STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045305	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN TRACE REHABILITATION AND CARE CENTER	**22515 I 30 BRYANT, AR 72022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure wound care was provided in a manner to prevent cross contamination for 2 (Residents #3 and #5) of 5 (Residents #3, #4, #5, #6 and #7) case mix residents who had Physician order [REDACTED]. The facility also failed to ensure gloves were changed after wiping feces from the resident's skin while providing catheter care and incontinent care for 1 (Resident #4) of 3 (Residents # 3, #4, and #5) case mix residents who had a indwelling catheter and were dependent for incontinent care on the 100 Hall. This failed practice had the potential to affect 2 residents that had indwelling catheters and 20 residents that were dependent for incontinent care on the 100 Hall, according to lists received from the Director of Nurses on 7/10/2020. The findings are: 1. Resident #4 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 5/11/2020 documented the resident scored 14 (13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of 1 person for bed mobility, transfer and toilet use, extensive assistance of 1 person for dressing, personal hygiene and total of 1 person for bathing; had an indwelling catheter and was frequently incontinent of bowel; had one unhealed pressure ulcer and one untraceable slough-eschar with one pressure ulcer present on admission to the facility. a. Physician order [REDACTED]. Foley catheter care Q (every) shift and PRN (as needed) with soap and water or wipes as needed and every shift. b. On 7/10/2020 at 11:05 a.m., the Certified Nursing Assistant (CNA) #1 cleaned the fecal material from the left inner thigh with a disposable wipe. With the same contaminated gloves, CNA #1 repositioned the indwelling catheter tubing that was secured on the right thigh. Using the same contaminated gloves, CNA #1 provided catheter care. CNA #1 wiped around the tip of the penis with a disposable wipe. CNA #1 changed wipes and cleaned from the insertion site down the tubing securing the indwelling catheter. With the same contaminated gloves, the CNA continued to provide the incontinent care wiping the left groin area, changed wipes and then wiped the right groin area. CNA #1 explained to the resident what she was doing and turned the resident on the left side. With the same contaminated gloves, CNA #1 cleaned the rectal area and outer buttock of semi-liquid feces. With the same contaminated gloves, CNA #1 picked up the clean incontinent brief off the bedside table and applied the clean incontinent brief. Using the same contaminated gloves CNA #1 rolled the resident and removed the soiled draw sheet. CNA #1 removed the left glove only and checked the resident's top drawer bedside table for barrier cream. Using the contaminated right glove, fastened the resident's incontinent brief, touched the covers, and the heel lift boot with the contaminated right glove. c. On 7/10/2020 at 1:42 p.m., the DON was asked if the staff should change gloves between dirty to clean. The DON stated, Yes. 2. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) documented the resident was severely impaired cognitive skills for daily decision making according to an Staff Assessment for Mental Status (SAMS); and required total dependence of 2 person for transfer, dressing and toilet use, total dependency of 1 person for personal hygiene and extensive assistance of 2 person for bed mobility and extensive assistance of 1 person for eating; had functional limitation in range of motion (ROM) of the upper and lower extremities on one side; had 1 unhealed pressure ulcer, with slough and eschar and 1 Moisture Associated Skin Damage. a. The Skin & (and) Wound Evaluation right foot, right great toe dated for 7/6/2020 at 11:40 a.m. documented, Right Foot, 1st Digit (Hallux) .Abrasion with the onset date 6/28/2020. Measurements, Length 1.6 cm (centimeters) x (by) width 1.7 cm x depth 0.2 cm. b. The Skin & Wound Evaluation the Right Knee dated for 07/06/2020 11:44 a.m. documented, Pressure .In-house acquired .start date, 5/18/2020 .Unstageable: Obscured full-thickness skin and tissue loss. The measurements, length 2.8 cm x width 3/1 cm x depth not applicable. c. The Skin & Wound Evaluation right buttocks dated for 07/06/2020 14:29 (2:29 p.m.) documented, Pressure, Unstageable: Obscured full-thickness skin and tissue loss, with the start date of 7/6/2020. Measurements Length 3.4 cm x width 2.3 cm x depth not applicable. d. The Physician order [REDACTED]. Apply Collagen and then Cover with Dry Dressing as needed for becoming dislodged or soiled. Every day shift every Monday, Wednesday, Friday Phone Active 06/29/2020 .Cleanse Pressure Ulcer to Right Buttocks with Wound Cleanser, Pat Dry. Apply Santyl to Slough then Cover with Calcium Alginate and Dry Dressing as needed for becoming dislodged or soiled. Every day shift Phone Active 06/16/2020 .Cleanse Pressure Ulcer to Right Knee with Wound Cleanser, Pat Dry. Apply Santyl to Necrotic tissue then Cover with Dry Dressing every day shift and as needed for becoming dislodged or soiled. e. On 7/10/2020 at 8:23 a.m., observation was made of wound care for Resident #5. The Treatment Nurse set up the supplies on the treatment cart. There were 3 small Styrofoam containers sitting on the tray covered with a plastic. The Treatment Nurse removed the scissors from her right uniform leg pocket. The Treatment Nurse cut the collagen package dressing in squares and placed in the Styrofoam container. The Licensed Practical Nurse (LPN) did not clean the scissors after removing the scissors from the pocket on the leg of her uniform and before she had replaced the scissors in the pocket on right leg of her uniform. During observation of wound care, the Treatment Nurse applied the contaminated collagen squares on the wound bed on the right foot and right ischial area. 3. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly MDS with (ARD) OF 5/23/2020 documented the resident severely impaired cognitive skills for daily decision making according to a SAMS; and required extensive assistance of 2 person for transfers, extensive assistance of 1 person with bed mobility, dressing, toilet use and personal hygiene; had1 unhealed pressure ulcer, 2 unstageable pressure ulcers and a skin tear. a. Progress Notes dated 5/19/2020 documented, Pressure Stage 4: Full-thickness skin and tissue loss Location is Left Trochanter. The skin/wound concern was In-House Acquired. The skin/wound concern has been present Exact Date 02/03/2020. The wound area measurement, the length is 0.5 cm, the width is 0.7 cm, depth is 0.2 cm, undermining 4.5 cm, Tunneling Not Applicable. b. Progress Notes dated 5/19/2020 documented, Resident has Pressure Unstageable: Obscured full-thickness skin and tissue loss Location is Right Trochanter. The skin/wound concern was In-House Acquired. The skin/wound concern has been present Exact Date 01/15/2020. The wound area measures 0.1 cm 2. The length is 0.4 cm, the width is 0.5 cm, depth is 0.2 cm, undermining Not Applicable, Tunneling 3.8 cm. c. The Progress Notes dated 5/19/2020 documented by the Treatment Nurse documented, Resident has Pressure Unstageable: Obscured full-thickness skin and tissue loss Slough and/or eschar Location is Right Buttock. The skin/wound concern was In-House Acquired. The skin/wound concern has been present Exact Date 05/18/2020 . d. The July 2020 Physician order [REDACTED]. Pack with Calcium Alginate and Collagen Powder and Cover with [MEDICATION NAME] as needed for becoming dislodged or soiled. AND everyday shift Phone Active 06/16/2020. Cleanse PU to Right Hip with Wound Cleanser, pat dry. Pack with Calcium Alginate and Collagen Powder then cover with [MEDICATION NAME] as needed for becoming dislodged or soiled everyday shift Phone Active 06/16/2020 .Cleanse PU to Right Hip with Wound Cleanser, pat dry. Pack with Calcium Alginate and Collagen Powder then cover with [MEDICATION NAME] as needed for becoming dislodged or soiled everyday shift. e. On 7/10/2020 at 10:22 a.m., observation was made of wound care by Treatment Nurse #1 and assisted by Certified Nursing Assistant #3. The Treatment Nurse had 3 small Styrofoam containers. The Treatment Nurse had her scissors in the right leg pocket of her uniform. The Treatment Nurse removed the scissors from the right leg pocket of her uniform and cut the collagen dressing and placed the scissors on top of the Treatment Cart, then placed the scissors back in the right leg pocket of her uniform. The Treatment Nurse provided the wound care and placed the contaminated Calcium Alginate dressing to the wound bed on the Right hip and Left Hip Pressure Ulcers and the Right Ischial area Pressure Ulcer. 4. On 7/10/2020 at

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 12:35 p.m., the Treatment Nurse was asked did you clean the scissors before you cut the wound dressing for Resident #3 and #5 that will be going next to a wound? The Treatment Nurse stated, No. The Treatment Nurse was asked, Is your uniform considered clean? The Treatment Nurse stated, No.