STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. BUILDING ______ B. WING ______	C 02/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703

(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 Complaint # 13264 was substantiated (all or in part) with deficiencies cited at F309 and F314.	F 000		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #13264 was substantiated (all or in part) with these findings. Based on observation, interview and record review the facility failed to ensure wound care was provided for 1 (Resident #1), wound care was provided in a manner to reduce the risk for infections for 3 (Resident #1, #2 and #3) and assessments of wounds were documented for 1 (Resident # 3) of 6 (Resident #1, #2, #3, #4, #5 and #6) case mix residents with orders for wound care. These failed practices had the potential to affect 12 residents with orders for wound care/dressing changes according to the Administrator on 2/6/08. The findings are: 1. Resident #1 had diagnoses of Diabetes Mellitus, Respiratory Methicillin Resistant Staphylococcus Aureus and left buttock wound. The Initial Minimum Data Set (MDS) dated 1/2/08 documented the resident was independent in cognitive skills for daily decision making and had a Stage IV pressure ulcer.	F 309		

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 309	Continued From page 1 a. The Wound Record dated 1/23/08 documented the resident had a Stage IV surgical wound on the left mid buttocks measuring 0.4 centimeters by 0.4 centimeters with a depth of 5.4 centimeters. b. A Physician's Order dated 2/5/08 documented, "Resume previous order for tx (treatment): [Left] buttocks Stage IV. Cleanse with N.S. (normal saline). Pack with iodosorb glazed packing strip. Cover with Abd (abdominal) pad and secure [with] large DuoDerm. [Change] Q (every) day." c. On 2/5/08 at 1:40 p.m., the Treatment Nurse provided wound care. The Treatment Nurse opened a bottle of sterile packing strips and opened a tube of iodosorb. Then holding the packing strip, which touched against the iodosorb tube, the Treatment Nurse applied iodosorb ointment to the packing strip. The Treatment Nurse used a Q-tip to pack the iodosorb coated packing strip into the wound. The resident jerked away from the nurse when she started packing, saying "Oh, Oh!" The Treatment Nurse filled the wound with the iodosorb coated packing strip then removed scissors from her pocket and cut the packing strip placing one end into the wound and the other end into the bottle. d. On 2/6/08 at 10:20 a.m. Licensed Practical Nurse (LPN) #3, the LPN assigned to hall on which resident resided, was asked if the resident had a pain medication ordered. The LPN stated "No, my other residents who get wound treatments do and I give it 30 minutes or so before treatments but he's never had anything ordered for pain. Does he need something before treatments?"	F 309		

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F 309	Continued From page 2 e. On 2/6/08 at 11:45 a.m., the Treatment Nurse was asked where the tube of iodosorb came from. The Treatment Nurse stated, "It was a stock tube out of the treatment cart." The Treatment Nurse was asked if the packing strip was clean if it rubbed/touched the outside of the tube of iodosorb. The Treatment Nurse stated, "No." The Treatment Nurse was asked what did you do with the scissors that you removed from your pocket. The Treatment Nurse stated, "Cut packing, contaminated it, put part in the resident and part in the bottle of packing strips." The Treatment Nurse was asked what's going to happen to the bottle of packing strips. The Treatment Nurse stated, "Throw away opened ones, they are contaminated from scissors." 2. Resident #3 had diagnoses of Repair of Abdominal Aortic Aneurysm and Statis Ulcers. The MDS dated 1/22/08 documented the resident had modified independence in cognitive skills for daily decision making, had two Stage II stasis ulcers and surgical wounds. a. The Wound Record dated 1/22/08 documented a stasis ulcer on the right outer ankle measuring 0.4 x 0.3 x 0.1 (length, width and depth in centimeters). b. A Physician's Order dated 2/1/08 documented, "[Right] ext (external) ankle stasis. Clean [with] N.S. (normal saline). Apply Poly-mem & secure [with] Mepitac. [Change] QOD (every other day) and PRN (as needed). [Left] ext ankle. Cover with Biatain for prevention and secure with Mepitac. [Change] QOD. Burn area to [upper] abd (abdomen). Cover with Polymem & secure with Mepitac. [Change] QOD. ..." There was no	F 309		

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F 309	Continued From page 3 documentation on a Wound Record or the Nurse's Notes regarding the burn area, other than the initial assessment dated 1/10/08. c. The Wound Record dated 2/4/08 documented a stasis ulcer on the right interior ankle measuring 0.8 x 1.2 centimeters in size with no depth. d. The Wound Record dated 2/4/08 documented a stasis ulcer on the left outer ankle as a Stage I measuring 0.6 by 0.8 centimeters in size. e. A Physician's Order dated 2/5/08 documented, "[Right] interior ankle stasis. Cleanse [with] N.S. Apply poly-mem & secure with Mepitac. [Change] QOD. DC (Discontinue) Mepitac - use paper tape [with] all tx (treatments)." f. On 2/5/08 at 10:40 a.m., the Treatment Nurse failed to set up a clean field for supplies used for treatments to the ankles and upper abdominal area. The Treatment Nurse initially set a stack of three 4 by 4s on the over bed table and used the last 4 x 4 in the stack to clean the right outer ankle area with the contaminated 4 x 4. During wound treatments the Treatment Nurse repeatedly used scissors from her uniform pocket to cut squares of PolyMem that were applied over the right outer ankle and right upper abdominal area. The Treatment Nurse used scissors removed from her pocket to cut Biatain that was placed over the left outer ankle area. The Treatment Nurse also placed gloves removed from the box in the bathroom in her left pocket using then later during the wound treatment. h. On 2/6/08 at 11:45 a.m., the Treatment Nurse was asked if she was taught to set up a clean field. The Treatment Nurse stated, "I was never	F 309		

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F 309	Continued From page 4 taught to do that." The Treatment Nurse was asked the initial stack of 4 x 4's that where placed on the over bed table, should the last one in the stack have been used. The Treatment Nurse stated, "No, because you don't know what was on the table - it contaminated the wound." The Treatment Nurse was asked what was in her uniform top pockets. The Treatment Nurse stated, "Scissors, keys, pens, treatment stuff." The Treatment Nurse was asked if her pockets were a clean field. The Treatment Nurse stated, "No. I cut bandages with scissors in my pocket - so if not in a clean field it does no good." The Treatment Nurse was asked if there should be documentation of the upper abdominal area burn area. The Treatment Nurses stated, "Yes." The Treatment Nurse was asked if it was documented anywhere. The Treatment Nurse stated, "No." The Treatment Nurse was asked if her pockets were a clean field for gloves used during treatments. The Treatment Nurse stated, "No, I contaminated those too didn't I." 3. Resident # 2 had diagnoses of Rotator Cuff Repair and Paraplegia. The Medicare 5 Day MDS documented the resident was independent in cognitive skills for daily decision making and had a surgical wound. a. A Physician's Order dated 1/24/08 documented, "Ortho (Orthopedics): Orders to go with patient to rehab. ... Daily dressing changes to right shoulder. ..." b. On 2/4/08 at 1:30 p.m., the dressing on the resident's right shoulder was dated 2/2/08. c. On 2/4/08 at 3:00 p.m., there was no treatment administration record (TAR) for this resident in	F 309		

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F 309	Continued From page 5 the treatment book. d. On 2/5/08 at 9:55 a.m., the dressing on the resident's right shoulder was dated 2/2/08. The resident was asked how often the dressing was changed. The resident stated, "About every other day when I take a bath - got bath last on Saturday (2/2/08) or was it Sunday." e. On 2/5/08 at 10:05 a.m., the Treatment Nurse started treatments on E hall, the hall on which the resident resided. At 10:40 a.m., the treatment nurse had not provided wound care for the resident . The Treatment nurse was asked if she was done with treatments on E hall except for 2 residents who were out of their room. The Treatment Nurse stated, "Yes." There was no TAR for the resident in the treatment book. f. On 2/5/08 at 2:50 p.m., the Treatment Nurse was asked if she was doing daily dressing changes for the resident. The Treatment Nurse stated, "No, I didn't know he had an order until now." g. On 2/5/08 at 3:30 p.m., Licensed Practical Nurse (LPN) #1, who signed the admission orders on 1/24/08, was asked who took off the original orders on admit to the nursing home on 1/24/08. The LPN stated, "Two of us were working on it together - [LPN # 2] and me." LPN # 1 and # 2 were asked how did the order for daily dressing changes get missed. LPN # 1 stated, "I don't know." LPN # 2 stated, "I didn't see the order for ortho dated 1/24/08." LPN # 1 and # 2 were asked if daily dressing changes had been done. LPN # 1 stated. "Not done daily, I change it every day I'm here, but I haven't charted it."	F 309		

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F 309	Continued From page 6 4. On 2/6/08 at 12:07 p.m., the Director of Nurses (DON) was asked if nurses should use a clean field when doing wound care/dressing changes. The DON stated, "Yes." The DON was asked if nurse's pockets were clean fields. The DON stated, "No." The DON was asked if the Treatment Nurse should use scissors from her pocket to cut the packing strips for the resident. The DON stated, "No, he should have his own scissors that are used only for him." The DON was asked if the Treatment Nurse should use scissors from a pocket to cut dressing for any resident. The DON stated, "Not without cleaning them first." The DON was asked if the Wound Record should include all areas that are being treated - coccyx and burn area for the resident. The DON stated, "Yes, it should be documented some where, if not there then in nursing notes. We should be looking at everything weekly." 5. The policy entitled "Admission Physician Orders" documented, "... Written orders by physician received: Orders received in writing by the physician should be handled as follows: a) Transcribe onto facility's Physician's Orders sheet; double check for accuracy ... III. For all admission orders: a) Physician orders should be signed by the Licensed Nurse transcribing the orders, by signing the nurses' full name, acronym, date and time. ..." 6. The policy entitled "Dressings - Clean" documented, "Purpose: To provide guidelines for the care of wounds and soiled dressings, to decrease the potential for nosocomial infection. ... A disposable cloth (paper towel is adequate) is placed on the over bed table to establish a clean filed; if the table is soiled, wipe with a clean towel first. ..."	F 309		

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F 309	Continued From page 7 7. The policy entitled "Pressure Ulcers" documented, "... Standard: ... I. ... Vascular ulcers (stasis ulcers) due to peripheral vascular disease (PVD) should be considered separately. ... As wound progress through the various stages of healing, they should be classified according to the current stage, rather than by the beginning stage or stage present upon admission. ... III. Documentation: a) The physician should be informed of the presence of a pressure ulcer, or the failure of an ulcer to respond to treatment; physician orders for care should be recorded. ... c) The status of ulcers should be recorded on the Ulcer Record weekly ... e) Observations pertinent to the resident's skin status should be recorded in the nurses' notes, as appropriate. ..."	F 309		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint # 13264 was substantiated (all or in part) with these findings. Base on observation, record review and interview the facility failed to ensure clean technique was maintained during treatment of Pressure Ulcers for 2 (Resident #3 and #4) and failed to ensure	F 314		

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F 314	Continued From page 8	F 314		

assessments of pressure sores were documented for 1 (Resident #3) of 6 (Resident #1, #2, #3, #4, #5 and #6) case mix residents with with orders for wound care. These failed practices has the potential to effect 6 residents in the facility with Pressure Ulcers according to the Resident Care Nurse on 2/6/08. The findings are:

1. Resident #4 has a diagnosis of Pressure Ulcers. The Quarterly Minimum Data Set (Minimum Data Set) dated 1/14/08 documented the resident was moderately impaired in cognitive skills for daily decision making, totally reliant on staff for hygiene, bathing and incontinent care and had one Stage I Pressure Ulcer and one Stage II Pressure Ulcer.

a. A Physician's Order dated 1/29/08 documented, "[Left] heel preventative measures. Cleanse [with] NS (normal saline). Cover [with] hydrofil [and] wrap [with] Kerlix. Secure [with] Mefix. [Change] QOD (every other day)."

b. A Physician's Order dated 1/29/08 documented, "Stg (stage) 2 [right] buttock. Cleanse [with] NS. Apply Polymem [and] secure [with] tegaderm. [Change] QOD."

c. On 2/6/08 at 9:22 a.m., the a.m. Treatment Nurse provided care for the resident. The Treatment Nurse went to the treatment cart and gathered supplies. She put several gloves in her left uniform pocket and put a pair of scissors in her right uniform pocket. She then gathered all her other treatment supplies and entered the resident's room. She deposited all of the treatment supplies (except the gloves and the scissors) on the bedside table next to the resident's bed. She did not create a clean field on

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F 314	Continued From page 9 the bedside table and did not cleanse the top of the bedside table before she put the supplies on the table. She applied gloves and removed the dressing from the resident's left heel using the scissors obtained from the pocket of her uniform. After she had cut the dressing off of the resident's left heel she dropped the scissors onto the floor. She picked the contaminated scissors up off of the floor and placed them back into her uniform pocket with out cleansing them. She then removed her gloves and put on a new pair of gloves she obtained from her uniform pocket. She cleansed the Pressure Ulcer on the resident's left heel with Saline Wound Wash she had obtained from a can she had placed on the bedside table. She laid the can on the resident's bed when she was finished with it. After she had cleansed the wound on the left heel, she laid the unprotected wound directly on the resident's bed. She obtained supplies off of the bedside table, picked up the resident's left foot, applied a Hydrofil wrap with Kerlix and secured it with Mefix. She did not cleanse the wound again after she had laid it on the bed linens. She took the remaining treatment supplies off of the bed side table and put them on the resident's bed. She walked around the other side of the resident's bed to treat the Pressure Ulcer on the right buttock. She removed her gloves and obtained another pair of gloves from her uniform pocket. She then cleansed the Pressure Ulcer on the resident's right buttocks with Saline Wound Wash, applied Poly-mem and secured the dressing with Tegaderm. She removed her gloves, washed her hands and gathered up her treatment supplies and returned the remaining supplies to the treatment cart. She put the contaminated can of Saline Wound Wash in the drawer of the treatment cart. She did not cleanse the outside of	F 314		

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F 314	Continued From page 10 the can before putting it into the drawer. She did not cleanse the scissors she had picked up off of the floor and put in her uniform pocket. The Treatment Nurse then went down the hall to the door of another resident's room. She gathered supplies for the next treatment she was going to provide. She cut some of the dressings she was preparing with the contaminated scissors she had obtained from her uniform pocket. The scissors was not cleansed before they were used. She took the supplies into the other resident's room to provide treatment. d. On 2/6/08 at 12:03 p.m., the Treatment Nurse was asked what she should have done differently during the treatment of the resident's Pressure Ulcers. She stated, "I should have washed my scissors before and after each treatment. I should have had a clean field. The can of Saline Wound Wash should have either been left in the (resident's) room or the outside of the can of Saline Wound Wash should have been cleaned before putting it on the treatment cart." 2. Resident #3 had diagnoses of Repair of Abdominal Aortic Aneurysm and Statis Ulcers. The Initial MDS dated 1/22/08 documented the resident had modified independence in cognitive skills for daily decision making. had two Stage II stasis ulcers and surgical wounds. a. A Physician's Order dated 2/4/08 documented. "DuoDerm applied to vertebrae for prophylactic Tx [treatment] [change] M - W - F [Monday, Wednesday, Friday] ..." "DC (discontinue) DuoDerm to coccyx area. Coccyx cleanse [with] N.S. apply PolyMem and Mepitac. [Change] QOD & PRN." There was no documentation on	F 314		

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F 314	Continued From page 11 the wound record or nurse's notes regarding these areas. b. On 2/5/08 at 10:40 a.m., the Treatment Nurse failed to set up a clean field for supplies used for treatments to the coccyx. During wound treatments, the Treatment Nurse used scissors from her uniform pocket to cut squares of PolyMem that were applied over the coccyx. The Treatment Nurse also placed gloves removed from the box in the bathroom in her left pocket using then later during the wound treatment. c. On 2/6/08 at 11:45 a.m., the Treatment Nurse was asked if she was taught to set up a clean field. The Treatment Nurse was stated, "I was never taught to do that." The Treatment Nurse was asked what was in her uniform top pockets. The Treatment Nurse stated scissors, keys, pens, treatment stuff. The Treatment Nurse was asked if her pockets were a clean field. The Treatment Nurse stated, "No. I cut bandages with scissors in my pocket - so if not in a clean field it does no good." The Treatment Nurse was asked if there should be documentation of the coccyx area. The Treatment Nurse stated, "Yes, I usually measure and write Treatment Notes on Thursday. Should I be documenting when I find something?" The Treatment Nurse was asked if the coccyx area was a pressure area. The Treatment Nurse stated, "Yes." The Treatment Nurse was asked what stage the coccyx area was. The Treatment Nurse stated, "Stage two." The Treatment Nurse was asked if her pockets were a clean field for gloves used during treatments. The Treatment Nurse stated, "No, I contaminated those too didn't I." d. On 2/6/08 at 12:07 p.m., the Director of	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	**3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703**

(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 314	Continued From page 12 Nurses (DON) was asked should nurses use a clean field when doing wound care/dressing changes. The DON stated, "Yes." The DON was asked if nurse's pockets were clean fields. The DON stated, "No." The DON was asked should nurses use scissors from pocket to cut dressing for any resident. The DON stated, "Not without cleaning them first." The DON was asked if the Wound Record should include all areas that are being treated - coccyx and burn area for the resident. The DON stated "Yes, it should be documented some where, if not there then in nursing notes. We should be looking at everything weekly." 3. The policy entitled "Dressings - Clean" documented, "Purpose: To provide guidelines for the care of wounds and soiled dressings, to decrease the potential for nosocomial infection. ... Process: ... 3. A disposable cloth (paper towel is adequate) is placed on the over bed table to establish a clean filed; if the table is soiled, wipe with a clean towel first. ...". 4. The policy entitled "Pressure Ulcers" documented, "... Standard: ... I. ... Vascular ulcers (stasis ulcers) due to peripheral vascular disease (PVD) should be considered separately. ... As wound progress through the various stages of healing, they should be classified according to the current stage, rather than by the beginning stage or stage present upon admission. ... III. Documentation: a) The physician should be informed of the presence of a pressure ulcer, or the failure of an ulcer to respond to treatment; physician orders for care should be recorded. ... c) The status of ulcers should be recorded on the Ulcer Record weekly ... e) Observations pertinent to the resident's skin status should be recorded in	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. BUILDING ______ B. WING ______	C 02/06/2008

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F 314	Continued From page 13 the nurses' notes, as appropriate. ...".	F 314		