STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and physician interview, the facility failed to clarify wound care orders, provide wound care on a scheduled basis, and document when wound care was provided as ordered for 1 (Resident #1) of 3 residents reviewed for professional standards. Findings included: Resident #1 was admitted to the facility from the hospital on [DATE] with multiple [DIAGNOSES REDACTED]. [DIAGNOSES REDACTED] is a condition that causes tissue to become necrotic, or dead cells, leading to ulcers and chronic wounds, commonly on the leg. Resident #1 was discharged from the facility against medical advice on 8/7/20. Documentation in the admission minimum data set assessment dated [DATE] coded Resident #1 as cognitively intact with surgical wounds and a wound infection. Documentation on the care plan, dated as initiated on 7/14/20, revealed a problem area for impaired skin integrity relative to a surgical wound to the leg. One of the interventions was to, See current physician orders for current treatment as ordered by physician. Documentation in the discharge instructions from the hospital for wound care dated 7/14/20 revealed Resident #1 was diagnosed with [REDACTED]. Resident #1 received surgical debridement at the hospital after which the vascular surgeons recommended antibiotics and a wound vac (vacuum assisted care) with a dressing change to the wound vac scheduled every Monday, Wednesday and Friday. The discharge instructions further revealed Resident #1 had three wounds with specific instructions for care. Wound #1 was measured as 8.3 centimeters in length, 3.5 centimeters in width and 1.7 centimeters in depth. Wound #2 was measured as 1.5 centimeters in length and 2 centimeters in width with tunneling connecting in to wound #1. Wound #1 and Wound #2 were to receive negative pressure wound therapy (NPWT) or wound vac every Monday, Wednesday, and Friday. Resident #1 had a third wound that measured 12.5 centimeters in length, 13 centimeters in width and 0.2 centimeters in depth. Wound #3 had specific instructions for care on the discharge summary but it did not give a frequency for the wound care. There was no documentation in the electronic medical record to confirm the hospital discharge orders were implemented after the resident was admitted to the facility as indicated by the care plan. Documentation in the physician orders for Resident #1 revealed the resident did not have any physician orders for wound care from admission 7/14/20 to 7/23/20. There was no documentation on the treatment administration record for wound care for Resident #1 from 7/14/20 to 8/3/20. An interview with the facility Administrator on 8/18/20 at 12:00 PM revealed that it was a standing order, from the physician for Resident #1, to have the facility follow the discharge instructions from the hospital upon admission to the facility. Documentation in the wound management detail report revealed the three wounds on the right leg of Resident #1 were assessed upon admission on 7/14/20 and again on 7/23/20, although both assessments were documented as entered into the medical record on 7/23/20. The first wound was assessed on 7/14/20 to be 8.3 centimeters in length and 3.5 centimeters in width. The first wound was noted as being treated with NPWT and had tunneling that connected to the second wound. The assessment information on 7/14/20 and 7/23/20 were identical for wound #1. The second wound on the right leg was assessed on 7/14/20 as being 1.5 centimeters in length, 2 centimeters in width, and receiving NPWT. The second wound was assessed on 7/23/20 as increased in width to 2 centimeters. The third wound on the right leg was assessed on 7/14/20 and 7/23/20 as being 12.5 centimeters in length and 13 centimeters in width. An interview was conducted with Nurse #1 on 8/12/20 at 4:30 PM and again on 8/18/20 at 11:17 AM for clarification. Nurse #1 completed the admission paperwork for Resident #1 on 7/14/20. Nurse #1 stated that she was a floor nurse and she did not put orders into the electronic medical record upon admission for Resident #1. Nurse #1 revealed that it was her impression that either the former interim agency Director of Nursing (Nurse #2) or the staff development coordinator (Nurse #3) would have put the wound care orders into the electronic medical record for Resident #1. Nurse #1 stated that Resident #1 did not arrive at the facility with the wound vac on. Nurse #1 stated that she was told by Nurse #2 that in a phone conversation with the hospital, the facility was to not provide wound care until clarification of the orders was obtained from the wound clinic. Nurse #1 revealed that Nurse #2 told her she would call the wound clinic the next day to obtain this clarification from the wound clinic. An interview was conducted with Nurse #2, the former interim agency Director of Nursing, on 8/12/20 at 3:12 PM. Nurse #2 stated that when she arrived at the facility there was no time for orientation and no time for her to learn the electronic medical record system used by the facility. She stated that when the resident was first admitted she spoke with vascular surgery at the hospital and clarified the wound care orders. Nurse #2 further explained that she used the treatment orders that were on the hospital discharge instructions and a video of wound care that she viewed on the phone of Resident #1. Nurse #2 explained she provided wound care for Resident #1 a couple of times with the assistance of Nurse #4, because she did not know how to document treatments or put in treatment orders into the electronic medical record and Nurse #4 did. Nurse #2 did not recall the specific dates or the specific treatment orders she followed when she provided wound care for Resident #1. Documentation in the nursing notes for Resident #1 dated 7/16/20 revealed Nurse #2 consulted a physician's assistant at vascular surgery at the hospital and then provided a wound dressing change to the right leg. The nursing note did not document the specific wound care treatment Nurse #2 provided on 7/16/20. This was the only documentation in the progress notes indicating Nurse #2 provided wound care to Resident #1. An interview was conducted with Nurse #3, the staff development coordinator, on 8/12/20 at 2:33 PM. Nurse #3 revealed that she helped with the admission paperwork for Resident #1 but did not put in the wound care orders. Nurse #3 stated that she did not provide any wound care for Resident #1 and that Nurse #2 and Nurse #4 performed the wound care in the facility at the time of the admission of Resident #1. An interview was conducted with Nurse #4 on 8/12/20 at 11:35 AM. Nurse #4 stated that when Resident #1 was first admitted , she helped Nurse #2 with the wound care for the resident. Nurse #4 did not recall what the treatment orders were, what treatment orders were followed, when the wound care was provided, or where it was documented for Resident #1 when she was first admitted . Documentation in the treatment administration history for Resident #1 revealed a treatment order was added on 7/23/20. Documentation of the treatment order stated, Apply [DEVICE] dressing to RUE (right upper extremity) wound only. Apply calcium alginate and abd (army battle dressing) pad to mid wound below right knee but above lower open wound, cover with Kerlix and tape. This order had a frequency of, as needed. There was no documentation on the treatment administration history that this treatment order was provided from 7/23/20 to the discontinuation of the order on 8/4/20. An interview was conducted with Nurse #5 on 8/12/20 at 12:59 PM. Nurse #5 was the nurse who put the treatment order for Resident #1 into the electronic medical record on 7/23/20. Nurse #5 stated that the former DON, Nurse #2, handed her a piece of paper and requested that she put the treatment order into the electronic medical record. Nurse #5 stated that she put the order into the electronic medical record exactly as it was stated on the paper. Nurse #5 stated that the only time she ever was involved with the wound care for Resident #1 was when Nurse #2 requested she assist her in providing wound care on 7/23/20. Nurse #5 stated that Resident #1 was complaining that the wound vac was beeping all night. Nurse #5 noted that the wound vac did not have a good seal and she observed Nurse #2 perform wound care for the wound that required the wound vac on 7/23/20. Documentation in

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the census data and the facility map revealed Resident #1 was moved to the Covid-19 positive unit within the facility on 7/28/20. Nurse #6 was interviewed on 8/12/20 at 10:40 AM. Nurse #6 revealed that on 8/3/20 Resident #1 requested that her wound care be provided because there was drainage coming from the wound vac and the evening nurse had not changed the wound vac the night before. Nurse #6 stated that she observed that Resident #1 had a lot of drainage coming out of the wound and the wound was beefy red. Nurse #6 stated that the resident was on the phone and showing her family the wound care as Nurse #6 was changing the dressing on the leg of Resident #1. Nurse #6 stated that after she completed the wound care for Resident #1, a family member of Resident #1 called her and requested Resident #1 be sent to the emergency room for evaluation of her wounds. Nurse #6 stated that Resident #1 was sent to the emergency room and returned with no new orders. An interview was conducted with a family member of Resident #1 on 8/18/20 at 10:30 AM. The family member stated that Resident #1 called her at midnight on 8/3/20 because she was very upset. Resident #1 told her family member that wound care had not been provided to her leg since she was moved to the Covid-19 unit of the facility. The family member stated that she called the facility on 8/3/20 and spoke with the nurse on the Covid-19 unit, who told her she would check Resident #1 but that she did not have any orders for treatment to the wounds. The family member stated that in a video chat with her mother she observed the wound. The family member stated that she was very concerned because the major wound that required daily wound changes was bleeding profusely and was really red. The family member stated she called the nurse again and requested that she be sent to the emergency room to have the wound evaluated. An interview was conducted with the facility nurse consultant, Nurse #7, on 8/12/20 at 11:00 AM. The nurse consultant revealed Resident #1 tested positive for Covid-19 and was moved to the isolation unit for Covid positive residents on 7/28/20. Nurse #7 stated that she became aware of concerns with the wound care for Resident #1 on 8/3/20 when a family member of Resident #1 lodged a grievance regarding Resident #1 not receiving wound care over the weekend. Nurse #7 stated that she noted in the treatment orders dated as 7/23/20 there was a transcription error and that the wound care needed to be separated out into three separate orders. Nurse #7 stated that she called the resident's physician for clarification of the orders and the orders were changed on 8/4/20. Nurse #7 stated that it was the physician's intention for the three wound areas to have three separate orders. Nurse #7 stated that the grievance was resolved with the clarification of the orders. Documentation on the physician orders revealed an order dated 8/4/20 that stated, Apply wound vac dressing to RUE wound only Mon- Wed- Fri. The frequency was to be once daily every Monday, Wednesday and Friday. Documentation on the treatment administration history revealed this order was provided for Resident #1 only on one occasion, on Wednesday, 8/5/20. Documentation on the physician orders revealed an order dated 8/4/20 that stated, Apply calcium alginate and abd pad to mid wound below the right knee. The frequency for this order was once daily. Documentation on the treatment administration history revealed this order was provided for Resident #1 on 8/4/20, 8/5/20, and 8/6/20. Documentation on the physician orders revealed an order dated 8/4/20 that stated, Apply calcium alginate to wound to lower right leg, cover with kerlix and tape daily until healed. The frequency for this order was once daily. Documentation on the treatment administration history revealed this order was performed for Resident #1 on 8/4/20, 8/5/20, and 8/6/20. An interview was conducted with the physician for Resident #1 on 8/12/20 at 11:29 AM. The physician stated that he did not recall the request for clarification on the wound care orders and did not have any information to provide regarding the wound care or orders for Resident #1. The physician did not recall seeing the resident for a telehealth visit while she was in the facility. An interview was conducted with the current interim agency Director of Nursing (DON) on 8/12/20 at 4:00 PM. The DON stated she asked Resident #1 if she could look at her wounds prior to her leaving the facility against medical advice on 8/7/20. The DON stated that Resident #1 refused to have the wound observed, so an assessment prior to her discharge was not completed. The DON stated that when the resident arrived, the facility was going to have a vascular surgeon assess the resident and review the orders but, that did not occur. The DON indicated that Resident #1 declined to have a telehealth visit with the facility physician during her stay.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff (stakeholder) interviews and record review the facility failed to implement infection control audits to ensure in-servicing was provided to staff regarding the correct use of PPE (Personal Protective Equipment) and that education provided was understood and implemented by staff caring for residents potentially exposed to COVID 19 or positive with the COVID 19 virus for 6 of 8 staff (Nurse Aide #'s 4, 5, 6 and 7; Nurse #'s 5 and 8); and failed to recognize that a staff member continued to work with residents throughout the facility during a week that she felt ill with an infection for 1 of 1 staff members (Nurse Aide #5), and failed to prevent cross contamination by taking unused dressing supplies from a general population resident room and placing them in the treatment cart for 1 of 1 resident's (Resident #12) treatment change observed. Findings included: 1. Facility documentation reviewed included the following: Stakeholder and Resident Tracking for COVID -19 Excel Spreadsheet, Stakeholder Screening Log for the month of July 2020, Stakeholder schedules for the month of July 2020, COVID-19 Stakeholder Attestation, Infection Control Policies and Practices, and Coronavirus (COVID-19)-Pandemic Plan Information. Review of the July staffing schedules revealed 8 different staff members had worked on the COVID unit between 7/24/20 and 7/26/20. Facility in-services provided to staff were reviewed. The facility provided evidence of five in-services that were provided to staff beginning on 4/15/2020 to 8/13/20 and one computer training that was completed by staff. The in-services included: 1) 04/15/20: Isolation for COVID 19-Stakeholder provided training for proper PPE-droplet isolation (COVID 19), donning and removal with return demonstrations. One of the eight staff members who worked on the COVID unit on 7/24, 25 or 26, 2020 signed this attendance sheet. 2) 05/21/20: Special Droplet Precautions and PPE-Review policy for special droplet precautions/contact precautions in addition to standard precautions: Review attached sheet regarding required PPE and hand hygiene. Reviewed with special attention to COVID 19 requirements. Stakeholder reviewed sequence for putting on PPE and how to safely removal of PPE with return demonstrations of each with each stakeholder. None of the eight staff members who worked on the COVID unit on 7/24, 25 or 26, 2020 signed this attendance sheet. 3) 06/8/20: Handwashing Competency: Handwashing surveillance-monitored stakeholders performing hand washing according to policy and procedure attached. Signature sheet not provided. 4) 07/23/20: COVID 19 Isolation Unit: Stakeholders will follow policy for COVID 19-isolation droplet precautions-proper procedure for donning and doffing PPE and hand washing/hand sanitizing. Observed donning and removal of PPE and hand washing. None of the staff who worked on the COVID unit on 7/24, 25 or 26, 2020 signed this attendance sheet. 5) 07/27/20: Surgical mask and face shields/N95 PPE: Stakeholders will follow guidelines and wear surgical mask and face shield/goggles when in the facility. Face shields will be stored in the office or proper storage area as assigned with individual name on label. Cleanse daily with alcohol/and bleach wipes. N95 discard according to policy. PPE donning and doffing - stakeholder will follow procedures according to guidelines CDC (Centers for Disease Control) and facility policy-observed with return demonstration hand washing and hand sanitizing according to policy will be followed by all stakeholders. Signature sheet was not provided. 6) Computer competency course: hand washing. Two of eight staff members who worked on the COVID unit on 7/24, 25 or 26, 2020 completed this course. In an interview conducted on 08/13/20 at 11:50 AM with the facility Infection Control Preventionist/Staff Development Coordinator, she stated on 07/24/20 when the facility received their first COVID 19 positive resident the doors at room [ROOM NUMBER] were closed and a temporary door was installed at room [ROOM NUMBER] to make the hallway a COVID unit. She said signage was put up for enhances droplet precautions on the hallway doors and the doors of the infected residents. PPE was placed outside resident rooms, hand washing was performed in the rooms and dirty linens and PPE were left in the rooms. She relayed the facility was having staffing problems because thirteen (13) staff members had tested positive for COVID and were at home quarantining and twenty-seven (27) residents were quarantined on the COVID unit. In an additional interview conducted on 08/18/20 at 12:28 PM she stated she had not conducted documented audits to ensure staff were using PPE correctly and performing hand washing as instructed. She commented at the beginning of the pandemic she had conducted undocumented observations on day shift and had done on-the-spot in-servicing if she noticed staff were not following infection control protocol. She said she quit doing the observations after a while because staff complained to her they felt like they were being drilled and knew to wash their hands for 20 seconds. She added that she could only comment about day shift because she only worked day shift and observations on the other two shifts had not been done. She confirmed the in-service documentation and attendance sign in sheets she provided were all she had. A telephone interview was conducted with Nurse Aide #4 on 08/15/20 at 1:00 PM. She stated she cared for COVID positive residents at the facility on 07/24/20. She said she put on a hair cover, N95 mask, gown, face shield and shoe coverings before entering the room. She discarded all her PPE in the room before leaving except for her face shield and mask which she discarded in a barrel outside the room. She commented she washed her hands before entering the room and before leaving. An interview was conducted with Nurse Aide #5 on 08/15/20 at 1:20 PM via telephone. She stated she cared for residents who were known to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) COVID positive on 07/25/20. She said she wore a mask, face shield, gown, gloves, shoes coverings and a head cover every time she entered a COVID positive room. She commented when leaving the room she discarded her PPE in the room, washed her hands and opened the door with a clean paper towel. After leaving the room she put on clean gloves, took off her N95 mask, put it in a plastic bag and stored it in the empty drawer on the bottom of the PPE supply cart outside the room. In an additional interview on 08/24/20 at 12:38 PM she confirmed she had worked for a week prior to testing positive for COVID with what she believed to be a sinus infection. She stated her symptoms included a headache, fatigue and sinus pressure which she attributed to having a history of recurrent sinus infections, migraine headaches and fatigue caused by the lack of iron in her blood. She stated she answered the questions on the screening each time she worked with no because she did not have a fever, had not been out of the country, had not been around anyone active with COVID, was not short of breath, and had not been to New York, New Jersey or Connecticut. She commented she felt none of the screening criteria fit her. She stated she would have never known she had [MEDICAL CONDITION] if the facility wide testing had not been done. (Review of the facility Stakeholder Screening Log revealed fatigue and headache were two of the symptoms listed.) On 7/23, 24, 25, 27 and 28, 2020 Nurse Aide #5 answered no to all signs or symptoms on the screening logs. She stated she had not told anyone at the facility that she had not been feeling well. Records revealed on 06/04/20, Nurse Aide #5 had signed a COVID-19 Stakeholder Attestation stating she would not come to work if she had signs or symptoms of a respiratory infection. An interview was conducted with Nurse Aide #6 on 08/15/20 via telephone at 2:30 PM. She stated she cared for two COVID positive residents on her assignment on 07/26/20. She stated when she came out of an isolation room she discarded her PPE equipment in a red barrel (by the door of the room but not in the hallway) and washed her hands. She said she had her own N95 masks and threw each mask away every time she exited an isolation room. She corrected herself and said she only had one N95 mask that she sprayed with a disinfectant between residents. In a telephone interview on 08/17/20 at 9:08 AM with Nurse #8 she stated she worked on the COVID unit on 07/24/20 and 07/25/20 and cared for two COVID positive residents on isolation. She commented she wore a head cap, gown, N95 mask and shoe coverings in isolation rooms. She administered medications and conducted assessments while in the rooms. After leaving each room she discarded her PPE and put on new PPE before caring for the next resident. She stated there were no barrels in the resident rooms and PPE was taken off after exiting the rooms. She commented she had two isolation rooms so she provided care for those residents either at the beginning of her shift or at the end to avoid spreading [MEDICAL CONDITION] to other residents on the unit. An interview was conducted with Nurse #5 on 08/18/20 at 8:55 AM via telephone. She stated she helped set up the COVID unit on 07/24/20 and cared for the COVID positive residents. She said she wore a head cover, an N95 mask, gown, gloves, shield and foot covers. She stated she took off her gown before leaving the room and took off the rest of her PPE after exiting the room and walking to the shower room on the unit. In the shower room she took off the rest of her PPE and sprayed her N95 with a disinfectant. A telephone interview was conducted on 08/19/20 at 1:30 PM with the facility Medical Director. He stated the facility had contacted him 3 or 4 times during the pandemic. He commented he had exchanges with the Administrator and had advised her to try to limit or stop new admissions until the facility got a handle on their situation. He knew a special COVID unit had been set up. He commented it made sense for PPE worn while caring for a COVID positive resident be removed before leaving the isolated room. In a telephone interview conducted with the facility Administrator on 08/13/20 at 1:10 PM she stated she had been in Texas when the first COVID unit was created and did not return to the facility until 07/29/20. In a subsequent telephone interview on 08/24/20 at 3:06 PM she stated she had been preaching to staff throughout the pandemic to stay home if they felt even the slightest bit sick or to call the facility if they were unsure about calling off. She said if a staff member called with even the simplest symptom or even if the staff member thought the ill feeling might be an allergic reaction they were told to stay home and get tested for COVID. She felt it was common sense for staff to call off if they thought they had a sinus infection and would not expect a staff member to work with residents if they suspected they had an infection. She said the screening tool worked well when staff answered the questions honestly. 2. On 08/24/20 at 4:30 PM, a left foot dressing change for resident #12 was observed to be conducted by the Director of Nursing (DON). At the completion of the dressing change, the DON placed the roll of tape on the bed as she wrapped Resident #12's foot with gauze. Then the DON used two pieces of tape to secure the dressing. The DON then picked up the tape, a unopened package of dressing from the bedside table and 3 rolls of unopened gauze wrap from the top of the resident's chest of drawers with her gloves still on. The DON went outside the resident's room and set the tape and packaged dressing on the top of the treatment cart, opened the treatment cart drawer and put the 3 packages of rolled gauze in the drawer and shut the drawer. An interview was conducted immediately following on 8/24/20 at 5:04 PM. The DON stated she brought the unused supplies out of the resident's room to put them away in the treatment cart because she did not want to let things lay around. The DON stated she assumed everything was dirty on the treatment cart because the only clean part would be what was inside of the package. The DON further stated only the sterile inside of the package should be of concern because that was the part that went to the residents wound. The DON stated she wouldn't normally take items out of a one resident room to another resident room. On 08/25/20 at 8:33 AM an interview was conducted with the Administrator who stated it was her expectation that nurses use professional standards of practice when handling dressing supplies.