| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676255 | A. BUILDING _____ B. WING _____ | 03/31/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| FORT WORTH CENTER OF REHABILITATION | 850 12TH AVENUE FORT WORTH, TX 76104 |

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) |
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| F 0314<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Some | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure that residents who had pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for seven (Residents #1, #2, #4, #5, #6, #7 and #8) of 19 reviewed for pressure ulcers.<br>1. The facility failed to off-load Resident #2's heels when she had an unstageable pressure ulcer to her right heel.<br>2. The facility failed to keep pressure off Resident #8's left leg when she had an unstageable pressure ulcer to her left calf. The staff failed to recognize the device to off-load the resident's heels created pressure to her left calf pressure ulcer until surveyor intervention.<br>3. RN A failed to follow proper infection techniques when providing treatment to Resident #1's multiple pressure ulcers.<br>4. LVN B failed to follow proper infection control techniques when providing treatment to Resident #5's Stage II pressure ulcer.<br>5. ADON E failed to follow proper infection control techniques when providing treatment to Resident #4's Stage IV pressure ulcer.<br>6. The facility failed to provide treatment to Resident #6's unstageable pressure ulcer on 03/26/16 and 03/27/16.<br>7. The facility failed to provide treatment to Resident #7's Stage III pressure ulcer on 03/26/16 and 03/27/16.<br>These failures could affect the 10 residents in the facility with identified pressure ulcers by placing them at risk for deteriorating pressure ulcers, infections, pain, and development of additional pressure ulcers.<br>Findings included:<br>1. Resident #2's MDS assessment, dated 02/02/16, reflected she was a [AGE] year-old female, who was initially admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. The resident had moderately impaired cognition and required extensive assistance with all of her ADLs to include bed mobility. The resident was at risk for pressure ulcer development and had one unstageable pressure ulcer measuring 1.0 cm x 1.0 cm with eschar.<br>Resident #2's comprehensive care plan dated 10/05/15 reflected Resident #2 was at risk for skin breakdown due to recent surgery and limited mobility. Interventions included assisting with repositioning every two hours.<br>The Braden Scale for Predicting Pressure Sore Risk dated 10/19/15 and 11/02/15 reflected Resident #2 was identified as at severe risk for developing pressure ulcers.<br>An update to the plan of care on 12/02/15 identified the resident as having actual skin breakdown to the right heel which was unstageable (the base of the ulcer was not visible). A secondary care plan also dated 12/02/15 reflected Resident #2 was at risk for alterations related to bilateral deep tissue injury to bilateral heels. The care plan reflected interventions which included, Assist resident to a position of comfort, utilizing pillows as appropriate positioning devices.<br>A progress note from the contracted wound-care company dated 01/06/16 reflected Resident #2 was seen for an unstageable wound of the right heel which measured 1 cm x 1.4 cm and was greater than 32 days in duration. Weekly progress notes by the Wound Care Physician reflected the Resident's wounds had deteriorated on 02/03/16, 02/10/16, and 02/24/16. On 02/24/16, Resident #2's right heel pressure ulcer was unstageable and measured 2.5 cm x 4 cm. The note reflected the wound had deteriorated and recommended off-loading of the pressure ulcer (pressure ulcer not touching a surface).<br>Resident #2's comprehensive physician's orders [REDACTED]. No order for off-loading of the heels was reflected.<br>An interview on 03/02/16 at 11:30 a.m. with CNA K revealed Resident #2 had a pressure ulcer on the right heel, and the resident's heels were supposed to be off-loaded with her feet elevated. The CNA stated she received frequent in-servicing on topics related to turning and repositioning.<br>An observation on 03/02/16 at 12:25 p.m. of Resident #2 revealed her heels were resting on the pillow. At that time, the Wound Care Physician measured the pressure ulcer on the resident's right heel, and he stated it measured approximately 1.6 cm x 1.8 cm.; the wound bed was approximately half covered with a dark brown necrotic tissue; and the surrounding skin was intact. After assessment, the Wound Care Physician positioned the resident's heels in the same position as when he entered, resting on the pillow.<br>An observation on 03/16/16 at 10:05 a.m. revealed Resident #2 was lying flat on her back with her heels touching a pillow, which created pressure on her heels.<br>An observation on 03/16/16 at 11:30 a.m. revealed Resident #2 was lying flat on her back with her heels touching a pillow, which created pressure on her heels. Resident #2 revealed staff always placed her heels on a pillow, and her heels were never floated (heels not touching a surface).<br>An observation on 03/16/16 at 4:30 p.m. revealed the resident was lying flat on her back with socks covering her feet, and her heels were resting directly on top of a pillow.<br>An observation on 03/16/16 at 6:10 p.m. revealed the resident was lying flat on her back with socks covering her feet, and her heels were resting directly on top of a pillow.<br>An observation on 03/16/16 at 6:25 p.m. with LVN D revealed Resident #2 lying on her back in bed with her heels resting on a pillow. LVN D stated the resident's heels were not off-loaded, and there was no point in using a pillow if the heels were just going to rest on the pillow. LVN D left the room without repositioning the resident or off-loading her heels.<br>Review of Resident #2's ADL sheet dated 03/31/16 reflected the CNAs were to assist with repositioning every two hours. No direction related to off-loading of the heels was reflected.<br>2. Resident #8's MDS assessment, dated 02/25/16, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. The resident was at risk for pressure ulcer development and had one unstageable pressure ulcer measuring 5.0 cm x 4.0 cm with eschar. The skin and ulcer treatments included pressure reducing device for chair and bed.<br>The Wound Care Specialist Initial Evaluation dated 01/13/16 reflected Resident #8 had an unstageable pressure ulcer to her right heel which measured 5.0 cm x 4 .0 cm and an unstageable pressure ulcer to her left heel which measured 2.0 cm x 2.0 cm.<br>The comprehensive care plan for Resident #8, dated 01/14/16, reflected she had been identified for actual skin breakdown to the right heel which was unstageable due to pressure. Interventions included float heels while in bed and instruct/assist resident in methods of reducing friction and shear.<br>The weekly wound care progress notes reflected on 01/27/16 the left heel ulcer had resolved.<br>An update to the care plan on 03/17/16 reflected Resident #8 had a wound to the left calf. The updated intervention was to |

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

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| F 0314<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>cleanse the left lateral lower leg with normal saline or wound cleanser, pat dry with gauze, apply Santyl (a [MEDICATION NAME] agent to remove dead tissue)/calcium alginate (an antimicrobial to prevent infection), and cover with a dry dressing daily. The care plan continued to reflect the previous interventions of floating heels while in bed and instruct/assist resident in methods of reducing friction and shear.<br>The weekly wound care progress notes reflected on 03/23/16 the right heel wound had resolved. An unstageable wound of the left calf was initially evaluated on 03/23/16 which measured 2 cm x 2 cm. Surgical debridement of muscle (cutting out dead tissue) was performed by the physician on that date.<br>An observation on 03/30/16 at 10:20 a.m. revealed Resident #8 lying in bed with her heels floated. A gauze dressing was on the resident's left calf where the calf rested on a foam off-loading device. CNA F stated at that time the device was to keep the resident's heels from touching the mattress. When asked if the device was appropriately positioned, she straightened the device out slightly and positioned it where the resident's calf wound again rested directly on the off-loading device. The CNA confirmed the resident's heels were not touching the mattress and the off-loading device was appropriately positioned. CNA F acknowledged the Resident had a dressing to the left calf and stated she was unsure of any additional information about, or care needs for the pressure ulcer. The CNA indicated the primary concern for off-loading was to keep pressure off of the heels.<br>An observation on 03/30/16 at 1:45 p.m. revealed Resident #8 lying in bed in the same position. The DON and LVN G agreed the resident's calf pressure ulcer was resting directly on the off-loading device. The DON stated Resident #8 scooted in bed and could have moved her legs down onto the device. After attempting to reposition the resident using the off-loading device, the LVN and DON stated the device was not appropriate for off-loading due to the location of the calf pressure ulcer and would instead utilize pillows to position the Resident #8.<br>An interview on 03/30/16 at 3:45 p.m. with the DON revealed she was able to successfully off-load Resident #8's heels with pillows while keeping pressure off of the pressure ulcer on the resident's calf.<br>An observation on 03/31/16 at 4:55 p.m. revealed Resident #8 lying in bed with pillows placed under her lower legs with the pressure ulcer on her calf resting directly on the pillow. The DON stated at that time she did not know why the pressure ulcer was resting directly on the pillow, and not the way she had positioned the resident the previous day. The DON folded the pillow in half and repositioned the resident to prevent pressure to the area. She removed the dressing to the left calf and exposed the wound which measured approximately 2.5 cm x 1.5 cm x 0.5 cm. The wound bed was pink and the surrounding tissue was pink. (Note: pressure ulcer was debrided on 03/23/16 and pink tissue was consistent with procedure performed)<br>3. Resident #1's MDS assessment, dated 02/05/16, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. The resident had modified independence with his cognitive skills for daily decision making and required extensive assistance with bed mobility. The resident was at risk for pressure ulcer development and had two unstageable pressure ulcers with slough/eschar and two unstageable pressure ulcers that were deep tissue. The largest of these pressure ulcers measured 8.0 cm x 7.0 cm x 0.2 cm with eschar.<br>Observation of the consulting wound care physician's treatment of [REDACTED]. These pressure ulcers were as follows:<br>- left ischium, 5 cm x 5 cm x 1 cm with 30 percent of the wound being necrotic;<br>- right hip measured 7 cm x 6 cm x 1.5 cm and was 50 percent necrotic;<br>- right buttock measured 8 cm x 6 cm x 1.5 cm and the wound base was covered with granulation tissue; and<br>- coccyx the final wound measured 3 cm x 2.5 cm x 0.7 cm.<br>An observation on 03/16/16 at 1:20 p.m. revealed RN A donned a pair of gloves without washing/sanitizing his hands. He then picked up the trash can and moved it closer to Resident #1's bed. Next, he applied an antiseptic to the four pressure ulcers with 4 x 4 gauze. Wearing the same gloves, he covered the pressure ulcers with ABD pads and tape.<br>An interview on 03/02/16 at 1:30 p.m. with RN A revealed he recently graduated from nursing school and was not very experienced with wounds and pressure ulcers. RN A stated he had not received any wound-specific training since he began his employment at the facility.<br>4. Resident #4's MDS assessment, dated 02/28/16, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE].<br>Review of Resident #4's comprehensive plan of care, initiated on 01/20/16, revealed the resident had actual skin breakdown to his right heel related to contractures, a history of pressure ulcer, limited mobility, and [MEDICAL CONDITION]. Interventions to address the skin breakdown included providing wound treatment as ordered.<br>A progress note by the consulting wound care physician dated 02/24/16 reflected Resident #4 was seen for a stage IV pressure ulcer to the right heel which measured 2.0 cm x 2.5 cm x 0.3 cm. The physician ordered ongoing treatment with Santyl and calcium alginate, daily.<br>Resident #4's progress note by the consulting Wound Care Physician dated 03/02/16 reflected the pressure ulcer on the resident's right heel measured 1.5 cm x 2 cm and had improved since the previous week.<br>An observation on 03/02/16 at 12:35 p.m. revealed ADON E entered Resident #4's room to provide treatment his Stage IV pressure ulcer treatment on his right heel. She did not wash her hands upon entering the resident's room. The resident was sitting up in a chair and ADON E lifted the resident's right leg onto the bed to clean the pressure ulcer. ADON E donned clean gloves and cleaned the wound with four by four gauze. The pressure ulcer's wound bed was pink and the surrounding skin was dry and intact. She then applied the wound treatment as ordered by the consulting physician, without donning new gloves or washing her hands. She then applied a clean sterile dressing without donning new gloves or washing her hands.<br>An interview on 03/02/16 at 4:00 p.m. with ADON E revealed the facility's protocol was to wash hands upon entering a resident's room, put on gloves, remove a dressing, remove the dirty gloves, put on clean gloves, cleanse the wound, change gloves, apply the dressing, and wash hands before leaving the resident's room. The ADON revealed she could have changed her gloves more frequently during wounds rounds with the wound care physician. ADON E further revealed the facility was experiencing some staffing changes and was in between wound care nurses at the time.<br>5. Review of Resident #5's face sheet, dated 03/16/16, revealed a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses, including [MEDICAL CONDITION], pressure ulcer of the sacral region, [MEDICAL CONDITION], pressure ulcer of<br>the buttock, type 2 diabetes, and obesity.<br><br>The comprehensive care plan for Resident #5 dated 03/04/16 revealed she admitted to the facility with a pressure ulcer to the sacrum. Interventions included, Cleanse sacral wound with wound cleanser, pat dry with four by four gauze, apply collagen to wound bed, cover w/ (with) Duoderm (a gel filled dressing) q (every) 3 days and PRN (as needed).<br>Resident #5's MDS assessment, dated 03/08/16, reflected an alert and oriented resident who required extensive two person assistance with bed mobility, and totally dependent upon staff with transferring, dressing, toileting, and personal hygiene. The assessment reflected a Stage II pressure ulcer to her sacral region.<br>On 03/16/16 at 12:30 p.m., the Wound Care Physician measured Resident #5's sacrum pressure ulcer and stated it was 0.5 cm x 0.7 cm. LVN B did not wash her hands before cleaning the wound on Resident #5's sacrum. LVN B cleaned the sacral wound with wound cleanser and 4x4 gauze and then applied the treatment as ordered by the physician without donning new gloves or washing her hands.<br>6. Resident #6's MDS assessment, dated 03/17/16, revealed she was an [AGE] year-old female, admitted to the facility on [DATE].<br>An admission nurses note dated 03/17/16 reflected Resident #6 had been assessed for pressure ulcer risk by a Braden scale and was identified as at severe risk.<br>A Social Services admission note dated 03/21/16 reflected a cognition screen had been conducted and the resident was cognitively intact.<br>The Wound Care Specialist Initial Evaluation for Resident #6 dated 03/23/16 reflected she was seen for an unstageable pressure ulcer to her right buttock which measured 2 cm x 1.5 cm.<br>Resident #6's Physician's Telephone Order dated 03/24/16 reflected to cleanse the sacral wound with normal saline or wound cleanser, pat dry apply [MEDICATION NAME] (a foam dressing) with dry dressing every day shift. The treatment order for the Resident's coccyx wound dated 03/24/16 was to cleanse with normal saline or wound cleanser, pat dry with four by four gauze, then apply santyl, calcium alginate, and dry dressing every day shift.<br>The March, 2016 Treatment Administration Record for Resident #6 reflected RN H conducted pressure ulcer treatment on Friday, 03/25/16. On 03/26/16, LVN I signed she completed the treatment. No signature was reflected on Sunday, 03/27/16. |

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| F 0314<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>An interview with Resident #6 on 03/29/16 at 3:50 p.m. revealed she had a sore on her rear end that had been treated every day the previous week by RN H. Resident #6 stated no one did anything to the sore over the weekend and RN H resumed treatment on Monday (03/26/16). Resident #6 believed the RN had informed her she would receive wound treatments over the weekend, but since no one had conducted treatment, she wondered if she misunderstood the RN. Resident #6 stated her wound was getting better.<br>A telephone interview on 03/30/16 at 4:35 p.m. with LVN I revealed she completed Resident #6's pressure ulcer treatment on Saturday, 03/26/16. The LVN could not recall the location of the ulcer nor the treatment provided. She did not know why Resident #6 would say she had not completed the treatment.<br>7. Resident #7's MDS assessment, dated 03/18/16, reflected she was a [AGE] year-old female, admitted to the facility on [DATE].<br>The comprehensive care plan for Resident #7 dated 03/21/16 revealed she had been identified as at risk for skin breakdown as evidenced by impaired sensation, moisture/excessive perspiration, history of pressure ulcer, limited mobility, incontinence, and vascular disease. Preventative interventions included assisting the resident with repositioning and monitor skin for signs of breakdown. No actual breakdown was reflected in the plan of care.<br>A Social Services admission note dated 03/21/16 reflected a cognition screen had been conducted and the resident was cognitively intact.<br>Review of the Wound Care Specialist Evaluation dated 03/23/16 revealed Resident #7 had a Stage III pressure ulcer of the right buttock, which measured 3 cm x 2 cm x 0.1 cm and was evaluated by the physician for the first time on this date. The recommendations were for collagen dressing once daily.<br>Review of Resident #7's treatment administration record for March 2016 revealed on 03/25/16, pressure ulcer treatment was completed by RN H. On 03/26/16, LVN I signed she completed the treatment and on 03/27/16, LVN J signed she completed the treatment.<br>An interview with Resident #7 on 03/30/16 at 2:25 p.m. revealed she had been seen by the wound care physician and was receiving treatments to her buttock. The resident stated staff had changed the gauze on her bottom every day the previous week, but no dressing changes had been conducted over the weekend.<br>A telephone interview with LVN I on 03/30/16 at 4:35 p.m. revealed she completed Resident #7's pressure ulcer treatment over the weekend of 03/26/16 - 03/27/16. The LVN could not recall the location of the ulcer nor the treatment provided. She did not know why Resident #7 would say she had not completed the treatment.<br>A telephone interview with LVN J on 03/30/16 at 5:00 p.m. revealed she completed the pressure ulcer treatment for [REDACTED].<br>8. During an interview with the Wound Care Physician on 03/29/16 at 3:00 p.m., the physician was informed of the observed infection control issues. He stated he did not see infection control concerns during rounds with facility staff, but he was not surprised. He explained there was inconsistency in who conducted pressure ulcer treatments and there was no one at the top watching or monitoring.<br>During a telephone interview with the DON on 03/29/16 at 1:35 p.m., she revealed it had been a struggle to supervise the wound care program at the facility partly because of change in staff. When asked how she ensured pressure ulcer treatment was provided appropriately, she stated she did random spot checks and the wound care physician conducted weekly rounds. She stated, however, it had been a challenge and at some point she just had to trust her nurses.<br>An interview with RN H on 03/29/16 at 12:50 p.m. revealed she had been the wound care nurse for a short period and this was her second full week of work at the facility. RN H stated wound care had not been done over the weekend (03/26/16 and 03/27/16) by the charge nurses as ordered. RN H stated the dressings she applied and dated on Friday 03/25/16 were the same dressings she observed on Monday morning (03/28/16). The RN stated she reported to the Administrator on 03/28/16 that dressing changes had not been conducted over the weekend.<br>During an interview with the Administrator and the DON on 03/30/16 at 9:30 a.m. they revealed the wound care nurse (RN H) had resigned without notice the previous day and they found her allegation that weekend pressure ulcer care was not conducted to be invalid. The Administrator and DON stated the treatment record reflected that care was conducted and they could not get a hold of RN H, so no further investigation could or would be conducted into the concern.<br>9. The facility's current Skin Integrity Management policy, dated 03/15/16, reflected the following:<br>.4. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated<br>The facility's current Infection Control - Standard Precautions policy, dated 10/01/13, reflected the following:<br>.3. Change gloves between tasks and procedures on the same individual and after contact with material that may contain a high concentration of microorganisms.<br>4. Remove gloves promptly after use before touching non-contaminated items and environmental surfaces, and before going to another individual.<br>The facility's current Hand Hygiene policy, dated 10/01/13, reflected the following:<br>.2.1 Before any direct contact with patient;<br>2.2 Before putting on gloves; .<br>2.5 After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings (if visibly soiled, must wash hands);<br>2.6 When moving from contaminated body site to clean body site during patient care;<br>2.7 After contact with inanimate objects in the immediate vicinity of the patient; .<br>2.8 After removing gloves<br>10. The Resident Census and Conditions of Residents Form CMS-672, dated 03/30/16, reflected 10 residents had pressure ulcers. |
| F 0441<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Have a program that investigates, controls and keeps infection from spreading.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of disease and infection for three (Residents #1, #5, and #4) of 8 residents reviewed for wound care treatment.<br>1. RN A failed to change his gloves or wash or sanitize his hands after he picked up the trash can and moved it closer to Resident #1's bed and provided treatment to Resident #1's multiple pressure ulcers wearing contaminated gloves.<br>2. LVN B failed to wash her hands before cleaning Resident #4's Stage II pressure ulcer and failed to change her gloves and wash or sanitize her hands before applying the treatment to the resident's wound.<br>3. ADON E failed to wash her hands before putting on gloves, failed to change her gloves and wash or sanitize her hands prior to applying the treatment, and failed to change her gloves and wash or sanitize her hands prior to applying a sterile dressing to the resident's Stage IV pressure ulcer.<br>These failures could affect the 16 residents with wounds by placing them at risk for infection, deteriorating wounds, and hospitalization .<br>Findings included:<br>1. The face sheet for Resident #1, dated 12/22/15, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Resident #1's weekly Wound Care Specialist Evaluation, dated 02/24/16, from the contracted wound-care company reflected he had an unstageable pressure ulcer to his right buttock which measured 10 cm x 6.5 cm x2 cm and was unchanged from the previous week. A second unstageable pressure ulcer was noted to the right ischium (the lower and back part of the hip bone), which measured 7 cm x 7.5 cm x 1.5 cm and had improved since the previous week. A third unstageable ulcer was noted to his left ischium, which measured 4.5 cm x5.5 cm and had deteriorated since the previous assessment. A fourth unstageable pressure ulcer was noted to the coccyx (tailbone) area, which measured 3 cm x4 cm and had deteriorated since the previous assessment.<br>Observation of the consulting wound care physician's treatment of [REDACTED]. The first wound to his left ischium, according to the physician's measurements, was 5 cm x 5 cm x 1 cm with 30 percent of the wound being necrotic. The wound to the right hip measured 7 cm x 6 cm x 1.5 cm and was 50 percent necrotic. The wound to his right buttock measured 8 cm x 6 cm x 1.5 cm and the wound base was covered with granulation tissue. And the final wound measured 3 cm x 2.5 cm x 0.7 cm. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0441<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 3)<br>Observation of RN A on 03/16/2016 at 1:20 p.m. revealed he did not wash his hands prior to putting on gloves. After he put on the gloves, he picked up the trashcan and moved it closer to the resident's bed. He then applied an antiseptic to all four wounds with four by four gauze, while wearing contaminated gloves. Then he covered the pressure ulcers with ABD pads and tape, while still wearing the contaminated gloves.<br>During an interview with RN A on 03/02/16 at 1:30 p.m., he revealed he had recently graduated from nursing school and he was not very experienced with wounds and pressure ulcers. RN A stated he had not received any wound-specific training since hire.<br>2. Resident #4's face sheet dated 03/16/2016, revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>A progress note by the consulting wound care physician dated 02/24/16 reflected Resident #4 was seen for a stage IV pressure ulcer to the right heel which measured 2 cm x 2.5 cm x 0.3 cm. The physician ordered ongoing treatment with Santyl and calcium alginate, daily.<br>Observation on 03/02/16 at 12:35 p.m. revealed ADON E entered Resident #4's room and did not wash her hands upon entering the resident's room. ADON E donned clean gloves and cleaned the wound with four by four gauze. She then applied the wound treatment as ordered by the consulting physician, without donning new gloves or washing her hands. She then continued to apply a clean sterile dressing without donning new gloves or washing her hands.<br>Interview with ADON E on 03/02/16 at 4:00 p.m. revealed the facility's protocol was to wash hands upon entering a resident's room, put on gloves, remove a dressing, remove the dirty gloves, put on clean gloves, cleanse the wound, change gloves, apply the dressing, and wash hands before leaving the resident's room. The ADON revealed she could have changed her gloves more frequently during wounds rounds with the wound care physician. ADON E further revealed the facility was experiencing some staffing changes and was in between wound care nurses at the time.<br>3. Review of Resident #5's face sheet, dated 03/16/2016, revealed a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses, including fracture of the fibula, pressure ulcer of the sacral region, anemia, pressure ulcer of the buttock, type 2 diabetes, and obesity.<br>Observation on 03/16/16 at 12:30 p.m. revealed LVN B did not wash her hands before cleaning the wound on Resident #5's sacrum, LVN B cleaned the sacral wound with wound cleanser and 4x4 gauze and then applied the treatment as ordered by the physician without donning new gloves or washing her hands.<br>4. During an interview with the contracted wound care physician on 03/29/16 at 3:00 p.m. he was informed of the observed infection control issues. The physician stated he did not see infection control concerns during rounds with facility staff. He revealed he was not surprised. The physician stated there was inconsistency in who conducted wound care treatments and there was no one at the top watching or monitoring.<br>During a telephone interview with the DON on 03/29/16 at 1:35 p.m., she revealed it had been a struggle to supervise the wound care program at the facility partly because of change in staff. The DON stated, however, the wound care physician conducted weekly rounds and at some point she just had to trust her nurses to conduct treatment as ordered.<br>5. The facility's Standard Precautions policy dated 10/01/13 reflected the following infection control procedures:<br>3. Change gloves between tasks and procedures on the same individual and after contact with material that may contain a high concentration of microorganisms.<br>4. Remove gloves promptly after use before touching non-contaminated items and environmental surfaces, and before going to another individual.<br>The facility's Hand Hygiene policy dated 10/01/13 reflected staff was to decontaminate hands with an alcohol based rub or wash hands with soap and water in the following situations:<br>2.1 Before any direct contact with patient;<br>2.2 Before putting on gloves; .<br>2.5 After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings (if visibly soiled, must wash hands);<br>2.6 When moving from contaminated body site to clean body site during patient care;<br>2.7 After contact with inanimate objects in the immediate vicinity of the patient; .<br>2.8 After removing gloves.<br>6. The current, undated list of residents with wounds provided by the facility reflected 16 residents with wounds. |