| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345552 | A. BUILDING _____ B. WING _____ | C 04/03/2025 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 3/31/25 through 4/3/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# XRPC11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification and complaint investigation was conducted on 3/31/25 through 4/3/25. Event ID # XRPC11. The following intakes were investigated NC00224992, NC00223696, NC00223270, and NC00222734.<br><br>1 of 15 complaint allegations resulted in a deficiency. | F 000 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and | F 623 | | 4/30/25 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 04/24/2025 |

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| F 623 | Continued From page 1 | F 623 | | |

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

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| F 623 | Continued From page 2<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff and Ombudsman interviews, the facility failed to notify the Ombudsman, the residents and/or the | F 623 | F623<br><br>A Discharge/Transfer Notice to Hospital | |

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| F 623 | Continued From page 3<br>resident representatives in writing of a resident transfer for 2 of 3 residents reviewed for hospitalization (Resident #88 and Resident #81).<br><br>The findings included:<br><br>1. Resident #88 was initially admitted to the facility on 9/3/24 and a reentry date of 1/29/25.<br><br>The nursing progress note dated 1/28/2025 at 2:30 PM revealed Resident #88 was transferred to the hospital for evaluation.<br><br>Resident #88 was discharged from the facility on 1/28/25 and returned to the facility on 1/29/25.<br><br>A telephone interview was conducted on 4/2/25 at 1:07 PM with the Ombudsman who revealed she had not received written notification of hospital transfers since November of 2024.<br><br>Multiple attempts were made to interview the responsbile party however attempts were not successful.<br><br>An interview was conducted on 4/2/25 at 2:45 PM with the Administrator. He stated the facility has had administrative staff changes and he determined that notices of transfers had not been sent to the resident and resident representative or the Ombudsman since November of 2024. He further indicated that the notice of transfer for Resident #88 should have been provided to the resident representative and to the Ombudsman as required.<br><br>2. Resident #81 was admitted to the facility on 12/13/23 and had an re-entry of 03/12/25. | F 623 | was provided to the Resident Representative of Resident #81 by the facility Administrator (NHA) on 4/18/2025. Resident #88 has since expired.<br><br>To address other residents possibly affected, a list of discharge/transfers to the hospital was provided to the facility Ombudsman on 4/2/2025 by the Administrator. This list contained all residents transferred or discharged from the facility since December 2024.<br><br>To prevent future occurrences, the Administrator and the Medical Records Director were re-trained on the regulation to notify the Ombudsman, the resident, and/or the resident's representative in writing of a resident transfer. Training was completed 4/18/2025 by the Director of Operations.<br><br>To monitor performance and ensure compliance is sustained, the Director of Operations, or designee, will be responsible for reviewing all weekly discharges/transfers from the previous week to the hospital to ensure each resident has the appropriate notifications provided to the resident and/or resident representative and the Ombudsman. If any are needed upon review by the DOO, or designee, they will be addressed at that time. The DOO will report the activity from this plan of correction to the weekly QI meeting and quarterly to the Executive Quarterly QA meeting for the next 3 meetings. | |

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| F 623 | Continued From page 4<br>The significant change Minimum Data Set (MDS) assessment dated 02/25/25 revealed Resident #81 was moderately cognitively impaired.<br><br>The discharge MDS assessment dated 03/08/25 revealed Resident #81 was discharged to the hospital on 03/08/25 and was readmitted on 03/12/25.<br><br>The nursing progress note dated 03/08/25 revealed Resident #81 was transferred to the hospital.<br><br>An interview conducted with Resident #81's Resident Representative (RR) on 04/02/25 at 1:35 PM revealed he had not received any type of notice regarding discharge or transfers since Resident #81 was discharged to the hospital on 03/08/25.<br><br>A telephone interview was conducted on 4/2/25 at 1:07 PM with the Ombudsman who revealed she had not received written notification of hospital transfers since November of 2024.<br><br>An interview was conducted on 4/2/25 at 2:45 PM with the Administrator. He stated the facility has had administrative staff changes and he determined that notices of transfers had not been sent to the resident and resident representative or the Ombudsman since November of 2024. He further indicated that the notice of transfer for Resident #81 should have been provided to the resident representative and to the Ombudsman as required. | F 623 | The facility alleges compliance with this plan of correction as of 4/30/2025 | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g) | F 641 | | 4/30/25 |

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| F 641 | Continued From page 5<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnoses and urinary catheter for 2 of 20 residents reviewed for MDS accuracy (Residents #39 and #100).<br><br>The findings included:<br><br>1. Resident #39 was admitted to the facility on 6/30/18 with diagnoses that included schizoaffective disorder.<br><br>A record review indicated Resident #39 had an active diagnosis of Post-Traumatic Stress Disorder (PTSD) since 8/8/23.<br><br>The annual Minimum Data Set (MDS) assessment dated 5/7/24 did not indicate Resident #39 had an active diagnosis of PTSD in the Psychiatric/Mood Disorder section<br><br>An interview was conducted on 4/3/25 at 10:25 AM with Minimum Data Set (MDS) Nurse #1. She stated it was an oversight that she did not code an active diagnosis of PTSD in the Psychiatric/Mood Disorder section of Resident #39's annual MDS assessment dated 5/7/24.<br><br>An interview was conducted on 03/06/25 at 10:50 AM with the Administrator. He stated she expected the MDS assessments to be coded accurately. | F 641 | F641<br><br>A modified MDS section I for resident #39 and section H for resident #100 was submitted with confirmation and accuracy on 4/16/2025 by the MDS nurse.<br><br>The (RN) Clinical Reimbursement Officer, or designee, will audit quarterly and annual submitted assessments for urinary catheter status and presence of PTSD Diagnosis for the previous 30 days, completed by 4/30/2025.<br><br>Both MDS Nurses were educated on the accuracy of Section I and H of the MDS on 4/16/2025 by the RN Clinical Reimbursement Officer.<br><br>A new audit tool was established on 4/16/2025.The RN Clinical Reimbursement Officer, or designee, will audit prior to submission 5 MDS assessments for 4 weeks, 3 MDs assessments for 4 weeks, 3 MDS assessments for 4 weeks, and 2 MDS assessments monthly for 3 months.<br><br>Any inaccuracies will be corrected and reported to the weekly QI committee to address any issues. Information will also be provided to the next executive quarterly QI Committee Meetings by the Administrator. | |

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| F 641 | Continued From page 6<br><br>2. Resident #100 was admitted to the facility on 09/03/24 with diagnoses which included urinary retention.<br><br>Resident #100's quarterly Minimum Data Set (MDS) dated 10/16/24 revealed Resident #100 was cognitively intact and was frequently incontinent with bladder and was not coded to have an indwelling urinary catheter.<br><br>A review of Resident #100's care plan 10/30/24 revealed Resident #100 had an indwelling urinary catheter.<br><br>On 04/02/25 at 3:11 PM an interview was conducted with Nurse #1, and she indicated she was assigned to Resident #100 while he was in the facility. Nurse #1 reported Resident #100 had an indwelling catheter for urinary retention.<br><br>An interview was conducted on 04/03/25 at 11:33 AM with the Minimum Data Set (MDS) Nurse #1. The MDS Nurse #1 indicated the indwelling catheter should have been coded on the MDS. She stated, "I did care plan it".<br><br>An interview was conducted on 04/03/25 at 1:20 PM with the Administrator and he indicated it was his expectation the MDS assessments to be coded accurately. | F 641 | The facility alleges compliance with this plan of correction as of 4/30/2025 | |
| F 773 SS=D | Lab Srvcs Physician Order/Notify of Results<br>CFR(s): 483.50(a)(2)(i)(ii)<br><br>§483.50(a)(2) The facility must-<br>(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in | F 773 | | 4/30/25 |

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| F 773 | Continued From page 7<br>accordance with State law, including scope of practice laws.<br>(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff, Wound Care Physician, and lab vendor interviews, the facility failed to notify the Wound Care Physician of a positive wound culture lab result when it was reported to the facility which delayed initiating antibiotics for 3 days. This deficient practice affected 1 of 2 sampled residents (Resident #53).<br><br>Findings included:<br>Resident #53 was admitted to the facility on 8/11/22 with the diagnosis of dementia.<br><br>The annual Minimum Data Set dated 3/20/25 for Resident #53 documented she had an intact cognition, a diagnosis of one stage 3 pressure ulcer, and the pressure ulcer stage 3 was reported not present on admission or reentry. The resident was frequently incontinent of bladder and always incontinent of bowel.<br><br>The care plan dated 3/20/25 for Resident #53 had interventions for pressure reduction, nutrition supplementation for wound healing, and pressure ulcer wound care. The resident was at risk of developing pressure ulcers.<br><br>Resident #53 had a Wound Care Physician progress note dated 2/10/25 which documented | F 773 | F 773<br>Wound Nurse Notified the Wound MD of culture results on 2/17/2025. Resident #53 was prescribed and given a full course of antibiotics as ordered.<br><br>DON reviewed wound culture results from the last 90 days to determine if any additional notification delays occurred. This task was completed by 4/18/2025.<br><br>DON, or designee, to review labs from prior day, within 24 hours, to ensure results are communicated as required. Audits will occur daily for two weeks, then twice a week for 2 weeks, then randomly thereafter using the Wound Culture Audit tool.<br><br>100% of all licenses nurses will be educated by the DON, or designee, regarding obtaining lab results, appropriate clinical follow-up, and MD reporting requirements by 4/30/2025.<br><br>As a part of the weekly QI meeting, all variances will be identified and corrected immediately by the DON, or Nursing | |

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| F 773 | Continued From page 8<br>the progress of her pressure ulcer wound. The wound was not progressing and suspected to be infected. A deep swab technique was performed on the stage 3 pressure wound of the right buttock completed on 2/10/25 and order provided for culture.<br><br>Resident #53's physician ordered a wound culture for stage 3 right buttock pressure ulcer on 2/10/25 that was initiated by the Wound Care Nurse.<br><br>Resident #53's pressure ulcer wound culture lab result dated 2/14/25 documented the specimen was picked up on 2/11/25 and the final result was completed on 2/14/25. The report was sent to the facility directly into the resident's electronic medical record (EMR) on 2/14/25 and was positive for bacteria organism proteus mirabilis. The culture report had printing dates of 2/14/25 and 2/17/25 on the copy in Resident #53's EMR.<br><br>On 4/3/25 at 12:44 pm an interview was conducted with Nurse #2. Nurse #2 stated she was assigned to Resident #53 on day shift on 2/14/25. She was not aware of the lab result reported on 2/14/25 for Resident #53. She stated the process for lab results was a paper copy of the lab was provided to staff at the nurses' station by the Director of Nursing (DON). The result would then be reported to the ordering provider. Nurse #2 stated she was not aware that the lab was directly reported into the resident's individual EMR. The EMR type had changed on 12/2024, and the process had changed from paper to directly placed into the EMR. The lab could be reviewed in the lab portal if it was known a lab result had been reported. Nurse #2 stated she was not informed that the resident had a lab | F 773 | Home Administrator. This information will also be provided at the next four executive Quarterly QI Committee Meeting by the facility Administrator.<br><br>The facility alleges full compliance with this plan of correction by 4/30/2025. | |

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result received on 2/14/25 and there was no EMR notification.

On 4/2/25 at 10:33 am an observation was done of Resident #53's final lab culture report dated 2/14/25 with Nurse #2. The report had two dates for being printed, 2/14/25 and 2/17/25 on the form. Nurse #2 commented that the report was printed from the internet vendor site showing the two dates and then scanned into the resident's EMR on 2/17/25.

On 4/2/25 at 10:33 am an interview was conducted with the Wound Care Nurse. The Wound Care Nurse stated she was absent on Friday, 2/14/25 and returned on Monday 2/17/25. The wound culture result was reported to the Wound Care Physician on 2/17/25 when he was at the facility to see the residents, and the physician ordered antibiotics. The Wound Care Nurse stated she expected the nurse assigned Resident #53 on 2/14/25 to address the lab results reported that day. The Wound Care Nurse was aware the result was posted to the Resident #53's EMR, but thought the result was printed and provided to the staff nurse assigned on 2/14/25. The Wound Care Nurse stated printing a copy of lab results and providing it to assigned nursing staff was the process. The Wound Care Nurse stated she printed her own lab results and thought nursing staff printed their resident assignment lab result(s). The Wound Care Nurse was absent on 2/14/25 and she printed her own copy on 2/17/25.

Resident #53's Wound Care Physician progress note dated 2/17/25 documented the wound was exacerbated due to infection, there was a moderate amount of serous drainage (light red

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| F 773 | Continued From page 10 | F 773 | | |

liquid), and 100% of granulation tissue. A deep swab technique of stage 3 pressure wound of the right buttock demonstrates proteus mirabilis on 2/10/25. The wound care order remained unchanged, and the antibiotic Invanz 1 gram for 10 days was ordered.

Resident #53 had an order dated 2/17/25 for Ivanz (antibiotic) 1 gram intramuscular for 10 days.

On 04/02/25 at 10:46 am an interview was conducted with the lab vendor. She stated the wound culture for Resident #53 was posted in the resident's EMR when the final report was completed 2/14/25 at 9:48 am. All labs for facilities that use the connected EMR were automatically posted to their EMR including on the weekends. The labs were placed in the residents' EMR electronically. If the lab was critical the facility was called as well. Resident #53's would culture result was not considered critical. She further stated that this facility was connected directly to the lab to receive reports into the residents' EMR.

On 4/2/25 at 11:10 am the DON reviewed Resident #53's wound culture result and was interviewed. The DON stated she was not aware the lab would come directly to the EMR but was expecting a fax. "There was no notification in the EMR" that a lab result was posted. The DON stated she kept a written logbook of all labs to follow, and Resident #53's wound culture was not recorded in her logbook (the DON opened her logbook and reviewed). The DON stated she kept track of all labs in her book and if known she would have addressed the lab. The DON commented that this EMR type was new to the

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| F 773 | Continued From page 11<br>facility as of 12/2024. A review of the lab culture result revealed it was a final report on 2/14/25 at 9:48 am and was printed at the facility on 2/14/25 and 2/17/25 and scanned into the Resident #53's EMR. The DON further stated she was keeping a logbook of submitted labs and printing a copy of the result from the vendor site instead of accessing the result from the residents' EMR.<br><br>On 4/2/25 at 12:09 pm an interview was conducted with the Wound Care Physician. The Wound Care Physician stated he completed a wound culture swab of Resident #53's right buttock pressure ulcer on 2/10/25 and he was not informed of the culture report until 2/17/25. The Wound Care Physician indicated the wound culture result should have been reported to me on 2/14/25 when it was received, and he would have ordered the antibiotic on 2/14/25. He commented that the Wound Care Nurse was usually prompt in reporting culture results. The Wound Care Physician further commented that he was available 24/7 by phone, especially for wound culture reports. The delayed start of the antibiotic had not caused the resident harm, and her wound was now improving. | F 773 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must 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.<br><br>§483.80(a) Infection prevention and control | F 880 | | 4/30/25 |

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| F 880 | Continued From page 12 | F 880 | | |

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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| F 880 | Continued From page 13<br>contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interviews of the staff and wound care physician, the facility failed to follow their infection control policy for hand hygiene and glove use when the Wound Care Nurse did not perform hygiene and don new gloves after the dirty portion of the pressure ulcer dressing change and before beginning the clean portion of the dressing change (Resident #53). This deficient practice occurred for 1 of 2 staff observed for infection control practices.<br><br>Findings included:<br>The infection control policy last updated on 10/22/24 documented, in part, "1. Hand hygiene d. Wash hands after removing gloves. 2. Gloves e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one). g. Remove gloves promptly after use, before touching | F 880 | F880<br><br>Wound MD evaluated affected resident on 4/14/2025 and noted wound to be healing with no signs or symptoms of infection.<br><br>Wound MD assessed current open wounds in house on 4/14/2025 and found none to show signs or symptoms of infection.<br><br>Wound Nurses completed NC Spice Certification training 4/14/2025 through 4/16/2025. DON, or designee, to complete education with 100% of licenses nurses regarding infection control during wound care, to be completed by April 30th, 2025. Any nurse not in-serviced by April 30th, will be in-serviced prior to the start of their next shift. | |

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| F 880 | Continued From page 14<br>non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments."<br><br>On 04/02/25 at 10:35 am an observation of Resident #53's pressure ulcer wound care to her right buttock by the wound care nurse was done. The wound care nurse washed her hands and donned gloves. She placed all her supplies on a clean surface next to the resident's bed. The wound care nurse removed the wound dressing. The right buttock stage 3 pressure ulcer was approximately 2 centimeters (cm) around and 1 cm deep with a small amount of serous (light red) drainage present and there were no signs or symptoms of infection. She cleansed the pressure ulcer with normal saline and applied skin prep around the pressure ulcer. The wound care nurse used the same gloves and had not performed hand hygiene before she placed the silver alginate (medicated gauze) into the ulcer wound bed and then placed the dressing over the wound. There was no use of hand sanitizer or change of gloves in-between removing the dirty dressing, cleansing the wound and placement of the treatment and dressing. The wound care nurse was interviewed. The wound care nurse stated she only changed gloves during wound care when the resident had more than one wound. She would change gloves between each wound. If there was only one wound, she would use the same gloves. The wound care nurse commented she wore the same gloves and had not stopped for hand hygiene and re-glove in between the dirty dressing and placing the treatment and clean dressing because Resident #53 had one wound. | F 880 | DON, or designee, will complete wound care observations of four residents weekly for 4 weeks, then 3 residents weekly for 3 weeks, then 2 residents weekly for 2 weeks, then 6 residents monthly for 3 months using the CDC Wound Care Facility Observation Tool.<br><br>Any negative observations will be addressed and reported to the weekly QI committee to address any issues. Information will also be provided to the next four executive quarterly QI Committee Meetings by the facility Administrator.<br><br>The facility alleges compliance with this plan of correction as of 4/30/2025. | |

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| F 880 | Continued From page 15<br><br>On 04/02/25 at 12:09 pm an interview was conducted with the wound care physician. The wound care physician stated he remembered Resident #53. The wound care physician stated that the expected use of infection control during wound care would have been to use hand hygiene and don gloves and remove the old/soiled dressing and cleanse as required and then use hand hygiene and change to clean gloves before having placed the treatment and a clean dressing. This would be the same for each wound a resident would have.<br><br>On 4/1/25 at 4:40 pm an interview was conducted with the Administrator. The deficient practice by the wound care nurse when she failed to perform hand hygiene and change gloves after she removed the dirty pressure ulcer dressing, cleansed the wound and then placed the treatment calcium alginate and sterile dressing was discussed. The Administrator stated he thought that use of the same gloves was appropriate when there was only one wound on the resident. The facility owner was requested to attend the interview. The owner stated if the old dressing was not soiled and there was only 1 wound, it was not necessary to change gloves in-between removing the dirty dressing and cleansing and then placing the treatment and clean dressing. The owner stated the wound care nurse was certified/trained and he thought this process was what she learned. The owner stated he would provide information from SPICE (Statewide Program for Infection Control and Epidemiology) to corroborate the use of the same gloves for dirty dressing/cleanse and clean dressing and would get back to me tomorrow (4/2/25). | F 880 | | |

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| F 880 | Continued From page 16<br><br>On 4/2/25 at 10:15 am an interview was conducted with the Administrator. He stated the facility had nothing to add from SPICE or any other information regarding infection control and the use of hand hygiene and gloves during wound care. Hand hygiene and change of gloves would need to be performed during wound care.<br><br>On 04/03/25 at 11:28 am an interview was conducted with the Director of Nursing (DON). The DON stated the wound care nurse was confused that not changing dirty gloves before starting the clean process for wound care was not part of the SPICE recommendations. The DON informed the wound care nurse that hand hygiene and changing gloves was required during wound care after removing the soiled dressing and cleaning and then handling clean treatment and dressing for each wound. | F 880 | | |