FAYETTEVILLE CARE AND REHABILITATION CENTER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

F 280
SS=0

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Fayetteville Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F-280

1. On 10/6/10, Resident #5's code status was updated on her comprehensive care plan by the Clinical Case Manager to reflect the resident's current code status of a DNR.

2. Other resident's comprehensive care plans and orders will be reviewed and care plans revised as necessary by 10/27/10 by the Clinical Case Manager, Unit Managers, and Director of Nursing.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to ensure the comprehensive care plans were revised to reflect the resident's current status for cardiopulmonary resuscitation (CPR) or the use of oxygen for 2 of 15 (Residents #5 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #5 documented an admission date of 1/14/10 with diagnoses of Essential Hypertension, Iron
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Summary Statement of Deficiencies

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Deficiency Anemia secondary to blood loss. Dysphagia and Unspecified Staphylococcal Septicemia. Review of the care plan dated 9/20/10 documented, "Resident desires CPR..." Review of the physician's order dated 9/24/10 documented, "...FULL CODE STATUS CHANGED TO DNR [Do not resuscitate] PER FAMILY REQUEST DECLINE." The care plan was not revised to reflect the status change for DNR.

During an interview in the Administrator's office on 10/6/10 at 7:50 AM, the Clinical Case Manager was asked when changes related to orders updated on the care plans. The Clinical Case Manager stated, "Any order change we take to morning meeting and make updates the next day... orders are updated... when I do them... I will get a new one [care plan] on [pointing at Resident #5's chart] right now."

2. Medical record review for Resident #11 documented an admission date of 8/23/06 and a readmission date of 6/17/09 with diagnoses of Coronary Artery Disease, Hypertension, Diabetes, Depression, Chronic Obstructive Pulmonary Disease, Anemia and Osteoarthritis. Review of the physician's orders with an original start date of 6/25/10 and reordered and signed 9/10/10 documented "...O2 [Oxygen] @ [at] 2 LITERS PER MINUTE PRN [as needed]..." Review of the Minimum Data Set (MDS) with an assessment reference date of 8/18/10 documented Resident #11 had received oxygen therapy during the last 14 days. Review of the care plan dated 8/25/10 did not address Resident #11's use of O2.

Observations in Room 104 on 10/6/10 at 8:10 AM and at 9:25 AM, revealed Resident #11 lying in...
<table>
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<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded By Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced To The Appropriate Deficiency)</th>
<th>Completion Date</th>
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1. Observations in the kitchen by the dishwasher on 10/4/10 at 3:30 PM, dietary worker #1 scraped dirty dishes at the dirty side of the dishwasher, then went to the clean side of the dishwasher to remove the clean dishes and put them away without washing her hands.

Observations in the kitchen on 10/5/10 at 3:13 PM, dietary worker #1 wore gloves to scrap food from the dirty dishes and placed the dirty dishes in the dishwasher. Dietary worker #1 then went to the clean side of the dishwasher, put sanitizer on the gloves she was wearing and went out into the kitchen. Dietary worker #1 returned to the dishwasher room and removed the clean glasses from the tray without washing her hands.

During an interview in the kitchen on 10/4/10 at 4:22 PM, the Registered Dietician stated, "[Named dietary worker #1] should wear gloves on the dirty side and use a spoon to scrape, put [dishes] in [the] dish machine. She's [dietary worker #1] got to remove gloves and go wash her hands and come back and get dishes from the clean side."

2. Observations in the kitchen by the steam table on 10/5/10 at 9:05 AM, revealed a dietary worker #2 dropped a steam table lid on the floor, picked the lid off the floor, put the lid in the 3 compartment sink and continued putting steam lids on steam table without washing her hands.

Observations in the kitchen on 10/5/10 at 1:02 PM, revealed a dietary worker #2 wore gloves preparing the plates of food for the residents. While preparing plates of food dietary worker #2 rubbed behind her ear, pushed her glasses up on
Continued From page 4

her nose and continued fixing the plates of food without removing gloves and washing her hands.

Observations in the kitchen on 10/5/10 at 12:35 PM and on 10/6/10 at 7:40 AM, revealed dietary worker #2’s hair was protruding from under their hair nets.

During an interview in the kitchen on 10/5/10 at 1:23 PM, the DM was asked about dietary worker #2 rubbing behind her ear and adjusting her glasses. The DM stated, "She [dietary worker #2] should remove her gloves, wash her hands, and reglove."

3. Observations in the kitchen on 10/5/10 at 8:30 AM, revealed dietary worker #3 carried a stack of clean plate covers from the dishwasher room to the kitchen holding them close to her body touching her clothes. Dietary worker #3 then brought a stack of clean plates from the dishwasher room to the kitchen holding them close to her body touching her clothes with her name tag laying on the top plate.

Observations in the kitchen on 10/5/10 at 9:34 AM, revealed a dietary worker #3 loaded dirty dishes in the dishwasher, went to the clean side, removed clean dishes from the dishwasher, dropped a clean glass on the floor, picked the glass up off the floor, put the glass in the sink and continued to unload the clean glasses without washing her hands.

During an interview near the front door on 10/5/10 at 1:14 PM, the Dietary Manager (DM) was asked how dietary workers should carry clean dishes. The DM stated, "...dietary should carry clean dishes to kitchen... holding underneath the dishes..."

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F 371
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<th>(x) ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (each corrective action should be cross-referenced to the appropriate deficiency)</th>
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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 5 and away from the body. 4. Observation in the kitchen on 10/5/10 at 1:00 PM, revealed a DM from another facility picked up a bowl with her bare thumbs inside of the bowl, went to the stove, and put stewed potatoes in the bowl. During an interview in the hallway near the front door on 10/5/10 at 1:16 PM, the facility DM was asked what the DM from another facility should have done with the potatoes placed in the bowl. The facility DM stated, &quot;...should not be used cause of cross contamination. I saw that.&quot;</td>
<td>F 371</td>
<td>F-441 1. On 10/5/10, Nurse #1 was re-educated by the Staff Development Coordinator on how to appropriately place the cap from an eye drop bottle during instillation of eye drops utilizing appropriate infection control techniques. CNA's will be re-educated by 10/27/10 by the Staff Development Coordinator. Director of Nursing Services, and /or Unit Managers on appropriate hand washing after direct resident contact and/or contact with equipment during meal service.</td>
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<td>F 441</td>
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<td>Continued From page 8 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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<td>utilizing appropriate infection control techniques. 4. Random Meal Service audits of residents who receive meals in their room will be conducted 3 x a week by the Administrator, Staff Development Coordinator, Director of Nursing Services, and/or Unit Managers for three months to ensure staff are utilizing appropriate infection control techniques during meal service. The Performance Improvement Committee will review and analyze the results of the meal service audits monthly x 3 months in the Performance Improvement Meeting to identify any trends or issues that have been identified. The PI Committee consists of the Administrator, Director of Nursing Services, Medical Director, Clinical Case Manager, Nutritional Services Director, Activities Director, Maintenance Director, Environmental Services Director, and Business Office Manager. Subsequent plans of correction will be implemented as necessary.</td>
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This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to ensure 1 of 3 nurses (Nurse #1) maintained infection control practices to prevent the possibility of cross-contamination by improper handling of an eye drop container and 2 of 5 Certified Nursing Assistants (CNA's #1 and 2) failed to wash their hands between resident contact during dining observations.

The findings included:

1. Observations in Resident #9's room on 10/5/10 at 2:55 PM, Nurse #1 removed the eye drop cap from the eye drop bottle and placed the cap on the overbed table with the open side down without using a clean barrier. After administering the eye drop medication, Nurse #1 replaced the contaminated cap back in the eye drop bottle without cleaning it.

2. Observations in room 118B on 10/4/10 at 6:10 PM, CNA #1 placed the supper tray on the
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overbed table, adjusted the resident’s bed, and placed a clothing protector around the resident’s neck. CNA #1 then continued to serve the meal tray. CNA #1 did not wash her hands after direct resident contact.

Observations in room 106 on 10/4/10 at 6:25 PM, CNA #1 placed the supper tray on the overbed table, turned off the resident’s bed alarm, then continued to serve the meal tray. CNA #1 did not wash her hands after direct contact with the resident’s bed alarm.

3. Observations in room 118A on 10/4/10 at 6:15 PM, CNA #2 placed the supper tray on the overbed table, adjusted the resident’s bed, then continued to serve the meal tray. CNA #2 did not wash her hands after direct contact with the resident’s bed.