

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2008
NAME OF PROVIDER OR SUPPLIER ST ANDREWS PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3501 COLLEGE AVENUE CONWAY, AR 72032	
(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	F 000		
F 314 SS=D	<p>Complaint #14081 was substantiated (all or in part) with a deficiency cited at F314</p> <p>483.25(c) PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #14081 was substantiated (all or in part) with these findings:</p> <p>Based on observation and record review the facility failed to ensure physician orders were followed when providing treatment and staff did not use their gloved finger to pack a tunneling wound for 1 (Resident #6) of 2 (Residents #6 and #2) case mix residents with pressure sores. The failed practices had the potential to affect 5residents with pressure sores as identified on a list provided by Registered Nurse #1 on 12/03/08. The findings are:</p> <p>Resident # 6 had diagnoses of Crohn's Disease, Malnutrition, and Alzheimers Dementia. A Quarterly Minimum Data Set dated 10/10/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for all activities of daily living, was incontinent of bowel and bladder, and had</p>	F 314		

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 314	Continued From page 1 open lesions other than ulcers. a. A Physician's order dated 10/31/08 documented, "Use Hydrofera Blue- use Normal Saline or Sterile Water to moisten a strip and wring out, apply to wound cover with ABD (abdominal pad) and secure with Mefix Tape change daily ." b. A Physician Progress Note dated November 25, 2008 documented, "The patient has a stage IV to the right buttock. The skin is healing, but there is a large ulcer underneath. It measures 10 cm (centimeters) with a Q-tip. There is some purulent drainage. The opening is only 0.5 x (times) 0.9 cm. But the depth is anywhere from 7 to 10 cm." c. On 12/02/08 at 2:05 p.m., LPN (Licensed Practical Nurse) #1 placed a clear plastic bag on the bed and placed a bottle of Constant Clens and Some 4 x 4 cm gauze sponges on the bag. She removed the outer dressing on the right buttock placing it on the plastic bag on which the clean supplies had been placed. She picked up a 4 x 4. sprayed it with Constant Clens and cleansed the skin around the lesion. A strip of Hydrofera Blue material was protruding from the opening of the lesion. As she cleansed the area the drain strip fell out of the opening of the lesion. The LPN stated, "It is trying to close up but is still approximately 10 cm deep. ... " The LPN stated she would have to restock. TheLPN covered the resident with a sheet leaving the bag with the soiled dressing, 4 x 4's and bottle of Constant Clens in the bed. She removed her gloves and left the room with a baggie containing strips of Hydrofera Blue.	F 314			

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F 314	Continued From page 2 LPN #1 returned to the room carrying a small baggie with several blue strips of Hydrofera inside. The sheet was pulled back uncovering the lesion and supplies. The LPN donned gloves, opened the baggie, and removed one strip of Hydrofera. She placed the baggie on the bed partially on the open plastic waste bag along side the Constant Clens. She picked up the Constant Clens, sprayed the Hydrofera and placed the Constant Clens back on the bed. Without changing gloves she attempted to insert the Hydrofera strip into the lesion using her gloved fingers. With the same gloved hands she opened the ABD pad and Mefix and applied them to the lesion.	F 314			
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the staff followed the policy for maintaining aseptic technique during a dressing change, handling and disposal of contaminated linen and trash to prevent the potential for the spread of infection during treatment of a wound for 1 (Resident #6)	F 441			

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F 441	<p>Continued From page 3</p> <p>of 2 case mix residents (Residents #6 and #2) with pressure sore (s)/wound and failed to ensure that supplies used for incontinent care was not used for multiple residents when providing incontinent care for 1 (Resident #4) of 4 (Resident's #2 through 5) case mix residents who were incontinent of bowel and bladder. The failed practices had the potential to effect 23 residents with physician ordered dressing changes as documented on a list provided by Registered Nurse # 1 on 12/03/08 and 50 residents who were incontinent as documented on the Roster/Sample Matrix form dated 12/1/08. The findings are:</p> <p>1. Resident # 6 had diagnoses of Crohn's Disease, Malnutrition, and Alzheimers Dementia. A Quarterly Minimum Data Set (MDS) dated 10/10/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for all activities of daily living, was incontinent of bowel and bladder, and had open lesions other than ulcers.</p> <p>a. A wound culture report dated 10/23/08 documented the organisms Proteus Mirabilis and Enterococcus Faecalis were present in the lesion.</p> <p>b. A Physician Order dated 10/31/08 documented, "Use Hydrofera Blue - use Normal Saline or Sterile Water to moisten a strip and wring out, apply to wound cover with ABD (abdominal pad) and secure with Mefix Tape Change daily."</p> <p>c. A Physician's Progress Notes dated November 25, 2008 documented, "The patient has a stage IV to the right buttock. The skin is healing, but there is a large ulcer underneath. It measures 10 cm (centimeters) with a Q-tip. There is some</p>	F 441			

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F 441	<p>Continued From page 4</p> <p>purulent drainage. The opening is only 0.5 x [times] 0.9 cm. But the depth is anywhere from 7 to 10 cm."</p> <p>d. On 12/02/08 at 11:30 a.m., LPN (Licensed Practical Nurse) #1 stated, "By mid afternoon there will be drainage [on the outer dressings] and I will replace the ABD only. The night shift does the packing and everything."</p> <p>e. On 12/02/08 at 2:05 p.m., LPN # 1 and CNA (Certified Nursing Assistant) #1 uncovered the resident revealing a dressing on the right buttock secured with tape. The LPN opened a clear plastic bag and placed it on the bed just below the resident's buttocks. The LPN placed a spray bottle of "Constant Clens" wound cleanser, some gauze 4 x 4 sponges and an ABD (abdominal) dressing on the open plastic bag. The LPN donned gloves and removed the dressing placing it on the open bag. There was a grayish green drainage on the dressing. There was a small open area, approximately 1/2 to 1 c.m. in diameter, on the right buttock. The base was not visible. The LPN stated, "It is trying to close up but is still approximately 10 cm deep." There was a grayish green drainage running out of the lesion onto the under pad. She picked up the Constant Clens, sprayed a 4 x 4, and placed the bottle on the bed, partially on the open plastic bag. As she cleansed the area around the pressure sore the strip of Hydrofera Blue packing fell out. She stated she would have to restock. They covered the resident with a sheet leaving the bag with the soiled dressing, 4 x 4's and bottle of Constant Clens in the bed. The LPN removed her gloves and left the room.</p> <p>LPN #1 returned to the room carrying a small</p>	F 441			

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F 441	<p>Continued From page 5</p> <p>baggie with several blue strips of Hydrofera inside. The sheet was pulled back uncovering the lesion and supplies. The LPN donned gloves, opened the baggie, and removed one strip of Hydrofera. She placed the baggie on the bed partially on the open plastic waste bag along side the Constant Clens. She picked up the Constant Clens, sprayed the Hydrofera and placed the Constant Clens back on the bed. Without changing gloves she attempted to insert the Hydrofera strip into the lesion using her fingers. With the same gloved hands she opened the ABD pad and Mefix and applied them to the lesion.</p> <p>After the dressing was secured, the open plastic trash bag containing the soiled dressings, the baggie of Hydrofera strips and the bottle of Constant Clens remained on the bed. The LPN removed her gloves and placed them in the plastic bag. Without gloves she began to roll up the soiled underpad underneath the resident. She stated "It is wet." CNA #1 stated "It is drainage ". Without washing her hands LPN #1 opened the door, went to the communal linen cart, opened the cover, picked up a box of disposable gloves and after removing some, placed the box back on the linen cart, closed the linen cart cover and returned to the resident's room.</p> <p>LPN #1 donned a pair of gloves and assisted CNA #1 to change the soiled under pad. The LPN picked up the baggie of Hydrofera strips and Constant Clens and placed them in her pocket. She removed her gloves and then picked up the plastic bag with the soiled dressing, placed the gloves and the under pad partially in the bag and handed it to the CNA. LPN #1 then went into the</p>	F 441			

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F 441	<p>Continued From page 6</p> <p>resident's bathroom and washed her hands. She exited the room and returned the Constant Clens and Baggie of Hydrofera strips to the medication room. CNA #1 took the bag of soiled dressings and underpad to the soiled linen/trash cart in the hall. She placed the soiled underpad, soiled with drainage from the wound in with the regular soiled linen and the discarded dressings into the regular trash container.</p> <p>f. The facility Policy and Procedure titled "Dressings - Aseptic" documented "Prepare a clean dry work area at bedside. Wash hands thoroughly. Open Dressing set to provide clean field. Pour prescribed solution into container provided, if applicable. Wearing gloves, remove soiled dressings and discard in container. Remove gloves; wash hands. Wearing gloves, clean wound with prescribed solution apply gauze pads... remove gloves; wash hands. Put on gloves, apply dressings. Secure... Discard bag containing soiled dressings to biohazardous waste receptacle. Clean and return equipment to designated area. Discard disposable items. Essential Points. If wound is draining, wear gloves to remove soiled dressing and dispose of immediately. Dispose of all soiled material in an individual plastic bag and take directly to the biohazardous waste receptacle."</p> <p>2. Resident #4 had diagnoses of Organic Brain Syndrome, Senile Delirium and Chronic Urinary Tract Infection. A Minimum Data Set dated 11/11/08 documented the resident was severely impaired in cognitive skills for daily decision making, was totally dependent on staff for all activities of daily living and was incontinent of bowel and bladder.</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>a. On 12/2/08 at 1:35 p.m., CNA # 2 was providing incontinent care with the assistance of CNA #3. LPN #2 was holding a stack of disposable cloths and handing them to CNA #2. Each time the CNA wiped the resident's perineal area, abdomen, thighs and buttocks she sprayed a new cloth with a spray bottle of Aloe Vista peri-wash. Each time she picked up the spray bottle, she sprayed each cloth and placed the bottle in the bed. She did not change gloves after each cleansing of the resident before touching the spray bottle.</p> <p>b. When the pericare was complete the spray bottle of Aloe Vista was placed on the bed. It rolled off onto the floor and CNA #3 picked it up and placed it in his pocket. He was asked what he was going to do with the bottle and he stated he would rinse it off.</p> <p>c. On 12/3/08 at 12:00 noon CNA #3 was asked if each resident had their own bottle of Aloe Vista. He stated, "No, the CNA's had one bottle for all their residents. "</p>	F 441			