

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

PRINTED: 02/09/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2007
NAME OF PROVIDER OR SUPPLIER OZARK HEALTH NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 HIGHWAY 65 SOUTH CLINTON, AR 72031	
(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 167 SS=C	<p>483.10(g)(1) EXAMINATION OF SURVEY RESULTS</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure two Complaint Surveys were posted for examination and were accessible to wheelchair bound residents, and not hidden by other office materials. This failed practice had the potential to affect all 107 residents. The findings are:</p> <ol style="list-style-type: none"> On 1/23/07 at 11:07 a.m., the Annual Survey dated 2/15/06 was on the South Hall in a box marked "Survey" on the wall beside the Nurse's Station. The "Survey" box contained a Therapy clipboard, with an In and Out signing sheet. The clipboard was in front and hiding the binder holding the Annual Survey. According to the OSCAR 40 Report there was a complaint survey conducted on 4/26/06 and 1/2/07, but they were not in the survey binder and the binder was not wheelchair accessible. On 1/23/07 at 11:10 a.m., the Annual Survey dated 2/15/06 was on North Hall in a box marked "Survey" on the wall beside the Nurse's Station. 	F 167		

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 167	Continued From page 1 The "Survey" box contained a Physical Therapy clipboard that had "Do Not Remove" written on red stickers. The clipboard was in front of and hiding the binder holding the Annual Survey. According to the OSCAR 40 Report there was a complaint survey conducted on 4/26/06 and 1/2/07, but they were not in the survey binder and the binder was not wheelchair accessible.	F 167		
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure their Abuse Prohibition Policies and Procedures were developed in accordance with Office of Long Term Care (OLTC) regulations and State law. This failed practice had the potential to affect all 107 residents. The findings are: On 1/25/07 at 3:00 p.m., the facility's Abuse Policy Statement did not document the following: a. The OLTC Incident Reporting Regulation dated 1/27/00 documented, "The requirement that the facility ' s administrator or his or her designated agent immediately reports all cases of suspected abuse or neglect of residents of a long-term care facility as specified below. 1) Suspected abuse or neglect of an adult (18 years old or older) shall be reported to the local law enforcement agency in which the facility	F 226		

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F 226	<p>Continued From page 2</p> <p>is located, as required by Arkansas Code Annotated 5-28-203(b).</p> <p>2) The requirement that facility personnel, including but not limited to, licensed nurses, nursing assistants, physicians, social workers, mental health professionals and other employees in the facility who have reasonable cause to suspect that a resident has been subjected to conditions or circumstances which have or could have resulted in abuse or neglect are required to immediately notify the facility administrator or his or her designated agent."</p> <p>b. ABUSE INVESTIGATION REPORT</p> <p>1) "The facility must ensure that all alleged or suspected incidents involving resident abuse, exploitation, neglect or misappropriations of resident property are thoroughly investigated. The facility ' s investigation must be in conformance with the process and documentation requirements specified on the form designated by the Office of Long Term Care, Form DMS-762, and must prevent further potential incidents while the investigation is in progress.</p> <p>2) The results of all investigations must be reported to the facility ' s administrator, or designated representative, and to other officials in accordance with state law, including the Office of Long Term Care, within 5 working days of the facility ' s knowledge of the incident. If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>3) The DMS-762 shall be completed and mailed to the Office of Long Term Care by the end of the 5th working day following discovery of the incident</p>	F 226			

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F 226	Continued From page 3 by the facility. The DMS-762 may be amended and re-submitted at any time circumstances require."	F 226			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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 REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the care plan documented the amount of assistance required during meal times for 1 (Resident #7) of 12 case mix residents (Resident #6, 7, 8, 10, 12 and 14 - 20) who required supervision and set-up with meals. This failed practice had the potential to affect all 107 residents who received meals from the kitchen. The findings are: Resident #7 had diagnoses of Lupus	F 280			

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F 280	<p>Continued From page 4</p> <p>Erythematousus, Dementia, Dysphagia with Esophageal Stricture, Gastro Esophageal Reflux Disease and Temporo Mandibular Joint Disease (TMJ). The Quarterly Minimum Data Set (MDS) dated 11/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making, was a a planned weight change program and required assistance with set-up for meals.</p> <p>a. The care plan documented a problem dated 5/24/06 of nutritional risk with interventions of "Give resident adequate time to consume food... Encourage maximum fluid intake allowed..." The care plan did not document the amount of assistance the resident required at meal time.</p> <p>b. A physician order dated 9/15/06 documented mechanical soft diet with nutritional supplement.</p> <p>c. On 1/23/07 at 12:00 p.m., the resident was served three beverages: water in a glass, iced tea in a coffee cup, and apple juice in a carton. There was a straw in the tea. The resident had tremors of both hands. The juice box was unsealed but was not spread open for access and did not have a straw. The resident touched the juice box but did not open the box, or drink further or pour from the juice box. The Ensure pudding had a peel-off top, but was not opened. The resident did not consume any of the pudding.</p> <p>d. On 1/23/07 at 5:05 p.m., the resident was served milk in a 4 oz (ounce) carton. The milk seal was broken but was not spread open for access and there was not a straw. The resident did not consume any of the milk. The Ensure pudding had a peel-off top, but it was not opened. The resident did not consume any of the pudding.</p>	F 280			

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F 280	Continued From page 5 The resident had tremors in each hand.	F 280			
F 282 SS=E	<p>e. On 1/24/07 at 7:20 a.m., the resident was served Ensure pudding. The Ensure pudding had a peel-off top, but it was not opened. The resident did not consume any of the pudding. The resident had tremors in each hand.</p> <p>f. On 1/23/07 at 9:45 a.m. and 1/23/07 at 9:45 a.m., the resident was asked if she was able to place her own straw in the milk carton. She stated, "I can get it in eventually."</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure weekly weights were conducted for 3 (Residents #1, 5 and 10) of 19 case mix (Residents #1 through #19) who had a physician order for monitoring of weight. The facility failed to ensure the blood pressure was taken daily for 1 (Resident #5) who had a physician order for daily blood pressure checks. These failed practices had the potential to affect all 107 residents. The findings are:</p> <p>1. Resident #1 had diagnoses of Cerebrovascular Accident, Anemia, PEG (Percutaneous Endoscopic Gastrostomy) Tube and Alzheimer's Dementia. The Significant Change Minimum Data Set (MDS) dated 11/9/06 documented the</p>	F 282			

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F 282	<p>Continued From page 6</p> <p>resident was moderately impaired in cognitive skills for daily decision making, had a weight loss and a feeding tube.</p> <p>a. A physician order dated 11/3/06 documented, "Weigh: Q (every) week."</p> <p>b. On 1/25/07 at 11:30 a.m., the ADL (Activities of Daily Living) Flow Sheet dated 1/1/07 through 1/31/07 documented, "Weigh: Q Week." There were no entries of weight on the ADL Flow Sheet.</p> <p>c. On 1/24/07 at 8:45 a.m., the Administrator stated, "Both Restorative CNAs (Certified Nursing Assistants) resigned without giving notice, so our weekly weights didn't get done. We did not assign that to someone else."</p> <p>2. Resident #5 had diagnoses of Cerebral Vascular Accident, Hypertension, PEG (Percutaneous Endoscopic Gastrostomy) Tube, Reflux Esophagitis and Pernicious Anemia. The Quarterly MDS dated 12/20/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had no weight loss and a feeding tube.</p> <p>a. A physician order dated 10/10/06 documented, "Weigh weekly and fax results to MD (medical doctor) office."</p> <p>b. On 1/25/07 at 11:30 a.m., the ADL Flow Sheet dated 1/1/07 through 1/31/07 documented, "Weigh: Weekly and fax results to MD office." There were no entries of weight on the ADL Flow Sheet.</p> <p>c. On 1/27/07 at 4:10 p.m., the Director of Nursing (DON) stated, "The weekly weights didn't</p>	F 282			

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F 282	Continued From page 7 get done but, the monthly weights did." d. A physician orders dated 7/31/06 documented, "Monitor: BP (blood pressure) QD (every day) if over 140/90 call office." e. On 1/25/07 at 11:30 a.m., the ADL Flow Sheet dated 1/1/07 through 1/31/07 documented, "Monitor: BP QD if over 140/90 call office." There were no entries of blood pressure on the ADL Flow Sheet. f. On 1/27/07 at 5:05 p.m., the DON stated, "The nurse was unaware that [Resident #5] was to have daily blood pressure." 3. Resident #10 had diagnosis of Congestive Heart Failure, Alteration of Mental Status and Chronic Obstructive Pulmonary Disease. The Significant Change MDS dated 12/23/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had a swallowing problem and did not have a weight loss. a. A physician order dated 12/8/06 documented, "weigh weekly." b. The December 2006 Vital Signs Record documented a weight of 170 # on 12/13/06, there was no documentation of any other weights for December 2006. There was no documentation of weights on the January 2007 Vital Signs Record. c. The January 2007 Annual Weight Report documented a weight of 172.9 lbs. There was no documentation of the date of this weight. 4. The facility's Policy and Procedure for	F 282			

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F 282	Continued From page 8 Weighing and Measuring residents received from the Administrator on 1/29/07 documented, "The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The height and weight of the resident. 4. All assessment data obtained during the procedure. 5. How the resident tolerated the procedure. 6. If the resident refused the treatment and the reason(s) why. 7. The signature and title of the person recording the data."	F 282		
F 309 SS=D	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: Based on observation and record review the facility failed to ensure the catheter tubing was secured to the leg and not portioned between the bars of the side rail to prevent trauma to the urinary meatus for 1 (Resident #9) of 3 (Resident #9, 13 and 17) case mix residents who had a urinary catheter. This failed practice had the potential to affect 8 residents who had an indwelling catheter according to the Resident Census and Conditions of Residents form provided by the Administrator on 1/22/07. The findings are:	F 309		

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F 309	Continued From page 9 1. The Policy and Procedure provided by the Administrator on 1/25/07 at 9:50 a.m. documented, "Foley Catheter Insertion, Female Resident... Steps in Procedure... 25. Attach catheter to drainage tubing. Tape catheter to inner thigh or secure with leg band. Secure drainage tubing to bottom bed sheet with clip from drainage set." 2. Resident #9 had diagnoses of Alzheimer, Rheumatoid Arthritis and Osteoporosis. The Minimum Data Set dated 12/13/06 documented the resident was severely impaired in cognitive skills for decision making and had an indwelling catheter. a. The Care Plan dated 12/13/06 documented "081806 FC (Foley Catheter) to CSSD (Closed System Sterile Drainage) dx (diagnosis) decub to coccyx with residual of 600 cc (cubic centimeter) per TX (treatment) nurse... Leg Strap on at all times..." b. On 1/24/07 at 7:45 a.m., 8:50 a.m., and 2:15 p.m., there was no leg band in place securing the catheter tubing. c. On 1/24/07 at 9:20 a.m., CNA #1 put the catheter tubing between the 2nd and 3rd rail of the side rail and there was no leg band to secure the catheter tubing. d. On 1/24/07 at 2:15 p.m., the catheter drainage bag was hanging on the 2nd rail of the side rail.	F 309		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 10 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure assistance was provided for removing chin hairs for a (Resident #17) of 19 (Resident #1 - 19) case mix residents who required assistance with personal hygiene. This failed practice had the potential to affect all 107 residents. The findings are: Resident #17 had diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Paralysis and Cerebral Vascular Accident. The Quarterly MDS dated 1/4/07 documented the resident was moderately impaired in cognitive skills for daily decision making and required limited one person physical assistance with personal hygiene. a. The Care Plan dated 10/4/06 documented the resident required assistance with activities of daily living (ADL) with an intervention to shower 2 times a week and encourage participation in ADL's. b. On 1/22/07 at 6:17 p.m., the resident was in her room and when asked about the facial hair on her chin stated, "They (facial hairs) worry the heck out of me. I don't think about it. Maybe one of the aides will notice." The hairs were about 1/4 inch long. c. On 1/27/07 at 2:10 p.m., the resident stated she had asked Licensed Practical Nurse (LPN) #2 for a razor this morning and "she said okay." The resident's chin hair was still long.	F 312			

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F 312	Continued From page 11	F 312			
F 318 SS=E	<p>d. On 1/27/07 at 4:07 p.m., the Director of Nursing (DON) was told about the resident's chin hair and the DON stated, "They bother me too. I will take care of that right away. I do when I see it."</p> <p>483.25(e)(2) RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure restorative care was provided for 3 of 3 case-mix residents (Resident #1, 7 and 13) who had a physician order for restorative therapy. This failed practice had the potential to affect 17 residents who had a physician order for restorative therapy according to the Administrator on 1/24/07 at 10:06 a.m. The findings are:</p> <p>1. Resident #1 had diagnoses of Cerebral Vascular Accident, Syncope with History of Falls, Anemia, and Alzheimer's Dementia. The Significant Change Minimum Data Set (MDS) dated 11/9/06 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on staff for transfers, had functional limitation in range of motion both sides with partial loss in voluntary movement in arms and legs and was transferred manually.</p>	F 318			

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NAME OF PROVIDER OR SUPPLIER OZARK HEALTH NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 HIGHWAY 65 SOUTH CLINTON, AR 72031		
(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 318	Continued From page 12 a. A physician order dated 9/7/06 documented, "Restorative care to provide ROM (Range of Motion) to bilateral lower extremities." b. On 1/25/07 at 11:30 a.m., there was no documentation on the December 2006 or January 2007 Restorative Record the resident received Restorative care since 12/21/06. 2. Resident #7 had diagnoses of Temporo Mandibular Joint Disease (TMJ) and Osteoarthritis. The Quarterly MDS dated 11/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making and limited range of motion of one foot a. A physician order dated 8/18/06 documented, "Restorative care ambulate with rolling walker QD (every day); Restorative care exercises 3x/week and 1/17/07 Restorative care 3-5x/week for ambulation and exercises." b. On 1/24/07 at 12:45 p.m., there was no documentation on the January 2007 Restorative Record that the resident received restorative care. 3. Resident #13 had diagnoses of Arthritis and History of Compression Fracture. The Quarterly MDS dated 1/4/07 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent for transfer, had limitation in range of motion and partial loss of voluntary movement of both lower extremities and was transferred manually. a. A physician order dated 9/7/06 documented, "Restorative care 3 x week to maintain PROM	F 318			

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F 318	Continued From page 13 (Passive Range of Motion) and bilateral lower extremities..." b. On 1/24/07 at 12:45 p.m., there was no documentation on the January 2007 Restorative Record that the resident received Restorative care. 4. On 1/24/07 at 8:53 a.m., Licensed Practical Nurse (LPN) #1 stated, "We don't have a Restorative Certified Nursing Assistant (RCNA)." 5. On 1/24/07 at 8:56 a.m., the Administrator stated, "Both of the RCNAs left. The residents have been getting whatever the aides can do."	F 318			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure non-weight bearing residents were not lifted under the arms during a transfer for 1 (Resident #1) of 14 case mix residents (Residents #1 through 5, 8 through 13, 15 and 17) who were dependent on staff for transfers. This failed practice had the potential to affect 79 residents who were dependent on staff for transfers as documented on the Resident Census And Conditions of Residents report dated 1/23/07. The findings are: Resident #1 had diagnoses of Cerebrovascular Accident, Syncope with History of Falls and Alzheimer's Dementia. The Significant Change	F 324			

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F 324	Continued From page 14 Minimum Data Set dated 11/9/06 documented the resident was moderately impaired in cognitive skills for daily decision making, totally dependent on 2 staff persons for transfers, had functional limitation in range of motion of both arms and legs with partial loss of voluntary movement and was transferred manually. a. On 1/23/07 at 10:45 a.m., the resident was in bed. Certified Nursing Assistant (CNA) #2 and #4 stood on each side of the resident, lifted the resident's entire weight, from under both shoulders, and swung the resident from the bed to the wheelchair. The resident's feet did not touch the floor.	F 324		
F 364 SS=C	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure foods were not over-cooked to conserve the nutritive value and appearance, and were served at the proper temperature. These failed practices had the potential to affect 106 residents who received meals from the kitchen according to the Diet List dated 1/23/07. The findings are: On 1/23/07 at 3:00 p.m. during the group meeting 5 of 5 alert and oriented residents stated the food was over-cooked, undercooked, not always warm enough and the rolls never melt butter.	F 364		

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F 364	Continued From page 15 a. On 1/23/07, during the lunch meal, the baked chicken appeared dry and tough. Three non-case mix residents took a bite of the chicken and stated that it was too tough and dry to eat and left it on their plates. b. On 1/24/07 at 12:00 p.m., the broccoli served from the steam table able was mushy, pale and a dull yellowish green in color. c. On 1/26/07 at 7:55 a.m., a test tray at breakfast on the 700 and 800 hall dining rooms registered the following temperatures: 1) Scrambled eggs, 118 degrees Fahrenheit 2) Hot cereal, 118 degrees Fahrenheit 3) A pat of margarine on a biscuit would not melt.	F 364		