's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus (high blood glucose), acute respiratory failure with hypoxia (low oxygen level), congestive heart failure (CHF), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), kidney failure, and acquired absence of left leg above the knee. <p>Review of the resident's admission MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Intact cognition and interviewable;</p> <p>-Lower extremity impairment on one side;</p> <p>-Dependent for toilet hygiene;</p> <p>-Substantial/maximal assistance for personal hygiene;</p> <p>-Frequently incontinent of bladder and occasionally incontinent of bowel;</p> <p>-Partial/moderate assistance for toilet transfer;</p> <p>-Open lesions other than ulcers, rashes, or cuts;</p> <p>-Applications of nonsurgical dressings with or without topical medications/other than to feet;</p> <p>-Applications of ointments/medications other than to feet.</p> <p>Review of the resident's care plan, dated 7/25/24, showed the following:</p> <p>-Required moderate staff assistance with upper dressing and maximum assistance for lower dressing, two assistance for toileting and transfers;</p> <p>-Resident has an open abscess on left knee related to hardware;</p> <p>-On 01/14/25, staff initiated EBP to help protect the resident from infections related to his/her wound. Interventions included a sign placed on door alerting staff and visitors of precautions, staff and visitors to clean hands with alcohol-based hand sanitizer before and after entering and leaving room, and staff to wear gown and gloves when caring for his/her wound.</p> <p>Observation on 01/30/25, at 6:38 A.M., showed an EBP sign next to the door.</p> <p>Observation on 01/30/25, at 6:38 A.M., showed CNA F entered the room, put on a pair of gloves, without washing and or sanitizing his/her hands, did not put on a protective gown, and went into the bathroom where the resident sat in the wheelchair waiting for staff to toilet him/her. CNA F placed a gait belt around the resident and transferred the resident to the toilet. The resident did not bend his/her left knee. CNA F removed his/her gloves, and used the hand sanitizer on the wall in the room before leaving the room. At 6:43 A.M., CNA F knocked on the resident's room door, put on gloves, without washing and or sanitizing his/her hands, and did not put on a protective gown. CNA F went into the bathroom, assisted the resident to stand, wiped the resident with toilet paper, pulled up the resident's pants, and transferred the resident to the wheelchair. CNA F removed his/her gloves and sanitized his/her hands before pushing the resident in the wheelchair to the dining room.</p> <p>During an interview on 01/30/25, at 7:37 A.M., CNA G said the resident was on EBP because the resident's left knee had a wound.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Granby House		STREET ADDRESS, CITY, STATE, ZIP CODE 301 South Main Granby, MO 64844	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/30/25, at 7:50 A.M., CNA F said the resident had a wound on his/her leg which was bandaged and had tubi grips (elastic support bandage) on his/her legs. He/she would have put on a gown if they would get gowns down on the hall.</p> <p>6. During an interview on 01/30/25, at 7:37 A.M., CNA G said EBP was for staff to wear a gown, mask, and gloves for wound care, isolation, catheters, colostomies, and for contact precautions. They keep the gowns and gloves in the supply room or the nurses have them.</p> <p>During an interview on 01/30/25, at 7:50 A.M., CNA F said EBP was when they were to change the residents, and put ointment on them. The wound care nurse has training on EBP for wound care. PPE (Personal Protective Equipment) is gloves and if a resident was in isolation, they would put on a mask and a protective gown. They will wear gowns if the charge nurse instructs them to do this. The charge nurse will tell what they were to use.</p> <p>During an interview on 01/30/25, at 7:47 A.M., Licensed Practical Nurse (LPN) A (wound nurse) said there was a cart on the hall for gowns and gloves for EBP.</p> <p>During an interview on 01/30/25, at 8:00 A.M., LPN C said he/she was new at the facility and had not heard of EBP before and did not know who was the Infection Control Nurse at the facility. If the nursing staff asked him/her what they needed to put on to take care of a certain resident, he/she would tell staff to put on gloves, mask, and gown.</p> <p>During an interview on 01/30/25, at 9:05 A.M., the Assistant Director of Nursing (ADON) said he/she had been the Infection Preventionist nurse since June 2024. There had been a lot of nursing turnover and he/she had been working as charge nurse. Staff were to wash and or sanitize their hands before gloving and after removing their gloves, during wound care, when they entered a resident's room, and after perineal care performed. There was hand sanitizer in all residents' rooms on the wall. For EBP, staff were to gown up and wear gloves when in contact with any resident with wound, catheter, or colostomy. The gowns were out in the drawers in hall and in the supply room and in their shed. He/she was responsible for putting up the EBP signs on residents' doors. They have a risk meeting every week with all infections and wounds. They are constantly trying to educate nursing staff that have direct contact about EBP.</p> <p>During an interview on 01/30/25, at 8:56 A.M., the Administrator said staff were to wash and or sanitize hands when they go into a room and before leaving a room, before gloving, after removing gloves, and any times in between like with personal cares. They have had a couple of in-services about EBP and new staff need training on it. He/she did expect the staff to wear gowns when going into resident rooms to do personal cares.</p>		