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

October 5, 2021

Mr. William Kowalewski, Administrator
Woodridge Nursing Home
142 Woodridge Drive
Barre, VT 05641-0550

Dear Mr. Kowalewski:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 8, 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
	475045	A. BUILDING _____ B. WING _____	R-C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	**142 WOODRIDGE DRIVE BARRE, VT 05641**

(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
{F 000}	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite follow-up investigation on 9/8/21, and the following regulatory violations were identified.	{F 000}		
{F 658} SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to meet professional standards of practice regarding wound care for 2 of 3 sampled residents (Residents #1 and #3). The findings include the following: 1. Per record review for Resident #1, the resident was admitted to the facility with chronic leg ulcers. Physician orders state "dressing changes to bilateral lower extremities must be done with patient in bed for infection control reasons. Please give pre-med Dilaudid after patient is in bed". Bilateral Lower Extremity wound care: Cleanse surrounding intact skin with soap and water, cleanse open wounds on shins, feet, ankles in between toes with VASHE wound cleanser and gauze. Pat dry. Apply xeroform to all open areas, cover heavily draining areas with Opitlock dressings, cover remainder of legs/feet with ABD pads. Secure all bandages with Kerlix. Place silvercell in between toes and secure with small Kerlix.	{F 658}	F658 Meet Professional Standards 1. Resident # 1 and #3 are receiving wound care and dressing changes according to the professional standards of practice regarding wound care. 2. Since all Residents have the potential to be affected by this deficient practice, Woodridge will be applying the same measures as applied to Residents #1 and #3 identified above - to all Residents for whom wound care is relevant. 3. Education previously provided to meet professional standards of practice has been repeated and reinforced to include wound care and dressing change protocols, hand hygiene and infection prevention and control. This education continues to be provided during Orientation of new licensed Nurses. This education is further presented and reinforced at staff huddles, Teams education sessions and written documents. Wound care and dressing change standards of practice power point protocols are maintained in educational binders located for reference at each nurse's station. 4. Random audits of wound care and dressing changes performed by licensed nurses will be conducted as follows: (1) daily for two weeks then (2) three times per week for two weeks and then (3) once per week for another two weeks. Evidence of staff education and audits will be presented to the QAPI committee to assure compliance 5. Director of Nursing is the responsible party. Completion date October 11, 2021 and ongoing audits.	

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

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William Kowalewski 10/1/21

{F 658}		{F 658}		
	Continued From page 1 Arrangements had been made to observe the dressing change on 9/8/21 at approximately 1:30 PM to Resident #1's bilateral legs. The Registered Nurse (RN) who is a wound care specialist was to complete a dressing change. Resident #1's room was observed as disorganized and cluttered, it contained personal belongings on all surfaces in the room, including the bed. Four urinals were observed in the residents' room, an empty urinal was hanging on the resident's walker, another empty urinal was on the bedside table. Two additional urinals were observed sitting on the windowsill both contained a yellow substance that appeared to be urine in them. One was approximately ¼ full and the other was 1/3 full. The resident's room contained a three-tiered cart with the necessary supplies required for the treatment. This cart contained multiple packages of materials needed to complete the wound care. There was a bottle of medicated solution called "Dakin's" which is known to be used for wound cleaning on the cart. Nurse confirmed at this time that all cleaning solutions are kept on cart in residents' room, along with all the other supplies needed for the dressing change. The RN did indicate that the "Dakin's" was recently discontinued, and s/he removed the bottle from the cart into the trash receptacle. Additionally, there were 2 bottles of "VASHE" wound cleaning solution that were currently part of the wound care routine sitting on the cart. The following wound care was observed: RN put gloves on and cleaned bedside table for dressing change with a disinfectant wipe, then		**TAG F 658 POC Accepted on 10/5/21 by L. Lovell/P. Cota**	

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{F 658}		{F 658}		
	Continued From page 2 placed a protective/disposable pad/mat on table. Resident #1 at this time asked the RN to hand them their phone, the RN picked up the phone from a table in the room and handed the phone back to the resident and continued with the dressing change without changing gloves or sanitizing his/her hands. The RN then opened blue dressing pads, opened sterile gauze, 4 rolls, multiple Xeroform type dressings, s/he took a kidney basin from the three-tiered cart that contained all the residents' dressings supplies and poured "VASHE" wound cleansing solution into the kidney basin. The kidney basin was not disinfected prior to use. The RN opened multiple packages of gauze and then placed them into the solution in kidney basin. The RN then continued to open multiple packages of a variety of different dressings/gauze pads during the prep. The RN opened trash receptacle with gloved hands multiple times, with no hand sanitizing or changing gloves between opening of the dressing/gauze and opening of the trash receptacle. The RN also used scissor from the three-tiered cart to open multiple dressings, scissors were not observed to be cleaned or disinfected with anything prior to using them on packages containing the dressing materials. The RN then removed gloves, did not hand sanitize, then prepared tape and placed multiple pieces of tape hanging from the bedside table. Resident at this time, asked RN to change the fan setting from 1 to 2, the RN adjusted the fan setting and continued with the dressing change without changing gloves or sanitizing his/her hands. Upon entrance to the room the Resident was observed sitting in a recliner and self-transferred			

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{F 658}		{F 658}		
	Continued From page 3 to bed with walker. The resident sat on the edge of the bed with their feet on the floor. The RN confirmed to the nurse surveyor at this time that this is where they were going to complete the dressing change. The RN put gloves on and placed an approximate two foot by two foot protective/disposable pad/mat under residents' bare feet. The RN asked the resident to raise his/her feet and place his/her feet on the protective/disposable mat. The RN then removed gloves and exited room to put on gown. Upon return, the RN put gloves on and proceeded to remove the old dressing from the left leg. As the RN removed the left leg dressings materials s/he placed them on the protective/disposable mat that was on the floor beneath the resident's bare feet. Once all left leg dressing was removed the RN discarded the old dressings into a disposable bag/trash receptacle that was close to the nurse. The RN lifted lid on the trash receptacle with a gloved hand. The RN then removed the gloves and gave Resident #1 a pen and paper and asked him/her to document wound measurements as told s/he spoke the measurements aloud. The RN then applied gloves and kneeled on floor to measure wounds. A disposable measuring tape was used to measure wounds. The RN placed this tool onto the resident's left leg anterior shin area to measure, then placed tool on the floor on protective/disposable pad/mat next to both the resident's foot and the RN's own shoes which were standing on this protective/disposable floor mat. The RN did this throughout wound measurements.			

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{F 658}		{F 658}		
	Continued From page 4 The RN did not change gloves and proceeded to cleanse the left leg with the wound cleansing solution and gauze that was put into the kidney basin. The RN did not change gloves or sanitize her/his hands. Once the RN completed washing the left leg, she/he placed kidney basin on top of trash and then took it into bathroom. Upon return s/he changed gloves and hand sanitized. The RN then opened Silvergel gauze that is to be placed in between Resident #1 toes and opened each package, then took scissors and cut each gauze in half without disinfecting or cleaning the scissors prior to use. The scissors had previously been used in opening initial gauze/dressings and had never been cleaned or sanitized prior to the initial use. With same gloves and not sanitizing, the RN proceeded to place Xeroform dressing on left leg, the RN took these packages and placed them on the protective/disposable floor mat next to both the resident's foot and the RN's own shoes which were standing on the protective/disposable floor mat and proceeded to put them on left leg. Per facility policy of Woodridge Wound Care states the following under section C: "Cleansing and Dressing of Skin Impairment(s) Wounds: 5. Perform hand hygiene and don gloves (PPE if required) prior to the beginning of dressing change. 6. Remove and discard old dressing. 7. Remove and discard dirty gloves. 8. Perform hand hygiene and don clean gloves prior to accessing clean supplies. 10. Perform wound treatment as ordered. 12. Discard wound supplies in trash receptacle.			

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{F 658}		{F 658}		
	Continued From page 5 13. Remove gloves and perform hand hygiene." Reference: Lippincott Manual of Nursing Practice (9th & 10th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. 2. Per record review, Resident #3 has diagnoses of pressure ulcer of the sacral (lower back) region, pressure ulcer of the right buttock, and pressure ulcer of left heel. There is additional evidence in the chart showing active wounds on the left lateral (outer) knee, left hallux (big toe), scrotum, and right ischium (upper buttock). Wound care and dressing changes for the left heel, left lateral knee, right ischium, scrotal area, and sacrum were observed from approximately 10:45 AM to 11:30 AM on 9/8/2021. The care was provided by two wound care nurses. During observation there were approximately 17 observed opportunities for hand hygiene (sanitizing and gloving of the hands). It was observed by this surveyor that WN1 (wound nurse 1) did not wash their hands or use hand sanitizer prior to donning new gloves after removing a dressing from the left lateral knee. WN1 also did not wash their hands or use hand sanitizer prior to donning new gloves after opening packages of new dressings for the sacral and ischial wounds. During observation of wound care/dressing changes, WN2 (wound nurse 2) was observed by this surveyor to have used a gloved hand to touch the skin immediately surrounding the wound bed of the sacral wound, in an effort to assess its depth, following cleansing of the wound. This			

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{F 658}		{F 658}		
	Continued From page 6 gloved hand had been used to hold Resident #3 in place on their side and had touched the resident's back, buttocks, sheets, and bed frame (not considered clean surfaces). No hand hygiene or glove changes were performed prior to touching the skin surrounding the wound. Throughout the wound care/dressing change observation, the pen used to document wound measurements and label new dressings was touched both before clean activities and after activities that resulted in contaminated hands. This resulted in the pen becoming contaminated and then contaminating clean gloves prior to activities requiring clean gloves. A glove was placed over the pen with the writing end protruding out of the glove prior to wound care. Following measurement of the left lateral knee wound (which required touching the wound and surrounding skin), WN1 documented their measurements by touching the pen with the same gloved hands that touched the wound. This was prior to wound cleansing. Hand hygiene and donning of new gloves was performed after using the pen. WN1 then used the pen to date a clean dressing and used the same gloved hands to apply Iodosorb (an antimicrobial gel) to a clean swab for application to the wound bed. Later in the process, WN2 used the pen to document measurements taken on the sacral and ischial wounds with the same gloves used to take the measurements prior to cleansing the wound. Then, WN2 used the pen to date a clean dressing for the sacral wound, apply Santyl (wound ointment) to the sacral wound, and apply the clean dressing, all with the same pair of gloves. Per interview at 11:45 on 9/8/21, this surveyor shared their observations with WN1 and WN2.			

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{F 658}	Continued From page 7 Though they could not specifically remember what happened from their perspective during the exact moments discussed, they did not dispute this surveyor's observations. WN1 stated, "thank you for making me aware."	{F 658}		
{F 880} SS=E	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 persons in the facility;	{F 880}	F 880 Infection Prevention and Control 1. Residents #1 and 3 have received wound care and dressing changes as per professional standards of infection control and prevention and adhered to by licensed nurses. 2. Since all Residents have the potential to be affected by this deficient practice, Woodridge will be applying the same measures applied to Residents #1 and #3 identified above to all Residents for whom wound care is relevant. 3. Staff who provide wound care and/or dressing changes will receive education and reinforcement on the importance of and need for proper infection prevention and control techniques when performing wound care. This includes field preparation, proper use and storage of supplies, the following orders properly, separation of “dirty” and “clean” parts of dressing changes, glove use and hand hygiene. Education, which has been reviewed for accuracy, will include rationale and the importance of being diligent with infection prevention and control strategies. This will be done via staff huddles, and Teams meetings, group eMails and the Education binder with Power Point found at the nursing stations. Newly hired appropriate staff will receive the same education during orientation and reinforced during Staff huddles, Teams meetings, group eMails and the Education binder found at the nursing stations. 4. Random audits of wound care and dressing changes performed by licensed nurses to assure adherence to infection prevention and control standards of care will be conducted as follows: (1) daily for two weeks then (2) three times per week for two weeks and then (3) once per week for another two weeks . Evidence of staff education and audits will be presented to the QAPI committee to assure compliance. 5. Director of Nursing is the responsible party. Completion date 10/11/2021 and ongoing audits.	

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{F 880}		{F 880}		

Continued From page 8

(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 record review the facility failed to adhere to infection prevention and control program standards when providing wound care for 2 of 3 sampled

TAG F 880 POC Accepted on 10/5/21 by L. Lovell/P. Cota

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{F 880}		{F 880}		

Continued From page 9 residents (Residents #1 and #3). The findings include the following:

1. Per record review for Resident #1, the resident was admitted to the facility with chronic leg ulcers. Physician orders state "dressing changes to bilateral lower extremities must be done with patient in bed for infection control reasons. Please give pre-med Dilaudid after patient is in bed". Bilateral Lower Extremity wound care: Cleanse surrounding intact skin with soap and water, cleanse open wounds on shins, feet, ankles in between toes with VASHE wound cleanser and gauze. Pat dry. Apply xeroform to all open areas, cover heavily draining areas with Opitlock dressings, cover remainder of legs/feet with ABD pads. Secure all bandages with Kerlix. Place silvercell in between toes and secure with small Kerlix.

Arrangements had been made to observe the dressing change on 9/8/21 at approximately 1:30 PM to Resident #1's bilateral legs. The Registered Nurse (RN) who is a wound care specialist was to complete a dressing change.

Resident #1's room was observed as disorganized and cluttered, it contained personal belongings on all surfaces in the room, including the bed. Four urinals were observed in the residents' room, an empty urinal was hanging on the resident's walker, another empty urinal was on the bedside table. Two additional urinals were observed sitting on the windowsill both contained a yellow substance that appeared to be urine in them. One was approximately ¼ full and the other was 1/3 full.

The resident's room contained a three-tiered cart

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{F 880}	Continued From page 10 with the necessary supplies required for the treatment. This cart contained multiple packages of materials needed to complete the wound care. There was a bottle of medicated solution called "Dakin's" which is known to be used for wound cleaning on the cart. Nurse confirmed at this time that all cleaning solutions are kept on cart in residents' room, along with all the other supplies needed for the dressing change. The RN did indicate that the "Dakin's" was recently discontinued, and s/he removed the bottle from the cart into the trash receptacle. Additionally, there were 2 bottles of "VASHE" wound cleaning solution that were currently part of the wound care routine sitting on the cart. The following wound care was observed: RN put gloves on and cleaned bedside table for dressing change with a disinfectant wipe, then placed a protective/disposable pad/mat on table. Resident #1 at this time asked the RN to hand them their phone, the RN picked up the phone from a table in the room and handed the phone back to the resident and continued with the dressing change without changing gloves or sanitizing his/her hands. The RN then opened blue dressing pads, opened sterile gauze, 4 rolls, multiple Xeroform type dressings, s/he took a kidney basin from the three-tiered cart that contained all the residents' dressings supplies and poured "VASHE" wound cleansing solution into the kidney basin. The kidney basin was not disinfected prior to use. The RN opened multiple packages of gauze and then placed them into the solution in kidney basin. The RN then continued to open multiple	{F 880}		

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{F 880}		{F 880}		

Continued From page 11 packages of a variety of different dressings/gauze pads during the prep. The RN opened trash receptacle with gloved hands multiple times, with no hand sanitizing or changing gloves between opening of the dressing/gauze and opening of the trash receptacle. The RN also used scissor from the three-tiered cart to open multiple dressings, scissors were not observed to be cleaned or disinfected with anything prior to using them on packages containing the dressing materials. The RN then removed gloves, did not hand sanitize, then prepared tape and placed multiple pieces of tape hanging from the bedside table. Resident at this time, asked RN to change the fan setting from 1 to 2, the RN adjusted the fan setting and continued with the dressing change without changing gloves or sanitizing his/her hands.

Upon entrance to the room the Resident was observed sitting in a recliner and self-transferred to bed with walker. The resident sat on the edge of the bed with their feet on the floor. The RN confirmed to the nurse surveyor at this time that this is where they were going to complete the dressing change.

The RN put gloves on and placed an approximate two foot by two foot protective/disposable pad/mat under residents' bare feet. The RN asked the resident to raise his/her feet and place his/her feet on the protective/disposable mat.

The RN then removed gloves and exited room to put on gown. Upon return, the RN put gloves on and proceeded to remove the old dressing from the left leg. As the RN removed the left leg dressings materials s/he placed them on the protective/disposable mat that was on the floor beneath the resident's bare feet. Once all left leg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475045	A. BUILDING _____ B. WING _____	R-C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE NURSING HOME	142 WOODRIDGE DRIVE BARRE, VT 05641

(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
{F 880}	Continued From page 12 dressing was removed the RN discarded the old dressings into a disposable bag/trash receptacle that was close to the nurse. The RN lifted lid on the trash receptacle with a gloved hand. The RN then removed the gloves and gave Resident #1 a pen and paper and asked him/her to document wound measurements as told s/he spoke the measurements aloud. The RN then applied gloves and kneeled on floor to measure wounds. A disposable measuring tape was used to measure wounds. The RN placed this tool onto the resident's left leg anterior shin area to measure, then placed tool on the floor on protective/disposable pad/mat next to both the resident's foot and the RN's own shoes which were standing on this protective/disposable floor mat. The RN did this throughout wound measurements. The RN did not change gloves and proceeded to cleanse the left leg with the wound cleansing solution and gauze that was put into the kidney basin. The RN did not change gloves or sanitize her/his hands. Once the RN completed washing the left leg, she/he placed kidney basin on top of trash and then took it into bathroom. Upon return s/he changed gloves and hand sanitized. The RN then opened Silvergel gauze that is to be placed in between Resident #1 toes and opened each package, then took scissors and cut each gauze in half without disinfecting or cleaning the scissors prior to use. The scissors had previously been used in opening initial gauze/dressings and had never been cleaned or sanitized prior to the initial use. With same gloves and not sanitizing, the RN	{F 880}		

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{F 880}		{F 880}		

Continued From page 13 proceeded to place Xeroform dressing on left leg, the RN took these packages and placed them on the protective/disposable floor mat next to both the resident's foot and the RN's own shoes which were standing on the protective/disposable floor mat and proceeded to put them on left leg.

Per facility policy of Woodridge Wound Care states the following under section C:
"Cleansing and Dressing of Skin Impairment(s) Wounds:
5. Perform hand hygiene and don gloves (PPE if required) prior to the beginning of dressing change.
6. Remove and discard old dressing.
7. Remove and discard dirty gloves.
8. Perform hand hygiene and don clean gloves prior to accessing clean supplies.
10. Perform wound treatment as ordered.
12. Discard wound supplies in trash receptacle.
13. Remove gloves and perform hand hygiene."

Reference:
Lippincott Manual of Nursing Practice (9th & 10th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

2. Per record review, Resident #3 has diagnoses of pressure ulcer of the sacral (lower back) region, pressure ulcer of the right buttock, and pressure ulcer of left heel. There is additional evidence in the chart showing active wounds on the left lateral (outer) knee, left hallux (big toe), scrotum, and right ischium (upper buttock).

Wound care and dressing changes for the left heel, left lateral knee, right ischium, scrotal area, and sacrum were observed from approximately 10:45 AM to 11:30 AM on 9/8/2021. The care was

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{F 880}		{F 880}		

Continued From page 14 provided by two wound care nurses. During observation there were approximately 17 observed opportunities for hand hygiene (sanitizing and gloving of the hands). It was observed by this surveyor that WN1 (wound nurse 1) did not wash their hands or use hand sanitizer prior to donning new gloves after removing a dressing from the left lateral knee. WN1 also did not wash their hands or use hand sanitizer prior to donning new gloves after opening packages of new dressings for the sacral and ischial wounds.

During observation of wound care/dressing changes, WN2 (wound nurse 2) was observed by this surveyor to have used a gloved hand to touch the skin immediately surrounding the wound bed of the sacral wound, in an effort to assess its depth, following cleansing of the wound. This gloved hand had been used to hold Resident #3 in place on their side and had touched the resident's back, buttocks, sheets, and bed frame (not considered clean surfaces). No hand hygiene or glove changes were performed prior to touching the skin surrounding the wound.

Throughout the wound care/dressing change observation, the pen used to document wound measurements and label new dressings was touched both before clean activities and after activities that resulted in contaminated hands. This resulted in the pen becoming contaminated and then contaminating clean gloves prior to activities requiring clean gloves. A glove was placed over the pen with the writing end protruding out of the glove prior to wound care. Following measurement of the left lateral knee wound (which required touching the wound and surrounding skin), WN1 documented their

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{F 880}	Continued From page 15 measurements by touching the pen with the same gloved hands that touched the wound. This was prior to wound cleansing. Hand hygiene and donning of new gloves was performed after using the pen. WN1 then used the pen to date a clean dressing and used the same gloved hands to apply Iodosorb (an antimicrobial gel) to a clean swab for application to the wound bed. Later in the process, WN2 used the pen to document measurements taken on the sacral and ischial wounds with the same gloves used to take the measurements prior to cleansing the wound. Then, WN2 used the pen to date a clean dressing for the sacral wound, apply Santyl (wound ointment) to the sacral wound, and apply the clean dressing, all with the same pair of gloves. Per interview at 11:45 on 9/8/21, this surveyor shared their observations with WN1 and WN2. Though they could not specifically remember what happened from their perspective during the exact moments discussed, they did not dispute this surveyor's observations. WN1 stated, "thank you for making me aware."	{F 880}		