

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2024
NAME OF PROVIDER OR SUPPLIER  Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2649 Topeka Street Riverbank, CA 95367	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</b></p> <p>Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan for one of six sampled residents (Resident 1) when Resident 1 did not have a care plan with measurable goals and interventions after testing positive for Coronavirus disease 2019 (COVID-19-a highly contagious infectious disease caused by a virus from respiratory droplets that can spread from person to person) on 11/10/23 and Licensed Nurses did not develop a care plan for oxygen therapy since her admission to the facility on [DATE].</p> <p>These failures had the potential for Resident 1's COVID-19 and oxygen therapy care needs to go unmet.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR-document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included type 2 diabetes mellitus (high levels of sugar in the blood), atrial fibrillation (a fib-type of abnormal heartbeat), history of pulmonary embolism (a blood clot travels through the bloodstream to the lungs), weakness, and difficulty in walking.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental process) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was cognitively intact.</p> <p>During a concurrent interview and record review on 3/27/24 at 12:00 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's care plans were reviewed. LVN 1 stated she was unable to locate a COVID-19 care plan initiated on 11/10/23. LVN 1 stated Resident 1 had a change of condition when she tested positive for COVID-19 and a care plan should have been initiated. LVN 1 stated Resident 1's care plans should have included specific interventions to guide the care for treating COVID-19 and preventing complications.</p> <p>During an interview on 3/27/24 at 1:35 p.m. with the Infection Preventionist (IP), the IP stated Resident 1 tested positive for COVID-19 on 11/10/23.</p> <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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/24/23 at 2:37 p.m. with LVN 1, Resident 1's COVID-19 care plan dated 11/13/23 was reviewed, the care plan indicated, . Resident has DIAGNOSIS OF COVID-19 and is experiencing respiratory complications, and flu like symptoms . cough . Goal . Resident will maintain airway and oxygen exchange as evidence [evidenced] by normal O2 [oxygen] saturation and respiratory rate x 30 days . Will be able to initiate interventions timely and appropriately once s/s of respiratory illness such SOB, cough, elevated temp etc [et cetera-abbreviation for other similar things] is/are identified daily . Apply surgical mask to resident and isolate in a single room . contact county public health . diagnostic testing . place sign on door identifying PPE [personal protective equipment-equipment worn to minimize exposure to hazards] requirements . Staff to observe contact [prevent spread of diseases by touch] and droplet precautions [prevent spread of diseases by air] . LVN 1 stated she was unsure why the COVID-19 care plan was entered three days after the COVID-19 diagnosis. LVN 1 stated the interventions would not be effective in meeting the goal of maintaining Residents 1's airway and oxygen exchange. LVN 1 stated the interventions were not personalized to meet Resident 1's needs. LVN 1 stated the goal which indicated normal O2 saturation was not appropriate because normal was different for everyone. Resident 1's physician orders dated November 2023 were reviewed. The orders indicated, . Oxygen 3 liters / min [LPM] or to keep O2 above 92 % . via Nasal Cannula [a device that delivers oxygen through a small tube into the nose], Humidification [addition of heat or moisture to a gas] . Continuously via concentrator [medical device that provides extra oxygen] . LVN 1 stated Resident 1 received supplemental oxygen at 3 LPM via nasal cannula since admission to the facility on [DATE]. LVN 1 stated she was unable to locate a care plan for oxygen use and the licensed nurses should have initiated on upon admission.</p> <p>During a concurrent telephone interview and record review on 4/24/24 at 4:24 p.m. with the infection preventionist (IP), Resident 1's Infection Note, dated 11/10/23, at 10:04 p.m., was reviewed. The IP stated she had received a phone call from the charge nurse on 11/10/23 notifying her Resident 1 had tested positive for COVID-19. The IP stated the process when a resident tested positive for COVID-19 was the charge nurse to complete an assessment, SBAR and change of condition note, notify the physician, obtain orders if appropriate, notify the family and initiate a care plan. The IP stated she was unable to locate a care plan initiated before 11/13/23.</p> <p>During a concurrent interview and record review on 4/25/24 at 3:56 p.m. with the Director of Nursing (DON), Resident 1's care plans were reviewed. The DON stated she was unable locate a COVID-19 care plan initiated on 11/10/23. The DON stated a COVID-19 care plan should have been initiated within one day of the positive test result. The DON reviewed Resident 1's COVID-19 care plan dated 11/13/23. The DON stated Resident 1's care plan goal indicated, . Resident will maintain airway and oxygen exchange as evidence [evidenced] by normal O2 saturation and respiratory rate . The DON stated when the care plan was developed, Resident 1's medical history and baseline status should have been considered in determining person-centered goals. The DON stated Resident 1's COVID-19 care plan was generic, not personalized and did not include specific care needs such as supplemental oxygen, vital signs, or symptom management. The DON stated care plans were important because they directed the plan of care provided to the residents. The DON reviewed Resident 1's care plans in the EMR and stated she was unable to locate a care plan for oxygen therapy. The DON stated when Resident 1 was admitted to the facility, an oxygen care plan should have been initiated and included individualized goals and interventions.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&amp;P indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan Includes measurable objectives and timeframes describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents; conditions change . the interdisciplinary team reviews and updates the care plan . when there has been a significant change in the resident's condition .</p> <p>During a review of the facility's P&amp;P titled Oxygen Administration, dated 10/2010, . purpose of this procedure is to provide guidelines for safe oxygen administration . Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Review the resident's care plan to assess for any special needs of the resident . After completing the oxygen setup or adjustment, the following information should be recorded . rate of oxygen flow, route, and rationale . All assessment data obtained before, during and after the procedure . How the resident tolerated the procedure .</p> <p>During a review of the facility's P&amp;P titled Change in a Resident's Condition or Status, dated 2/2021, the P&amp;P indicated, . Our facility promptly notifies the resident, his or her attending physician . the nurse will notify the resident's attending physician or physician on call when there has been . need to alter the resident' medical treatment significantly . A significant change of condition is a major decline . in the resident's status that . will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . requires interdisciplinary review and/or revision to the care plan . The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</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>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</b></p> <p>Based on interview and record review, the facility failed to meet professional standards of practice for one of six sampled residents (Resident 1) when Licensed Vocational Nurse (LVN) 2 did not follow professional standards for the administration of oxygen (O2- an odorless gas that is present in the air and necessary to maintain life) on 11/14/23 when she administered oxygen to Resident 1 with a non-rebreather mask (a special mask placed over the nose and mouth to provide oxygen in emergencies) without a physician's order.</p> <p>This failure placed Resident 1 at risk for suffocation (die from being unable to breathe) from improper usage of a non-rebreather mask.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR-document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included type 2 diabetes mellitus (high levels of sugar in the blood), atrial fibrillation (a fib-type of abnormal heartbeat), history of pulmonary embolism (a blood clot travels through the bloodstream to the lungs), weakness, and difficulty in walking.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental process) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was cognitively intact.</p> <p>During an interview on 3/27/24 at 1:35 p.m. with the Infection Preventionist (IP), the IP stated Resident 1 had tested positive for COVID-19 on 11/10/23. The IP stated when a resident tests positive for COVID-19, their vital signs with oxygen (O2) saturation were checked every 2 hours.</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 a concurrent interview and record review on 4/24/23 at 2:37 p.m. with LVN 1, Resident 1's physician orders dated November 2023 were reviewed. The orders indicated, . Oxygen 3 liters / min [LPM-the flow of oxygen received from the oxygen delivery system] or to keep O2 above 92 % . via Nasal Cannula [a device that delivers oxygen through a small tube into the nose], Humidification [addition of heat or moisture to a gas] . Continuously via concentrator [medical device that provides extra oxygen] . LVN 1 stated Resident 1 was on oxygen at 3 LPM via nasal cannula when she was admitted to the facility on [DATE]. LVN 1 stated Resident 1 tested positive for COVID-19 on 11/10/23. Resident 1's Nurses Note, dated 11/14/23, at 5:03 a.m. , written by LVN 2 was reviewed. The note indicated, resident is noted to remove nasal cannula. Education provided. Non Rebreather Mask provided. O2 [saturation- amount of oxygen circulating in the blood] is at 93% . Resident 1's Nurses Note, dated 11/14/23, at 10:58 p.m., was reviewed. The note indicated, resident is noted to remove nasal cannula. Education provided. Non Rebreather Mask provided. O2 [saturation] is at 94% . Resident 1's physician orders titled Medication Review Report, dated November 2023, were reviewed. The orders indicated, . Oxygen 3 liters / min or to keep O2 above 92 % . via Nasal Cannula, Humidification . Continuously via concentrator . Start Date . 10/31/23 . LVN 1 stated Resident 1 did not have an order for a non-rebreather mask. Resident 1's nurses notes were reviewed, LVN 1 stated she was unable to locate a note to indicate LVN 2 had contacted Resident 1's physician to request an order for a non-rebreather mask. LVN 1 stated LVN 2 should have contacted the physician for an order if Resident 1 required a non-rebreather mask.</p> <p>During a review of a professional reference retrieved from <a href="https://www.ncbi.nlm.nih.gov/books/NBK593208/#:~:text=Oxygen%20is%20considered%20a%20medication,its%20safe%20and%20effective%20use">https://www.ncbi.nlm.nih.gov/books/NBK593208/#:~:text=Oxygen%20is%20considered%20a%20medication,its%20safe%20and%20effective%20use</a>. Titled Chapter 11 Oxygen Therapy, dated 2021, the reference indicated, . Oxygen Therapy . Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use . nasal cannula is the simplest oxygenation device . a non-rebreather mask consists of a mask attached to a reservoir bag that is attached with tubing to flow meter . The flow rate for a non-rebreather mask should be set to deliver a minimum of 10 to 15 L/minute . Disadvantages . there is a high risk of suffocation if the gas flow is interrupted .</p> <p>During a concurrent interview and record review on 4/25/24 at 3:56 p.m. with the Director of Nursing (DON), Resident 1's nurse's notes dated 11/14/23, at 5:03 a.m. and 10:58 p.m., written by LVN 2, were reviewed. The DON stated the notes indicated Resident 1 had removed her nasal cannula and LVN 2 placed a non-rebreather mask on the resident. The DON stated a non-rebreather mask was usually used if a resident was in respiratory distress (a condition where the body needs more oxygen) and LVN 2's notes did not indicate the resident was in distress. The DON stated if a resident needed a non-rebreather, it was usually an emergency, and the physician should have been notified after the mask was applied. The DON stated an order was needed for a non-rebreather mask but in case of an emergency, the nurse could apply the mask and call the physician as soon as possible. The DON stated LVN 2's notes indicated the non-rebreather mask was used because Resident 1 was removing her nasal cannula. The DON reviewed LVN 2's documentation and stated she was unable to determine if a non-rebreather mask was necessary.</p> <p>During a professional reference review of Lippincott Manual of Nursing Practice 10th Edition, dated 2014, pages 16-17, indicated, .Standards of Practice .General Principles .Common Departures from the Standards of Nursing Care .Legal claims most commonly made against professional nurses include the following departures from appropriate care .failure to .follow physician orders .adhere to facility policy or procedure . administer medications as ordered .</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 a review of the facility's policy and procedure (P&amp;P) titled Coronavirus Disease (COVID-19)-Identification and Management of Ill Residents, dated 9/2022, the P&amp;P indicated, . Residents with signs and/or symptoms of COVID-19 (SARS-COV-COV-2 infection) are identified and isolated to help control the spread of infection . Clinical Care . Clinical monitoring of residents with suspected or confirmed SARS-CoV-2 infection is increased including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection .</p> <p>During a review of the facility's P&amp;P titled, Oxygen Administration, dated 10/2010, . purpose of this procedure is to provide guidelines for safe oxygen administration . Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Review the resident's care plan to assess for any special needs of the resident . After completing the oxygen setup or adjustment, the following information should be recorded . rate of oxygen flow, route, and rationale . All assessment data obtained before, during and after the procedure . How the resident tolerated the procedure .</p> <p>During a review of the facility's P&amp;P titled Change in a Resident's Condition or Status, dated 2/2021, the P&amp;P indicated, . Our facility promptly notifies the resident, his or her attending physician . the nurse will notify the resident's attending physician or physician on call when there has been . need to alter the resident' medical treatment significantly . A significant change of condition is a major decline . in the resident's status that . will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . requires interdisciplinary review and/or revision to the care plan . The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective infection control program for two of six sampled residents (Residents 4 and 6) when the Treatment Nurse (TN) failed to follow infection control precautions during wound care.</p> <p>These failures placed Residents 4 and 6 at risk for wound infections.</p> <p>Findings:</p> <p>During a review of Resident 4 ' s Admission Record (AR-a document with person identifiable and medical information), undated, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of bladder (lack of bladder control caused by nervous system condition), pressure ulcer (injury to the skin and tissue below the skin due to long periods of pressure) of sacral region (bottom of the spine) stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle), pressure ulcer of left hip stage 3 (full thickness tissue loss without exposed bone, tendon, or muscle) and paraplegia (paralysis of the legs).</p> <p>During a review of Residents 4 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 4 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 4 was cognitively intact.</p> <p>During a concurrent observation and interview on 3/27/24 at 10:09 a.m. with the TN, the TN prepared Resident 4 ' s wound care supplies on top of the treatment cart. The TN had a blue plastic basket on top of the cart and placed the wound care supplies into the basket. The TN took the blue basket into Resident 4 ' s room and placed it onto the bedside table without a barrier in between the table and basket. The TN donned (put on) gloves without sanitizing her hands and removed the soiled dressing. The TN placed the soiled dressing and gloves into a plastic bag and donned a new pair of gloves without performing hand hygiene. The TN cleaned the wound with a moist gauze (a fabric bandage to dress wounds), patted it dry and doffed (took off) the gloves. The TN did not perform hand hygiene, donned new gloves, and applied the cover dressing. The TN stated she was not aware she should sanitize her hands in between glove changes. The TN stated the purpose of hand hygiene was to make sure nothing dirty gets into the wound.</p> <p>During a review of Resident 6 ' s AR, undated, the AR indicated, Resident 6 was admitted to the facility on [DATE] with diagnoses which included non-pressure chronic ulcer (wound caused by poor circulation) of left lower leg, infection of amputation (partial or total loss of the limbs) stump (part of a limb left following amputation), and type 2 diabetes mellitus (disease that occurs when your blood sugar is too high).</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>During a review of Residents 6 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 6 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 6 was cognitively intact.</p> <p>During a concurrent observation and interview on 3/27/24 at 10:50 a.m. with the TN and Resident 6, Resident 6 was sitting up in bed, his right leg was missing from the mid-thigh down. The TN prepared the wound care supplies and placed them into the blue basket. The TN took the basket, a bottle of hand sanitizer and a box of gloves into the room and placed them directly onto Resident 6 ' s bed. The TN sanitized her hands with hand gel, donned gloves, removed the soiled dressing, and discarded the gloves and dressing into a plastic bag. The TN sanitized her hands and donned new gloves and performed the wound care. The TN discarded her gloves and sanitized her hands. The TN took the basket, hand sanitizer and box of gloves off Resident 6 ' s bed and placed them on top of the treatment cart without sanitizing the items. The TN stated the cardboard box of gloves could not be properly sanitized and should not have been placed on Resident 6 ' s bed. The TN stated she should have placed the items on a barrier and not directly on the bed because it could spread an infection to the other residents.</p> <p>During an interview on 3/27/24 at 1:35 p.m. with the Infection Preventionist (IP), the IP stated her expectation when the nurses provide wound care was for hands to be washed before and after wound care, the nurse should don gloves, remove the dirty dressing, and change her gloves. The IP stated wound supplies are single use, should not be taken into a resident ' s room and back to treatment cart. The IP stated If reusable supplies were taken into a room, then a barrier would need to be placed under the items and the items cleaned properly before returning to the treatment cart. The IP stated if a box of gloves were taken into a resident room, the box should be left in the room. The IP stated a resident ' s bed was not a clean area and wound care supplies should never be placed on the bed. The IP stated the treatment nurse should always place the wound care supplies on a barrier on top of the bedside table for infection control. The IP stated she was unsure if the nurse ' s hands needed to be sanitized in between glove changes while providing wound care. The IP stated it was important for staff to follow the infection control guidelines during wound care to prevent infections and cross contamination.</p> <p>During an interview on 3/27/24 at 1:58 p.m. with the Director of Nursing (DON). The DON stated gloves should be changed after a dirty dressing is removed, during wound care, and prior to applying a clean dressing. The DON stated her expectation for hand hygiene was for hands to be washed with soap and water or use hand sanitizer. The DON stated if proper hand hygiene was not performed during wound care, it could introduce bacteria into the wound. The DON stated if wound supplies were taken into a resident room, there should be a barrier between the bedding and the basket with the wound supplies. The DON stated the basket would need to be cleaned thoroughly after being in the resident room. The DON stated if infection control procedures were not followed it could spread infections to other residents.</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>During a review of a professional reference retrieved from <a href="https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html">https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html</a> CDC ' s Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, undated, . Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings . Hand Hygiene . Use an alcohol-based hand rub or wash with soap and water for the following clinical indications . Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site . After touching a patient or the patient ' s environment . After contact with . contaminated surfaces . Immediately after glove removal .</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled Wound Care, dated 10/2010, the P&amp;P indicated, . purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Steps in the Procedure . Use disposable cloth (paper towel is adequate) to establish clean field on resident ' s overbed table. Place all items to be used during procedure on the clean field . Wash and dry your hands thoroughly . put on exam glove . remove dressing . pull the glove over dressing and discard . Wash and dry your hands thoroughly . Put on gloves . Use no-touch technique . Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound . Dress wound . Be certain all clean items are on clean field . Wipe reusable supplies with alcohol as indicated . Return reusable supplies to resident ' s drawer in treatment cart . Take only the disposable supplies that are necessary for the treatment into the rooms . Disposable supplies cannot be returned to the cart . wash and dry your hands thoroughly .</p>		