

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

PRINTED: 12/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04A313</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>JAMESTOWN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2001 HAMPTON PLACE</b> <b>ROGERS, AR 72758</b>	
(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  Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.  Complaint #15797 was substantiated (all or in part) with deficiencies cited at F309 and F312.  Complaint #15865 was substantiated (all or in part) with deficiencies cited at F309 and F314.	F 000		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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: Complaints #15865 and #15797 were substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure a wound dressing was changed daily per the physician order, failed to ensure clean technique was	F 309		11/10/10

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	<p>Continued From page 1</p> <p>followed during wound care to prevent cross-contamination from one wound to another or from a soiled dressing to a clean one for 1 (Resident #5) of 3 (Residents #1, 4, 5) case mix residents who required dressing changes and failed to ensure a urinary catheter was secured to minimize the potential for trauma to the urinary meatus for 1 (Resident # 5) of 2 (Residents #4, 5) case mix residents who required the use of an indwelling catheter. These failed practices had the potential to affect 9 residents who required dressing changes and 4 residents who required the use of an indwelling urinary catheter as identified by lists provided by the Director of Nursing on 10/20/10. The findings are:</p> <p>Resident #5 was admitted to the facility on 10/11/10 according to the October 2010 Physicians Orders sheet and had diagnoses of Varicella, Herpetic Meningoencephalitis and Congestive Heart Failure.</p> <p>1.) A physician's order dated 10/14/10 documented, "Right Knee skin tear. Cleanse with wound cleanser, dry gauze, Apply TAO [Triple Antibiotic Ointment] and Telfa dressing Q [every] D [day]. "</p> <p>2.) On 10/18/10 at 11:20 a.m., the dressing on the resident's right knee was dated 10/15. The Treatment Nurse stated, "That was the last day I worked. It wasn't changed over the weekend."</p> <p>3.) On 10/18/10 at 12:15 a.m., the Treatment Nurse applied a dressing to the resident's feeding tube site and then used the same gloves to remove the old dressing from the skin tear on the resident's right knee, cleanse the area and apply a new dressing.</p>	F 309			

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F 309	Continued From page 2  b. The Admission Care Plan dated 10/11/10 documented, "Catheter Care."  1.) On 10/18/10 at 11:20 a.m., the catheter was not secured and was pulled taut against the urinary meatus pulling the penis sideways and down against the resident's right side.  2.) The facility ' s Policy and Procedure for Catheter Care provided by the Director of Nursing on 10/20/10 documented, "Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site."  3.) Best Practices - A Guide to Excellence in Nursing Care, copyright 2003 by Lippincott Williams & Wilkins, page 437 documented, "Tape the catheter to the male patient's anterior thigh to prevent pressure on the urethra at the penoscrotal junction, which can lead to formation of urethrocutaneous fistulas. Taping also prevents traction on the bladder and alterations in the normal direction of urine flow in males."	F 309			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure baths were	F 312		11/10/10	

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F 312	<p>Continued From page 3</p> <p>provided regularly for 3 (Residents #1, #2, and # 4) of 5 (Residents #1-5) case mix residents who required assistance with bathing, failed to ensure assistance with meals was provided promptly for 1 (Resident #5) of 2 (Residents #1 and #5) case mix residents who required assistance with meals and failed to ensure all soiled body parts were cleansed during incontinent care for 1 (Resident #3) of 3 (Residents #1, #3, and #5) residents who required staff assistance with incontinent care. These failed practices had the potential to affect 40 residents who required assistance with bathing, 8 residents who required assistance with meals and 8 residents who required assistance with incontinent care, as identified by lists provided by the Director of Nursing on 10/20/10. The findings are:</p> <p>1. On 10/17/10 at 6:30 p.m., the weekend Registered Nurse (RN) #1 Supervisor stated that a Certified Nurse Assistant (CNA) Shower Sheet form was filled out by the CNA's on each resident when they were given a bed bath, regular bath or a shower. When asked by the surveyor where it would be documented if a resident refused their bath, RN #1 stated the sheet was also filled out every time a resident refused.</p> <p>On 10/18/10 at 9:00 a.m., the Director of Nursing (DON) was asked if the baths were documented anywhere else besides the bath sheets and she stated, "No. That's the only place they are documented." The DON confirmed that a bath sheet was filled out even when the resident refused.</p> <p>2. On 10/18/10 at 9:00 a.m., the DON provided the September 2010 and October 2010 CNA Shower Sheets that had been completed for each</p>	F 312			

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F 312	Continued From page 4 resident.  3. Resident #1 had diagnoses of End Stage Renal Disease, Multiple Sclerosis and Pressure Sores. The 14 day Medicare Part A Minimum Data Set (MDS) with an assessment reference date of 10/4/10 documented the resident ' s Brief Interview for Mental Status (BIMS) score was 10 with a score of 8 to 12 indicating the resident was moderately impaired. The MDS also documented the resident was dependent on staff for bed mobility, was incontinent of bowel and bladder, required extensive assistance with toileting, personal hygiene and bathing, had 4 Stage II pressure ulcers and received ulcer care.  a. The Plan of Care dated 9/21/10 documented, "Care plan for skin integrity management. Skin Risk Assessment Score 12. ...Approaches: ...Bath/Shower 3 times a week."  b. On 10/18/10 at 9:00 a.m., there were only 3 CNA Shower Sheets for September 2010 and October 2010. They indicated the resident was bathed on 9/22/10, 10/6/10 and 10/8/10. No other bath sheets were available for review for this resident.  4. Resident #2 had diagnoses of Dementia and Cardiovascular Disease. The Quarterly MDS with an assessment reference date of 9/28/10 documented the resident had modified independence in cognitive skills for daily decision-making and required limited assistance with transfers, personal hygiene and bathing.  a. The Plan of Care dated 7/6/10 documented, "Care plan for skin integrity management. Skin risk assessment score 19. ...Bath/Shower 3	F 312			

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F 312	<p>Continued From page 5 times a week."</p> <p>b. On 10/18/10 at 9:00 a.m., there were only 2 CNA Shower Sheets for September 2010 and October 2010, which indicated the resident was bathed on 9/13/10 and 10/8/10. There were no other bath sheets available for review for this resident.</p> <p>5. Resident # 4 had diagnoses of Osteoporosis and Congestive Heart Failure.</p> <p>a. The facility Admit/Discharge Report from 8/1/10 through 10/31/10 documented [Resident #4] was discharged from the facility on 9/15/10 and readmitted to the facility on 10/7/10.</p> <p>b. The Initial MDS with an assessment reference date of 10/17/10 documented the resident ' s BIMS score was 5, with a total of 0-7 indicating severe impairment, was readmitted to the facility on 10/7/10 and was dependent on staff for bathing.</p> <p>c. The Plan of Care dated 10/18/10 documented, "Care plan for skin integrity management. Skin risk assessment score 13. ...Bath/Shower 3 times a week."</p> <p>d. On 10/18/10 at 9:00 a.m., there were a total of 3 CNA Shower Sheets for the period of 9/1/10 through 9/15/10. They indicated the resident was refused a bath on 9/7/10, was bathe on 9/9/10 and 9/14/10. There were 2 shower sheets dated 10/7/10 and 10/14/10. There were no other bath sheets available for review for this resident.</p> <p>6. Resident #3 had diagnoses of Malignant Neoplasm of Bladder and Chronic Airway</p>	F 312			

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F 312	Continued From page 6 Obstruction. The MDS with an assessment reference date of 9/7/10 documented the resident was independent in cognitive skills for daily decision-making, was incontinent of bowel, had an ostomy and required extensive assistance for toileting and personal hygiene.  a. The Plan of Care dated 8/26/10 documented, "1-2 assist with toileting."  b. The October 2010 Physicians Orders sheet documented, 8/26/10 Ostomy/Urostomy bag ... "  c. On 10/18/10 at 9:13 a.m., the resident was lying in bed with urostomy bag connected to bedside drainage bag. The resident had been incontinent of a large amount of soft feces. CNA #5 and CNA #6 unfastened the resident's brief. CNA #6 pushed the soiled brief down between the resident's legs. The CNA's turned the resident onto his right side. CNA #5 washed the resident's buttocks and anal area and the resident was turned back onto his back. A new brief was applied. The resident's penis, scrotum and groin creases were not cleansed.  7. Resident #5 was admitted to the facility on 10/11/10 and had diagnoses of Varicella Herpetic Meningoencephalitis and Congestive Heart Failure. The Admission Nursing Assessment dated 10/11/10 documented, "Needs Assist with eating" and the Admission Care Plan dated 10/11/10 documented, "Eating assist."  a. On 10/19/10 at 9:30 a.m., the resident was in bed. The breakfast tray was on an overbed table by the bed. The food on the plate was undisturbed and covered. The milk carton was not opened and there was a clear plastic wrap	F 312			

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F 312	Continued From page 7 intact over the oatmeal and the juice glass.	F 312			
F 314 SS=G	<p>b. On 10/19/10 at 9:35 a.m., CNA #4 stated, "I took the tray in the room at 8 [8:00 a.m.] but the nurse was giving him his medicines so I just left it in there. I was going to go back." The CNA stated the resident was not able to eat without assistance. The breakfast tray had been on the overbed table for an hour and a half with no assistance provided to the resident.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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 #15865 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure pressure sores were immediately communicated to the physician, which resulted in a delay in treatment, failed to accurately measure and stage the pressure sores to facilitate the ability to identify and track healing or deterioration, failed to ensure heel protectors were provided or offloading of the heels was addressed consistently, failed to ensure a pressure sore was not contaminated</p>	F 314		11/10/10	

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F 314	<p>Continued From page 8</p> <p>during personal care, failed to thoroughly cleanse all soiled areas during incontinent care and failed to ensure staff promptly reported and addressed dislodgement of a pressure sore dressing for 1 (Resident #1) of 2 (Residents #1and #5) case mix residents at risk for pressure sores. The failed practice resulted in actual harm to Resident #1, who developed unstageable pressure sores with eschar to both heels, and had the potential to affect 3 residents at risk for the development of pressure sores as identified by a list provided by the Administrator on 10/20/10. The findings are:</p> <p>Resident #1 had diagnoses of End Stage Renal Disease, Multiple Sclerosis and Pressure Sores. The 14 day Medicare Part A Minimum Data Set (MDS) with an assessment reference date of 10/4/10 documented the resident ' s Brief Interview for Mental Status (BIMS) score was 10 with a score of 8-12 indicating the resident was moderately impaired. The MDS also documented the resident was dependent on staff for bed mobility, was incontinent of bowel and bladder, required extensive assistance with toileting, personal hygiene and bathing, had 4 Stage II pressure ulcers and received ulcer care.</p> <p>a. The Braden Scale - For Predicting Pressure Sore Risk dated 9/21/10 documented the resident ' s total pressure ulcer risk score was 12, with a score of 12 or less indicating the resident was at high risk for the development of pressure sores.</p> <p>b. The Admission Nursing Assessment dated 9/21/10 documented, "See Admission Skin Audit."</p> <p>The Admission Skin Audit dated 9/21/10 documented a circle around both heels on the anatomical diagram, with an arrow pointing to the</p>	F 314			

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F 314	Continued From page 9 right heel labeled "soft." There was no documentation on the form of interventions for heel protectors or offloading put in place to minimize the potential for further deterioration of the heels.  1.) The Nurse's Note dated 9/21/10 documented, "Right buttock open pressure sore. Clean with wound cleanser, dry with gauze, Apply TAO [Triple Antibiotic Ointment] QD [every day]. " There was no documentation of descriptive information or treatment for the heels.  2.) The Certified Nursing Assistant (CNA) Shower Sheet dated 9/22/10 documented, "Huge Blister on Rt. [right] foot."  3.) The Nurse's Note dated 9/23/10 at 11:00 p.m. documented, "New Order. Wound Care Treatment Nurse for ulcer to R [right] heel for evaluation."  4.) The Plan of Care for Skin Integrity Management dated 9/23/10 documented, "Heel Protectors."  5.) The September 2010 Treatment Sheet documented, "9/25/10. Skin prep to unopened blisters on heels daily. Change treatment if blisters open. Heel protectors on while in bed." There was no documentation that the physician was notified, a treatment order obtained or preventative measures initiated prior to 9/25/10, approximately 3 days after the right heel blister was initially documented and 4 days after the right heel was identified as "soft."  6.) The Wound Care Note dated 10/1/10 documented, "Areas to R/L [right and left] heels.	F 314			

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F 314	<p>Continued From page 10</p> <p>Large fluid filled blisters. Fluid appears red to deep purple in color. R heel measures 7 X 6.5 [centimeters]. L heel measures 5.2 X 5. Surrounding skin tissue normal. Unable to determine depth beneath blister. R heel moderate amount of serosanguineous drainage from small opening to upper part of blister. L heel has moderate amount of serosanguineous drainage to lower small opening of blister. Physician notified... Currently on low air loss mattress. Has foam boots for protection." There was no documentation in the nurse's notes, wound care notes, or treatment sheets that either heel sore had been measured until 10/1/10, approximately 9 days after the right heel blister was first identified.</p> <p>The Weekly Pressure Ulcer Record for the right heel documented the date of onset as 10/1/10 and described the wound as a Stage II. The Weekly Pressure Ulcer Record for the left heel documented the date of onset as 10/1/10 and described the wound as a Stage II.</p> <p>7.) The Wound Clinic Report dated 10/7/10 documented the Right heel measured 6.2 x 3.0 x &lt; [less than] 0.1 cm [centimeter] with partial coverage eschar, moderate slough and black wound base before debridement and measured 4 x 1.2 x 0.1 after debridement. Left heel measured 6.4 x 5.0 x &lt; 0.1 cm with partial coverage eschar, minimal slough and a yellow/pale pink/black wound base before debridement and measured 1.5 x 1.0 x 0.1 cm after debridement. The wounds were not staged.</p> <p>8.) The facility ' s Weekly Pressure Ulcer Record dated 10/7/10 documented the right heel wound measured 7 x 6 x 0.1 with a pink wound bed and</p>	F 314			

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F 314	Continued From page 11 on 10/8/10 the left heel measured 5 x 5 with no depth documented and a pink wound bed. The facility's measurements were not comparable to the measurements taken before or after the debridement by the wound clinic. Both wounds were documented as Stage II. The Weekly Pressure Ulcer Record dated 10/7/10 also documented, "Stage II pressure area left buttock resolved. White/pink scar left."  9.) On 10/17/10 at 6:10 p.m., the resident was lying in bed on his back. There were no heel protectors in place on either foot. Both of the resident's heels were in direct contact with the bed surface.  c. On 10/18/10 at 3:25 p.m., the resident was lying in bed and had been incontinent of urine and a large amount of soft feces. CNA #1 and CNA #3 folded the soiled brief and pushed the front down between the resident's legs. The CNA's then turned the resident onto his right side. CNA #1 was in front of the resident and helped hold the resident on his side. CNA #3 stood behind the resident. CNA #3 cleaned the resident's anal area. CNA #1 lifted the resident's top left leg up and CNA #3 wiped between the resident's legs. There was a residue of a beige cream on the resident's sacral area and buttocks. CNA #3 did not cleanse this area before applying a white barrier cream to the area. The white cream turned a beige, brown color when she rubbed it over this area. The resident was then positioned onto his back. The anterior perineal area, penis and front part of the scrotum were not cleansed. CNA #1 and CNA #3 removed the soiled draw sheet from underneath the resident. A new brief was applied. The bandage on the resident's left heel had dislodged, the foam dressing was flapped open	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04A313</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>JAMESTOWN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2001 HAMPTON PLACE</b> <b>ROGERS, AR 72758</b>		
(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	<p>Continued From page 12</p> <p>and an open pressure sore was visible. CNA #1 reached down and tried to push the foam dressing back in place over the pressure ulcer with her right gloved hand that had been used to push the soiled brief between the resident's legs and to change the soiled draw sheet. The contaminated glove touched the open wound. The resident's right bandaged heel was not offloaded and was in direct contact with the bed surface. The exposed pressure sore on the resident's left heel was in direct contact with the bed surface. The CNA's covered the resident and left the room.</p> <p>d. On 10/18/10 at 5:30 p.m., the Director of Nursing (DON) and the Treatment Nurse were asked what the CNA's were instructed to do if they observed a bandage was dislodged or missing. The Treatment Nurse stated they were to report it to her if she was here or to the charge nurse if she was not here so that the dressing could be replaced. The DON stated that it should be reported within "a few minutes" of noticing it. The Treatment Nurse stated that there had been nothing reported to her in the past two hours of any dressings that were not in place. The DON and Treatment Nurse were asked to check the resident's heel bandage. The resident was in bed with the right bandaged heel in direct contact with the bed surface. The exposed pressure sore on the resident's left heel was in direct contact with the bed surface. The wound bed was covered with a yellow/green/tan slough, had a moderate amount of serosanguinous drainage and measured approximately 1.0 x 1.0 cm per visual inspection by the surveyor.</p> <p>e. The Weekly Pressure Ulcer Record dated 10/18/10 documented the left heel was a Stage II</p>	F 314			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04A313</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>JAMESTOWN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2001 HAMPTON PLACE</b> <b>ROGERS, AR 72758</b>		
(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 13 and measured 6 x 3 x 0.1 with scant serosanguinous drainage and a pink wound base.  f. The Weekly Pressure Ulcer Record dated 10/20/10 documented the right heel was a Stage II and measured 0.5 x 0.5 x 0.1 with scant serosanguinous drainage and a red wound base.  g. The Guide for Wound Assessment and Documentation provided by the Director of Nursing on 10/20/10 documented, "Pressure Ulcer - Definitions and Stages: Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.	F 314			