Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 2, 2021

Ms. Melissa Haupt, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Dear Ms. Haupt:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 6, 2021**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced onsite annual emergency preparedness review was conducted, in conjunction with the annual recertification survey, by the Division of Licensing & Protection on 10/4-10/6/21. There were no regulatory deficiencies identified as a result of the review.	E 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law. F 578	
F 000	INITIAL COMMENTS An unannounced on-site annual recertification survey was conducted by the Division of Licensing and Protection at St. Albans Health and Rehabilitation Center on 10/4-10/6/21. The following regulatory violations were identified:	F 000	Resident #61 no longer resides at the center. Resident #34's order for DNR/DNI and COLST have been corrected.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578	All residents that reside in the center have the potential to be affected by this alleged deficient practice. An audit of all COLST and resuscitation orders have been completed. Education will be provided to licensed nurses and social service personnel regarding COLST and resuscitation orders. Random audits of residents will occur weekly times 4, then monthly times 2 or until substantial compliance has been achieved. CED/SS/CNE is responsible to ensure accuracy of COLST and resuscitation orders. Date of compliance: November 6, 2021	

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

CED — 10/22/2021

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F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) if an adult Individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain a copy of an updated Advanced Directives for 2 of 24 applicable residents (Resident #61 and Resident #34). Findings include: 1.) Per record review Resident #61 has a physician's order from 6/15/2021 that reads "DO NOT RESUSCITATE (DNR)/DNI" (Do Not Intubate). There is no evidence in the record that a copy of an Advanced Directive for Resident #61 was obtained. Per interview on 10/6/21 at 12:28 PM wit the Social Worker, S/He stated that Advanced Directives were obtained upon admission and then reviewed quarterly at care conferences. S/He stated that for Resident #61, the "COLST (Clinician Orders for Life Sustaining Treatment) was just not done".	F 578	TAG F 578 POC Accepted on 11/01/21 T. Dougherty/ P. Cota	

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F 578	Continued From page 2 Per review of the policy "Health Care Decision Making"-reviewed 4/13/20, it reads "Practice Standards 1. Upon admission, determine whether the patient has an advance directive and/or portable medical record orders such as POSLT, MOLST, etc. 1.1 If the patient/resident representative has a copy with them, make copies, place in medical record, and notify the interprofessional team. 1.1.1 If the patient/resident representative has not brought the document(s) to the Center, the Center Admissions Designee will advise the patient/representative that wishes cannot be honored without a copy in the medical record. 2. Throughout the stay, advance care planning conversations will be conducted as part of the care plan process and with significant change in condition to identify, clarify, and review existing advance directives and/or portable medical orders and determine whether the patient wishes to change or continue these instructions." 2. Per record review, Resident #34's legal representative signed a COLST (Clinician Orders for Life Sustaining Treatment) form on 8/19/2019 indicating a desire for Resident #34 to receive cardiopulmonary resuscitation (CPR) if their heart stops but to not intubate Resident #34 if clinically indicated. Per review of Resident #34's clinician orders, Resident #34 has an order for "full code" which indicates the need for both CPR and intubation if the resident is found without signs of life. Per interview on 10/6/2021 at approximately 4:00 PM, the Unit Manager confirmed that Resident #34 had an order for "full code" status and that this is also reflected on nurses' report sheets. They also confirmed that this is what a nurse	F 578		

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F 578	Continued From page 3 would reference to know what the code status is for a resident. Per interview on 10/6/2021 at approximately 4:30 PM, the (DON) Director of Nursing confirmed that they would expect Resident #34's orders to reflect their DNI (Do Not Intubate) status as well as their desire for CPR. The DON also confirmed that, while facility staff are not responsible for intubation, that facility staff inform emergency response services of a resident's code status immediately upon arrival and that they are able to provide intubation if necessary.	F 578	F 657 A care plan meeting has been held for resident # 20, #33, and #48. All residents that reside in the center have the potential to be affected by this alleged deficient practice. An audit of all residents and date of last care plan has been completed. Education has been provided to department heads on the process for care plan meetings. Random audits of care plan meetings will occur weekly times 4 then monthly times 2 or until substantial compliance has been achieved. SS/CNE is responsible for ensuring that care plan meetings are held timely. Date of compliance: November 6, 2021	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		

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F 657	Continued From page 4 or as requested by the resident. (III)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record reviews, the facility failed to provide evidence of the participation of all required members of the Interdisciplinary Team (IDT) including the resident and resident representative(s) in care plan meetings or that meetings had been taking place at all for 3 of 17 sampled residents. Resident #20, 33, and 48. Findings include: (1) Per record review of resident #20 in the Electronic Health Record (EHR) there was no evidence that a care plan meeting had taken place since February 2021. Per interview on 10/6/21 at 4:31pm the facility social worker stated if there is no record in the resident record, the meeting must have been missed. (2) Per record review of resident #33 in the Electronic Health Record (EHR) there was no evidence that a care plan meeting had taken place since February 2021. Per interview on 10/6/21 at 4:31pm the facility social worker stated if there is no record in the resident record, the meeting must have been missed. (3) Per interview on 10/4/21 with Resident #48, S/He stated that S/He had "no meetings". Per record review the last care plan meeting documented for Resident #48 was on 6/3/2020. Since that time, there was no evidence that Resident #48's care plan had been reviewed by	F 657	**TAG F 657 POC Accepted on 11/01/21 T. Dougherty/ P. Cota**	

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F 657	Continued From page 5 the IDT, the resident, and/or their representative. Per interview on 10/6/21 at 4:18 PM with the Director of Nursing (DNS), S/He confirmed that there was no evidence that a care plan review for Resident #48 had taken place since June of 2020.	F 657		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		

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F 755	Continued From page 6 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation as evidenced by the facility failing to keep an accurate count of a controlled drug and following its policies and procedures for record keeping for one of 24 residents (Resident #29). Findings include: 1. Per record review, a progress note in Resident #29's chart states that on 7/23/21, 2 tablets of Ativan (a controlled medication used to treat anxiety) were reported missing from Resident #29's bottle of Ativan during shift count at approximately 11:00 PM. Per interview on 10/6/21 at approximately 12:00 PM, The DON (Director of Nursing) confirmed that they had alerted all appropriate agencies immediately and an investigation had been conducted. The DON provided this surveyor with the investigation documentation. Per review of the documentation, Resident #29 was admitted to hospice services on 5/25/21. The hospice provider's pharmacy mailed a bottle of 30 0.5 milligram Ativan tablets to the facility. The bottle of Ativan was accepted by the facility on 6/3/21. Per review of resident #29's MAR (medication administration record), no 0.5 mg Ativan tablets were administered after receipt of the bottle and Resident #29 did not have a physician order for 0.5 mg Ativan tablets. Per review of the investigation summary, Nurse 2	F 755	Past noncompliance: no plan of correction required.	

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F 755	Continued From page 7	F 755		

attested that Nurse 1 and Nurse 2 counted the Ativan tablets in the bottle during shift change on 7/20/21 at approximately 11:00 PM, verified that all 30 tablets were in the bottle, and documented the count as such on the narcotic count sheets. During shift change on 7/21/21 at approximately 7:00 AM, nurse 2 and Nurse 3 then documented that there were 30 tablets in the Ativan bottle, but "[Nurse 3] did not count them" according to Nurse 2. Per Nurse 2, at shift change on 7/21/21 at approximately 11:00 PM, Nurse 1 and Nurse 2 counted the Ativan tablets and there were only 28 tablets in the bottle. No loose medications were found during a search of the medication cart.

Per review of the investigation summary, Nurse 1 confirmed that Nurse 1 and Nurse 2 counted the Ativan tablets during shift change on 7/20/21 at approximately 11:00 PM, verified that all 30 tablets were present, and documented the count as such. Per Nurse 1, on 7/21/21 at approximately 9:30 PM, Nurse 1 and Nurse 3 documented 30 tablets of Ativan on the count sheet but Nurse 1 confirmed that they did not count each individual pill and stated it "looked like they were all there." Nurse 1 confirmed that during shift change on 7/21/21 at approximately 11:00 PM, the Ativan count was off when counting with Nurse 2.

Per review of the investigation summary, Nurse 3 confirmed that they did not count the Ativan tablets during shift change on 7/21/21 at 7:00 AM with nurse 2, nor did they observe Nurse 1 count them during shift change on 7/21/21 at 9:30 PM. Nurse 3 stated, "we don't use it, so I assumed that they were all there."

Per review of the facility's policy Management of

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Controlled Drugs, the section titled Storage and Maintenance of Controlled Drugs states, "2.2 If a discrepancy is found after the controlled drug has been accepted: 3.3.1 Notify pharmacy 3.3.2. Give drug to Center Nurse Executive or designee for disposition according to federal and state regulations." The section titled Ongoing Inventory of Controlled Drugs states, "5.1.3. both licensed nursing staff participating in the count must: 5.1.3.1 Confirm that the inventory page reflects the quantity of drugs present in the container, and that the integrity of each container is intact 5.1.3.2 verify the amount remaining as noted in the 'Amount Left' column if the inventory page 5.1.3.3 both licensed nursing staff sign the shift count page in the control substances book to acknowledge completion of the shift count."

Per interview on 10/6/21 at approximately 2:00 PM, the DON stated that the hospice provider does not use the same pharmacy and should not be sending medications to the facility. The hospice provider's system should not have mailed the medication, as there was no order for the Ativan tablets, and the facility should not have accepted them or should have accepted them and then given the medications to the DON for disposal. The DON confirmed that this did not happen. The DON also confirmed that Nurses 1 and 3 did not follow the procedure for proper inventory of narcotics during shift change. The DON also confirmed that Nurses 1 and 3 are no longer employed at the facility.

This regulatory violation is considered past noncompliance, as the following interventions have already been implemented by the facility:
- All nursing staff were educated on the policies and procedures for recieving medications and

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F 755	Continued From page 9 counting narcotics during shift handoff - The nurses involved in the incident were individually educated and put on a performance improvement plan - Audits were conducted of narcotics in medication carts	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on information obtained through staff interview and record review, the facility failed to ensure that each resident's drug regimen is free from unnecessary drugs used without adequate indications for its use for one of 24 residents	F 757	F757 Resident #24's order has been changed Residents that have "Hold" orders have the potential to be affected by this alleged deficient practice. An audit has been completed of orders Licensed nurses and in house provider will be educated on the process for holding medications that have parameters. Random audits of new orders will occur weekly times 4 then monthly times 2 or until substantial compliance has been achieved. CNE is responsible for ensuring that orders are followed Date of compliance November 6, 2021 **TAG F 757 POC Accepted on 11/01/21 T. Dougherty/ P. Cota**	

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F 757	Continued From page 10 (Resident #24). Findings include: 1. Per record review, Resident #24 had an order for "Furosemide Tablet 20 milligrams - give 1 tablet by mouth one time a day for diuretic. Hold if weight is under 104 pounds, use weight from Monday, Wednesday, Friday." Furosemide is a diuretic medication, meaning that is used to rid the body of excess water. This order was placed by the provider on 8/25/21. Per Resident #24's Medication Administration Record, Resident #24 was administered the full dose of medication on 9/1/21 for a weight of 101.5 lbs, on 9/11/21 for a weight of 101.8 lbs, on 9/18/21 for a weight of 103.7 lbs, on 9/20/21 for a weight of 103.7 lbs, on 9/22/21 for a weight of 103.2 lbs, on 9/25/21 for a weight of 102.8 lbs, on 9/26/21 for a weight of 103.2 lbs, on 9/27/21 for a weight of 103.2 lbs, on 10/2/21 for a weight of 103.1 lbs, on 10/4/21 for a weight of 101.4 lbs, and on 10/5/21 for a weight of 101.2 lbs. Per interview on 10/6/21 at approximately 3:00 pm, the Director of Nursing confirmed that these 11 administrations of Furosemide had been administered to Resident #24 without adequate indications.	F 757	F758 Resident #6 and #58's orders for Lorazepam have been discontinued due to non-usage Resident #59's Lorazepam has a diagnosis for usage. Residents on psychotropic drugs have the potential to be affected by this alleged deficient practice An audit has been completed on all residents with psychotropic drugs Licensed nurses and in house provider will be educated on the process for psychotropic drugs. Random audits of psychotropic drug orders will be completed weekly times 4 then monthly times 2 or until substantial compliance has been achieved. CNE is responsible for ensuring that the process for psychotropic drugs is followed. Date of compliance: November 6, 2021	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		

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F 758	Continued From page 11 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758	**TAG F 758 POC Accepted on 11/01/21 T. Dougherty/ P. Cota**	

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	475021	A. BUILDING _____ B. WING _____	C 10/06/2021

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F 758	Continued From page 12	F 758		

the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that residents were free from unnecessary psychotropic medications as evidenced by a failure to ensure as needed (PRN) orders were limited to 14 days and that there was a specific diagnosis/condition documented in the medical record for 3 of 5 applicable residents (Resident #6, Resident #58, and Resident #59). Findings include:

1.) Per record review, resident #6 has diagnoses of Alzheimer's disease and adult failure to thrive. S/He started receiving Hospice services on 4/2/21. Per review of a physician's order from 5/8/2021 it read, "Lorazepam (medication for anxiety) Tablet 0.5 mg (milligrams) Give 1 tablet by mouth every 2 hours as needed for agitation/anxiety for 12 Months po (by mouth)/SL (given under the tongue)". There was no evidence in the provider's progress notes of a rationale for extending the medication beyond the 14 days. Per interview on 10/6/21 at 3:45 PM with the DNS, S/He confirmed the above information.

2.) Per review of Resident #59's record, a physician's order from 6/30/21 read, "Lorazepam Tablet 0.5 mg Give 1 tablet by mouth at bedtime for anxiety". There was no specific condition and/or diagnosis in the record that provided a rationale for the use of this medication.
(3) Per record review, Resident #58 had a physician's order for Lorazepam (an anti-anxiety medication) 0.5 milligrams by mouth every 2 hours as needed. Reassess in 1 year. There is no evidence in the clinical records that the

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F 758	Continued From page 13 physician documented their rationale for extending the medication beyond 14 days as required by Federal Regulations. This was confirmed by the Director of Nursing (DNS) on 10/6/21 at 3:45pm.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based observation and staff interview, the facility failed to ensure that drugs and biologicals used in the facility are labeled in accordance with	F 761	F761 The refresh, Trelogy, and symbicort have been thrown away All residents with eye drops and inhalers have the potential to be affected by this alleged deficient practice. All four medication carts have been audited to ensure medications are labeled. Licensed nurses have been educated on the process for labeling medications when opened Random audits will occur weekly times 4, monthly times 2 or until substantial compliance has been achieved. CNE is responsible to ensure medications are labeled. Date of compliance November 6, 2021	

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F 761	Continued From page 14 currently accepted professional principles on two of two units. Findings include: 1. Per observation on 10/5/21 at approximately 4:00 PM, one of two medication carts on West unit (the cart farthest from the entrance to the unit) contained inadequately labeled medications for two residents. An opened bottle of Refresh Relieva Solution 0.5-0.9% eye drops belonging to Resident #54 did not have an open date listed on the medication. The manufacturers instructions on the bottle instruct the user to discard the opened bottle after 90 days. Without an open date, it is unknown when staff should discard the opened bottle. A Trelegy Ellipta Aerosol Powder 200-62.5-25 mcg inhaler belonging to Resident #51 did not contain the name of the Resident it was prescribed for on the inhaler. Per interview at the time of observation, the nurse assigned to the cart that shift confirmed that there was no open date on the opened Refresh eye drops bottle, nor was the Trelegy inhaler labeled with the name of the Resident it belonged to, 2. Per observation on 10/6/21 at approximately 3:30 PM, one of two medication carts on East unit (the cart at the end of long hall) contained an inadequately labeled medication for one resident. A Symbicort 80/4.5 inhaler for Resident #24 did not contain the name of the Resident it was prescribed for on the inhaler. Per interview at the time of observation, the nurse assigned to the cart that shift confirmed that the Symbicort inhaler was not labeled with the name of the Resident it belonged to. Medication labels at a minimum must include the	F 761	**TAG F 761 POC Accepted on 11/01/21 T. Dougherty/ P. Cota**	

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F 761	Continued From page 15 medication name, prescribed dose, strength, the expiration date when applicable, the resident's name, and route of administration. For medications designed for multiple administrations, the label must identify the specific resident for whom it was prescribed.	F 761	F880 All residents that reside in the center has the potential to be affected by this alleged deficient practice	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control 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 §483.70(e) 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	F 880	The facility has established 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 A root cause analysis has been completed Education has been provided to staff regarding hand washing focusing on diligence with infection control Education has been provided regarding MDROs Audits of dressing changes will occur 3 times weekly with results to QAPI weekly times 4, monthly times 2, or until substantial compliance is achieved IPP/CNE is responsible for ensuring infection prevention procedures are followed Date of compliance: November 6, 2021	

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F 880	Continued From page 16 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 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review the facility failed to establish and maintain an infection prevention and control program that	F 880	**TAG F 880 POC Accepted on 11/01/21 T. Dougherty/ P. Cota**	

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F 880	Continued From page 17 provides a safe, sanitary, and comfortable environment that helps to prevent the development and transmission of communicable disease and infections as evidenced by failing to follow hand hygiene procedures during a dressing change and following/maintaining precautions for 2 applicable residents (Resident #7 and Resident #56). Findings include: 1. Per observation on 10/5/21 at 2:40 PM of a dressing change for Resident #7, the resident was lying in bed with his/her left foot elevated and uncovered with the dressing exposed. A package of 4x4 gauze, a package of Telfa gauze (nonstick gauze), and a roll of Kerlex wrap were on the resident's bare bedside table along with scissors, wound cleaner, tape, and a sharpie. The nurse stated that S/He bleached the table prior to the surveyor entering the room and that was the facility's policy. The nurse then sanitized his/her hands, donned gloves, removed the old dressing, removed gloves, sanitized hands, donned new gloves, cleansed the wound, removed gloves, sanitized hands, donned new gloves, applied clean dressings to the wound and wrapped the resident's foot. The nurse then proceeded to remove his/her gloves and without washing and/or sanitizing his/her hands, picked up a sharpie, wrote on the tape, applied the tape to the dressing, gathered up the dressing supplies from the table, assisted the resident with a snack, and without washing and/or sanitizing his/her hands donned new gloves applied the resident's sock, removed gloves and without washing and/or sanitizing his/her hands obtained a ginger ale from the resident's dresser and proceeded to touch multiple items in the room. The nurse then left the room with the resident's dressing supplies, proceeded to put the supplies in a cart	F 880		

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F 880	Continued From page 18 and at that point had still failed to wash/sanitize his/her hands. Per interview on 10/5/21 at 2:55 PM with the nurse, the surveyor asked what the facility's policy regarding hand hygiene and glove use was, S/He stated that hand hygiene was to be performed after gloves were removed. S/He stated that I "didn't think I needed to sanitize" the "tape was clean"; and further confirmed that S/He did not wash and/or sanitize his/her hands per policy. Per review of the policy "Hand Hygiene" -reviewed 11/15/20, it states "1. Perform Hand Hygiene: 1.1 Before patient care; 1.2 Before an aseptic procedure; 1.3 After any contact with blood or other body fluids, even if gloves are worn; 1.4 After patient care; 1.5 After contact with the patient's environment. Per review of the policy "Wound Dressings: Aseptic"-revised 6/1/21, it states "2. Gather supplies...3. Use personal protective equipment as indicated. 4. Clean over-bed table. 5. Place clean barrier on the over-bed table and place supplies on the barrier ...14. Open dressing (s) without contaminating. Keep the dressing/gauze within the open packet and place it directly on top of the barrier". 2. Per record review, Resident #56 has a diagnosis of "Methicillin Resistant Staphylococcus Aureus (MRSA) infection" that was added to the record on 11/5/2019. The "special instructions" section of Resident #34's chart also states, "MRSA - urine and wound." MRSA is a drug-resistant bacteria that requires extra precautions to prevent its spread to other people.	F 880		

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F 880	Continued From page 19	F 880		

It is part of a class of bacteria called MDROs (Multi-Drug Resistant Organisms). Per the record, Resident #56 has a diagnosis of "pressure ulcer of the sacral (lower back) region" and orders to have this wound covered in a dressing, which were entered on 9/24/2020. The record also shows orders for care of a suprapubic catheter (a tube that enters through the lower abdomen into the bladder and drains urine into a bag), such as the order "Provide hygiene care to suprapubic catheter site every shift for hygiene AND as needed for hygiene" entered on 6/6/2021.

Per review of Resident #34's care plan, there is a care plan focus of "MDRO: MRSA in urine and wound" entered on 1/6/2020 with the intervention "standard precautions: wear gloves and gown when performing wound care and any care activities when contact with blood, excretions, secretions or body fluid is anticipated."

Per review of the facility's MDRO policy, staff providing direct care to a resident with MDRO colonization should use standard precautions for care at the MDRO source/site of infection when the infectious agent (i.e. wound drainage or urine) can be contained.

The Centers for Disease Control define standard precautions as:
- Use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non-intact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis) or OPIM.
- Use of protective clothing to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated.
- Use of mouth, nose, and eye protection

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F 880	Continued From page 20 during procedures that are likely to generate splashes or sprays of blood or other body fluids. Per observation of Resident #34's room on 10/4/2021 at approximately 3:30 PM, there were no signs or indicators in or around the entrance to the room regarding MRSA precautions or what personal protective equipment to use. There were also no gowns stored in or around Resident #34's room. Per interview on 10/5/21 at approximately 10:45 AM, the Unit Manager confirmed that gowns should be used for Resident #34's wound and catheter care but that there are no gowns stocked in/near Resident 34's room or anywhere else on the unit. Per interview on 10/6/21 at approximately 11:30 AM, the LPN (licensed practical nurse) assigned to Resident #34 confirmed that they provided catheter care and wound care earlier that morning. They stated they did not wear a gown during either of those tasks and was not aware that gowns were indicated.	F 880		

ROOT CAUSE ANALYSIS REPORT FORM[1]

St. Albans Health and Rehabilitation Center			
Name:			
City/Town: St. Albans, Vermont	Date of Event: 10/5/2021	Date RCA Completed: 11/6/2021	
1.	**THE EVENT** Infection control citation during annual recertification survey (F880)	RCA Team Members: See sign in sheet.	
2.	**BACKGROUND & FACTORS SUMMARY–** *Answer the following questions (brief summary only- attach supporting documents).*		
2.1	What was the sequence of events that was expected to take place?	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 disease and infections	
2.2	Was there a deviation from the expected sequence?	Yes	Nurse did not wash their hands per policy
2.3	Was any deviation from the expected sequence likely to have led to or contributed to the adverse event?	Yes	If YES, describe with causal statement. Per observation on 10/5/21 at 2:40 PM of a dressing change for Resident #7, the resident was lying in bed with his/her left foot elevated and uncovered with the dressing exposed. A package of 4x4 gauze, a package of Telfa gauze (nonstick gauze), and a roll of Kerlex wrap were on the resident's bare bedside table along with scissors, wound cleaner, tape, and a sharpie. The nurse stated that S/He bleached the table prior to the surveyor entering the room and that was the facility's policy. The nurse then sanitized his/her hands, donned gloves, removed the old dressing, removed gloves, sanitized hands, donned new gloves, cleansed the wound, removed gloves, sanitized hands, donned new gloves, applied clean dressings to the wound and wrapped

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			the resident's foot. The nurse then proceeded to remove his/her gloves and without washing and/or sanitizing his/her hands, picked up a sharpie, wrote on the tape, applied the tape to the dressing, gathered up the dressing supplies from the table, assisted the resident with a snack, and without washing and/or sanitizing his/her hands donned new gloves applied the resident's sock, removed gloves and without washing and/or sanitizing his/her hands obtained a ginger ale from the resident's dresser and proceeded to touch multiple items in the room. The nurse then left the room with the resident's dressing supplies, proceeded to put the supplies in a cart Per interview on 10/5/21 at 2:55 PM with the nurse, the surveyor asked what the facility's policy regarding hand hygiene and glove use was, S/He stated that hand hygiene was to be performed after gloves were removed. S/He stated that I "didn't think I needed to sanitize" the "tape was clean"; and further confirmed that S/He did not wash and/or sanitize his/her hands per policy. Per review of the policy "Hand Hygiene" -reviewed 11/15/20, it states "1. Perform Hand Hygiene: 1.1 Before patient care; 1.2 Before an aseptic procedure; 1.3 After any contact with blood or other body fluids, even if gloves are worn; 1.4 After patient care; 1.5 After contact with the patient's environment. Per review of the policy "Wound Dressings: Aseptic"-revised 6/1/21, it states "2. Gather supplies...3. Use personal protective equipment as indicated. 4. Clean over-bed table. 5. Place clean barrier on the over-bed table and place supplies on the barrier ...14. Open dressing (s) without contaminating. Keep the dressing/gauze within the open packet and place it directly on top of the barrier". 2. Per record review, Resident #56 has a diagnosis of "Methicillin Resistant Staphylococcus Aureus (MRSA) infection" that was added to the record on 11/5/2019. The "special instructions" section of Resident #34's chart also states, "MRSA - urine and wound." MRSA is a drug-resistant bacteria that requires extra precautions to prevent its spread to other people.

			It is part of a class of bacteria called MDROs (Multi-Drug Resistant Organisms). Per the record, Resident #56 has a diagnosis of "pressure ulcer of the sacral (lower back) region" and orders to have this wound covered in a dressing, which were entered on 9/24/2020. The record also shows orders for care of a suprapubic catheter (a tube that enters through the lower abdomen into the bladder and drains urine into a bag), such as the order "Provide hygiene care to suprapubic catheter site every shift for hygiene AND as needed for hygiene" entered on 6/6/2021. Per review of Resident #34's care plan, there is a care plan focus of "MDRO: MRSA in urine and wound" entered on 1/6/2020 with the intervention "standard precautions: wear gloves and gown when performing wound care and any care activities when contact with blood, excretions, secretions or body fluid is anticipated." Per review of the facility's MDRO policy, staff providing direct care to a resident with MDRO colonization should use standard precautions for care at the MDRO source/site of infection when the infectious agent (i.e. wound drainage or urine) can be contained. The Centers for Disease Control define standard precautions as: - Use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non-intact skin (e.g., exposed skin that is chapped, abraded, or with dermatitis) or OPIM. - Use of protective clothing to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated. - Use of mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids. Per observation of Resident #34's room on 10/4/2021 at approximately 3:30 PM, there were no signs or indicators in or around the entrance to the room regarding MRSA precautions or what personal protective equipment to use. There were also no gowns stored in or around Resident #34's room.

			Per interview on 10/5/21 at approximately 10:45 AM, the Unit Manager confirmed that gowns should be used for Resident #34's wound and catheter care but that there are no gowns stocked in/near Resident 34's room or anywhere else on the unit. Per interview on 10/6/21 at approximately 11:30 AM, the LPN (licensed practical nurse) assigned to Resident #34 confirmed that they provided catheter care and wound care earlier that morning. They stated they did not wear a gown during either of those tasks and was not aware that gowns were indicated.
2.4	Was the expected sequence described in policy, procedure, written guidelines, or included in staff training?	Yes	If YES, cite source. IC203-hand hygiene IC301-contact precautions Wound dressings MDRO

2.5	Does the expected sequence or process meet regulatory requirements and/or practice standards? Cite references and/or literature reviewed by the team.	Yes	If NO, describe deviation from requirements/standards. Genesis Policies.
2.6	Did human action or inaction appear to contribute to the adverse event?	Yes	If YES, describe the actions and how they contributed. General nervousness with regulator
2.7	Did a defect, malfunction, misuse of, or absence of equipment appear to contribute to the event?	No	
2.8	Was the procedure or activity involved in the event being carried out in the usual location?	Yes	If NO, describe where and why a different location was utilized.
2.9	Was the procedure or activity being carried out by regular staff familiar with the consumer and activity?	Yes	If NO, describe who was carrying out the activity and why regular staff were not involved.
2.10	Were involved staff credentialed/skilled to carry out the tasks expected of them?	Yes	If NO, describe the perceived inadequacy.
2.11	Were staff trained to carry out their respective responsibilities?	Yes	If NO, describe the perceived inadequacy.
2.12	Were staffing levels considered to have been adequate at the time of the incident?	Yes	If NO, describe why.
2.13	Were there other staffing factors identified as responsible for or contributing to the adverse event?	No	If YES, describe those factors.
2.14	Did inaccurate or ambiguous information contribute to or	No	

	cause the adverse event?		
2.15	Did a lack of communication or incomplete communication contribute to or cause the adverse event?	No	
2.16	Did any environmental factors contribute to or cause the adverse event?	No	
2.17	Did any organizational or leadership factors contribute to or cause the adverse event.	No	
2.18	Did any assessment or planning factors contribute to or cause the adverse event?	No	
2.19	What other factors are considered relevant to the adverse event?	Describe:	
2.20	Rank order the factors considered responsible for the adverse event, beginning with the proximate cause, followed by the most important to less important contributory factors. Attach Contributory Factors Diagram, if available.	1. Brand new unit manager, had never been through an annual survey, nerves got the best of her 2. Lack of communication regarding MDROs	
	Was a root cause identified?	Yes	If YES, describe the root cause. As above
3.	**RISK REDUCTION ACTIONS TAKEN** – List the actions that have already been taken to reduce the risk of a future occurrence of the event under consideration. Note the date of implementation.		

Action Taken - Description	Date Implemented
Education to professional staff regarding handwashing during dressing change, gown use in MDRO rooms	11/6/2021

4. PREVENTION STRATEGIES – List from highest priority to lowest priority the recommended actions designed to prevent a future occurrence of the adverse event. Begin with a rank of 1 (highest). For each strategy or action provide an estimated cost, if known, and any additional considerations or recommendations for implementing the strategy (e.g., phase-in, immediate need, triage by risk).

Rank	Strategy	Estimated Cost	Special Considerations
1	Education on MDRO and handwashing during dressing changes	Zero	Licensed staff
2	Audits of dressing changes and MDRO signage	Zero	Licensed staff
3			
4			
5			
6			
7			

5 INCIDENTAL FINDINGS – List and describe any incidental findings that should be carefully reviewed for corrective action.

6. APPROVAL – After review of this summary report, all team members should notify the team leader of either their approval or recommendations for revision. Following all revisions the report should be signed by the team leader prior to submission.

Signature of Team Leader:	Date Signed:

The information contained in this report is confidential and is intended solely to promote safety and reduce consumer risk.

Forward this report to all RCA team members and to the following individuals:

Name	Title	Organization	Address	Email
		Genesis HealthCare		

Infection control audit F880

Today's date	Resident	Dressing change per policy?	MDRO signage appropriate?	Gown usage appropriate	Miscellaneous notes

IC203 Hand Hygiene

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC203 Hand Hygiene
APPLICATION:	Genesis HealthCare Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/20
REVISION DATE:	11/15/20

POLICY

Adherence to hand hygiene practices is maintained by all Center personnel. This includes hand washing with soap and water when hands are visibly soiled and after exposure to known or suspected Clostridioides difficile or infectious diarrhea (i.e., Norovirus) and the use of alcohol based hand rubs for routine decontamination in clinical situations. Per the Centers for Disease Control and Prevention (CDC), when hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for hand hygiene.

Alcohol based hand rubs will be placed near entrances and in common areas.

PURPOSE

To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms.

PROCESS

1. Perform hand hygiene:

    1.1 Before patient care;

    1.2 Before an aseptic procedure;

    1.3 After any contact with blood or other body fluids, even if gloves are worn;

    1.4 After patient care;

    1.5 After contact with the patient's environment.

2. Hand hygiene techniques:

    2.1 To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use towel to turn off faucet.

    2.2 To decontaminate hands with alcohol based rub: Apply product to palm of one hand and rub hands together, covering all surfaces of the hands and fingers until the hands are dry. Follow manufacturer's instructions for amount and application of product.

    2.3 Keep hands and fingernails in good condition, with nails at a recommended length of no more than ¼".

IC301 Contact Precautions

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC301 Contact Precautions
APPLICATION:	Genesis HealthCare Skilled Nursing Centers
EFFECTIVE DATE:	02/15/01
REVIEW DATE:	11/15/20
REVISION DATE:	06/15/19

POLICY

In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient's environment. State regulations will be followed when applicable.

PURPOSE

To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact.

PROCESS

1. Place patient in private room, if possible.
    - 1.1 Patient may cohort with an individual who has the same organism.
    - 1.2 Do **not** place colonized or infected patient with another patient who has:
        - 1.2.1 A different multi-drug resistant organism;
        - 1.2.2 An invasive device such as a port, IV line, trach, or indwelling bladder catheter;
        - 1.2.3 A recent post-operative wound;
        - 1.2.4 Open wound(s) (including pressure injury);
        - 1.2.5 Severe immunosuppression (e.g., cancer, HIV, etc.).
2. Place a "STOP. Please see nurse before entering room." sign on door.
3. Instruct staff, patient and his/her representative, and visitors regarding Precautions and the use of personal protective equipment (PPE).
4. Staff must use barrier precautions when entering the room.
    - 4.1 Wear gown and gloves.
    - 4.2 Wear eye protection if splashing of infectious material is likely.
    - 4.3 Change gloves and gowns during care if gloves/gowns come in direct contact with infectious material.
    - 4.4 Change gown and gloves and perform hand hygiene before providing care to other patient in the room.
    - 4.5 Before exiting room, remove and bag gown and gloves and wash hands upon exiting room.
        - 4.5.1 Remove bagged PPE from room and discard in soiled utility.
        - 4.5.2 Wash hands.
5. Dedicate personal care equipment (e.g., thermometer, blood pressure cuff, stethoscope, etc.) or use disposable equipment when available.
    - 5.1 If use of common equipment is unavoidable, clean and disinfect item before use with another patient.
6. Limit transport of such patients to essential purposes such as diagnostics and therapeutic procedures that cannot be performed in the patient's room. Provide cover/ containment of .infected area when the patient is outside of his/her room. Patients will follow respiratory hygiene/cough etiquette. Staff will assist the patient with hand hygiene as needed.
    - 6.1 Notify the healthcare provider in the receiving area of the impending arrival of the patient and of the precautions necessary to prevent transmission; and

6.2 For patients being transported outside the Center, inform the receiving facility and the medi-van or emergency vehicle personnel in advance about the type of transmission-based precautions being used.

7. Clean and disinfect frequently touched surfaces daily (e.g., doorknobs, bed rails, over-bed table).
8. Once the patient is no longer a risk for transmitting the infection (i.e., duration of the illness and/or can contain secretions), discontinue precautions.

Refer to:

- *Multi-Drug Resistant Organisms (MDROs) procedure*
- *Appendix A: Type and Duration ofPrecautions Recommended for Selected Infections and Conditions*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*
- *In-service: Use of Reusable Plates and Utensils for Patients on Transmission Based Precautions*

Multi-Drug Resistant Organisms (MDROs)

Effective Date: 09/01/04 **Review Date:** 11/15/20 **Revision Date:** 11/15/20

1. Identify presence of MDRO by reviewing culture reports.
2. Notify Infection Preventionist or designee and physician.
3. When caring for a patient who is colonized or infected with an MDRO, Precautions will be followed according to the level of risk for transmission of organisms and per state regulations.

   Standard Precautions will be followed:

   - When giving direct care;
   - When there is a potential for exposure to infected/colonized material; and
   - As long as the source/site of infection/colonization can be contained.

   Contact Precautions will be followed when there is a high risk for transmission, such as patients who are/have:

   - Highly draining wounds, with uncontainable drainage;
   - Tracheostomy with copious or unmanageable respiratory secretions;
   - Urinary or fecal incontinence uncontained by usual methods/products;
   - Infected secretions/excretions that cannot be contained.

4. Implement appropriate infection control Precautions. Refer to *Infectious Disease Management* and *Standard Precautions* or *Contact Precautions* policies.
5. If single-patient rooms are available, assign priority for these rooms to patients who have known or suspected MDRO colonization or infection. Give highest priority to those patients who have conditions that may facilitate transmission, e.g., uncontained secretions or excretions.
6. If single-patient rooms are not available, cohort patients with the same MDRO in the same room or patient care area.
7. When cohorting patients with the same MDRO is not possible, place MDRO patients in rooms with patients who are at low risk for acquisition of MDROs and associated adverse outcomes from infection.
8. Instruct staff, patients, and visitors regarding level of Precautions needed and use of personal protective equipment.
9. Maintain separate line listings for all known patients infected or colonized with MDROs.

   9.1 Do not attempt eradication of MDROs from colonized patients.

10. Routine cultures are not required to move a patient from Contact to Standard Precautions. Patients may be moved on a case by case basis after considering the following:

    10.1 No active infection or draining wounds, OR

    10.2 Patient may still be colonized but risk factors for transmission are no longer present, OR

    10.3 Per state/local Health Department specific Precautions discharge requirements.

11. If individual who has a MDRO receives services from an outside resource (e.g., labs, consultants, etc.), notify outside service staff.
12. If individual who has an MDRO is being transferred:

    12.1 Notify department, receiving facility, ambulance personnel, and accepting physician;

    12.2 Clean and disinfect room and dedicated equipment after transfer.

13. If a MDRO outbreak occurs, all patients colonized or infected with a target MDRO must be placed on Contact Precautions. (Refer to *Outbreak Investigation/Management* policy.)
14. Document:

    14.1 Level of risk for transmission;

    14.2 PPE use required while caring for patient.

Refer to:

- *Infectious Disease Management policy*
- *Hand Hygiene policy*
- *Standard Precautions policy*
- *Contact Precautions policy*
- *Patient Placement in Transmission Based Precautions policy*
- *Discontinuing Transmission Based Precautions policy*
- *Outbreak Investigation/Management policy*
- *Safety and Health Policies and Procedures, Personal Protective Equipment policy*
- *Centers for Disease Control and Prevention (CDC), General Recommendations for Routine Prevention and Control of MDROs in Healthcare Settings*

Wound Dressings: Aseptic

Effective Date: 06/01/96 **Revision Date:** 06/01/21

Review Date:

These policies and procedures are not intended to replace the informed judgment and professional discretion of individual clinicians, nor are they intended to establish the standard of care applicable to the assessment or treatment of any particular condition and the unique needs of each patient.

1. Verify order and review Skin Integrity Report.
2. Gather supplies:
    - 2.1 Approved disinfectant
    - 2.2 Bed protector, if applicable (e.g., clean towel, chux, etc.)
    - 2.3 Clean barrier (plastic bag, towel, etc.)
    - 2.4 Specific type of wound wash/irrigation
    - 2.5 Gloves (two pairs)
    - 2.6 Prepared label with date and initials
    - 2.7 Gauze
    - 2.8 Personal protective equipment, if indicated
    - 2.9 Dressing/Medication/Ointment as ordered
    - 2.10 Plastic bags
3. Use personal protective equipment as indicated.
4. Clean over-bed table
5. Place clean barrier on the over-bed table and place supplies on the barrier.
6. Introduce yourself to the patient and verify patient identification.
7. Explain the procedure and provide privacy.
8. Evaluate pain and treat as indicated.
9. Position the area to be treated.
10. Place a plastic bag for soiled dressing supplies within easy reach.
11. Cleanse hands.
12. If patient has multiple wounds:
    - 12.1 In close proximity: Treat the less contaminated wound first;
    - 12.2 In separate locations: Treat each as a separate procedure.
13. If a break in aseptic technique occurs, stop the procedure, remove gloves, cleanse hands, and apply clean gloves.
14. Open dressing(s) without contaminating. Keep the dressing/gauze within the open packet and place it directly on top of the barrier
15. Prepare medication/ointment, if indicated, by placing on inner sterile package.
16. Expose area to be treated.
    - 16.1 Apply clean gloves. If applicable, place bed protector under or adjacent to wound site and remove the soiled dressing.
    - 16.2 Discard dressing and gloves according to infection control policy.
17. Cleanse hands.

18. Apply gloves.
19. Cleanse or irrigate wound as ordered.
20. Wipe any excess fluid from the surrounding skin using a dry, gauze wipe.
21. If indicated, measure the wound (refer to Wound Measuring procedure).

    21.1 If gloves become contaminated, remove gloves, cleanse hands, and apply clean gloves.

22. Using swab or applicator, apply treatment medication as ordered.
23. Apply and secure clean dressing.
24. Remove gloves and discard according to infection control procedure.
25. Apply prepared label.
26. Cleanse hands.
27. Assist patient to a comfortable position with call light within easy reach.
28. Unused supplies are discarded according to infection control procedure or remain dedicated to the patient and stored appropriately.

    28.1 Opened dressings are discarded per manufacturer's instructions.

29. Reusable dressing care equipment (e.g., bandage scissors) must be cleaned and disinfected according to manufacturer's instructions if shared between patients.
30. Document:

    30.1 Patient's response to treatment:

        30.1.1 Pain, if present,

        30.1.2 Effect of pain control;

    30.2 Wound evaluation on Skin Integrity Report (Forms On Demand #GHC-692R); with unanticipated wound decline and/or or if weekly assessment is due;

    30.3 Treatment on Treatment Administration Record (TAR).

Refer to:

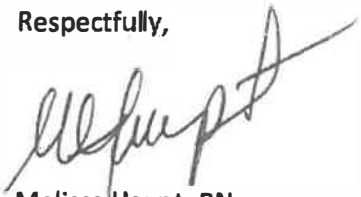
- *Skin Integrity Management policy*
- *Wound Dressings policy*
- *Treatments policy*
- *Wound Measuring procedure*
- *Skin Integrity Care Delivery Process*
- *CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008*

October 21, 2021

To Whom it May Concern:

This letter is to inform you that the elements of the plan of correction will be completed by November 6, 2021. Please consider this the required attestation statement of completion. Please let us know if you have any questions.

Respectfully,



Melissa Haupt, RN

Administrator

St. Albans Health & Center