STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to enter a new wound care order to prevent skin breakdown which resulted in a pressure sore (skin and soft tissue injuries that form as a result of constant or prolonged pressure exerted on the skin) and did not enter in new orders for the treatment of a pressure wound for 2 (R #11 and R #54) of 3 (R #11, R #37 and R #54) residents looked at for wounds. This deficient practice did contribute to resident's decline in condition and resulted in the resident going to the hospital. The findings are: R #11 A. Record review of R #11's face sheet indicated the resident was admitted from the hospital to the facility on [DATE]. She was admitted for pneumonia (lung infection) and sepsis (a serious condition in which the body responds improperly to an infection). Resident also had atrial fibrillation [A-fib; an irregular and often very rapid heart rhythm (arhythmia that can lead to blood clots in the heart)], type 2 diabetes mellitus (the body does not use insulin properly) with diabetic neuropathy (nerve damage caused by high blood sugar levels), and osteoporosis (weakens the bones and makes them brittle). This was not an all inclusive list of diagnoses. B. Record review of R #11's admit progress note, dated [DATE], indicated the resident had some redness on her intergluteal area (the groove between the buttocks that runs from just below the sacrum [bone located at the base of the spine] downward) of her tailbone. The area was blanchable (when the skin temporarily loses color where pressure is applied) when touched and was covered with a optifoam gentle bandage (protects bony areas) to prevent further breakdown. C. Record review of R #11's progress note, dated [DATE], indicated staff cleaned the resident's buttock, applied skin prep (a film to protect the skin by reducing friction during the frequent removal of tapes and films) to the surrounding area, and applied opti-foam dressing. The resident had redness and skin breakdown to sacrum. D. Record review of R #11's nursing progress note, dated [DATE], indicated the resident had skin breakdown to the tailbone area. Staff applied skin prep to surrounding area and barrier ointment to wound. Staff to inform Assistant Director of Nursing (ADON) the resident should be evaluated by wound care team tomorrow. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0686 Level of Harm - Actual harm Residents Affected - Few	E. Record review of R #11's physician orders, dated [DATE], indicated an order to apply therahoney (wound treatment), calcium alginate (wound dressing) to coccyx breakdown, and cover with optifoam dressing once per day. F. Record review of the Medication Administration Record (MAR) for R #11 dated on [DATE] indicated the following order was in place: - Wound care to sacral wound every Monday, Wednesday and Friday and as needed. 1. Wash area with wound cleanser. 2. Apply skin prep to periwound (is the skin around the wound that has been affected by the wound) site. 3. Apply therahoney to wound beds. 4. Apply sections of calcium alginate to wounds. 5. Cover area with bordered optifoam gentle 4 x (by) 4 foam dressing. G. Record review of the initial wound care note for R #11, dated [DATE], indicated the wound measured length 3.0 cm, width 2.5 cm with slough (tissue damage and infection, and it can be black, tan, or brown in color) and the wound was unstageable (an ulcer that has full thickness tissue loss but is either covered by extensive dead tissue). H. Record review of the physician orders for R #11, dated [DATE], indicated that orders for the following: - Reposition or turn patient every 2 hours while in bed. - Pressure reduction cushion to wheelchair verify placement every shift. - Air mattress to bed. - Barrier cream to peri area (is the space between the anus and scrotum in the male, or between the anus and the vulva in the female) after each incontinent episode. I. Record review of a nursing progress note for R #11, dated [DATE], indicated the the nurse checked the resident's coccyx area and noted the previous dressing was dated ,d+[DATE]. The nurse cleaned the open area with wound cleanser, applied medihoney and calcium alginate, and covered with an opti-foam dressing. J. Record review of the MAR for R #11 on [DATE], [DATE], and [DATE] indicated staff completed wound care as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0686 Level of Harm - Actual harm Residents Affected - Few	K. Record review of the wound care note for R #11, dated [DATE], revealed the wound on the coccyx measured 3.5 cm in length and 5.0 cm in width, with eschar (collection of dry, dead tissue within a wound), and a large amount of drainage with odor evident on entering the room. Wound #2 on the right ischium (lower back region of the hip bone) measured 5.0 cm length, 2.5 cm in width, and was a deep tissue injury (DTI; a pressure injury that appeared as a localized area of discoloration, usually purple or maroon, with the skin remaining intact). Wound #3 on the left ischium measured 0.3 in length, 0.2 width, and was a deep tissue injury. Resident was referred to the emergency room for immediate imaging and possible debridement (removes unhealthy tissue) with bone biopsy (removal of bone tissue for further examination), wound culture (test to see if there is infection in the wound), and IV antibiotics. L. On [DATE] at 8:57 am, during an interview with the ADON, she stated she was not aware of the redness to R #11's coccyx area on [DATE], and she was not aware of R #11's redness and skin breakdown on [DATE]. She stated the first time staff made her aware of R #11's wound was on [DATE]. An order for wound care was put into place at that time. The ADON stated the process for wounds was for staff to tell her if the resident had a wound that was worse or a new wound. The ADON could not remember if staff told her about R #11's wound before [DATE]. She stated the wound care team would not get involved unless it was necessary because they do not see every wound. She did not feel that the wound care needed to be involved until the DON told her to involve them on [DATE]. The ADON stated she did not see the wound until [DATE] when the Director of Nursing (DON) told her the resident needed a consult from the wound specialist. The ADON stated that was when she noted that the wound was 3.5 centimeters (CM) length, 2 cm width, and it was unstageable (full-thickness wound in which the base is obscured by dead tissue). She did not have give a reason why she did not see the wound before [DATE]. M. On [DATE] at 9:28 am, during an interview with DON, she stated she had worked on Thanksgiving day, [DATE], and she provided wound care for R #11. She stated at that time she felt like the wound was probably a Stage II (wound had broken the skin and appeared as an open wound or blister) The DON stated she was first made aware of the wound when she did the dressing change on [DATE] The DON stated she told the ADON on [DATE] that R #11 needed to get on the list to be seen by the wound specialist. The DON stated a nurse made her aware on [DATE] or [DATE] that staff marked wound care off on the MAR as completed, but the dressing on the wound was dated [DATE]. Resident #54 N. Record review of the physician orders for R #54 indicated the following orders: - Start date [DATE] and end date [DATE]. Cleanse coccyx ulcer right buttock and surrounding area with normal saline (supply water and salt to the body), apply skinprep to periwound (tissue surrounding the wound), and cover with foam dressing once per day. - Start date [DATE]. Cleanse with wound cleanser, apply skin prep to periwound, apply therahoney to wound bed cover with optifoam dressing every Monday, Wednesday and Friday and as needed. O. Record review of the MAR for R #54, dated [DATE], indicated the following: On [DATE] through [DATE], there were not any wound care orders in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0686 Level of Harm - Actual harm Residents Affected - Few	P. Record review of a wound care note, dated [DATE], for R #54, indicated the wound care specialist came in to evaluate a chronic, non-healing, stage 3 pressure sacral ulcer (wound may go into the skin's fatty layer) that has existed for over three months. Q. On [DATE] at 1:18 pm, during an interview with the wound care specialist/Family Nurse Practitioner (FNP), she stated the new orders were written on [DATE], because the order was discontinued. She said the previous orders did not change; they expired. She stated the order dated [DATE] was faxed to the facility. She stated she was not aware of who received the orders at the facility or who was responsible to enter them into the electronic medical record for R #54. R. On [DATE] at 8:43 am, during an interview with the ADON, she stated R #54 was admitted to the facility with a right buttock wound. She stated she put wound orders into the medical record, but the nurses were responsible to do the wound care. The ADON confirmed that she did not see an order from [DATE] to [DATE]. The ADON stated she did not find a wound care order for [DATE] to [DATE]. She stated she may have missed the order. The ADON stated the nursing staff would continue to do the wound care if the wound was not healed yet, even if they did not see an order. S. On [DATE] at 10:27 am, during an interview with the Licensed Practical Nurse (LPN) #1, she stated she would not automatically continue wound care without an order. She stated even if the wound was not healed, she would not automatically assume the wound care was the same. She would let the ADON know since she handled the wound care and see what wound care should be in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 45426 Based on record review, observation and interview, the facility failed to meet professional standards of care for 3 (R #55, R #165, and R #169) of 3 (R #55, R #165, and R #169) residents reviewed for respiratory care by not properly dating and monitoring the oxygen delivery tubing for residents and not dating the humidifier bottle (bottle of water that provides water to the oxygen to prevent the air from being too dry) for residents. This deficient practice has the likelihood of residents developing bacterial and viral infections if the oxygen tubing and humidifiers were not changed as ordered and nursing staff may be unaware as to when the tubing and humidifiers were changed last. A. Record review of R #165's physician's orders revealed the following: -An order with date of 12/08/23 for oxygen per nasal cannula (a device that delivers extra oxygen through a tube and into your nose) to maintain SpO2 (oxygen saturation-a measurement of how much oxygen your blood is carrying as a percentage of the maximum oxygen it could carry) greater than 90%. Document LPM (liters per minute) each shift. -An order with date of 12/08/23 to change oxygen tubing and humidifier bottle each week on Saturday during the evening shift and to date and initial the long and short oxygen tubing and the humidifier bottle B. On 12/11/23 at 10:44 am, during an observation, R #165 was in his room receiving oxygen by nasal cannula. The oxygen tubing and the humidifier bottle were not dated. C. On 12/11/23 at 1:12 pm, during an interview, Certified Nursing Assistant, CNA, #5 confirmed R #165's nasal cannula and humidifier bottle were not dated. D. Record review of R #55's physician's orders revealed the following: -An order with date of 11/16/23 for oxygen per nasal cannula. Document LPM each shift. -And order with date of 11/16/23 to change oxygen tubing and humidifier bottle each week on Saturday during the evening shift and to date and initial the long and short oxygen tubing and the humidifier bottle. E. On 12/11/23 at 1:24 pm, during an observation, R #55 was receiving oxygen by nasal cannula in her room. The nasal cannula tubing was not dated. F. Record review of R #169's physician's orders revealed the following: -An order dated 12/05/23 for oxygen per nasal cannula) to maintain SpO2 greater than 90%. Document LPM each shift. -An order dated 12/05/23 to change oxygen tubing and humidifier bottle each week on Saturday during the evening shift and to date and initial the long and short oxygen tubing and the humidifier bottle (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 12/11/23 at 2:20 pm, during an observation, R #169 was receiving oxygen by nasal cannula in her room. The oxygen tubing and the humidifier bottle was not dated. H. On 12/12/23 at 11:05 am, during an interview with the Director of Nursing, she confirmed oxygen tubing and humidifiers were missing dates of when last changed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on observation and interview the facility failed to properly store medications in a medication cart by allowing loose medications to be found under the medication cards. This deficient practice has the likelihood to result in all residents that have medications in medication cart #1 that were identified on the census list provided by the administrator on [DATE], to receive expired or improperly temperature-controlled medications that have either lost their potency or effectiveness. The findings are: A. On [DATE] at 8:19 am, during an observation of medication cart #1, loose medications were found under the medication cards (medication stored in vertical cards). Loose medications found under the medication cards included a yellow oval tablet, white capsule, pink capsule, orange capsule, white tablet, and a pink tablet. B. On [DATE] at 8:20 am, during an interview with Registered Nurse #1, she stated loose medications should not be in the medication carts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45426 Based on observation and interview, the facility failed to store foods under sanitary conditions and follow safe food handling practices by not ensuring food items in the walk in freezer were properly labeled and dated. These deficient practices are likely to affect all 47 residents listed on the resident census list provided by the Administrator on 12/11/23 and are likely to lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 12/11/23 at 8:34 am, during an initial tour of the kitchen, the following observations were made of the walk-in freezer: - Two (2) boxes of beef steak variety packs, and a package of cage free chicken were not dated. -Several packages of unlabeled vacuum sealed meats and one open package of an unknown meat, stored in a milk crate, were not dated and labeled. -A milk crate was filled with several, sealed packages of unknown rolls or buns and did not have dates and labels. B. On 12/11/23 at 8:38 am, during an observation and interview with the Dietary Manager, she observed and identified the opened package of meat as Salisbury steak, and the unsealed packages of meats as ham, 2 packages of pork loin, and ribs. She identified the sealed and unlabeled bread packages as hoagies. She confirmed the unlabeled and undated items were missing dates and labels. She stated all meats and frozen items in the freezer should have a label and a date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48645 Based on observation, record review, and interview the facility failed to maintain proper infection prevention measures by: 1. Not disinfecting the glucose meter (device to measure sugar in the blood) correctly for medication cart #1. 2. Dragging oxygen tubing on the floor. 3. Not wearing gloves prior to providing nursing care. Failure to adhere to an infection control program could likely cause the spread of infections and illness to all residents of unit 2 listed on the census provided by the Nursing Home Administrator (NHA) on 12/11/23. The findings are: A. On 12/11/23 at 12:58, during an observation of a blood glucose check, Registered Nurse (RN) #1 was cleaning medication cart #1's glucose meter with alcohol wipes. B. On 12/11/23 at 1:00 pm, during an interview of RN #1, she stated she always cleaned her glucose meter with alcohol wipes. C. On 12/11/23 at 1:05 pm, during an interview of the Director of Nursing (DON), she stated alcohol wipes are not to be used to clean the glucose meter. The DON further stated the only approved wipes used to disinfect (remove viruses and bacteria) from the glucose meters are the Medline Micro-Kill (Trademark) Bleach Germicidal Bleach Wipes (EPA Registration Number: 69687-1). D. Record review of the Evencare G2 glucose meters manufacturer approved disinfectants include: Dispatch(R) Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8), Medline Micro-Kill+ (Trademark) Disinfecting, Deodorizing, Cleaning Wipes with Alcohol (EPA Registration Number: 59894-10), Clorox Healthcare(R) Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12), and Medline Micro-Kill (Trademark) Bleach Germicidal Bleach Wipes (EPA Registration Number: 69687-1). E. Record review of the CDC website lists alcohol wipes as not being approved to disinfect glucose meters (https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#anchor_1556215586). 49196 Findings for oxygen tubing on floor (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive NE Albuquerque, NM 87107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 12/11/23 at 10:55 AM, during an observation of R #55 being pushed down the hallway in her wheelchair, Occupational Therapist (OT) #1 was observed carrying an oxygen cannula (a device that delivers extra oxygen through a tube and into a person's nose) and the connecting tubing was dragging behind her on the hallway floor. OT #1 was then observed connecting this tubing to portable oxygen (transportable device used to deliver supplemental oxygen to a person) on the back of R #55's wheelchair and assisting her in donning the cannula. G. On 12/14/23 at 09:56 AM, during an interview Director of Nursing/Infection Preventionist (DON/IP) confirmed the oxygen tubing should not be touching the floor, and doing so was not consistent with the facility's infection control expectations. Findings for nursing care provided without gloves on H. On 12/13/23 at 2:48 pm, during an interview with a resident representative (RR) for R #37, RR stated that a RN (Registered Nurse) identified by RR as RN #2 provided wound care to R #37 without wearing gloves. I. On 12/14/23 at 08:47 AM during an interview with Assistant Director of Nursing (ADON), she acknowledged there was an incident involving a nurse providing care without gloves while smoothing the adhesive on the wound vac (a machine that provides vacuum assisted therapy to help a wound heal). ADON added that regardless of the care being provided there was patient contact, and the nurse should have been wearing gloves. J. On 12/14/23 at 09:56 AM during an interview with DON, she confirmed that RN #2 admitted to providing care to the resident without donning (putting on) gloves and as a result RN #2 was re-educated on the facility's infection control expectations regarding PPE (personal protective equipment) and corrective action (a set of actions taken to rectify errors) was taken.