STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birch at Sutherland	333 Maple Street Sutherland, NE 69165

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09B Based on record review and interview, the facility failed to code dialysis on the Minimum Data Set (MDS a federally mandated assessment tool utilized to develop resident care plans) assessment for 1 (Resident 1) of 1 sampled resident. The facility census was 48. The Findings Are: A record review of facility policy MDS 3.0 Completion dated 8/1/2023, revealed Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. A record review of Resident 1's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease and Dependence on Renal Dialysis. A record review of Resident 1's End of PPS Part A Stay MDS dated [DATE], Section O revealed dialysis was not indicated as a special treatment that resident had received. A record review of Resident 1's Discharge, Return Anticipated MDS dated [DATE], Section O revealed dialysis was not indicated as a special treatment the resident had received. A record review of Resident 1's Quarterly MDS dated [DATE], Section O revealed dialysis was not indicated as a special treatment the resident had received. An interview on 2/14/24 at 11:05 AM with the Director of Nursing (DON) revealed that Resident 1 received dialysis treatment on Mondays, Wednesdays, and Fridays at a dialysis center. The DON further revealed, that the resident was receiving dialysis treatment prior to their admission to the facility. The DON also revealed, that all MDSs that had been completed on the resident since their admission should have had dialysis treatment indicated in Section O and that the MDSs completed on 12/1/23, 1/16/24, and 1/23/24 did not have dialysis treatment indicated in Section O.

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09C1c Based on record review and interview, the facility failed to revise a Care Plan for a provider order 1 (Resident 1) of 1 sampled resident. The facility census was 48. The Findings Are: A record review of Resident 1's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease (ESRD) and Dependence on Renal Dialysis. A record review conducted on 2/14/24 of Resident 1's undated Care Plan revealed The resident needs hemodialysis related to (r/t) ESRD. Presence of right subclavian catheter (removed on 12/20/2023). Stitches in place: Daily Dressing Change. A record review conducted on 2/14/2024 of Resident 1's current Physician's Orders revealed the resident did not have an order for a daily dressing change related to stitches being in place post-removal of a right subclavian catheter. A record review of Resident 1's January 2024 Medication Administration Record revealed the order Clean area to right clavicle with soap and water, apply antibiotic ointment and cover with dressing. Change daily. was discontinued on 2/1/2024 at 10:40 AM. An interview on 2/14/24 at 11:05 AM with the Director of Nursing (DON) confirmed Resident 1 no longer had stitches in place or an order for daily dressing changes to their subclavian catheter removal site. The DON confirmed that the resident's Care Plan still stated the resident had stitches and a daily dressing change to the subclavian catheter removal site. A record review of facility policy Comprehensive Care Plan dated 8/1/2023, revealed Policy Explanation and Compliance Guidelines: 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. The MDS is a federally mandated assessment tool utilized to develop resident care plans.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09D1c Based on observation, interview, and record review, the facility failed to provide assistance with grooming to 3 (Residents 1, 12, and 15) of 3 sampled residents. The facility census was 48. A. A record review of Resident 1's Admission Record revealed the resident was admitted to the facility on [DATE]. A record review of Resident 1's Minimum Data Set (MDS), a federally mandated assessment tool utilized to develop resident care plans, dated 1/23/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 4/15, which indicated the resident had moderate cognitive impairment. Section GG revealed the resident required partial or moderate assistance for toileting, personal hygiene, and transfers. The resident required substantial or maximum assistance with upper body dressing and was dependent on staff assistance for lower body dressing. A record review of Resident 1's undated Care Plan revealed the resident required extensive, one-person physical assist with personal hygiene. An observation on 2/6/24 at 8:55 AM revealed Resident 1 self-propelling in wheelchair throughout the hallways. The resident was wearing a black sweatshirt that had a large amount of food debris all over the front of it. An observation on 2/6/24 at 11:45 AM revealed Resident 1 sitting in their wheelchair at a table in the dining room. The resident's hair was unkempt, sticking up and to the sides. An observation on 2/13/24 at 12:15 PM revealed Resident 1 sitting at table in the dining room. The resident's hair was unkempt. An observation on 2/13/2024 at 2:33 PM revealed Resident 1 sitting in a recliner in their room with their eyes open. The resident's hair was unkempt. An observation on 2/13/24 at 5:28 PM revealed the resident sitting in their recliner in their room. The resident's hair was unkempt and was sticking straight up in some sections. 46245 B. A record review of Resident 12's Admission Record revealed they were admitted to the facility on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 12's Minimum Data Set (MDS- a comprehensive assessment tool used to develop a resident's Care Plan) with a date of 12/31/2023, Section GG-Functional Abilities and Goals revealed the resident required setup or clean-up assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for personal hygiene (including combing their hair, washing/drying their face/shaving). A record review of Resident 12's POC Response History ADL (activities of daily living) Bathing documentation revealed the resident had a bath on 2/2/2024 at 1:29 PM and one on 2/14/2024 at 1:59 PM. An observation on 2/13/2024 at 2:10 PM in Resident 12's room revealed the resident sitting in a wheelchair (w/c) next to their bed. Resident 12 had long grey facial hair covering their chin. An observation on 2/13/2024 at 5:55 PM in the hallway revealed Resident 12 self-propelling their w/c. Resident 12 had long grey facial hair covering their chin. An observation on 2/14/2024 at 4:18 PM in Resident 12's room revealed they had long grey whiskers/facial hair covering their chin. An interview on 2/13/2024 at 5:56 PM with Resident 12 revealed they prefer to have their facial hair shaved off. The facility staff shave their facial hair every time they bath them, and they receive a bath twice a week. An interview on 2/14/2024 at 4:18 PM with Resident 12 confirmed they had a bath that day (2/14/2024) and said they get a bath every few days. An interview on 2/14/2024 at 4:31 PM with the Director of Nursing (DON) confirmed that Resident 12 had a bath that day (2/14/2024) and had long grey facial hair covering their chin. The DON revealed Resident 12 will refuse their bath and care at times and it should be reported to the charge nurse should this occur. The DON revealed there was no refusal documented for Resident 12 to be shaved today (2/14/2024). An interview on 2/14/2024 at 4:33 PM with Licensed Practical Nurse (LPN)-C confirmed Resident 12 had a bath that day (2/14/2024) and knew this because the resident had asked for a pop since they had taken a bath. LPN-C revealed they had noticed the facial hair covering Resident 12's chin yesterday and said the whiskers on their chin had been there for a week or a while. A record review of the facility's policy, Grooming a Resident's Facial Hair with an implemented date of 8/1/2023 under Policy: revealed, It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice. C. A record review of Resident 15's Admission Record revealed they were admitted to the facility on [DATE]. Resident 12 had a diagnoses of: diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela, and unspecified intellectual disabilities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 15's Care Plan with a printed date of 2/14/2024 revealed a Focus of Resident 15 is dependent on staff for meeting emotional, intellectual, physical, spiritual, and social needs r/t (related to) cognitive deficits initiated on 8/15/2023. A Focus of I have increased risks for actual/potential limitation(s) in my ability to perform my ADLs with an initiated date of 8/15/2023. Interventions included Personal Hygiene: The resident requires 1 staff with personal hygiene prn (as needed) and oral care with a revised date of 8/23/2023. An observation on 2/13/2024 at 1:24 PM revealed Resident 15 was lying supine in bed with their eyes open and their left leg crossed over their right (at the ankles). Resident 15's toenails on both feet were long and yellow, and the tips of them were jagged. The big toe on their left foot's nail was spilt up the middle. An observation on 2/14/2024 at 4:20 PM revealed Resident 15's toes nails on their bilateral feet were long, thick, yellow, and jagged, and the big toenail on their left foot was split down the middle. An interview in Resident 15's room on 2/14/2024 at 4:25 PM with the DON revealed when the staff gave residents their baths, they were to offer to trim their fingernails and toenails. The DON confirmed that Resident 12's toenails were long, jagged, thick, and yellow, and the left-foot big toenail was split down the middle. The DON said they expected the staff to trim residents' nails on their bath days. An interview in Resident 15's room on 2/14/2024 at 4:25 PM with the DON revealed when the staff gave residents their baths, they were to offer to trim their fingernails and toenails. The DON confirmed that Resident 12's toenails were long, jagged, thick, and yellow, and the left-foot big toenail was split down the middle. The DON said they expected the staff to trim residents' nails on their bath days. An interview in Resident 15's room on 2/14/2024 at 4:25 PM with the resident revealed they had told the DON at that time that the aide(s) giving them their baths had not offered to trim their nails. Resident 15 said they used to trim their toenails with a pedicure set their parent had brought them, but their toenails were too thick, and were unable to trim them (Resident 15 had shown the DON their manicure set and showed them they could not trim their toenails with the larger clippers). Resident 15 had again verbalized they would like their toenails trimmed. An interview on 2/14/2024 at 4:33 PM with LPN-C confirmed Resident 15's toenails were long, jagged, and thick, and the big toe on the left foot's nail was split. LPN-C revealed they knew Resident 15's toenails were in that condition but had said it had not been a focus at the time as the resident was going through their third biopsy on their perineal area and was a very ill resident. LPN-C explained they did not know why the facility did not utilize podiatry services, but they didn't. A record review of the facility's Nail Care policy with an implemented date of 8/1/2023 revealed under Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Number 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Number 4. Routine nail care, to include trimming and filing, will be provided during scheduled bathing. Nail care will be provided between scheduled occasions as the need arises. Number 5. Nails should be kept smooth to avoid skin injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Based on observation, record review, and interview the facility failed to remove a dressing per the physician's order and failed to document in the Treatment Administration Record that the AV fistula dressing was being removed and the site was being monitored as required. This affected 1 (Resident 1) of 1 sampled resident. The facility census was 48. The Findings Are: A. A record review of Resident 1's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease and Dependence on Renal Dialysis. A record review of Resident 1's progress note dated 1/15/2024 at 9:08 AM by the Director of Nursing (DON) revealed the DON, Administrator, resident's child, and a social worker from the dialysis center had a meeting to discuss how the resident was tolerating dialysis and concerns from the dialysis center. The social worker voiced a concern that the dressing on the resident's arteriovenous (AV) fistula site was not always being removed between dialysis treatments. A record review conducted on 2/6/2024 of Resident 1's current physician's orders revealed an order of Remove dressing from left AV fistula 4 hours after dialysis treatment in the afternoon every Monday, Wednesday, and Friday. A record review of Resident 1's Treatment Administration Record (TAR) for February 2024 revealed the order Remove dressing from left AV fistula 4 hours after dialysis treatment in the afternoon every Monday, Wednesday, and Friday was documented as completed by Licensed Practical Nurse (LPN)-A on 2/5/2024. A record review of Resident 1's Progress Notes revealed there was no documentation on 2/5/2024 or 2/6/2024 of a new dressing being applied to the resident's AV fistula site by the facility staff. An observation on Tuesday, 2/6/2024 at 8:55 AM of Resident 1 revealed the resident's AV fistula site had an undated dressing of gauze and tape over it. An interview on Tuesday, 2/6/24 at 11:49 AM with Nurse Aide (NA)-B confirmed Resident 1 did still have a dressing over the AV fistula site on their left upper arm when NA-B changed the resident's shirt after breakfast that day. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on Tuesday, 2/6/24 at 2:57 PM revealed the DON pushed Resident 1 to their room in their wheelchair. After the resident was transferred from their wheelchair to their recliner, the administrator rolled up the resident's left shirt sleeve until it was above the resident's AV fistula site. The fistula site had a dried bloody gauze on it which was secured with white tape. No date was observed on the dressing. The DON obtained sterile Normal Saline and put on gloves. The DON used the saline to moisten the bloody gauze because it was stuck to the resident's skin. The DON finished removing the dressing and the skin to the AV fistula site was observed to be healthy in appearance with no active bleeding. An interview on Tuesday, 2/6/24 at 3:03 PM with the DON confirmed there had been a dressing present over Resident 1's AV fistula site. The DON stated there was not a date written on the dressing but that the dressing was probably applied the day before (2/5/24) after the resident's dialysis treatment. B. A record review of the facility policy Hemodialysis Access Care with last revised date of September 2010, revealed in section Steps in the Procedure 4. To prevent infection and/or clotting: G. Check patency of the site at regular intervals. Palpate the site to feel the thrill or use a stethoscope to hear the whoosh or bruit of blood flow through the access. The policy also revealed in the section Documentation: The general medical nurse should document in the resident's medical record every shift as follows: 2. Condition of dressing (interventions if needed), and 5. Observations post-dialysis. A record review of Resident 1's undated Care Plan revealed a focus of The resident needs hemodialysis r/t ESRD. Presence of Left AV Fistula. Interventions in this section included Assess AV shunt for bruit and thrill every shift and Dressing to be removed 4 hours after dialysis treatment. A record review of Resident 1's Treatment Administration Record (TAR) for January 2024 revealed the order Remove dressing from left AV fistula 4 hours after dialysis treatment in the afternoon every Monday, Wednesday, Friday was not documented as having been completed as required on the 22nd or the 24th. A record review of Resident 1's Treatment Administration Record (TAR) for January 2024 revealed the order Monitor Left AV Fistula for bruit and thrill every day and night shift was not documented as having been completed as required during the day on the 2nd, 6th, or 30th. The order was also not documented as having been completed as required during the night on the 5th or the 10th. A record review of Resident 1's Treatment Administration Record (TAR) for February 2024 through the 14th revealed the order Monitor Left AV Fistula for bruit and thrill every day and night shift was not documented as having been completed as required during the day on the 7th. The order was also not documented as having been completed as required during the night on the 13th.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46245 Licensure Reference Number 175 NAC 12-006.17 Based on observations, interviews, and record reviews; the facility staff failed to perform wound care to prevent the potential for cross-contamination and infection. This failure had the potential to affect 2 (Resident 2 and 9) of 2 sampled residents. The facility census was 48. Findings are: A. A record review of Resident 2's Admission Record revealed the resident had an Original admitted [DATE]. Resident 2 had a diagnosis of a pressure ulcer of the sacral region, stage III. A record review of Resident 2's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's Care Plan) with a date of 12/23/2023 under Section-M- Skin Conditions revealed the resident was at risk for developing pressure ulcers/injuries and had a pressure ulcer/injury, a scar over a boney prominence. Resident 2 had one stage 2 pressure ulcer. A record review of Resident 2's Treatment Administration Record (TAR) from 2/1/2024 to 2/29/2024 revealed an order with a start date of 2/9/2024 to cleanse the left sacrum wound with normal saline or wound cleanser, Cavilon/skin prep and cover with mepilex, change daily and PRN (as needed), add collagen Monday and Friday in the morning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation in Resident 2's room on 2/13/2024 at 3:22 PM revealed Licensed Practical Nurse (LPN)-A was preparing to perform a wound treatment and dressing change for Resident 2's left sacral wound. LPN-A did not set up a clean field for the wound care supplies (e.g., they did not clean the bedside table next to Resident 2's bed or an over-the-bed table) and placed the dressing supplies on the resident's bed, next to Resident 2 on a cloth soaker pad (chuck) that they had been lying on. Resident 2 was lying supine in their bed with their eyes open. Nursing Aide (NA)-E assisted Resident 2 onto their right side and held the resident in place. LPN-A had pulled Resident 2's pants down, exposing their buttocks. LPN-A removed the old dressing which was saturated. LPN-A cleansed the sacral wound with gauze moistened with Dermal Wound Cleanser and placed the soiled gauze onto the clean foam dressing package that was lying on the bed instead of in a bag or trashcan. LPN-A applied skin prep around the peri-wound edges and placed the wrappers on the clean dressing package that was lying on the bed just below Resident 2's buttocks. LPN-A had reported there was undermining around the wound edges. LPN-A also reported there was a moderate amount of drainage that soaked through the dressing and there was an odor to it. LPN-A attempted to open the wound dressing package with the soiled gauze and gloves that held the old wound dressing but was unsuccessful. LPN-A carried the unopened wound dressing package that was holding soiled dressing supplies, grabbed a paper towel, placed the paper towel on top of the three-tiered storage container, and poured the trash onto the paper towel. LPN-A had not changed their gloves and opened the wound dressing package. LPN-A had removed a Mepilex dressing from the package and placed it on Resident 2's left sacral wound. LPN-A retrieved the paper towel with the old/soiled dressing supplies and placed them on their medication/treatment cart and retrieved a trash bag to throw them away. LPN-A did not clean/sanitize the top of the three-tiered plastic storage bin in Resident 2's bathroom and some areas appeared moist from the soiled dressing supplies. An interview on 2/13/2024 at 5:29 PM with LPN-A confirmed they had not followed the facility's Clean Dressing Change policy with an implemented date of 8/1/2023 as they had not set up a clean field on an overbed/bedside table and did not establish an area for soiled products to be placed (e.g., a plastic bag or trashcan). LPN-A also confirmed they had not sanitized the top of the plastic storage bin in the bathroom that had visible moist spots on it from the old dressing and used supplies. B. A record review of Resident 9's Admission Record revealed an Original admitted 8/19/2023. A record review of Resident 9's Order Summary Report revealed an order with a start date of 2/10/2024 for Suprapubic catheter care daily and as needed. Primary dressing gauze square, daily change, and prn. An observation on 2/14/2024 at 11:49 AM revealed that LPN-C was preparing to change Resident 9's suprapubic wound dressing change and gathered supplies. Resident 9 was lying supine in their bed. LPN-C had not set up a clean field (e.g., on an over-the-bed table or a nightstand). LPN-C did not get a trashcan or a trash bag for trash. LPN-C placed wound treatment and dressing supplies on Resident 9's bed, next to the resident. LPN-C exposed Resident 9's suprapubic site and noted there was no dressing in place. LPN-C cleansed the suprapubic insertion site with wound wash and gauze. LPN-C had placed the used/soiled dressing supplies on half of the T-Drain sponge dressing wrapper that was lying on Resident 9's bed. There was some dried blood around the affected area, a small bruise just below the suprapubic catheter insertion site, and two stitches holding the catheter tubing in place. LPN-C had placed a new T-Drain sponge on the suprapubic insertion site. (continued on next page)

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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 - Few	An interview on 2/14/2024 at 11:57 AM with LPN-C confirmed they had not followed the facility's Clean Dressing Change policy with an implemented date of 8/1/2023 as they had not set up a clean field (e.g., on an overbed/bedside table or a clean chuck/soaker pad) and did not establish an area for soiled items to be placed (e.g., a plastic bag or a trashcan) and had placed the dressing supplies as well as the soiled supplies/trash on Resident 9's bed. LPN-C revealed Resident 9's bed table was full of stuff and had done the best they could with what they had. LPN-C said Resident 9 gets confused and was also concerned that the resident could have knocked the dressing supplies off of the bed. LPN-C was not aware of the facility's policy and procedure for wound care and/or wound dressing changes as they did not have access to the facility's policies and procedures. An interview on 2/14/2024 at 3:22 PM with the Director of Nursing (DON), revealed they had started working at the facility in June of 2023 and they had not completed any competencies or skills checklist on staff caring for residents with wounds. There was not a binder/manual at the nurse's station with policies and procedures that the facility staff/agency staff had access to, and the policies and procedures could not be accessed electronically. The DON said they and the Administrator had checked to see if they could find/access facility policy and procedures but could not and they had to contact the company who had taken over the facility to request policies/procedures because when the company had taken over, they were told the policies were going to be updated. When the DON asks the company for a policy/procedure, they will print it off and provide it. The DON said they knew that it may not be consistent. A record review of the facility's Clean Dressing Change policy with an implemented date of 8/1/2023 revealed under the Policy Explanation and Compliance Guidelines: 1. Explain the procedure to the resident and screen for privacy. 5. Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: a. If the table is soiled, wipe clean. b. Place a disposable cloth or linen saver on the overbed table. C. Place only the supplies to be used per wound on the clean field at one time (include wound cleanser, gauze for cleaning, disposable measuring guide and pen/pencil, skin protectant products as indicated, dressings, and tape). 6. Establish area for soiled products to be placed (Chux or plastic bag). 9. Loosen the tape and remove the existing dressing. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 17. Discard disposable items and gloves into appropriate trash receptacle and wash hands.