

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

PRINTED: 03/06/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2006
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 000	INITIAL COMMENTS	F 000			
F 221 SS=D	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure that after re-evaluation of a restraint, attempts were made to eliminate restraint use for 1 (Resident #16) of 17 (Residents #1, #2, #3, #5, #6, #8, #9, #10, #12, #13 and #16 thru #22) case-mix residents reviewed for restraints. This failed practice had the potential to affect 26 residents with restraints, according to the Resident Census and Condition of Residents form dated 2/13/06. The findings are:</p> <p>1. Resident #16 had diagnoses of Syncope and Vertigo. The Quarterly Minimum Data Set dated 1/20/06 documented the resident was moderately impaired cognitively for daily decision making, required limited assist for transfers and ambulation, had no falls in the past 180 days and had a trunk restraint.</p> <p>a. A Physician order dated 9/24/05 that documented "Soft belt restraint while up in the w/c (wheelchair) check q (every) 30 minutes and</p>	F 221			

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 221	<p>Continued From page 1</p> <p>release q 2 hours x (times) 10 minutes to prevent resident form rising."</p> <p>b. The Physical restraint elimination assessment form dated 10/20/05 and 1/25/06 documented the resident scored 24 [score of 21-35 Good candidate], indicating [he/she] was a good candidate for restraint elimination. The reverse side of the form dated 10/20/05, in the space provided for documentation of the specific reason the restraint could not be reduced, was left blank. In the space provided for additional comment the form documented "cont (continue) current p.o.c. (plan of care)" There was no specific reason why the restraint could not be reduced or any documentation of an attempt to reduce the restraint.</p> <p>c. On 1/25/06 the reverse side of the form dated 10/20/05, in the space provided for documentation of the specific reason the restraint could not be reduced, was left blank. In the space provided for additional comment the form documented "requires soft belt while up in w/c unable to stand without define boundaries." There was no specific reason why the restraint could not be reduced or any documentation of an attempt to reduce the restraint.</p> <p>d. The plan of care dated 1/26/06 documented: "At risk for falls or injury related to: HX (History) of falls, vertigo, syncope, dementia, impaired mobility, osteoarthritis, poor eyesight" with interventions that included "Soft belt restraint while in w/ch, (wheelchair) due to attempts to rise alone and inability to do so. Check Q 30 min, release q 2 hours and exercise for 10 min."</p> <p>e. On 2/14/05 at 10:20 a.m., the resident was in</p>	F 221		

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F 221	Continued From page 2 [his/her] room in a wheelchair with a blue belt restraint in place. The restraint was marked by placing a piece of scotch tape over the loop of the restraint and on the lower bar in the back of the wheelchair. f. On 2/14/05 at 11:00 a.m., the resident was in [his/her] room and the restraint was in the same marked position. g. On 2/14/05 at 1:40 p.m., Certified Nurse Aide (CNA) #12 and CNA #14 released the restraint for 5 minutes while the incontinent brief was changed. They left the room at 1:45 p.m., without providing any exercise for the resident. The restraint had been on the resident for 3 hours and 20 minutes.	F 221			
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure personal care was provided in a manner that enhanced respect and preserved dignity and serving and feeding assistance was provided in a manner to maintain the residents' dignity by not making residents wait at the table for long periods of time before receiving service or assistance after tablemates had received their trays. These failed practices had the potential to affect all 106 residents in the facility, according to	F 241			

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F 241	Continued From page 3 the Resident Census and Condition or Residents form dated 2/13/06. The findings are: 1. Resident #4 had diagnoses of Alzheimer's Disease, Depression and Anxiety. The Quarterly Minimum Data Set (MDS) dated 2/8/06 documented the resident had moderately impaired cognitive skills for daily decision-making and was dependent on staff for personal hygiene and bathing. a. The Plan of Care dated on 2/8/06 documented, "Assistance needed for ADL's (Activities of Daily Living). Keep [resident's name] clean, dry and odor free. Maintain dignity." b. On 02/11/06 at 2:45 p.m., the resident was transported back to the resident's room in a shower chair by Certified Nurse Aide (CNA) #1. The resident was draped with a thin, damp cotton sheet and had a towel wrapped around her wet hair. The CNA stated, "She just got her shower." CNA #1 and CNA #2 gathered new linen and supplies. At 2:52, CNA #1 removed the sheet and the towel from the resident. The resident was completely naked and still wet from the shower. The resident folded [his/her] arms across [his/her] breasts. Both CNAs changed the linens on the bed, while the resident sat naked and wet in the shower chair. CNA #2 placed a small pillow under the resident's arm. The resident placed the pillow over [his/her] genital area. CNA #2 took the pillow back and placed the pillow back under resident's arm. The CNAs transferred the resident from the shower chair to the bed via the mechanical lift and incontinent care was then performed. The resident remained completely naked, without any portion of [his/her] body covered, during the procedure. An incontinent brief was placed on the	F 241			

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F 241	Continued From page 4 resident at 3:02 p.m. and then a pajama top. The resident touched the pillow and said, "These are wet." Neither CNA responded verbally or by changing the now damp linens. At 3:08 p.m., the resident was covered with the top sheet and stated, "Feels good. So cold." 2. On 2/12/06 at 11:50 a.m., during meal observation, a resident at the end of table 1, in the dining room, received and was fed [his/her] noon meal. The other 6 residents at the table were not served until 12:20 p.m., after the first resident had completed [his/her] meal. At table 2, one resident received [his/her] tray at 12:00 noon. At 12:20 p.m. the other resident was served [his/her] tray after yelling several times "Where is my food?" 3. On 2/12/06 at 4:45 p.m., Resident #16 was in the dining room at the end of the assist table. At 5:00 p.m., the resident at the other end of the table was served and fed [his/her] supper tray while the 5 other residents watched. At 5:25 p.m., the resident was served a cup of coffee. The other 5 residents were served their trays at 5:30 p.m. At 5:46 p.m., after Resident #16 stated, "Where is my food?" CNA #1 was asked about the resident's tray. CNA #10 walked off to the dietary cart and retrieved the resident's food tray and served it.	F 241		
F 248 SS=C	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

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F 248	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure weekend activities were provided for residents. This failed practice had the potential to affect 106 residents in the facility, according to the Resident Census and Conditions of Residents form dated 2/13/06. The findings are: 1. On 2/12/06 at 9:30 a.m., during the group interview, the alert and oriented residents stated there were no planned activities on the weekends. When asked "What do you do on weekends?" The residents stated, "We have to watch the boob tube [television], because there is no one here to do activities." The resident's further stated that it made for a very long weekend because they were bored. 2. The December 2005 activity calendar documented that on Saturday the 10th and the 17th, the activity was Dominoes on your own and TV time. On Sunday the 4th and the 18th the morning activity was listed as TV time. 3. The January 2006 activity calendar documented on Saturday the 7th the afternoon activity as Dominoes, on the 14th the calendar documented TV time and Dominoes and the 21st documented the a.m. activity as Dominoes. On Sunday the 1st, 8th, 15th, 22nd and 29th, the calendar documented the a.m. activity as Dominoes. 4. The February 2006 activity calendar documented that on Saturday the 4th and 11th the p.m. activity was TV time, on your own. On	F 248			

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F 248	Continued From page 6 Saturday the 18th the a.m. activity was documented as TV time on your own. On Sunday the 12th, 19th and 26th the a.m. activity was documented as TV time on your own. 5. On 2/14/06 at 3:00 p.m., the Activity Director stated that the Dominoes are in the cabinet by the sink in the dining room. She further stated that the CNAs would bring the residents to the dining room, the residents were on their own and the residents get them out if they want to on weekends.	F 248		
F 314 SS=E	483.25(c) PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that 7 (Residents #3, #4 and #16 thru #20) of 18 (Resident #1, #3 thru #10, #13 thru #20 and #26) case mix residents with and/or at risk for developing pressure sores received the necessary treatment and services to promote healing, prevent infection and prevent the potential for the development of new pressure sores. This failed practice had the potential to	F 314		

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F 314	Continued From page 7 affect 65 residents identified as at risk for developing pressure sores, according to list provided by the facility dated 2/15/06. The findings are: 1. The facility's Policy and Procedures for "Skin Audits-Treatments-&-Documentation" documented: "WEEKLY descriptions and progress notes are REQUIRED until an area is completely healed." 2. Resident #4 had diagnoses of Alzheimer's Disease, Depression and Anxiety. The Quarterly Minimum Data Set (MDS) dated 2/8/06 documented the resident had moderately impaired cognitive skills for daily decision-making, was incontinent of bowel and bladder, dependent on staff for personal hygiene and had a Stage IV pressure sore. a. A Physician order dated 11/30/05 documented: "Treatment change sacral decub (Decubitus) drsg (dressing) with NS (normal saline) and pack with guaze (gauze) coated with Panafil daily." b. The Plan of Care dated 2/8/06 documented: "Position off of site to promote healing. Reposition q (every) 2 hours. Record healing progress q day." c. On 2/11/06 at 3:00 p.m., Licensed Practical Nurse (LPN) #1 performed the dressing change on the sacral wound after the resident's shower. The LPN applied Panafil in a thin layer to one side of four 2-by-2 inch dry gauze pads. The gauze was packed into the wound crater one after another without the LPN ensuring the Panafil side of the gauze was against the wound crater wall; this resulted in the non-medicated, dry side of the	F 314			

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F 314	<p>Continued From page 8</p> <p>gauze to be in contact with the crater surface. The wound was then covered with a gauze pad that was secured on either side but not at the bottom. This allowed a gap in the wound dressing at the resident's anal area.</p> <p>d. On 02/12/06 at 12:00 noon, the resident's position was marked in a Geri chair with a piece of paper place under the right leg. At 3:30 p.m., CNA #2 and CNA #3 transferred the resident from the marked position in the Geri chair, back to bed. The incontinent brief was saturated with urine and had a large amount of soft feces in it. The brief that was removed was marked "9:25 a.m." The dressing over the sacral wound was wet and had dried feces on the bandage and under the edge of the bottom of the dressing. CNA #2 wiped the feces from the anal area with a back to front swipe followed by a front to back swipe followed by a side to side swipe.</p> <p>e. On 02/13/06 at 11:00 a.m., LPN #2, the treatment nurse was asked for the most recent wound report. The "Weekly Pressure Sore QI (Quality Indicator) Log" was dated 1/23 - 1/27. LPN #2 stated that [he/she] had been working the floor for the past couple of weeks and had not been scheduled as the treatment nurse. LPN #2 stated, "The floor nurses do the treatments and document the wound descriptions in the nurse's notes when there's not a treatment nurse scheduled." The resident's clinical record was reviewed with LPN #2. The most recent wound documentation in the nurse's notes was dated 1/30/06 at 0720 (7:20 a.m.) and was signed by LPN #2.</p> <p>3. Resident #3 had diagnoses of Alzheimer's Dementia with Depression, Rheumatoid Arthritis</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>and Osteoarthritis. The Annual MDS dated 2/1/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required staff assistance for ADLs, had a Stage II stasis ulcer and required a trunk restraint. The Braden Scale dated 2/1/06 identified the resident as being at risk for the development of pressure areas.</p> <p>a. The Plan of Care dated on 2/1/06 documented, "Soft lap belt in wheelchair. Check q (every) 30 minutes. Release q 2 hours for exercise.</p> <p>b. On 2/12/06 at 9:35 a.m., the resident was toileted and the incontinent brief was timed by CNA #4. The resident's position and restraint were marked for position with a pen mark where the restraint was connected to the wheelchair.</p> <p>c. On 02/12/06 at 12:55 a.m., the resident and restraint were in the same marked position. The incontinent brief that was removed at this time was marked 9:35 a.m.</p> <p>4. Resident #17 had diagnoses of Cerebrovascular Accident and Depression. The Quarterly MDS dated 11/16/05 documented the resident had moderately impaired cognitive skills for daily decision-making, was totally dependent on staff for transfers and required the use of a chair that prevented rising.</p> <p>a. The Plan of Care dated on 2/8/06 documented, "Lap Buddy while in wheelchair. Check q 30 minutes, release q 2 hours and exercise for 10 minutes."</p> <p>b. On 2/14/06 at 10:45 a.m., the resident's position and restraint were marked for position by</p>	F 314			

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F 314	Continued From page 10 placing a piece of tape from the chair arm to the lap buddy. c. On 02/14/05 at 1:35 p.m., the resident and restraint were in the same marked position of 10:45 a.m. The incontinent brief removed at this time was marked "10:10 a.m." and was urine soaked. d. On 02/14/06 at 1:35 p.m., CNA #8 stated, "We mark their briefs to prove we change everyone at least every 2 hours. We try to get everyone every 2 hours but some days we can't take breaks and don't take lunch and still can't get everyone done. Sometimes we only have time for 2 or 3 hall rounds a shift." 5. Resident #20 had diagnoses of Alzheimer's Disease and Depression. The Annual MDS dated 1/25/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required staff assistance for ADL and required the use of a trunk restraint. a. The Plan of Care dated on 1/26/06 documented, "Check restraint at least q 30 minutes, release q 2 hours and exercise for 10 minutes" and "Monitor q 2 hours for incontinent episodes." b. On 2/14/06 at 9:45 a.m., the resident's soft belt restraint was marked for position with a pen mark where the restraint was connected to the chair. c. On 02/14/06 at 1:35 p.m., the restraint was in the marked position of 9:45 a.m. The incontinent brief removed at this time was marked "9:40 a.m." There was a puddle of urine in the seat of the wheelchair after the resident was transferred.	F 314		

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F 314	Continued From page 11 LPN #4 stated, "She's soaked." 6. Resident #19 had diagnoses of Hypertension, End Stage Alzheimer's Dementia, Osteoporosis and Cerebrovascular Disease. The Quarterly Minimum Data Set dated 1/25/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total assistance of two for transfers, bed mobility, ambulation in room and toilet use and was incontinent of bladder and bowel and required the use of a chair that prevented rising and side rails. a. A Braden Risk Assessment Scale dated 1/25/06 documented the resident was at high risk for the development of pressure ulcers. The plan of care documented: Interventions - A pressure mattress on the bed, A turning and repositioning program and incontinent care after each incontinent episode. b. On 2/14/06 at 9:30a.m., the resident was sitting in a Geri chair in the facility day room. At 11:40 a.m. CNA #19 moved the resident in the Geri chair, to the main dining room. The CNA did not check the resident for incontinence, change the residents clothing or reposition the resident in the Geri chair. At 1:30 p.m. the resident remained up in the Geri chair. CNA #19 took the resident into [his/her] room. The CNA placed the resident into bed and removed a wet, soiled with bowel movement, brief dated 2/14/06 at 9:00 a.m. from the resident. CNA #19 and CNA #20 provided incontinent care. The resident had a red line on the right leg that was approximately 8 inches long. The resident was left sitting in the Geri chair for 4 hours, without being checked for incontinence or being repositioned.	F 314			

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F 314	<p>Continued From page 12</p> <p>7. Resident #18 had diagnoses of Abdominal Aortic Aneurysm, Osteoporosis and Dementia. The Quarterly MDS dated 12/7/05 documented the resident was severely impaired in cognitive skills for daily decision making, required limited assistance of two for transfers, bed mobility, was totally dependent for ambulation and toilet use and was incontinent of bladder and bowel, required the use of a chair that prevented rising and side rails and had no current pressure ulcers. The Annual MDS dated 9/7/05 documented that the resident had a stage II pressure ulcer.</p> <p>a. A Braden scale dated 8/31/05 documented the resident was at high risk for the development of pressure ulcers.</p> <p>b. A plan of care dated 10/6/05 documented on page 4 a problem of "Assistance needed for ADL's (Activities of Daily Living) with Approaches of "2) Turn and Reposition Q (every) 2 hrs (hours) using supportive devices for good body alignment and comfort. 6) Incontinent of bowel & bladder. Check Q 2 hrs. peri care with each episode."</p> <p>c. On 2/14/06 at 10:15 a.m., the resident was in the facility day room in a Geri chair. At 11:35 a.m., CNA #17 moved the resident, in the chair, to the dining room for lunch.</p> <p>d. On 2/14/06 at 1:40 p.m., the resident was taken out of the Geri chair by CNA #17 and CNA #18 and transferred into the bed. The CNAs removed a wet disposable brief that contained a small amount of bowel movement; the brief was dated 2/14/06 at 10:15 a.m. The resident was provided incontinent care and left in the bed.</p> <p>The resident was not repositioned or checked for</p>	F 314			

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F 314	Continued From page 13 incontinence from 10:15 a.m. until 1:40 p.m.; a total of 3 hours and 30 minutes. 8. Resident #16 had diagnoses of Syncope and Vertigo. The Quarterly MDS dated 1/20/06 documented the resident was moderately impaired cognitively for daily decision making, required limited assistance for transfers and ambulation, had a Stage II pressure sore and a trunk restraint. a. The plan of care dated 1/26/06 documented a problem of "At risk for skin breakdown secondary to impaired mobility and incontinency of bladder & weight loss" with interventions that included "Provide incontinent care after each episode and turn and reposition every 2 hours." b. On 2/14/05 at 10:20 a.m., the resident was in [his/her] room up in a wheelchair with a blue belt restraint in place. The restraint was marked by placing a piece of scotch tape over the loop of the restraint and on the lower bar in the back of the wheelchair. c. On 2/14/05 at 11:00 a.m., the resident was again in [his/her] room and the restraint was in the same marked position. d. On 2/14/05 at 1:40 p.m., CNA #12 and CNA #14 changed the resident's urine soaked incontinent brief without providing incontinent care. CNA #12 was asked "Did you wash the resident? The CNA stated "No." The urine soaked brief that was removed from the resident documented the time the brief was applied as 10:10 a.m.; the resident was up in the wheelchair for 3 hours and 20 minutes.	F 314			

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F 318	Continued From page 14	F 318			
F 318 SS=D	<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:</p> <p>Based on observation and record review, the facility failed to ensure that 1 of 1 (Resident #4) case mix resident who had decreased range of motion (ROM) received services to prevent possible further decline in ROM. This failed practice had the potential to affect 47 residents with contractures that required hand devices, according to a list provided by the Administrator on 2/15/06. The findings are:</p> <p>1. Resident #4 had diagnoses of Alzheimer's Disease, Depression and Anxiety. The Quarterly Minimum Data Set dated 2/8/06 documented the resident had moderately impaired cognitive skills for daily decision-making and was dependent on staff for all Activities of Daily Living. The Plan of Care dated 2/8/06 did not identify the resident's contracted left hand or the use of a hand roll to prevent further decline.</p> <p>a. Nurse's Notes dated 1/18/06 at 3:30 p.m. documented: "Res (resident) having contractures in L (left) hand...Call placed to [physician name] for OT (Occupational Therapy) eval (evaluation). New order for them to eval et (and) Tx (treat) as indicated..."</p>	F 318			

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F 318	Continued From page 15 b. Nurse's Notes dated 1/27/06 (no time given) documented: "...It was decided to D/C (discontinue) OT orders and place pillow in contracted hand to prevent further contractures." c. On 2/11/06 at 12:20 p.m., and 3:00 p.m. and on 2/12/06 at 8:40 a.m., the resident's contracted left hand did not have any positioning device in place. d. On 2/12/06 at 12:00p.m., 2:30 p.m. and 5:22 p.m., the resident did have a positioning device in place in the left hand.	F 318		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure a restraint was applied as per the manufactures guidelines for 2 (Residents #9 and #16) of 3 (Residents #3, #9 and #16) case mix residents with a belt restraint. This failed practice had the potential to affect 26 residents with restraints, as identified by the Resident Census and Condition of Residents form dated 2/13/06. The findings are 1. Resident #16 had diagnoses of Syncope and Vertigo. The Quarterly Minimum Data Set dated 1/20/06 documented the resident was moderately impaired cognitively for daily decision making and had a trunk restraint.	F 323		

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F 323	Continued From page 16 a. A Physician order dated 9/24/05 documented: "Soft belt restraint while up in the w/c check q 30 minutes and release q 2 hours x 10 minutes to prevent resident from rising." b. On 2/12/06 at 11:45 a.m., the resident was up in a wheelchair at the feeding assist table. The blue belt restraint strap was over the top of the right wheelchair arm, instead of threaded down between the seat and the wheelchair frame. The restraint was taut under the resident's breast, instead of across the lap. 2. Resident #9 had diagnoses of Alzheimer, Dementia with Psychomotor Agitation, and Pressure Ulcer. The Quarterly MDS dated 9/15/05 documented the resident had moderately impaired cognitive skills for daily decision making and side rails while in bed. a. A Physician Order dated 1/27/06 documented: "soft belt restraint while up in wheelchair." b. On 2/13/06 at 1:40 p.m. the resident was sitting in a wheelchair with a soft belt restraint positioned loosely above the waist, over the top of the resident's breast area and back under the resident's arms. The straps were not crossed at the back of the wheelchair and were connected by both loops on the bottom left side of the wheelchair. 3. The Manufacturers guideline documented the application instructions as "2) Bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt. 3) Go around the back past and cross the straps behind the patient. Secure the loops on the wheelchair tilt levers. The	F 323			

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F 323	Continued From page 17 belt should be over the patient's hips at a 45 [degree] angle holding the hips against the back of the chair."	F 323			
F 326 SS=E	483.25(i)(2) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a therapeutic diet was provided, as order by a physician and/or recommended by a Registered Dietitian (RD) for 2 of 2 (Residents #6 and #18) case mix residents. This failed practice had potential to affect 14 residents with physician orders for fortified foods, according to the facility Diet list dated 2/11/06. The findings are: 1. Resident #18 had diagnoses of Alzheimer's Disease, Hypertension and Nutritional Deficiency A Physician order dated 12/27/04 documented: "fortified Mechanical Soft diet." The quarterly Minimum Data Set (MDS) dated 8/24/05 documented the resident was moderately impaired in cognitive skills for daily decision making and required set-up for eating. a. On 2/12/06 at 5:55 p.m., during the supper meal observation, the resident was served ground breaded chicken, baked apple, one slice of bread, scalloped potatoes, tea, coffee, water and a	F 326			

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F 326	<p>Continued From page 18</p> <p>carton of whole milk. There was no fortified food items served to the resident.</p> <p>b. On 2/13/06 at 7:43 a.m., during the breakfast meal observation, the resident was served one biscuit, gravy, two bowls of bran flakes, ground dried sausage, a carton of whole milk and a carton of apple juice. There was no fortified food items served to the resident with the meal.</p> <p>2. Resident #6 had diagnoses of Arthritis, Pernicious Anemia, Indigestion, Osteoporosis, Weight Loss and Deep Vein Thrombus. The Quarterly MDS dated 11/17/05 documented the resident was moderately impaired cognitively in daily decision making skills, required extensive assistance of one with eating and had a weight loss.</p> <p>a. The plan of care dated 11/15/05 documented a problem of "At risk for poor nutritional status with weight loss related to confusion, gastric problems, anemia, occasional poor intake" with interventions that included "Dietary Supervisor or R.D. (Registered Dietician) to assess for nutritional adequacy."</p> <p>b. The RD note dated 1/4/06 documented: "Jan wt. (weight) 115# down (#6 x 1 mo., 13# x 3 mo., 19# x 6 mo) recently hospitalized c (with) DVT (deep vein thrombosis) LLE (left lower extremity) and also had UTI(Urinary Tract Infection) earlier in December. Diet cont. (continues) as soft 2GM (Gram) NA (Sodium), intake poor. Megace, Oxandrin not indicated as can ^ (increase) risk of blood clots. Recommend: Liberalize diet to Soft NAS (No added salt), Add fortified foods, Weight committee address c recommendations."</p>	F 326		

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F 326	Continued From page 19 c. The RD note dated 1/30/06 documented: "Wt. (weight) 110# [arrow down] 5# 1/24/06. Diet unchanged. Again rec. (recommend) liberalized diet to Mech (Mechanical) Soft NAS c fortified foods and start 2 Cal Med Pass." d. On 1/12/06 at 12:25 p.m., during the noon meal observation, the resident was served ground Roast Beef, Mashed Potatoes, Carrots, Roll, one carton of Whole Milk, Peach Clobber. There was no Yogurt, Cottage Cheese or boiled egg on the tray as per the facility policy for fortified foods. e. On 1/12/06 at 5:46 p.m., the resident was served regular Au Gratin Potatoes, Ground Chicken, Peas, one carton of Whole Milk and cooked apples. There was no Yogurt, Cottage Cheese or Boiled egg on the tray as per the facility policy for fortified foods. The diet card for the supper meal documented the resident was to receive 2 GM Na, Mechsft (Mechanical Soft) diet. There was no documentation on the card for Fortified foods. 3. The facility policy on fortified foods reference provided by dietary employee #2 on 2/13/06 at 10:40 a.m., documented: "Fortified foods are ordered by the physician. An additional serving of protein is given. Examples include: boiled egg, yogurt and cottage cheese."	F 326			
F 327 SS=E	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced	F 327			

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F 327	Continued From page 20 by: Based on observation, record review, and interview the facility failed to ensure that sufficient fluid intake was provided to maintain proper hydration, fluids were kept within reach, assessments were conducted to determine hydration needs, reassessments were conducted if Urinary Tract Infections (UTI), constipation or dehydration occurred, care plans were developed to include specific interventions to meet hydration needs and a system of recording fluid intake was developed for 2 (Residents #6 and #16) of 22 (Residents #1 thru #20, #25 and #26) case mix residents at risk for dehydration. These failed practices had the potential to affect 90 residents at risk for dehydration, according to a list provided by the facility on 2/15/06. The findings are: 1. On 2/14/06 at 1:40 p.m., Certified Nurse Aide (CNA) #3 stated the facility's method of determining meal consumption included the fluids offered on the residents' trays and there was no separate documentation for fluid consumption. 2. Resident #6 had diagnoses of Pernicious Anemia and Weight Loss. The Annual Minimum Data Set dated 8/31/05 documented the resident had moderately impaired cognitive skills for daily decision making, severely impaired vision, required extensive assistance with eating, had a weight of 135 [pounds] and received a diuretic for the past 7 days. a. The "MDS Primary Assessment Further Assessment Report" dated 8/31/05 documented: "Dehydration/Fluid Maintenance RAPS - Has there been a decrease in thirst perception? Yes. Is the Resident unaware of the need to intake sufficient fluids? Yes. Could the resident or staff	F 327		

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F 327	Continued From page 21 have restricted intake to avoid urinary incontinence? Yes. Would a sad mood or depression cause the resident to refuse foods or fluids? Yes." The reason to proceed to the plan of care was documented as "At this time requires assistance c (with) feeding is able to drink from cup at bedside. Increased weakness too tired & exerts too much energy to fed (feed) self." b. The Centers for Medicare and Medicaid Services interpretive guidelines document: "A general guideline for determining baseline daily fluids needs is to multiply the resident's body weight in kg (kilograms) times 30cc (cubic centimeters) (2.2kg = 1kg)." c. The Dietary Progress Record dated 11/14/05 documented the resident's weight at 119.5 and the fluid needs to be 1335cc, 294 cc less than required. [119.5 divided by 2.2 = 54.3 kilograms X 30cc = 1629 cc]. d. The plan of care dated 11/16/05 documented a problem of "At risk for fluid volume deficit, related to: Diuretic Therapy & Cognitive Decline" with interventions of "Encourage Additional fluids as allowed with care, with meals and snacks and with medications. Keep water pitcher filled with fresh water and readily available to [name of resident] and with medications." e. The Quarterly Minimum Data Set dated 11/17/05 documented the resident's weight at 120 pounds and a significant weight loss. f. The weight record documented the resident's weight in August as 134.5, September as 128.5, October 128.1 and November as 119.5, which represented a significant weight loss of 11.15% in	F 327			

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F 327	<p>Continued From page 22</p> <p>three months. The December weight was documented as 121.6#, January as 115.1# and February as 109.8 #, which represented a significant weight loss of 9.7% in three months and 18.22% in 6 months.</p> <p>g. The Nutrition progress notes dated 1/4/06 and 1/30/06 and signed by the facility's RD did not document reassessments of the resident's fluid needs based on the loss of weight at those times or the potential for dehydration.</p> <p>h. A hospital discharge summary dated 1/17/06 documented the resident was admitted to the hospital on 12/7/05 with a diagnoses of Urinary Tract Infection and Dehydration. The resident was discharged back to the facility on 12/26/05.</p> <p>i. The Diet sheet, which contained the meal percentage, documented the resident consumed an average of 40% of the meal from 1/21/06 through the breakfast meal on 2/12/06.</p> <p>j. On 2/12/06 at 12:25 p.m., the resident was served the noon meal which contained only one carton of whole milk. The resident consumed approximately 60% of the noon meal and approximately 1/2 of the cartoon of milk. No one encouraged the resident to drink fluids.</p> <p>k. On 2/12/06 at 2:40 p.m., the resident was in bed and the resident's water was on the bedside table, out of the reach of the resident.</p> <p>l. On 2/12/06 at 5:46 p.m., the resident was served the evening meal which had a carton of whole milk and one cup of coffee. The resident drank approximately 1/2 carton of milk and 2 sips of coffee. No staff person encouraged the</p>	F 327			

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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		
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F 327	<p>Continued From page 23</p> <p>resident to drink more fluids.</p> <p>m. On 2/14/06 at 2:45 p.m., the resident's charge nurse, Licensed Practical Nurse (LPN) #5 was asked "Who calculates the fluid needs for residents after being dehydrated?" She replied "We would do that." She was then asked "How do you monitor fluid intake?" She replied "Monitor meal consumption and snacks." She further stated that residents were placed on I&O (Intake and Output) only with a Physician's order. She was then asked, "Is there anyone on your hall that fluids are being encouraged?" She replied " Yes, [name of another resident], because [he/she] is prone to UTIs."</p> <p>n. As of 2/14/06 at 5:00 p.m., there was no documentation in the nutritional notes, Nurses' Notes, Physician Progress Notes or the plan of care to indicate the fluids needs of this resident were calculated after the significant weight loss and hospital stay for dehydration.</p> <p>2. Resident #16 had diagnoses of Constipation and Dysphagia. The Quarterly (MDS) dated 10/26/05 documented the resident had moderately impaired cognitive skills for daily decision making, a swallowing problems and current weight of 107 pounds.</p> <p>a. The Dietary Progress record dated 10/21/05 did not address the fluid needs for this resident.</p> <p>b. A Physician order dated 10/24/05 documented: "Bactrim DS one tab po (by mouth) bid (twice a day) x 10 days, DX (diagnosis) UTI, Repeat UA (urinalysis) 72 hrs post ABT (Antibiotic Therapy)."</p> <p>c. The plan of care dated 1/26/06 documented:</p>	F 327			

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F 327	<p>Continued From page 24</p> <p>"Problem Identify Date: 5/31/2005 - At risk for recurrent constipation related to: Decreased activity and medications that may contribute to constipation. Approaches: 1) Encourage additional thickened fluids as per order while giving care to [name of resident]." The plan of care did not address Urinary Tract Infections.</p> <p>d. Nurses notes dated 12/12/05 documented: "O (No) BM (bowel movement) X 3 days One Dulcolax Supp (Suppository) R (rectal) given. At 0330 (3:30 a.m.) res resident) had XLG (extra large) in BSC (bedside commode)."</p> <p>e. Nurses notes dated 12/18/05 at 2:20 a.m., documented "Dulcolax supp one per rectum, no BM x 5 days."</p> <p>f. Nurses notes dated 12/23/05 at 1:00 a.m. documented, "Dulcolax Supp one per rectal, no BM x 6 days."</p> <p>g. Nurses notes dated 12/30/05 at 2:30 a.m., documented "Dulcolax 10 mg (milligrams) one PR (per rectum) given for c/o (complaint of) constipation."</p> <p>h. Nurses notes dated 1/6/06 at 4:00 a.m. documented: "Dulcolax 10 mg supp. one PR given for c/o of constipation."</p> <p>i. The Dietary Progress Record dated 1/23/06 documented the resident had a 5.8 pound weight loss from last quarter, the resident was only consuming 60% of meals, 80% of the Ensure BID snacks and 0% of the HS (hour of sleep) Snack. There was no assessment of fluid needs for this resident after the weight loss, Urinary Tract Infection or the frequent medications for</p>	F 327			

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F 327	Continued From page 25 constipation. j. The plan of care dated 1/26/06 identified the same problem with constipation and no new interventions were implemented. k. The Quarterly MDS dated 1/30/06 documented the resident weighed 101 pounds, had a significant weight loss and a Stage II pressure sore. l. A hospital History and Physical dated 1/31/06 documented the resident was admitted to the hospital with diagnoses of Bronchitis and Urinary Tract Infection. m. Discharge Summary from the hospital on 2/1/06 documented the resident was to be readmitted the facility with Levaquin 500 mg daily x 5 days and "Drink Extra Fluids." n. Nurses notes dated 2/8/06 at 2:00 p.m. documented "Dulcolax 10 mg supp one pr given for c/o constipation." o. On 2/12/06 at 5:20 p.m., the resident received her evening meal which contained 1 carton of Nectar Thickened Water and 2 containers of Nectar Thickened Apple Juice. The resident consumed all of her fluids. She then reached over and obtained a carton of Regular Apple juice from another resident's tray. A CNA took the juice from the resident and did not offer the resident any additional fluids. p. On 2/14/06 at 8:55 a.m., the resident was up in a wheelchair in [his/her] room, asleep. There were 3 nectar thickened waters and one carton of nectar thickened Apple Juice in a wash basin	F 327			

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F 327	Continued From page 26 filled with ice on the bedside table by the bathroom door. Each container was marked with a pen on the top. q. On 2/14/06 at 10:20 a.m., the resident was stilling sleeping in the wheelchair and the fluids had not been moved. r. On 2/14/06 at 1:10 p.m., the fluid was in the same basin, however the ice had melted and the water was tepid. The containers had not been moved. s. On 2/14/06 at 1:40 p.m., CNA #12 and CNA #14 changed the resident's incontinent brief and left the room at 1:45 p.m., without offering the resident fluids. The fluids remained in the same marked position. Both CNAs were asked if they had been instructed to encourage fluids for this resident and both stated "No." t. On 2/14/06 at 2:25 p.m., CNA #15 was asked if she had any residents that required extra fluids and she stated "No." u. On 2/14/06 at 2:35 p.m., CNA #16 was asked if she had any residents that required extra fluids and she stated "No." v. On 2/14/06 at 3:00 p.m. the Director of Nursing was asked "Who calculated the fluid needs for the residents?" She stated it was figured in the meal plans and the nurses instruct the CNAs to give extra fluids to residents. w. On 2/14/06 at 3:09 p.m., the resident's charge nurse, LPN #6, was asked if she had any residents on her halls that required extra fluids. She replied that she did and named two other	F 327			

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F 327	Continued From page 27 residents. x. As of 2/14/06 at 5:00 p.m., there was no documentation in the Dietary notes, Nurses notes, Physician progress notes, RAPS or plan of care that indicated the fluid needs for this resident had been assessed after the UTI in October, frequent use of Dulcolax for Constipation or after the resident had a UTI which required treatment in January.	F 327			
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure oxygen was administered as per Physician orders for 2 (Residents #11 and #12) of 4 (Residents #3, #7, #11 and #12) case mix residents with Physician orders for oxygen therapy. This failed practice had the potential to affect 19 residents that received respiratory treatments/oxygen therapy, according to the Resident's Census and Condition of Residents form dated 2/13/06. The	F 328			

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F 328	Continued From page 28 findings are: 1. Resident #11 had diagnoses of Chronic Obstructive Pulmonary Disease and Cardiovascular Disease. The Quarterly Minimum Data Set (MDS) dated 12/14/05 documented the resident had moderately impaired cognitive skills for daily decision making and received oxygen therapy in the last 14 days. a. A Physician order dated 3/31/05 documented: "Oxygen @ (at) 1 1/2 LPM (liters per minute) at all times." b. The plan of care dated 12/14/05 documented a problem of "Alteration in Respiratory function related to: COPD" with interventions that included "O2 (oxygen) as per physician's order." c. On 2/11/06 at 12:45 p.m., the resident was in a wheelchair in the dining room with a portable oxygen tank on the back of the chair. The cannula was in the resident's nose, but the tank gauge showed that the oxygen tank was empty. d. On 2/11/06 at 2:24 p.m., the resident was in a wheelchair at the nurse's station. The resident was receiving oxygen by way of an Oxygen Concentrator at 2 liters per minute instead of 1 and 1/2 liters. e. On 2/12/06 at 8:14 a.m., 10:20 a.m., 11:20 a.m., 2:00 p.m. and 5:00 p.m., the resident was receiving oxygen at 2 liters per minute. 2. Resident #12 had diagnoses of Arteriosclerotic Heart Disease, Congestion Heart Failure and Chronic Atrial Fibrillation. The Annual MDS dated 12/28/05 documented the resident had	F 328			

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F 328	Continued From page 29 moderately impaired cognitive skills for daily decision making and required limited assistance with activities of daily living. a. A Physician order dated 7/8/04 documented: "Oxygen @ 2 lpm via NC (nasal cannula) DX (diagnosis) of CHF." b. The plan of care dated 12/28/05 documented a problem of "Fluid Volume Excess, related to: CHF (Congestive Heart Failure)" with interventions that included "O2 (Oxygen) as per physician order." c. On 2/11/06 at 1:00 p.m., the resident was in a wheelchair in the dining room with a portable oxygen tank on the back of the chair. The cannula was hooked on the back hand rest of the wheelchair. d. On 2/11/06 at 2:30 p.m., the resident was up in a wheelchair in [his/her] room. The wall Oxygen was turned on, but the cannula was not on the resident. e. On 2/12/06 at 10:30 a.m. and 1:45 p.m., the resident was in a recliner with oxygen at 3 liters per minute. f. On 2/12/06 at 3:00 p.m., the resident was receiving oxygen at 3 liters per nasal cannula by way of the wall unit. At 3:30 p.m. the Assistant Director of Nurses was asked to check the oxygen, she stated the oxygen was at 3 liters per minute. g. On 2/12/06 at 4:45 p.m., the resident was up in a wheelchair in the dining room. A portable oxygen tank on the back of the wheelchair was off and the cannula was hooked on the back hand	F 328			

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F 328	Continued From page 30 rest of the wheelchair.	F 328		
F 330 SS=D	<p>483.25(l)(2) ANTIPSYCHOTIC DRUGS</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure that 1 of 1 (Resident #2) case-mix resident did not receive antipsychotic medication without adequate indications for its use and for an excessive duration. This failed practice had the potential to affect 26 residents receiving antipsychotic medications, according to the Resident Census and Conditions of Residents form dated 2/13/06. The findings are:</p> <p>Resident #2 had a diagnosis of Dementia. The Annual Minimum Data Set dated 11/30/05 documented the resident had no short/long term memory problem, modified independence in cognitive skills for daily decision making, no mood or behavior problems and received an antipsychotic for the past 7 days.</p> <p>a. A Physician order dated 3/23/05 documented: "Zyprexa 2.5 mg one tab daily at 7:00 p.m. DX Psychosis."</p> <p>b. A "Note to Attending Physician" from the</p>	F 330		

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F 330	<p>Continued From page 31</p> <p>Consultant Pharmacist dated 5/24/05 documented: "This resident has been on Zyprexa 2.5 -since- 12-04. ...Reasons for not reducing dosages, why patient is not considered stable or a dosage reduction is clinically contraindicated must be documented. Please consider a doseage (dosage) reduction of - Zyprexa 2.5 on this resident." The "Physician Response" documented: "[check mark by 'Disagree'] Continue present Rx (prescription). Date: 6/3/05"</p> <p>c. A "Note to Attending Physician" from the Consultant Pharmacist dated 10/24/05 requested a risk versus benefit statement from the Physician for the use of Zyprexa. The Physician documented "Continue present meds at same dosage."</p> <p>d. The plan of care dated 11/30/05 documented problems of "At risk for side effects, related to use of Antipsychotic Medication and At risk for mental distress, changes in cognitive status r/t dx of Dementia, HX of delirium & psychosis" with interventions that included " ... observe for and document behavior that substantiates use of psychoactive medication."</p> <p>c. The nurse's notes dated from 9/30/05 revealed there was no documentation of behaviors to warrant the use of the medication.</p> <p>d. On 2/13/06 at 10:45 a.m., Licensed Practical Nurse (LPN) #4 was asked "What types of behaviors does this resident have?" She replied, "[He/She] has episodes of unrealistic fears, such as when a storm comes up, you just can't console her."</p> <p>e. On 2/13/06 at 12:30 p.m., the Social Director</p>	F 330		

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F 330	Continued From page 32 was asked about the resident's behaviors and the use of Zyprexa. She stated the resident was put on the medication while she was in the hospital December 2004, when she experienced situational psychosis. She further stated the resident never resisted care, was never abusive and only exhibited behaviors when she was ill. f. As of 2/13/06 at 5:00 p.m., there was no documentation in the Physician progress notes, Social notes, Nurse's notes or Physician orders that the resident had behaviors that warranted the use of the antipsychotic.	F 330		
F 331 SS=D	483.25(l)(2)(ii) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that 1 of 1 (Resident #2) case mix resident did not receive antipsychotic medication without attempted dose reductions. This failed practice had the potential to affect 26 residents receiving antipsychotic medications, according to the Resident Census and Conditions of Residents form dated 2/13/06. The findings are: Resident #2 had a diagnosis of Dementia. The Annual Minimum Data Set dated 11/30/05 documented the resident had no short/long term	F 331		

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F 331	Continued From page 33 memory problem, modified independence in cognitive skills for daily decision making, no mood or behavior problems and received an antipsychotic for the past 7 days. a. The plan of care dated 11/30/05 documented problems of "At risk for side effects, related to use of Antipsychotic Medication and At risk for mental distress, changes in cognitive status r/t dx of Dementia, HX of delirium & psychosis" with interventions that included "Assess medication for dose reduction or alteration and consult appropriate health profession and observe for and document behavior that substantiates use of psychoactive medication." b. A Physician order dated 3/23/05 documented: "Zyprexa 2.5 mg one tab daily at 7:00 p.m. DX Psychosis." c. A "Note to Attending Physician" from the Consultant Pharmacist dated 5/24/05 documented: "This resident has been on Zyprexa 2.5 -since- 12-04. ...Reasons for not reducing dosages, why patient is not considered stable or a dosage reduction is clinically contraindicated must be documented. Please consider a doseage (dosage) reduction of - Zyprexa 2.5 on this resident." The "Physician Response" documented: "[check mark by 'Disagree'] Continue present Rx (prescription). Date: 6/3/05" d. A "Note to Attending Physician" from the Consultant Pharmacist dated 10/24/05 requested a risk versus benefit statement from the Physician for the use of Zyprexa. The Physician documented "Continue present meds at same dosage."	F 331			

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F 331	Continued From page 34 e. The nurse's note dated from 9/30/05 revealed there was no documentation of behaviors to warrant the use of the medication. f. On 2/13/06 at 10:45 a.m., Licensed Practical Nurse (LPN) #4 was asked "What types of behaviors does this resident have?" She replied, "[He/She] has episodes of unrealistic fears, such as when a storm comes up, you just can't console her." g. On 2/13/06 at 12:30 p.m., the Social Director was asked about the resident's behaviors and the use of Zyprexa. She stated the resident was put on the medication while she was in the hospital December 2004, when she experienced situational psychosis. She further stated the resident never resisted care, was never abusive and only exhibited behaviors when she was ill. h. As of 2/13/06 at 5:00 p.m., there was no documentation in the Physician progress notes, Social notes, Nurse's notes or Physician orders that a reduction had been attempted.	F 331			
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by:	F 363			

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(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 363	<p>Continued From page 35</p> <p>Based on observation and interview, the facility failed to ensure food items were prepared and served according to the written menu for 2 residents on an 1800 calorie American Dietetic Association/2 gram (gm) sodium diet, according to the facility diet list dated 2/11/06 and enough food was prepared to serve all residents at the lunch meal on 2/12/06. These failed practices had the potential to affect 104 residents who received their meal trays from the kitchen, according to the facility Resident Census and Conditions of Residents dated 2/13/06. The findings are:</p> <p>1. On 2/12/06, during the noon meal observation, the menu for the lunch meal called for pot roast with potatoes and carrots.</p> <p>a. On 2/12/06 at 12:20 p.m., the facility ran out potatoes and carrots. There were 14 residents that were served mashed potatoes, instead of whole potatoes and carrots, as per the written menu.</p> <p>b. On 2/13/06 at 10:10 a.m., dietary employee #2 stated that they ran out of potatoes and carrots.</p> <p>2. On 2/12/06, during the supper meal preparation, the menu for 2 gm sodium diabetic diet called for low salt/fat free scalloped potatoes and low salt/fat free green beans. There were no low salt/fat free green beans or low salt/fat free scalloped potatoes prepared for the residents the on 2 gm sodium diabetic diet.</p> <p>3. Resident #14 had diagnoses of Hypertension, Insulin Dependent Diabetes Mellitus and Weight loss. A Physician order dated 9/10/05 documented a 1800 calorie American Diabetic Association/2 gm sodium diet. The Minimum Data</p>	F 363			

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F 363	Continued From page 36 Set dated 2/1/06 documented the resident was severely impaired in cognitive skills for daily decision making and required one person physical assist for eating. a. On 2/12/06 at 5:25 p.m., during the supper meal observation, the resident was served low salt scalloped potatoes and low salt green beans, instead of low salt/fat free scalloped potatoes and green beans, as per the written menu. b. On 2/12/06 at 5:25 p.m., during the supper meal observation, the resident was served ground breaded chicken, instead of low salt chicken tender, as per the menu. 4. Resident #16 had diagnoses of Congestive Heart Failure and Dysphagia. A Physician order dated 9/24/05 documented a fortified low sodium diet with nectar thickened liquids. The Quarterly MDS dated 1/25/06 documented resident had moderately impaired cognitive skills for daily decision making and required set up help only for eating. a. On 2/12/06 at 5:45 p.m., during the supper meal observation, the resident was served breaded ground chicken, instead of low salt chicken tender, as per the menu b. On 2/13/06 at 7:41 a.m., during the supper meal observation, the resident not did one cup of milk, as per the written menu.	F 363			
F 364 SS=E	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	F 364			

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F 364	<p>Continued From page 37</p> <p>palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure food items were prepared in manner to conserve nutritive value, flavor and appearance for 12 residents with 2 Gram (Gm) Sodium diets, according to the Diet list dated 2/11/06 and food was served at the proper temperature for 87 residents who received their meal trays in the dining room, according to the list provided by Registered Dietician on 2/13/06. This failed practice had potential to affect 105 residents who received their meal trays from the kitchen, according to the Diet list dated 2/11/06. The findings are:</p> <ol style="list-style-type: none"> 1. On 2/12/06 at 9:30 a.m., during the group meeting, 6 of 6 alert residents stated foods were over-cooked, cold at times and the meat was tough. 2. On 2/12/06, during the noon meal observation, the roast beef prepared and served to the residents was burnt, dried and green in color; it could not be cut with a knife and had a 'jerky' texture. 3. On 2/12/06, during the supper meal observation, chicken tenders prepared and served for the residents on 2 gm sodium diets had a dried-looking consistency. <p>a. Resident #11 had a Physician order for a 2 Gm Sodium diet. On 2/12/06 at 5:10 p.m., the resident was served chicken tenders, peas, vegetable</p>	F 364			

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F 364	<p>Continued From page 38</p> <p>soup, bread and baked apples. The resident stated he could not eat the baked chicken because it was too tough. At 5:20 p.m., Licensed Practical Nurse #1 was asked to cut the meat. She stated the meat was tough. The resident did not eat the chicken.</p> <p>b. Resident #12 had a Physician order for a 2 Gm Sodium diet. On 2/12/06 at 5:07 p.m., the resident was served baked Chicken tenders. The resident asked what the strips were and the Certified Nurse Aide (CNA) did not know. CNA #2 was asked to cut up the chicken for the resident. The CNA stated the meat was tough. The resident did not eat the meat.</p> <p>c. On 2/12/06 at 6:15 p.m., when the texture of the chicken tender was tested by a dietary employee #1, she stated it was a little tough.</p> <p>4. Resident #15 had diagnoses of Carcinoma of Breast, Nausea and Depression. She had a Physician order dated 11/25/03 for a puree diet with nectar thickened liquid. The quarterly MDS dated 12/28/05 documented the resident was severely impaired in cognitive skills for daily decision making and required one person physical assist for eating.</p> <p>On 2/12/06 at 5:20 p.m., during the supper meal observation, the resident had a tray in front of her that consisted of pureed fried chicken tenders, scalloped potatoes and peas. The food was untouched. At 6:00 p.m. CNA #2 came to feed the resident and was asked by surveyor to remove the tray to the side counter to allow for a check of the food temperatures. The temperatures of the items on the resident's tray, when tested, were:</p>	F 364			

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F 364	<p>Continued From page 39</p> <p>a. Pureed Scalloped Potatoes - 86 degrees F.</p> <p>b. Pureed meat - 80 degrees F.</p> <p>c. Pureed Peas - 70 degrees F.</p> <p>5. On 2/13/06, the recipe for cream of wheat and oatmeal called for water, margarine and salt. On 2/13/06 at 10:10 a.m., when the cream of wheat and oatmeal were tested by dietary employee #2, she stated, "They need seasonings. The employee stated, "I only add water in cream of wheat and oatmeal."</p> <p>6. Resident #18 had diagnoses of Depression, Abdominal Aortic Aneurysm and Nutritional Deficiency. The Quarterly MDS dated 12/7/05 documented the resident was severely impaired in cognitive skills for daily decision making and required one person physical assist for eating.</p> <p>a. A Physician order dated 7/1/05 documented a Mechanical soft with pureed meats.</p> <p>b. On 2/13/06 at 7:40 a.m., during breakfast meal observation, the resident's meal tray consisted of scrambled eggs, ground sausage with gravy, one biscuit with jelly with margarine on top of it, a carton of whole milk and a carton of apple juice. The tray sat in front of the resident while the resident was sleeping.</p> <p>At 8:00 a.m., when CNA #3 was about to feed the resident, the temperatures of the foods on the resident's tray when tested were:</p> <p>1) Milk - 58 degrees F.</p> <p>2) Scrambled eggs - 78 degrees F.</p>	F 364			

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F 364	Continued From page 40 3) Sausage with gravy - 80 degrees F.	F 364		
F 366 SS=B	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure substitutes were offered for 2 of 2 (Residents #19 and #20) case mix residents who disliked a food item. This failed practice had potential to affect 105 residents who received their meal trays from the kitchen, according to the facility Diet list dated 2/11/06. The findings are: 1. Resident #19 had diagnoses of Alzheimer's End Stage, Hypertension and Dementia. The Quarterly Assessment dated 1/25/06 documented, resident was severely impaired in cognitive skills for daily decision making. a. A Physician order dated 10/26/04 documented a fortified pureed diet with honey thickened liquids/high fiber. b. On 2/12/06, during the noon meal observation, resident's tray card documented, "dislikes carrots." At 2:15 p.m., the resident was served carrots. c. On 2/12/06 at 12:20 p.m., dietary employee #2 stated, "We have tomato as a substitute." There was no substitute served to the resident in place	F 366		

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F 366	Continued From page 41 of the carrots, which were not eaten. 2. Resident #20 had diagnoses of Depression, Hypertension and Alzheimer's. The Minimum Data Set dated 1/25/06, documented, Resident was severely impaired in cognitive skills for daily decision making. a. A Physician order dated 6/22/05 documented a fortified diet. b. On 2/12/06, during the noon meal observation, the resident's tray card documented "dislikes carrots." At 2:16 p.m., the resident was served carrots. c. There was no substitute served to the resident in place of the carrots, which were not eaten.	F 366		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food items were stored in a manner to prevent the possibility of freezer burn and contamination and food was maintained and served to residents at temperatures that would prevent the possibility of food borne illness. These failed practices had the potential to affect 104 residents who received their meals from the kitchen, according to the facility diet list dated 2/11/06. The findings are:	F 371		

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F 371	Continued From page 42 1. On 2/12/06 at 2:32 p.m., during the kitchen tour, the following observations made were: a. Five bags of pancakes, in the freezer next to the hand washing sink, were not sealed, exposing the pancakes to freezer burn. b. Three bags of individual pre-made pizzas were stored in the freezer unsealed, exposing the pizzas to freezer burn. c. A bag of broccoli in the freezer was not sealed, exposing the broccoli to freezer burn. d. A bag of fish patties in the freezer was not sealed, exposing the patties to freezer burn. e. A bag of fried chicken in the freezer was not sealed, exposing the chicken to cross contamination and freezer burn. f. Two boxes of cookies in the freezer were not closed, exposing the cookies to freezer burn. g. A bag of shredded cheese in the freezer was not sealed, exposing the cheese to freezer burn. h. A box of cream of wheat and a box of baking soda, on the shelf above the food preparation counter were not sealed, exposing the contents to cross contamination. i. The meat-slicer on the counter was covered with saran wrap; there was dried meat on the blade. j. A box of bagels was stored opened on the shelf in the storage room.	F 371		

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F 371	Continued From page 43 k. A box of corn dogs and a box of vegetable blend stored on the shelf in the freezer room were sealed. 2. On 2/12/06 at 4:24 p.m., the temperatures of the food items on the steam table, when tested by a dietary employee #1, were: a. Chicken for the 2 gm sodium - 125 degrees F. b. Chicken fingers - 125 degrees F. c. Gravy for the 2 gm sodium - 124 degrees F. d. Pimento Cheese prepared for the residents and placed on a cart next to the steam table was 50 degrees F; Dietary employee #1 stated, "I'm supposed to set it on ice." 3. The Centers for Medicare and Medicaid Services interpretive guidelines document: "Hot foods which are potentially hazardous should leave the kitchen (or steam table) above 140 [degrees] F (Fahrenheit), and cold foods at or below 41 [degrees] F."	F 371			
F 441 SS=F	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	F 441			

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F 441	Continued From page 44 corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure universal precautions for the containment of potentially infectious blood/body fluids were followed for 2 (Residents #4 and #3) of 8 residents with pressure ulcers or other wounds (Residents #1, #3, #4, #9, #16, #23, #24 and #26). The failed practice had the potential to affect all 106 residents who resided in the facility, as documented on the facility 's Resident Census and Conditions of Residents form dated 2/13/06. The findings are: 1. The Isolation Precautions Policy and Procedure provided by the Director of Nursing on 2/13/06 documented: "...make sure that precautions are maintained to reduce the risk of transmission of microorganisms to others and contamination of environmental surfaces and equipment... do not touch potentially contaminated surfaces or items in the patient's room. This will avoid transfer of the microorganism to other patients and/or environments..." 2. Resident #4 had diagnoses of Alzheimer's Disease, Depression and Anxiety. The Quarterly Minimum Data Set (MDS) dated 2/8/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, dependent on staff for personal hygiene, had a Stage IV pressure ulcer and a wound infection. a. On 2/11/06 at 12:20 p.m. during the initial tour	F 441		

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F 441	<p>Continued From page 45</p> <p>of the facility, Certified Nursing Assistant (CNA) #9 stated the resident was on contact isolation for Methicillin-Resistant Staphylococcus Aureus (MRSA) of a coccyx decubitus.</p> <p>b. On 2/11/06 at 2:45 p.m., the resident was transported from the shower to the resident ' s room in a shower chair by CNA #1. The seat of the shower chair was constructed like a toilet seat, with the center open; under the resident was an open mesh lift sling. The following observations were made:</p> <p>1) The resident sat in the shower chair in the room from 2:45 p.m. until 2:52 p.m. The Stage IV pressure ulcer on the resident ' s coccyx was steadily dripping blood and serosanguineous drainage onto the floor under the chair.</p> <p>2) At 2:52, there was a puddle beneath the resident in the floor measuring 6 inches in diameter. The resident was lifted in a lift sling by CNA ' s #1 and #2 then transported 6 feet across the floor to the bed, leaving a trail of blood and serosanguineous drainage. CNA #2 told CNA #1 to get a Housekeeper to come in and clean up the floor. CNA #1 walked through the drainage in the floor and rolled the shower chair's wheels through the large puddle and out into the hallway.</p> <p>3) Licensed Practical Nurses (LPN ' s) #1 and #3 entered the room to replace the dressing to the wound. Both LPN ' s walked through the puddle and across the trail of drainage when they entered the room.</p> <p>4) The LPN ' s and CNA #2 walked through the bloody drainage before leaving the room and entering the hallway.</p>	F 441			

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F 441	Continued From page 46 3. Resident #3 had diagnoses of Alzheimer's Dementia with Depression, Rheumatoid Arthritis and Osteoarthritis. The Annual MDS dated 2/1/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, required limited assistance of 2 or more staff for transfers and of 1 staff member for locomotion and had a Stage II stasis ulcer. a. The Plan of Care dated 2/1/06 documented: "...Instruct staff about risk for infection related to open wound... Nursing staff will use gloves while giving care to promote infection control." b. A physician order dated 2/9/06 documented: " Keflex 500 mg [milligrams] TID x 10 days [3 times daily for 10 days]. DX [diagnosis]: Cellulitis. " c. On 02/11/06 at 12:40 p.m., the resident was sitting in a wheelchair in the dining room eating lunch. The single layer telfa bandage on the resident's left outer ankle was soaked with bloody wound drainage. The left outer foot, below the dressing, was wet with wound drainage and bare, resting on the floor. d. On 2/11/06 at 2:25 p.m., the resident had been transferred back to bed. The saturated dressing remained to the resident ' s left foot.	F 441			
F 445 SS=C	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 445			

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F 445	Continued From page 47 by: Based on observations, the facility failed to ensure that soiled linens were handled in a manner to prevent the potential spread of infection for 1 (Resident #1) of 23 case-mix residents (Residents #1 thru #23). This failed practice had the potential to affect all 106 residents in the facility, according to the Roster Matrix provided by the Administrator on 2/12/06. The findings are: Resident #1 had diagnoses of Alzheimer's with Dementia, Profound Weakness, Cerebrovascular Accident and Dehydration. The Quarterly Minimum Data Set dated 11/16/05 documented that the resident was moderately impaired in cognitive skills for daily decision making and incontinent of bowel and bladder. On 2/13/06 at 1:40 p.m., Certified Nursing Assistant (CNA) #17 removed the soiled spread from the resident's bed; holding the soiled spread in hand and against the front and right side of her uniform, the CNA walked down the hall and placed the spread in a container. The CNA returned to the resident's room and changed the linens and provided incontinent care for the resident.	F 445			
F 498 SS=E	483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 498			

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

PRINTED: 03/06/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2006
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 498	<p>Continued From page 48</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure that Direct Care staff were proficient in transfer techniques to ensure safe transfers without injury for residents requiring weight-bearing support during transfers as evidenced by failure to support the lower torso during transfers for 4 of 4 (Residents #3, #5, #17 and #20) case mix residents who required weight-bearing support. This failed practice had the potential to affect 20 residents identified by the facility as requiring staff assistance during transfers, according to the Resident Census and Condition of Residents form dated 2/13/06. The findings are:</p> <p>1. Resident #3 had diagnoses of Alzheimer's Dementia with Depression, Rheumatoid Arthritis and Osteoarthritis. The Annual Minimum Data Set (MDS) dated 02/01/06 documented the resident had moderately impaired cognitive skills for daily decision-making and required limited assistance of two persons for transfer.</p> <p>a. On 02/12/06 at 9:35 a.m., the resident was transferred from a bedside commode to a wheelchair by Certified Nurse Aide (CNA) #4 and CNA #5. The CNAs stood on either side of the resident and lifted [him/her] by lifting under the resident's armpits. The resident was non-weight bearing during transfer. There was no lower body support and the resident's feet were suspended off of the floor. There was no gait belt used.</p> <p>b. On 02/12/06 at 4:25 p.m., the resident was transferred from a wheelchair to a bedside commode by CNA #6 and CNA #7. The CNAs stood on either side of the resident and lifted</p>	F 498			

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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		
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F 498	<p>Continued From page 49</p> <p>[him/her] by lifting under the resident's armpits. The Resident was non-weight bearing during the transfer; there was no lower body support and the resident's feet were dragged along the floor. There was no gait belt used.</p> <p>2. Resident #17 had diagnoses of Cerebrovascular Accident and Osteoarthritis. The Quarterly MDS dated 11/16/05 documented the resident had moderately impaired cognitive skills for daily decision-making and was totally dependent on staff for transfers.</p> <p>On 02/14/06 at 1:35 p.m., CNA #1 and CNA #8 transferred the resident from a wheelchair to the bed. The CNAs stood on either side of the resident and lifted [him/her] by lifting under the resident's armpits. The resident was non weight-bearing during transfer; there was no lower body support and the resident's feet were dragged along the floor. There was no gait belt used.</p> <p>3. Resident #20 had a diagnosis of Alzheimer's Disease. The Annual MDS dated 1/25/06 documented the resident had moderately impaired cognitive skills for daily decision-making and limited assistance of one person for transfers.</p> <p>On 02/14/06 at 9:40 a.m., CNA #1 and CNA #8 transferred the resident from the wheelchair to the bedside commode. The CNAs stood on either side of the resident and lifted [him/her] by lifting under the resident's armpits and by the waistband on the resident's jogging pants. The resident was non-weight bearing during transfer; there was no lower body support and the resident's feet dragged along the floor. There was no gait belt</p>	F 498			

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F 498	Continued From page 50 used. 4. Resident #5 had diagnoses of Alzheimer Disease and Bilateral Knee Arthroplasty. The Quarterly MDS dated 1/25/06 documented that the resident had moderately impaired cognitive skills for daily decision making and required total assistance of two people for transfers. a. The plan of care dated 8/8/05 documented: "Resident unable to stand related to decreased muscle strength and endurance. Approaches - Assist with transfers to ensure safety. Support extremities when changing position to alleviate increased pain." b. On 2/12/06 at 4:00 p.m., CNA # 10 and CNA #21 sat the resident up on side of the bed and placed their arms under the resident's arms. While holding the back waist area of the resident's pants, the CNAs lifted the resident up off the bed and into a wheelchair. c. On 2/14/05 at 1:50 p.m., CNA #1 and CNA #7 sat the resident up on side of the bed and placed their arms under the resident's arms. The CNAs lifted the resident up off the bed and transferred [him/her] to the shower chair. The resident did not bear any weight; the resident's shoulder joints supported all [his/her] weight.	F 498			