| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676385 | A. Building<br>B. Wing | 09/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Nursing & Rehabilitation | 611 Rose Marie Blvd<br>Hearne, TX 77859 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for two of five (Resident #7 and Resident #47) residents reviewed for dignity.<br><br>1. The facility failed to ensure Resident #7 had a privacy cover on their urinary catheter bag.<br><br>2. The facility failed to ensure Resident #47 was served lunch at the same time as the other residents at her table for two days.<br><br>These failures could affect the resident's dignity and affect their quality of life.<br><br>Findings included:<br><br>1.<br><br>Review of Resident #7's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] and 07/21/2024 with diagnoses of surgical amputation of left leg below knee, hypertension (elevated blood pressure), and type 2 diabetes (disease that affects how your body uses insulin and glucose).<br><br>Review of Resident #7's Quarterly MDS assessment, dated 07/16/2024 reflected a BIMS score of 04 indicating severe cognitive impairment. MDS further reflected resident had a urinary catheter.<br><br>Review of Resident #7's care plan, dated 09/04/2024, reflected resident had an indwelling urinary catheter and the bag should be placed in a privacy bag.<br><br>Observation on 09/08/2024 at 09:45 AM in Resident #7's room revealed the resident had a urinary catheter bag hanging from the bed without a privacy cover and contents exposed to anyone who enters the room.<br><br>Observation on 09/09/2024 at 11:30 AM in Resident #7's room revealed the resident's urinary catheter bag still exposed with no privacy cover in place.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 09/10/2024 at 09:45 AM Resident #7 stated she would like her catheter bag to be covered. Informed resident that the bag now has a cover on it for privacy.<br><br>In an interview on 09/10/24 at 10:03 AM CNA D stated urinary catheter bags should always have a blue slipcover on them to maintain privacy and dignity of the residents.<br><br>In an interview on 09/10/24 at 10:08 AM RN B stated urinary catheter bags should have a cover on them at all times, even if the resident is alone in their room with the curtain pulled. She stated she did not realize Resident #7 did not have a cover because the previous nurse changed the catheter a couple nights ago and did not put one on and she has since corrected it and placed a cover on the bag. She stated it is policy to always have a cover on the bag.<br><br>In an interview on 09/10/24 at 10:55 AM the DON stated urinary catheter bags should be covered at all times, even when the resident is in their room. She stated the reason Resident #7's bag was not covered was because it had been changed the night before and the staff did not put the cover back on. She stated although the policy does not specifically reflect the use of covers, it is the expectation to maintain dignity for the residents.<br><br>In an interview on 09/10/2024 at 12:55 PM the ADM stated urinary catheter bags need be covered when out of the room or when visible to others from the doorway. He stated the purpose of the bag is to maintain dignity for the residents.<br><br>Review of facility policy for Catheter Care, dated 02/13/2007 does not address the use of a dignity cover under general guidelines for catheter care.<br><br>2.<br><br>Record review of the undated Face Sheet for Resident #47 reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of Myocardial Infarction (heart attack).<br><br>Record review of the Quarterly MDS assessment for Resident #47 dated 07/11/2024 reflected she had a BIMS score of 8 indicating moderate cognitive impairment. Section GG - Functional Abilities and Goals reflected she required supervision or touching assistance with eating.<br><br>Record review of the Care Plan for Resident #47 dated 05/20/2024 reflected she was at risk for unplanned weight loss or gain. Goal: Resident will maintain ideal weight and receive proper nutrition X 90 days. Interventions: Encourage meal completion. Serve diet and snacks as ordered.<br><br>On 09/08/2024 an observation was made at 11:45 AM of Resident #47. Resident #47 was sitting at a table with other residents, she had been sitting there since before trays were served. All trays at her table were served. Resident #47 made a few comments to the other residents at her table saying she was still waiting for her food. Resident #47 waited approximately 20 minutes after the other residents at her table were served before she received her food tray.<br><br>On 09/09/2024 at 11:50 AM Resident #47 was observed sitting at the same table as before with the same other residents. All the trays at her table were served and Resident #47 waited approximately 25 minutes after her table mates were served when her food tray was served.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 09/09/2024 at 12:15 PM an interview with Resident #47 revealed she does not usually eat in her room, that she always eats at the dining room.<br><br>On 09/10/2024 at 11:15 AM an interview was completed with Resident #47. Resident #47 stated she always ate in the dining room. She stated that her tray was always late compared to her table mates.<br><br>On 09/10/2024 at 12:00 PM an interview was conducted with DON. DON stated Resident #47 typically comes into the dining room for meals, but if they are taking too long she would leave and go to her bedroom. DON stated that a negative outcome of not providing a tray to all residents at the same time could cause a resident to feel forgotten about. DON stated that the policy states to try and serve all residents at a table together if it is possible.<br><br>On 09/10/2024 at 12:11 PM an interview was conducted with the Kitchen Manager. KM stated the process of passing trays out consists of looking out the kitchen window to see who was in the dining room and trying to serve the trays from tables front right to back left if possible. She stated if a new resident comes to the table, the staff in the dining room lets the kitchen staff know and that is how they ensure that all residents get a tray at the table. KM stated if a resident was missed at a table it was likely due to the staff not letting the kitchen know that there was a resident at the table.<br><br>On 09/10/2024 at 12:17 PM an interview was conducted with RN A. RN A stated she always helps in the dining room. RN A stated Resident #47 always eats in the dining room for her meals. She stated she is always seated at the same table with the same residents. RN A stated the method used for serving trays is the kitchen provides the trays on a cart, and the staff in the dining room pass them out. She stated if a table is served except for one resident, they let the kitchen know and the kitchen quickly gets the tray out to the resident. RN A stated a resident could feel forgotten about due to not being provided a tray with the rest of their table. RN A stated the trays are served from table to table starting at the front right table closest to the kitchen.<br><br>On 09/10/2024 at 12:50 PM an interview was completed with the administrator. ADM stated the expectation for the dining room is to pass out trays and to try to serve the whole table at the same time. The staff should then hand sanitize in between trays. He stated the reason a resident may be forgotten at the table possibly if a resident comes in late they may not get their tray on time. He stated a resident having to wait for their tray table for a long time could leave the resident feeling hungry.<br><br>On 09/10/2024 the facility provided a policy for Nursing Responsibilities at Meal Service dated 2012. This policy revealed the following:<br><br>3. Communicate to the dietary department if a resident will be eating in other than the usual area. Dietary must be notified prior to beginning the tray line.<br><br>4. Distribute food trays to residents in resident rooms, dining rooms, and ancillary dining rooms. Try to serve residents seated together at the same time, when possible.<br><br>5. A tray sequence is used in dining rooms so all residents at a table are served at the same time.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 49851 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>Based on observation, interview, and record review the facility failed to immediately inform the resident's Physician when the nurse was unable to follow wound care orders for one of one Residents (Resident #49) reviewed for physician notification of changes.<br><br>The facility failed to ensure RN C notified the Physician and family of her inability to follow wound care orders for Resident #49.<br><br>This failure could have delayed the progress of the coccyx wound healing for Resident #49.<br><br>Findings included:<br><br>Record review of the undated Face Sheet for Resident #49 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of Pressure Ulcer of sacral (bony area of the spine) region, Stage 4 (open sore extending into muscles, tendons (cord like tissues that connect muscles to bones or other structures), and ligaments (short band of connective tissue which connects two bones or holds together a joint), can also expose bone).<br><br>Record review of the Quarterly MDS assessment dated [DATE] for Resident #49 reflected he had a BIMS score of 10 indicating moderate cognitive impairment.<br><br>Record review of the Care Plan for Resident #49 dated 07/24/2024 and revised on 08/19/2024 reflected Resident #49 had a pressure ulcer Stage 4 to coccyx with wound vac [a wound dressing system that uses a suction pump to apply negative pressure to a wound to promote healing] in place to be changed 3 X week. Goal: Resident #49's pressure ulcer will show signs of healing and remain free from infection. Interventions: Administer treatments as ordered and monitor for effectiveness. Replace loose ormissing dressings PRN. Specify treatment: WOUND VAC.<br><br>Record review of Physicians orders dated 07/23/2024 for Resident # 49 reflected Stage 4 pressure wound to coccyx. Clean with n/s, pat dry, apply granular foam in both ends and connecting in the middle, dress with clear wound vac tape 150 mmHg continuous pressure. 3 times per week.<br><br>Observation and interview on 09/08/2024 at 10:07 AM Resident #49 stated the wound on his coccyx (tailbone) was supposed to have a wound vacuum attached to it but the nurse who did his wound care that morning told him she had applied a wet to dry dressing. He stated he was ready to go home and had been at the facility for a little over a month. A wound vacuum machine was observed on his bedside table without a reservoir and was not attached to anything.<br><br>In an interview on 09/08/2024 at 1:09 PM LVN E stated RN C was the treatment nurse who had changed Resident #49's dressing that morning. LVN E stated RN C had told her she had put a wet to dry dressing on his wound but did not indicate why the treatment had changed. She stated RN C did not give her any other information regarding Resident #49's wound care and had left for the day.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 09/08/2024 at 1:17 PM LVN E stated she had called the Nurse Practitioner for an order for a wet to dry dressing for Resident #49 since RN C had failed to call the clinician.<br><br>In a phone interview on 09/08/2024 at 2:10 PM, RN C stated she was a weekend supervisor and was not a wound care nurse per se and it was not her forte. She stated there was no order for a wet to dry dressing however that is what she put on Resident #49's wound that morning. She stated she had completed the wound care around breakfast time, and she was aware she had not charted the wound care. She further stated she was coming back to the facility that day.<br><br>In an interview on 09/08/2024 at 3:18 PM RN C stated she had been with the company since 2017 and had been in the facility since 2021. She stated she had been a floor nurse then started working prn in December 2024. She stated she had completed a wound care training course before 2017. She stated technically she had not had any wound care training at the facility. She was shown a checkoff list for the wound vacuum dated 08/24/2024 that had her name on it and was signed by the DON. She stated that was probably when she was shown how to do Resident #49's wound vacuum dressing. She stated she was making wound care rounds on Sunday 09/08/2024 and she needed an extra hand to help her with the resident. She stated his wound vac needed to be changed out and she was having problems doing it. She stated she should have called the on-call nurse for assistance. She stated she had decided the next best thing would be to put a wet to dry dressing on the wound. She stated she forgot to document the actions she took and did not call the Physician for orders or to notify them she was unable to complete the dressing change as ordered. She stated she should have stayed at the facility and taken her time. She stated wound care was probably not her strong point.<br><br>Observation and interview on 09/08/2024 at 2:33 PM the DON and Medical Records Clerk showed that there were three wound vac canisters available in the central supply room. The Medical Records Clerk stated she was present when RN C was in the facility on Sunday 09/08/2024 and RN C had not asked for any supplies for Resident #49's wound care.<br><br>In an interview during a wound care observation on 09/09/2024 at 1:45 PM Resident #49 stated Why did that nurse remove the wound vac yesterday? She should have put the wound vac back on. I need to call those state people. I'm trying to get well. The DON stated there were two state people in the room and the nurse should have replaced the wound vac instead of putting on a wet to dry dressing.<br><br>In an interview on 09/09/2024 at 2:25 PM Resident #49 stated the lady who put that patch (dressing) on yesterday said the wound vac did not need to go back. He further stated that was the second time that nurse had not replaced his wound vac. He stated he was at the facility to get well and go home. He stated, that nurse should have known better.<br><br>In an interview on 09/10/2024 at 9:45 AM the DON stated her expectations were for wound care to be done as ordered, that nurses document anything they do, notify the physician and family of any changes to the wound care. She further stated the potential risk to the resident was it could have halted progress on his wound healing.<br><br>In an interview on 09/10/2024 at 12:55 PM the ADM stated his expectations were for Dr. orders to be followed and the nurse probably should have documented her care. He stated he did not know what the potential risk for the resident could be of the nurse not following the Dr. orders for wound care.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of a facility Policy and Procedure titled Skin Integrity Management dated 2003 and revised on October 5, 2016, reflected General Guidelines: 3. Wound care should be performed as ordered by the physician. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>Based on interview and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one (Resident #49) of two residents reviewed for pressure injuries.<br><br>The facility failed to ensure RN C followed Physician's orders for wound care for Resident #49.<br><br>The facility failed to ensure RN C documented the wound care she provided for Resident #49 without a Physician order.<br><br>These failures could have delayed the progress of the coccyx wound healing for Resident #49.<br><br>Findings included:<br><br>Record review of the undated Face Sheet for Resident #49 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of Pressure Ulcer of sacral (bony area of the spine) region, Stage 4 (open sore extending into muscles, tendons (cord like tissues that connect muscles to bones or other structures), and ligaments (short band of connective tissue which connects two bones or holds together a joint), can also expose bone).<br><br>Record review of the Quarterly MDS assessment dated [DATE] for Resident #49 reflected he had a BIMS score of 10 indicating moderate cognitive impairment.<br><br>Record review of the Care Plan for Resident #49 dated 07/24/2024 and revised on 08/19/2024 reflected Resident #49 had a pressure ulcer Stage 4 to coccyx with wound vac [a wound dressing system that uses a suction pump to apply negative pressure to a wound to promote healing] in place to be changed 3 X week. Goal: Resident #49's pressure ulcer will show signs of healing and remain free from infection. Interventions: Administer treatments as ordered and monitor for effectiveness. Replace loose ormissing dressings PRN. Specify treatment: WOUND VAC.<br><br>Record review of Physicians orders dated 07/23/2024 for Resident # 49 reflected Stage 4 pressure wound to coccyx. Clean with n/s, pat dry, apply granular foam in both ends and connecting in the middle, dress with clear wound vac tape 150 mmHg continuous pressure. 3 times per week.<br><br>Observation and interview on 09/08/2024 at 10:07 AM Resident #49 stated the wound on his coccyx (tailbone) was supposed to have a wound vacuum attached to it but the nurse who did his wound care that morning told him she had applied a wet to dry dressing. He stated he was ready to go home and had been at the facility for a little over a month. A wound vacuum machine was observed on his bedside table without a reservoir and was not attached to anything.<br><br>In an interview on 09/08/2024 at 1:09 PM LVN E stated RN C was the treatment nurse who had changed Resident #49's dressing that morning. LVN E stated RN C had told her she had put a wet to dry dressing on his wound but did not indicate why the treatment had changed. She stated RN C did not give her any other information regarding Resident #49's wound care and had left for the day.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 09/08/2024 at 1:17 PM LVN E stated she had called the Nurse Practitioner for an order for a wet to dry dressing for Resident #49 since RN C had failed to call the clinician.<br><br>In a phone interview on 09/08/2024 at 2:10 PM, RN C stated she was a weekend supervisor and was not a wound care nurse per se and it was not her forte. She stated there was no order for a wet to dry dressing however that is what she put on Resident #49's wound that morning. She stated she had completed the wound care around breakfast time, and she was aware she had not charted the wound care. She further stated she was coming back to the facility that day.<br><br>In an interview on 09/08/2024 at 3:18 PM RN C stated she had been with the company since 2017 and had been in the facility since 2021. She stated she had been a floor nurse then started working prn in December 2024. She stated she had completed a wound care training course before 2017. She stated technically she had not had any wound care training at the facility. She was shown a checkoff list for the wound vacuum dated 08/24/2024 that had her name on it and was signed by the DON. She stated that was probably when she was shown how to do Resident #49's wound vacuum dressing. She stated she was making wound care rounds on Sunday 09/08/2024 and she needed an extra hand to help her with the resident. She stated his wound vac needed to be changed out and she was having problems doing it. She stated she should have called the on-call nurse for assistance. She stated she had decided the next best thing would be to put a wet to dry dressing on the wound. She stated she forgot to document the actions she took and did not call the Physician for orders or to notify them she was unable to complete the dressing change as ordered. She stated she should have stayed at the facility and taken her time. She stated wound care was probably not her strong point.<br><br>Observation and interview on 09/08/2024 at 2:33 PM the DON and Medical Records Clerk showed that there were three wound vac canisters available in the central supply room. The Medical Records Clerk stated she was present when RN C was in the facility on Sunday 09/08/2024 and RN C had not asked for any supplies for Resident #49's wound care.<br><br>In an interview during a wound care observation on 09/09/2024 at 1:45 PM Resident #49 stated Why did that nurse remove the wound vac yesterday? She should have put the wound vac back on. I need to call those state people. I'm trying to get well. The DON stated there were two state people in the room and the nurse should have replaced the wound vac instead of putting on a wet to dry dressing.<br><br>In an interview on 09/09/2024 at 2:25 PM Resident #49 stated the lady who put that patch (dressing) on yesterday said the wound vac did not need to go back. He further stated that was the second time that nurse had not replaced his wound vac. He stated he was at the facility to get well and go home. He stated, that nurse should have known better.<br><br>In an interview on 09/10/2024 at 9:45 AM the DON stated her expectations were for wound care to be done as ordered, that nurses document anything they do, notify the physician and family of any changes to the wound care. She further stated the potential risk to the resident was it could have halted progress on his wound healing.<br><br>In an interview on 09/10/2024 at 12:55 PM the ADM stated his expectations were for Dr. orders to be followed and the nurse probably should have documented her care. He stated he did not know what the potential risk for the resident could be of the nurse not following the Dr. orders for wound care.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of a facility Policy and Procedure titled Skin Integrity Management dated 2003 and revised on October 5, 2016, reflected General Guidelines: 3. Wound care should be performed as ordered by the physician. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689<br><br>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 and to help prevent the development and transmission of communicable diseases and infections for one of one Residents (Resident #49) reviewed for pressure ulcers wound care.<br><br>The facility failed to ensure RN A followed standard precautions during wound care for Resident #49's Stage 4 coccyx pressure ulcer when she contaminated supplies prior to wound care and used contaminated scissors to cut foam used for wound care which she then placed into the open wound.<br><br>This failure could place residents at risk for developing wound infections.<br><br>Findings included:<br><br>Record review of the undated Face Sheet for Resident #49 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of Pressure Ulcer of sacral (bony area of the spine) region, Stage 4 (open sore extending into muscles, tendons (cord like tissues that connect muscles to bones or other structures), and ligaments (short band of connective tissue which connects two bones or holds together a joint), can also expose bone).<br><br>Record review of the Quarterly MDS assessment dated [DATE] for Resident #49 reflected he had a BIMS score of 10 indicating moderate cognitive impairment.<br><br>Record review of the Care Plan for Resident #49 dated 07/24/2024 and revised on 08/19/2024 reflected Resident #49 has a pressure ulcer. Stage 4 to coccyx with wound vac [a wound dressing system that uses a suction pump to apply negative pressure to a wound to promote healing] in place to be changed 3 X week. Goal: Resident #49's pressure ulcer will show signs of healing and remain free from infection. Interventions: Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN. Specify treatment: WOUND VAC.<br><br>Record review of Physicians orders dated 07/23/2024 for Resident # 49 reflected Stage 4 pressure wound to coccyx. Clean with n/s, pat dry, apply granular foam in both ends and connecting in the middle, dress with clear wound vac tape 150 mmHg continuous pressure. 3 times per week.<br><br>Observation on 09/09/24 at 1:35 PM of wound care for Resident #49 revealed RN A unlocked the treatment cart, sanitized her hands, and donned gloves. She opened the unclean drawer with her gloves on, obtained a piece of wax paper and patted the inside of the paper using her contaminated gloves. She grabbed extra gloves with her contaminated gloves and placed them on the wax paper. She then grabbed 4 X 4 gauze and placed it on the wax paper using the same contaminated gloves. She removed her gloves, sanitized her hands, donned gloves, and removed the dressing from the resident's coccyx area. She removed her gloves, sanitized her hands, re-gloved and placed wound prep around the wound. She used sanitized scissors to cut pieces of the tape used to seal around the wound. She placed those scissors on an unclean draw sheet which had been under the resident. She then used those contaminated scissors to cut foam which was then placed into the wound. She cut a hole in the dressing she had placed over the foam using the contaminated scissors and attached the dressing to the wound vac.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676385 | A. Building<br>B. Wing | 09/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crossroads Nursing & Rehabilitation | 611 Rose Marie Blvd<br>Hearne, TX 77859 |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 09/09/2024 at 2:30 PM RN A stated the wound care training she had received was not formal but rather on the job in a hospital medical/surgical unit and when she had worked in hospice care. She stated she was not wound care certified and did not perform wound care very much. She stated the facility had asked her to fill in to do wound care for the current week and she normally did floor nursing. She stated the potential risk to the resident of not following standard infection control practices during wound care was for infection and introducing bacteria into the wound.<br><br>In an interview on 09/09/2024 at 3:24 PM the DON stated her expectation for nurses performing wound care was for no contamination and for the wound to remain free of infection. She stated the staff need education on infection control and wound care. She stated the potential risk was delayed wound healing, infection, and potential sepsis (serious condition in which the body responds improperly to an infection and the infection fighting processes turn on the body.)<br><br>In an interview on 09/10/2024 at 12:55 PM the ADM stated his expectation for infection control during wound care was that the nurse should follow the protocols for wound care. He stated the potential risk was it could contaminate the wound and could cause infection.<br><br>Record review of a facility policy and procedure dated 2003 and titled Treatment Table reflected 3. Gather treatment supplies. Open up and place on top of wax paper. One end will be considered clean, and the other end of the table will be open for dirty (to replace scissors, etc. to be cleaned) No other wound care protocols were provided by the DON.<br><br>49851 |