STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675111	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE GARDENS REHABILITATION AND HEALTHCARE	**2135 N DENTON DR CARROLLTON, TX 75006**

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

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to review and revise the person-centered care planning for two (Residents # 408 and # 405) of five residents reviewed for care plans. The facility failed to address Resident #408's need for care related to Intravenous Antibiotic Therapy, Oxygen Therapy, and Pneumonia Diagnosis. The facility failed to address wound care to Resident 405's right great toe. This failure could place residents at risk of not receiving the care and services ordered by the physician and a decline in health status. Findings included: 1. Record review of Resident #408' s Demographic Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Record review of MDS Assessment, dated 01/24/20, reflected no PICC line, Intravenous Antibiotic Therapy, and Oxygen Therapy. Record review of Resident #408's Order Summary Report, dated 03/12/20, reflected a physician's orders [REDACTED]. Record review of Resident #408's Order Summary Report, dated 03/12/20, reflected a physician's orders [REDACTED]. On 0[DATE] at 11:22 a.m., MDS Coordinator provided Resident 408's care plans. Review of care plans reflected no care plan to address Resident 408's need for care of PICC Line for Intravenous Antibiotic Therapy, Oxygen Therapy and Pneumonia. On 03/12/20 at 10:45 a.m., DON provided a new set of undated care plans to address care of Resident # 408's PICC Line for Intraveous Antibiotic Therapy, Oxygen Therapy and Pneumonia. 2. Record review of Resident #405's medical record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #405's Order Recap Record, dated 03/01/20 - 03/31/20, reflected a physician's orders [REDACTED]. Record review of MDS Assessment, dated 01/14/20, reflected no wound to Resident 408's right great toe. On 0[DATE] at 11:22 a.m., MDS Coordinator provided Resident 405's care plans. Review of care plans reflected no care plan to address Resident 405's need for wound care to the right great toe. On 03/12/20 at 10:45 a.m., DON provided a new set of care plans for Resident # 405. Review of new set of care plans reflected no care plan to address Resident # 405's need for wound care to the right great toe. Interview with the DON on 03/11/20, at 1:30 p.m., revealed the MDS nurse initiated comprehensive care plans after the MDS Assessment. The DON, ADON and charge nurses completed the residents' acute care plans. The DON stated she did not know Resident 408's care plans were not reviewed and revised due to PICC Line insertion physician's orders [REDACTED]. The DON acknowledge Resident # 408 received physician's orders [REDACTED].< 94% on [DATE]. The DON stated her expectation was that the residents' care plans are reviewed and revised when there is a significant change of condition that changes the residents' needs. Record Review of the facility's Policy/Procedure for Care and Treatment, dated August 2017, reflected, It is the policy of the facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in comprehensive assessment. The Interdisciplinary team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.
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 observation, interview, and record review, the facility failed to provide services that met professional standards for two (Resident # 405) of five residents reviewed for standards of care. The facility failed to provide wound care treatment to Resident # 405's right great toe and right knee. This failure could place residents at risk of not receiving the care and services ordered by the physician and a decline in health status. 1. Record Review of Resident # 405's medical record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 405's quarterly Minimum Data set ((MDS) dated [DATE] revealed the resident was 2-person extensive assist with bed mobility; 2-person total dependence with transfers; and 1-person extensive assistance with toileting. The resident required limited assistance of one staff for her bed mobility, transfers, and supervision with personal hygiene. The MDS assessment reflected the resident had an unstageable pressure ulcer. The MDS assessment reflected Resident # 405 received [MED] injections daily since admission. Record review of Resident # 405's current Care Plan for right knee abrasion, no initiation date, reflected: 1. Monitor/document location, size and treatment of [REDACTED]. to MD. 2. Follow facility protocols for treatment of [REDACTED]. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Record Review of Resident # 405's Order Recap Record, dated 03/01/20 - 03/31/20 reflected: 1. physician's orders [REDACTED]. 2. physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Omission date 03/09/2020. Observation on 0[DATE] at 9:45 a.m. revealed Resident # 405 's dressing to right great toe was dated 03/06/20. Observation on 0[DATE] at 3:13 p.m. revealed Resident # 405 's dressing to right great toe was dated 03/06/20. Observation on 03/11/20 at 10:45 a.m. revealed Resident # 405's dressing to right great toe was dated 03/06/20. Observation on 0[DATE] at 9:45 a.m. revealed Resident # 405 's dressing right knee dated 03/06/20. Observation on 0[DATE] at 3:13 p.m. revealed Resident # 405 's dressing right knee dated 03/06/20. Observation on 03/11/20 at 10:45 a.m. revealed Resident # 405 's dressing right knee dated 03/06/20. An interview with the DON on 03/11/20, at 1:30 p.m., revealed she did not know why Resident # 405's wound care was not provided 03/09/20. The DON stated her expectation was that the residents received their treatments as ordered by the physician. The DON stated the ADON and treatment nurse reported to her daily treatments completed and she reviewed the reports of the treatment administration record documentation daily to verify the treatment was done to prevent recurrences.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services that met professional standards for one (Resident # 408) of five residents reviewed for standards of care. 1. The facility filed to administer Resident # 408's [MED]gen therapy in a safe manner. This failure could place residents at risk of not receiving the care and services ordered by the physician and a decline in health status. Findings included: 1. Record review of Resident # 408' s medical record reflected he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Record review of Resident # 408's quarterly Minimum Data set ((MDS) dated [DATE] revealed the resident was not receiving [MED]gen therapy or intravenous medications. The resident required limited assistance of one staff for his bed mobility, transfers, and supervision with personal hygiene. The MDS also reflected the resident had a [MEDICAL CONDITION] and occasionally incontinent. Record review reflected a physiciab's order, dated [DATE]20, Oxygen at 2 liters/minute via nasal cannula as needed for SOB, Respiratory Distress, Cyanosis, Labored Breathing. Record review of MDS Assessment, dated 01/14/20, reflected no [MED]gen therapy. Observation revealed Resident # 408 received Oxygen at 7.5 liters a minute via nasal cannula on 0[DATE] at 1:58 p.m. Observation revealed Resident # 408 received Oxygen at 7.5 liters a minute via nasal cannula on 0[DATE] at 3:12 p.m. Observation revealed Resident # 408 received Oxygen at 7.5 liters a minute via nasal cannula on 03/11/20 at 1:52 pm. An interview with the DON on 03/11/20, at 1:30 p.m., revealed the DON

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

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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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) stated Resident # 408 possibly turned his [MED]gen up to 7.5 liters. The DON stated Resident # 408 had no history changing the [MED]gen concentrator settings. After viewing the [MED]gen concentrator settings with the DON, she stated she was not doubting the settings were set on 7.5 liters. The DON stated, if the resident had a [DIAGNOSES REDACTED]. An interview with the DON on 03/12/20, at 10:00 a.m., revealed the DON stated she completed medication error reports for Resident # 408 receiving of 7.5 liters/minute [MED]gen via nasal cannula on 0[DATE] and 03/11/20. The DON stated the physician gave an order for [REDACTED]. Review of Policy/Procedure for Oxygen Therapy, revised November 2007, reflected The staff/charge nurse will report any [MED]gen safety violations observed and observations of anything unusual.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who used [MEDICAL CONDITION] drugs were re-evaluated for the use of the drug for two (Residents #8 and Resident #52) of four residents reviewed for antipsychotic medications. 1. The facility failed to ensure Resident #8, who had a [DIAGNOSES REDACTED]. 2. The facility failed to ensure Resident #52, who had a [DIAGNOSES REDACTED]. These failures could affect the residents who received antipsychotic medications by placing them at risk for possible adverse side effects, adverse consequences, and decreased quality of life. Findings included: 1. Review of Resident #8's Minimum Data Sheet (MDS) assessment dated [DATE] revealed he was a 70-year- old male admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. He was assessed with [REDACTED]. He was taking antipsychotic medication without known indications. The MDS assessment reflected he received an antipsychotic and a GDR had not been attempted and had not been documented as clinically contraindicated by the physician. Additionally, there was no evidence of a [DIAGNOSES REDACTED].#8's care plan dated 11/15/17 reflected he used [MEDICAL CONDITION] medications related to behavioral management including pacing, wandering, violence/aggression towards Staff/others. Review of Resident #8's March 2020 physician orders reflected he was prescribed [MEDICATION NAME] 25 mg tablet by mouth at bedtime for acute [MEDICAL CONDITION]. Review of Resident #8's MAR indicated [REDACTED]. There was no record or documentation of Resident #8's behavioral monitoring and concerns. Review of Resident #8's Pharmacy Monthly Medication Reviews and requests for GDR indicated none had been made for [MEDICATION NAME] since it was initiated on 12/10/20 Observation of Resident #8 on 03/11/20 at 10:05 a.m. revealed he was appropriately dressed. He was standing in the nurse's station and wandered around the halls. He ambulated by himself with unsteady gait. Resident #8 did not respond to specific commands due to advanced dementia. However, he was receptive and appeared to want to engage with staff. There was no evidence of behavioral issues observed. Interview with CNA E on 03/12/20 at 10:23 a.m, revealed she was the aide responsible for Resident #8 during the morning shift. She explained Resident #8 was a pleasant and nice man with no behavioral problems. She said the resident ambulated without assistance and wandered around the different halls. He had an alarm attached to him for elopement precaution and prevention. She stated Resident #8 did not have psychotic issues. She said the resident was compliant with care. Interview with LVN F on 03/12/20 at 10:29 a.m. revealed she was the charge nurse responsible for Resident #8 during the first shift. She said Resident #8 did not have behavioral issues that she was aware of. She explained the resident ambulated by himself and walked around the facility almost all day. She had not seen resident resisting care. 2. Review of Resident #52's MDS assessment dated [DATE] revealed he was an 80-year- old male admitted to the facility on [DATE]. Some of his [DIAGNOSES REDACTED]. He was assessed with [REDACTED]. He was taking antipsychotic medication without known indications. The MDS assessment reflected he received an antipsychotic and a GDR had not been attempted and had not been documented as clinically contraindicated by the physician. Additionally, there was no evidence of a [DIAGNOSES REDACTED]. Review of Resident #52's care plan undated reflected he used [MEDICAL CONDITION] medication for physical behavior related to dementia including agitation/swinging or punching staff during care. Review of Resident #52's March 2020 physician orders reflected he was prescribed [MEDICATION NAME] 25 mg tablet by mouth one time a day for depression. Review of Resident #52's MAR indicated [REDACTED]. There was no record or documentation of Resident #52's behavioral monitoring and concerns. Review of Resident #52's Pharmacy Monthly Medication Reviews and requests for GDR indicated none had been made for [MEDICATION NAME] since it was initiated on 12/10/20. Observation of Resident #52 on 03/11/20 at 11:15 a.m. revealed he was lying in bed. Resident #52 was clean and dressed. He required extensive assistance with most activity of daily livings (ADLs). Resident #52 was bed-bound. He was eager to engage with the surveyor with a military salute. There was no evidence of behavioral issues observed Interview with CNA E on 03/12/20 at 10:26 a.m. revealed she was the aide responsible for Resident #8 during the morning shift. She explained Resident #52 was a veteran and compliant with needed care and services. She was not aware of reported issues with the resident psychologically or otherwise. Interview with LVN F on 03/12/20 at 10:32 a.m. revealed she was the charge nurse responsible for Resident #52 during the first shift. She said Resident #52 was a quiet and calm resident. She stated the resident did not resist or fight while providing care to him. Resident #52 was close to family and an ideal resident. Interview on 03/12/20 at 2:20 p.m., the DON was asked to provide information of behavioral, psychological, Physician evaluation regarding Resident #8 and Resident #52's use of antipsychotics medication. She said she did have information on the evaluation of the residents for antipsychotic medication. The DON explained the facility missed it by not doing the necessary evaluation. She said the facility had a pharmacy consultant that visited every month and made the needed evaluation, The DON stated it was common for the hospitals to use antipsychotic as sleeping medication. However, the facility made the right adjustment on the medications once the residents arrived in the facility. In these cases, she said they missed it on Resident #8 and Resident #52. She stated, when asked the possible side effects of taking antipsychotic medication, the DON explained the resident could get extrapyramidal syndrome (EPS) which was a movement disorder due to long time use of antipsychotic medications. The FDA Black Box Warning Alert for [MEDICATION NAME] reflected, Increased Mortality in Patients with Dementia-Related [MEDICAL CONDITION] - FDA has determined that patients with dementia-related [MEDICAL CONDITION] treated with antipsychotic medications are at an increased risk of death. Based on currently available data, [MEDICATION NAME] is not approved for this indication (http://www.fda.gov, obtained 09/0[DATE]8). Review of the facility policy and procedure on unnecessary medication revised May 2007 reflected, It is the policy of this facility that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: 1) In excessive dose (including duplicate therapy); or 2) For excessive duration; or 3) Without adequate monitoring; or 4) Without adequate indications for its use; or 5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6) Any combination of the reasons above Some of the procedures includes a) Resident receives only those medications, in doses and for duration clinically indicated to treat the resident's assessed condition(s) . b) Monitor and track progress towards the therapeutic goal(s) and detect the emergence or presence of any clinically significant adverse consequences I order for them to be minimized.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure food stored in the dry storage was used or thrown away by the use-by date. 2.The facility failed to ensure food items in the dry storage, the refrigerator, and the freezer were dated, labeled, and sealed appropriately. These failures could affect the residents by placing them at risk for food-borne illness and food contamination. Findings included: Observation of the facility's dry storage on [DATE] at 8:55 a.m. revealed the following items: A 23-ounce bottle of chicken seasoning, not dated, not sealed/lid open; A 23-ounce bottle of ground ginger, not dated, not sealed/lid open; A 23-ounce bottle of ground cumin, not dated, not sealed/lid open; A 23-ounce bottle of chili powder, not dated, not sealed/lid open; A 23-ounce bottle of ground pepper, not dated, not sealed/lid open; A 23-ounce bottle of cayenne pepper, not dated, not sealed/lid open; A 23-ounce

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) bottle of cloves, not dated, not sealed/lid open; A 23-ounce bottle of steak seasoning, not dated, not sealed/lid open; A 23-ounce bottle of grill mates veg-seasoning, not dated, not sealed/lid open; A 23-ounce bottle of ground ginger, not sealed/lid open; A 23-ounce bottle of ground thyme, not sealed/lid open; A 23-ounce bottle of oregano, not sealed/lid open; A 23-ounce bottle of paprika, not sealed/lid open; A 23-ounce bottle of dried cilantro, not sealed/lid open; A 5-pound container of peanut butter, expired [DATE]; A 6-pound carton of rainbow decorettes, not sealed with a hole in the top, not dated; A 5-pound bag of cocoa, not sealed, expired [DATE]; Four 16-ounce bags of chips not sealed properly; top rolled down; Three 1-gallon jugs of salad dressing, not dated; Three large plastic bins of cereal, not labeled, not dated; Five 6-pound cans of tomato paste, not dated; Six 6-pound cans of marinara sauce, not dated; Four bags of hamburger buns, expired [DATE]; One bag of hamburger buns, not sealed properly, expired [DATE]; One bag of hamburger buns, not sealed properly, expired [DATE]; and One bag of hamburger buns, not sealed properly, expired [DATE], with mold. Observation of the facility's refrigerator on [DATE] at 9:55 a.m. revealed the following items: Several cheese slices wrapped in plastic wrap with a use by date of [DATE]; Several cheese slices wrapped in plastic wrap with a use by date of [DATE]; A large bag of sandwich meat, not labeled with a use by date of [DATE]; A five-pound bag of shredded mozzarella cheese, not sealed properly, expired [DATE]; A box of bell peppers, two on top rotting; and A box of celery turning brown. Observation of the facility's freezer on [DATE] at 10:25 a.m. revealed eight beef patties in a large bag not sealed/exposed to air, with freezer burn. During an interview with the Dietary Manager on [DATE] at 10:13 a.m., she stated that food items should be labeled/dated and sealed in either dry storage or in the freezer, and that prepared items in the refrigerator should have a date to indicate when they should be used by/expired. The Dietary Manager stated she went through all food items about every three months and throws out expired food items. The Dietary Manager stated items that were sealed with paper binder clips were an appropriate way to seal food items, however the food items that were sealed with paper binder clips were not completely sealed and pests would be able to obtain entry to food items. Review of the facility's Food Storage policy, revised [DATE], reflected, .2. All packaged food, canned foods, or food items stored shall be kept clean and dry at all times. Review of the facility's Storage of Food Leftovers policy, revised [DATE], reflected, Procedures: 1. Leftovers shall be stored in impervious containers which can be properly sanitized for each use.2. Leftover containers shall be labeled, indicating the name of the product and the date the product was originally prepared.4. Refrigerated leftovers will be used within forty-eight hours of the original date.6. Items such as ketchup, peanut butter, etc are to be dated when they are opened and may be stored up to one month if they are kept in the original container. The Food and Drug Administration Food Code dated 2017 reflected, ,[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food XXX,[DATE].11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of communicable diseases and infection for one (Resident #401) of four residents observed for infection control. LVN A failed to perform hand hygiene during a wound care procedure Resident #401 . This failure could place residents at risk for contracting wound infections, cross contamination [MEDICAL CONDITION]. Findings included: Review of Resident #401's face sheet, dated 03/19/20, reflected Resident #401 was a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with [REDACTED]. Review of Resident #401's Care Plan, undated, reflected he had moisture associated skin damage to the right and left buttocks. Resident #401's care plan goal reflected right, and left buttock shearing would decrease in size by review date. No review date documented. Review of Resident #401's Surgical Note, dated 03/09/20, reflected wound to right buttocks 5.8cm x 2.9cm x .7cm; wound 2 to right buttocks 6.8cm x 2.8cm x UTD (wound edge necrotic); left buttock wound 5.0cm x 2.9cm x .7cm. Surgical Notes reflected there was an indication of tissue degradation which will need continuing administration and may need future debridement. Surgical Note reflects wounds etiology moisture associated skin damage. Observation of wound care for Resident #401 B on 0[DATE] at 10:05 A.M., revealed LVN A, LVN B, and the ADON entered Resident #401's room and performed hand hygiene. LVN A identified the supplies needed to perform wound care treatment. LVN A placed wax paper with Dakin's solution 0.25%, Triad [MEDICATION NAME] Wound Dressing cream, absorbent dressing and red biohazard bag at the foot of Resident # 401's bed. Resident positioned on his right side. LVN A removed her dirty gloves; sanitized her hands; and donned clean gloves. LVN A removed the dressing from Resident #401's left trochanteric area and left sacral area. LVN A cleansed the left trochanteric wound with Dakin's solution 0.25%. Then, LVN A removed her dirty gloves; donned a clean pair of gloves without performing hand hygiene; applied cream with an applicator to the left trochanteric wound bed; and covered with absorbent dressing. LVN A removed her gloves and sanitized her hands. LVN A donned clean gloves; cleansed wound to Resident # 401's left sacral area with Dakin's 0.25%; without performing hand hygiene. LVN A applied cream with an applicator to sacral wound bed; and covered with absorbent dressing. LVN A, LVN B, and the ADON repositioned the resident on his left side. LVN A, LVN B, and the ADON repositioned washed their hands and donned clean gloves. LVN A removed the dressing from Resident # 401's right trochanteric wound site; cleansed with Dakin's solution 0.25%; removed dirty gloves; and without performing hand hygiene donned clean gloves. Then, LVN A applied cream with an applicator to the right trochanteric wound bed and covered with absorbent dressing. LVN A removed her gloves; applied hand sanitizer; donned clean gloves; cleansed right sacral area with Dakin's solution 0.25%; and covered with absorbent dressing. LVN A tied the biohazard bag and removed it from the foot of the bed. LVN A, LVN B, and the ADON repositioned Resident # 401 to the supine position. Interview with LVN A on 0[DATE], at 11:00 A.M., revealed she forgot to perform hand hygiene during the wound care procedure. LVN A stated the number of wound sites was a factor in her forgetting to perform hand hygiene during the wound care procedure. LVN A stated hand hygiene should be performed before, after and during the wound care procedure when changing from dirty to clean. LVN A stated she did not perform Resident # 401's wound care routinely; she came from a sister facility to perform wound care. Interview with the ADON on 0[DATE], at 11:40 A.M. revealed she expected the nurses to change gloves and perform hand hygiene prior to, during and after wound care to prevent infection and cross contamination. The ADON stated poor hygiene could cause wound infection and poor resident outcomes. Interview with the DON on 0[DATE], at 11:15 A.M. revealed she expected the staff to follow the infection control policy, including changing gloves and performing hand hygiene prior to, during and after wound care to prevent infection. The DON stated poor hygiene could cause wound infections,[MEDICAL CONDITION] and worsening of the wound. Review of the facility's Policy and Procedure Dressings, Clean revision date May 2007 reflected: 1. Identify resident and explain reason for procedure. 2. Screen and drape resident for maximum privacy. 3. Place plastic bag near foot of bed to receive soiled dressing. 4. Wash hands and apply gloves. 5. Open dressing pack. 6. Pour prescribed solution onto gauze to be used for cleaning. 7. Remove soiled dressing and discard in plastic bag. 8. Remove old adhesive with adhesive remover, taking care not to get solution into wound. 9. Wash hands and apply clean gloves. 10. Cleanse wound with prescribed solution if ordered. 11. Apply prescribed medication if ordered. 12. Apply dressings and secure with tape. 13. Assist resident to comfortable position. 14. Place call light within reach and instruct resident to call for assistance, if needed. 15. Wash hands. Review of the facility's Policy and Procedure Hand Washing, dated May 2007 reflected: 1. It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. 2. Waterless hand washing products are not to be used for skin care treatments or administration of eye drops.