STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675019	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apex Secure Care Brownfield	1101 E Lake St Brownfield, TX 79316

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Residents #1) reviewed for care plans. The facility failed to develop and implement a care plan area for physician order for wound treatment of left above the knee amputation (stump). These failures could place residents at risk of not receiving the care required to meet their individualized needs. Findings include: Resident #1: Record Review of Resident #1 face sheet, date retrieved on 05/21/2024, revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnosis of high blood pressure, depression, type 2 diabetes, high blood pressure, heart attack, amputation above the know on both right and left leg. Records Review of Resident #1's Admission MDS dated [DATE] revealed Resident #1 had a BIMS of 14 which means Resident #1 is cognitively intact. Record Review of Resident #1's Care Plan date received 05/21/2024, revealed: On 04/15/2024, revealed: 04/15/2024: Resident #1 has pressure area to right gluteal fold and sometimes removes dressing to the area. Interventions listed as: Cleanse with normal saline or wound cleanser, apply triad daily, cover as needed, utilize advanced wound care for autolytic debridement. 04/15/2024: Resident #1 has a pressure area to the left hip and will sometimes remove dressing in the area. Interventions listed as: Cleanse with normal saline or wound cleanser, apply triad daily, cover as needed, Utilize advanced wound care for autolytic debridement. Ensure low air loss mattress is on bed, encourage to leave dressing in place, weekly monitoring/ documentation o site using weekly wound tool. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/15/2024: Resident #1 has a wound to left stump area and will sometimes remove dressing. Interventions are listed as: Left above the knew amputation, cleanse with normal saline or wound cleanser, apply triad daily, cover with abd and wrap with gauze wrap. Utilize advanced wound care for autolytic debridement, encourage to leave dressing in place, monitor area for s/s of infection and notify doctor if indicated. 04/03/2024: Resident #1 has a potential for pressure ulcer development. Interventions listed as: Ensue a pressure relieving cushion is in wheelchair, ensure a low air loss mattress is in bed, partial/moderate assist from staff to reposition in bed, weekly skin assessment by nurse to ensure no new areas of breakdown, rash etc., notify doctor of abnormal findings, keep skin clean and dry, encourage daily hygiene and compliance with shower schedule, apply lotions and moisture barriers as indicated for skin protection, instruct to shift weight in wheelchair every 15 minutes. 04/03/2024: Resident #1 has pain with wound to left stump area and pressure areas. Interventions listed as: Administer pain medications as ordered, monitor/record/report to nurse resident complaints of pain or requests for pain treatment. 04/03/2024: Resident #1 has an ADL self-care performance deficit with left and right above the knee amputation. Interventions listed as: chair/bed to chair transfer self-performance dependent support provided one two person physical assist, eating self-performance independent, lower body dressing self-performance dependent, lying to sitting on side of bed self-performance dependent, oral hygiene self-performance dependent, personal hygiene self-performance dependent, roll left and right self-performance dependent, roll left and right self-performance partial/moderate/assist, shower/bath self-performance dependent, sit to lying self-performance dependent, toilet hygiene self-performance dependent, chair to bed to chair transfers self-performance dependent support provided one-two person physical assist, toilet transfer self-performance dependent, tub/shower transfer self-performance dependent, upper body dressing self-performance dependent, nurse aides to document my most dependent self-performance once per shift, monitor for s/s ADL decline and notify family/physician, identify causes and solutions. Allow sufficient time to complete as many subtasks as possible within physicial ability, providing physical only when necessary for safety and/or to complete the subtask. Record Review of Resident #1's physician orders dated 05/21/2024 revealed: phone orders placed on 03/30/2024 for pressure relieving device for mattress and wheelchair. Orders placed for wound care of right gluteal fold dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply collagen alginate, cover with hydrophilic super absorptive bordered gauze once a day. Utilizing advanced wound care dressing for autolytic debridement. Orders placed for wound care of left gluteal fold dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply collagen alginate, cover with hydrophilic super absorptive bordered gauze once a day. Utilizing advanced wound care dressing for autolytic debridement. Orders placed for wound care of left above the knee amputation dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply Santyl to hardened areas, apply betadine, cover with super absorptive dressing when out of bed, utilizing advanced wound care dressing for autolytic debridement. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's weekly wound observation dated 05/08/2024 listed left AKA (above the knee amputation) wound to be improving with epithelial tissue present, slough tissue (yellow devitalized tissue) present, and dry with no drainage. Listed wound as 8.5 cm in length, 13.5 cm in width. Listed on C. Treatment revealed: Cleanse with normal saline or wound cleanser, apply Santyl cover with hydrophilic super absorptive bordered gauze dressing once a day. Utilizing advanced wound care dressing for autolytic debridement. Observations of Resident #1 on 05/18/2024 at 3:32 PM. During observations of Resident #1 it was found that Resident #1 was sitting upright in the Geri chair with the tv on but halfway falling asleep. During an attempt to interview Resident #1, it was observed that the left amputated leg with wounds across the stump was left uncovered. Physician orders stated for the wound to be covered when out of bed. Observed no bandage laying on the floor or anywhere around the room. Observed wound with yellow crusting and some of the wound open with no drainage. Interview with LVN on 05/18/2024 at 3:55 PM. The LVN stated that he is not sure why Resident #1 did not have a bandage on her left stump, unless she had taken it off herself. The LVN stated that the orders say that Resident #1 is to have left stump bandaged when out of bed. The LVN stated that he did know that Resident #1 was in her Geri chair. The LVN stated that he is the one who usually changes the wounds. The LVN stated that he does bandage stump while out of bed. The LVN stated that with the bandage being off the wound could possibly worsen. Interview with DON on 05/21/2024 at 3:12 PM. The DON stated that she believes that Resident #1's orders for the left stump indicate to cover when Resident #1 is out of bed. The DON stated that she is not sure why it was uncovered if Resident #1 was out of bed. The DON stated that the negative outcome would be not following physician orders and adverse event. The DON stated that she and the nurse consultant is responsible for training by competency checks for wound care as well as in-services. No policy was provided for following physician orders or care plan.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observations, interviews and record reviews, the facility failed to ensure based on the comprehensive assessment of a resident the resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for (Residents #1) resident reviewed for pressure ulcer care, in that: 1. Resident #1's wounds were left uncovered and exposed on the left side above the knee amputation. These failures could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings included: Resident #1: Record Review of Resident #1 face sheet, date retrieved on 05/21/2024, revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnosis of high blood pressure, depression, type 2 diabetes, high blood pressure, heart attack, amputation above the know on both right and left leg. Records Review of Resident #1's Admission MDS dated [DATE] revealed Resident #1 had a BIMS of 14 which means Resident #1 was cognitively intact. Record Review of Resident #1's Care Plan date received 05/21/2024, revealed: On 04/15/2024, Resident #1 was care planned for having a pressure ulcer to the right gluteal (buttocks), pressure area to the left hip, and wound to left stump. Record Review of Resident #1's physician orders dated 05/21/2024 revealed: phone orders placed on 03/30/2024 for pressure relieving device for mattress and wheelchair. Orders placed for wound care of right gluteal fold dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply collagen alginate, cover with hydrophilic super absorptive bordered gauze once a day. Utilizing advanced wound care dressing for autolytic debridement. Orders placed for wound care of left gluteal fold dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply collagen alginate, cover with hydrophilic super absorptive bordered gauze once a day. Utilizing advanced wound care dressing for autolytic debridement. Orders placed for wound care of left above the knee amputation dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply Santyl to hardened areas, apply betadine, cover with super absorptive dressing when out of bed, utilizing advanced wound care dressing for autolytic debridement (a natural process that removes necrotic tissue from a wound). (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's weekly wound observation, dated 05/08/2024 listed left AKA (above the knee amputation) wound to be improving with epithelial tissue present, slough tissue (yellow devitalized tissue) present, and dry with no drainage. Listed wound as 8.5 cm in length, 13.5 cm in width. Listed on C. Treatment revealed: Cleanse with normal saline or wound cleanser, apply Santyl cover with hydrophilic super absorptive bordered gauze dressing once a day. Utilizing advanced wound care dressing for autolytic debridement. Observations of Resident #1 on 05/18/2024 at 3:32 PM. During observations of Resident #1 it was found that Resident #1 was sitting upright in the Geri chair with the tv on but halfway falling asleep. During an attempt to interview Resident #1, it was observed that the left amputated leg with wounds across the stump was left uncovered. Physician orders stated for the wound to be covered when out of bed. Observed no bandage laying on the floor or anywhere around the room. Observed wound with yellow crusting and some of the wound open with no drainage. Interviews with Resident #1 on 05/18/2024 at 3:35 PM. Resident #1 stated that staff hardly ever cover the wound on the left amputated stump. Resident #1 stated that the wound is sore some of the time. Resident #1 stated that she would like the wound covered because it is more comfortable, and she doesn't have to worry if it will hit something and make it bleed. Resident #1 stated that she does not remove the bandages herself because the staff don't put one on all the time. Resident #1 stated that she had not told the staff anything about not putting a bandage on because she assumed that they knew what they were doing. Interview with LVN on 05/18/2024 at 3:55 PM. The LVN stated that he is not sure why Resident #1 did not have a bandage on her left stump, unless she had taken it off herself. The LVN stated that the orders say that Resident #1 is to have left stump bandaged when out of bed. The LVN stated that he did know that Resident #1 was in her Geri chair. The LVN stated that he is the one who usually changes the wounds. The LVN stated that he does bandage stump while out of bed. The LVN stated that with the bandage being off the wound could possibly worsen. Interview with DON on 05/21/2024 at 3:12 PM. The DON stated that she believes that Resident #1's orders for the left stump indicate to cover when Resident #1 is out of bed. The DON stated that she is not sure why it was uncovered if Resident #1 was out of bed. The DON stated that the negative outcome would be not following physician orders and adverse event. The DON stated that she and the nurse consultant is responsible for training by competency checks for wound care as well as in-services. Record Review of the facility's policy titled, Wound Care, dated October 2022, reflected, Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: 1. Use a purple top wipe to clean overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies. 2. Wash and dry your hands thoroughly. 3. Position resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves, Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no-touch technique. 8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11. Place one gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 12. Remove dry gauze. Apply treatments as indicated. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date, and apply to dressing. Be certain all clean items are on clean field. 14. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. 15. Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed. 16. Place the call light within easy reach of the resident.

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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** 43150 Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 5 Residents observed for infection control for practices (Resident #1) in that: 1. Facility staff failed to change Resident #1's humidification bottle of oxygen t. The bottle on the oxygen tank was dated 02/04/2024. Resident #1 was observed actively using her oxygen. 2. CNA A failed to wash hands prior and during incontinent care with Resident #1. CNA A failed to use appropriate PPE during incontinent care for Resident #1 that was on barrier precautions for wounds. 3. LVN failed to wash hands before or during wound care for Resident #1. LVN failed to use the appropriate PPE during wound care for Resident #1 that was on barrier precautions for wounds. These failures could place residents at risk for infection through cross contamination of pathogens. The findings included: Resident #1: Record Review of Resident #1 face sheet, date retrieved on 05/21/2024, revealed a [AGE] year-old female, admitted on [DATE] with a primary diagnosis of high blood pressure, depression, type 2 diabetes, high blood pressure, heart attack, amputation above the know on both right and left leg. Records Review of Resident #1's Admission MDS dated [DATE] revealed Resident #1 had a BIMS of 14 which means Resident #1 is cognitively intact. Record Review of Resident #1's Care Plan date received 05/21/2024, revealed: On 04/15/2024, Resident #1 was care planned for having a pressure ulcer to the right gluteal, pressure area to the left hip, and wound to left stump. It had been care planned that Resident #1 is incontinent with bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's physician orders dated 05/21/2024 revealed: phone orders placed on 03/30/2024 for pressure relieving device for mattress and wheelchair. Orders placed for wound care of right gluteal fold dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply collagen alginate, cover with hydrophilic super absorptive bordered gauze once a day. Utilizing advanced wound care dressing for autolytic debridement (is a natural process that uses the body's enzymes and immune cells to break down and remove necrotic tissue from a wound). Orders placed for wound care of left gluteal fold (is a horizontal skin crease that separates the upper thigh from the buttocks) dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply collagen alginate, cover with hydrophilic super absorptive bordered gauze once a day. Utilizing advanced wound care dressing for autolytic debridement. Orders placed for wound care of left above the knee amputation dated 05/17/2024 revealed: cleanse with normal saline or wound wash, apply Santyl to hardened areas, apply betadine, cover with super absorptive dressing when out of bed, utilizing advanced wound care dressing for autolytic debridement. Observation and record review of Resident #1's humidification bottle on oxygen machine on 05/18/2024 at 4:23 pm. During observations of Resident #1 it was found that Resident #1 was actively using oxygen with the humidification bottle not changed. The date that was listed on the humidification bottle was 02/04/2024. The facility policy stated that the humidification bottle is to be changed weekly and had not been changed. Observations of incontinent care for Resident #1 on 05/18/2024 at 4:41 PM. Observed CNA A and CNA B get mechanical lift to lift Resident #1 from Geri chair to the bed to change her brief. CNA A and CNA B did not wash their hands prior to peri care. CNA A and CNA B placed on disposable gloves prior to getting the mechanical lift and remained in those same disposable gloves to remove Resident #1's brief to provide peri care. CNA B removed Resident #1's brief that was observed to be dry. CNA B used wipes to clean Resident #1. CNA B used one swipe per wipe starting from the front center of vagina, then the left side, and the right side. CNA B disposed of each wipe. CNA B did not wash hands or removed disposable gloves to place on a new pair of gloves. CNA B used the same gloves to place on a new clean brief for Resident #1. CNA A and CNA B did not wash hands after providing peri care for Resident #1. CNA A was getting mechanical lift to remove from the room and CNA B had gathered trash to take out of the resident's room. CNA A and CNA B did not use the appropriate PPE while providing peri care for Resident #1. Resident #1 was on barrier precautions which should include gown and gloves when providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of wound care with LVN for Resident #1 on 05/18/2024 at 5:10 PM. LVN did not wash hands or use hand sanitizer prior to gathering wound care supplies. LVN gathered needed supplies for wound care. LVN had a clear trash bag with gloves and yellow gowns in it for PPE. LVN did not put on PPE yellow gown to provide wound care for Resident. The LVN only put on disposable gloves. The DON assisted in turning Resident #1 to right side so that LVN could proceed in cleaning resident's wounds that were located on the buttocks. It was observed that the previous bandages did not have any initials or date. The LVN removed Resident #1's old bandage on the left buttock wound and disposed in the trash. The LVN removed gloves but did not wash hands or use hand sanitizer. The LVN disposed of old gloves in the trash. The LVN placed on new pair of disposable gloves. The LVN used the gauze that was wet with wound wash and began to clean the wound with one swipe per gauze, starting from outer wound to inner wound. The LVN covered wound with bordered gauze after placing foam on the wound. The LVN initial and dated the bandage prior to placing on Resident #1 wound. The LVN removed old gloves and discarded in the trash. The LVN washed hands for 11 seconds using soap and water by using friction. The LVN used 2 paper towels to dry both left and right hand. The LVN used the same paper towel used to dry hands to turn off the faucet. Interviews with LVN for humidification bottle on 05/18/2024 at 4:30 PM. The LVN stated that he is responsible for changing the humidification bottles on the oxygen tanks. The LVN stated that he is not sure why this one had not been changed because they are to be changed weekly. The LVN stated that it could cause respiratory issues such as infections. The LVN stated that he had been trained in infection control practices through weekly in-services. The LVN immediately changed the humidification bottle on the oxygen machine. Interviews with CNA A and CNA B for incontinent care on 05/18/2024 at 5:01 PM. CNA A stated that she did not know why she did not change gloves or wash hands. She stated that she was just focused on trying to get the resident changed. CNA A stated that she is supposed to wash hands before, during, and after providing care. CNA A stated that she had been provided training through weekly in-services. She stated that the negative potential outcome is the spread of germs. CNA B stated that she did not think about washing hands because they got the Hoyer lift and the resident into the bed, and she was trying to get the resident taken care of. CNA B stated that she also had training through weekly in-services. Interviews with LVN for wound care with the assistance of DON on 05/18/2024 at 5:16 PM. The LVN stated that he is the person who changed the wounds for Resident #1 the previous day and did not initial and date the bandages. The LVN stated that he is supposed to initial and date the bandages but was in a hurry the day he changed the wounds because of having to also take blood sugars for residents and had just gotten in a hurry. The LVN stated that he takes full responsibility. The LVN stated that he is supposed to wear PPE but did not think about the gown or washing hands before wound care because he was thinking about changing the wounds. The LVN stated that he had been trained in infection control practices by in-services approximately bi-weekly. He stated that the negative outcome is spread of infection or germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 05/21/2024 at 2:32 PM., The Administrator stated that his expectations for infection control practices is to follow hand washing protocol with either washing hands with soap and water or hand sanitizer. The Administrator stated that the humidification bottles on the oxygen machines should be changed weekly. The Administrator stated that the DON and himself are responsible for training. The Administrator stated that training consists of in-services weekly and quarterly computer training. The Administrator stated that the negative potential outcome is the spread of infection. During an interview with the DON on 05/21/2024 at 3:12 PM., The DON stated that her expectations with infection control practices is to follow policies and procedures. The DON stated that humidification bottles should be changed weekly, or it could cause infections. The DON stated that the negative potential outcome could run a risk of spreading infections. The DON stated that when the humidification bottles are not changed it is grounds for bacteria growth. The DON stated that for training she is responsible and the Nurse Consultant. The DON stated that the Nurse Consultant helps with training such as competency checks. The DON stated that she provides in-services also. The DON stated that training is weekly in-services and quarterly courses. Record review of the facility policy titled, Infection Control date Revised 10 2018 revealed: Policy Statement: This facility's infection control policies are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation: 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, [NAME] or veteran, or prayer source. 2. The objectives of our infection control policies and practices are to: b). Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. Record review of the facility policy titled; Handwashing/ Hand Hygiene date Revised August 2019 revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: (continued on next page)

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	675019	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apex Secure Care Brownfield	1101 E Lake St Brownfield, TX 79316

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	2. All personnel shall follow the handwashing hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. 6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a). When hands are visibly soiled 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. b). Before and after direct contact with residents. d). Before performing any non-surgical invasive procedures. g). Before handling clean or soiled dressing, gauze pads, etc. h). Before moving from a contaminated body site to a clean body site during resistant care. i). After contact with a resident's intact skin. j). After contact with blood or bodily fluids. k). After handling used dressings, contaminated equipment, etc. m). After removing gloves. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: a). Before aseptic procedures. b). When anticipating contact with blood or body fluids. c). When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. Washing Hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 5. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis. Using Alcohol-Based Hand Rubs: 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry. 3. Follow manufactures directions for volume of product to use. Record review of the facility policy titled; Wound Care date Revised October 2019 revealed: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure: 1. Use a purple top wipe to clean overbed table. 2. Wash and dry your hands thoroughly. 3. Position resident 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves, Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no-touch technique. 8. Pour liquid solutions directly on gauze sponges on their papers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 12. Remove dry gauze. Apply treatments as indicated. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply dressing. Be certain all clean items are on clean field.