

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

PRINTED: 05/02/2006
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 C 04/06/2006
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 225 SS=C	<p>Complaint #11571 was substantiated (all or in part) with deficiencies cited at F225, F226 and F324.</p> <p>483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the</p>	F 225		

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 225	<p>Continued From page 1</p> <p>incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11571 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to ensure an injury of unknown origin was reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency) and was investigated and the residents protected to prevent further potential abuse while the investigation is in progress for 1 (Resident #2) of 5 (Residents #1 thru #5) case-mix residents. This failed practice had the potential to affect all 107 residents in the facility, according to the Administrator on 4/3/06. The findings are:</p> <p>Resident #2 had diagnoses of Cerebrovascular Accident with Left Paralysis, Seizure Disorder and Degenerative Joint Disease. The Significant Change Minimum Data Set dated 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision-making, short/long-term memory problems and was totally dependent for all Activities of Daily Living (ADL).</p> <p>a. An Occurrence Form dated 3/29/06 at 4:30 p.m. documented: "Location of Occurrence - Resident's Room, Were side rails present? Yes - Up, Type of Occurrence - 037, 037 - Struck Against, Describe the event: Give brief objective description of occurrence, give factual information</p>	F 225			

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F 225	Continued From page 2 only, include vital signs/follow up care, property or equipment involved etc. - Resident noted c (with) bruise to L (left) eyebrow reported by Hospice CNA (Certified Nursing Assistant)...Nature of injury - 01, 01 - Bruise, Severity of Injury - 2, 2 - Minor Injury (injury is temporary & does not cause further complications)...Occurrence Report Analysis Form - Are there any process procedures or training or system modifications that need to be made to prevent reoccurrences - Yes, Please explain - Get padded side rails to prevent future occurances (sic)." b. On 4/5/06 at 11:00 a.m., Licensed Practical Nurse (LPN) #2, stated the hospice CNA (Certified Nurse Assistant) reported, to this LPN, a bruise to the resident's left eyebrow on 3/29/06 at 4:30 p.m. The LPN stated she then assessed the resident, called the Physician and the resident's family and completed the occurrence report. The LPN stated she marked "037 Struck against", which designated the type of occurrence because she "assumed that's what happened." She also stated she did not do any further investigation at that time or report to Administration. c. On 4/5/06 at 11:30 a.m., the Director of Nursing (DON), stated there had been no internal investigation concerning the resident's bruise. She stated she did not know about it until surveyors called it to her attention. She stated the resident's side rails were not padded until the incident was called to her attention and that an investigation would be started immediately.	F 225			
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written	F 226			

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F 226	<p>Continued From page 3</p> <p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11571 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview the facility failed to ensure that an injury of unknown origin was immediately reported to Administration and investigated per the facility's policy and procedures that concerned identification of injuries that may constitute abuse for 1 (Resident #2) of 5 (Residents #1 thru #5) case-mix residents. The facility further failed to ensure that new employees were trained on the facility's policy and procedure for reporting resident abuse, neglect, unusual occurrences, and misappropriation of resident property. These failed practices had the potential to affect all 107 residents in the facility as documented on the facility's Roster Sample Matrix dated 4/3/06. The findings are:</p> <p>1. Resident #2 had diagnoses of Cerebrovascular Accident with Left Paralysis, Seizure Disorder and Degenerative Joint Disease. The Significant Change Minimum Data Set dated 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision-making, short/long-term memory problems and was totally dependent for all Activities of Daily Living (ADL).</p> <p>a. An Occurrence Form dated 3/29/06 at 4:30 p.m. documented: "Location of Occurrence -</p>	F 226			

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F 226	<p>Continued From page 4</p> <p>Resident's Room, Were side rails present? Yes - Up, Type of Occurrence - 037, 037 - Struck Against, Describe the event: Give brief objective description of occurrence, give factual information only, include vital signs/follow up care, property or equipment involved etc. - Resident noted c (with) bruise to L (left) eyebrow reported by Hospice CNA (Certified Nursing Assistant)...Nature of injury - 01, 01 - Bruise, Severity of Injury - 2, 2 - Minor Injury (injury is temporary & does not cause further complications)...Occurrence Report Analysis Form - Are there any process procedures or training or system modifications that need to be made to prevent reoccurrences - Yes, Please explain - Get padded side rails to prevent future occurrences (sic)."</p> <p>b. On 4/5/06 at 11:00 a.m., Licensed Practical Nurse (LPN) #2, stated the hospice CNA (Certified Nurse Assistant) reported, to this LPN, a bruise to the resident's left eyebrow on 3/29/06 at 4:30 p.m. The LPN stated she then assessed the resident, called the Physician and the resident's family and completed the occurrence report. The LPN stated she marked "037 Struck against", which designated the type of occurrence because she "assumed that's what happened." She also stated she did not do any further investigation at that time.</p> <p>c. On 4/5/06 at 11:30 a.m., the Director of Nursing (DON), stated there had been no internal investigation concerning the resident's bruise. She stated she did not know about it until surveyors called it to her attention. She stated that the resident's side rails were not padded until the incident was called to her attention and that an investigation would be started immediately.</p>	F 226			

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F 226	<p>Continued From page 5</p> <p>d. On 4/6/06 at 1:00 p.m., the Assistant Director of Nursing (ADON) stated she thought her signature designated completeness of the report and did not realize it also indicated that she was responsible for follow-up actions/interventions.</p> <p>2. Personnel Records were reviewed on 4/5/06; two Nursing Assistants (NA), NA #1, hired 3/29/06 and NA #2 hired on 3/24/06 did not receive training on the facility's abuse protocol.</p> <p>3. On 4/6/06 at 9:20 a.m., the Director of Administrative Services provided a list of 10 new employees. She stated that orientation of new employees was changed from weekly to monthly on 3/23/06 and that these 10 new employees had not been oriented to the facility's abuse policy and procedure.</p> <p>4. The Nursing work schedule for 3/23/06 to 4/6/06 documented the Nursing Assistants, who had not been oriented, as follows:</p> <p>NA #1: Scheduled to work 4/3/06 and 4/6/06</p> <p>NA #2: Scheduled to work 3/24/06, 3/28/06, 3/29/06, 3/30/06, 3/31/06, 4/3/06, 4/4/06, 4/5/06 and 4/6/06</p> <p>NA #3: Scheduled to work 3/29/06, 3/30/06, 3/31/06, 4/1/06, 4/3/06, 4/4/06, 4/5/06 and 4/6/06</p> <p>NA #4: Scheduled to work 3/28/06, 3/29/06, 3/31/06, 4/1/06, 4/3/06, 4/4/06, 4/5/06 and 4/6/06</p> <p>NA #5: Scheduled to work 3/29/06, 3/31/06, 4/1/06, 4/2/06, 4/3/06, 4/4/06 and 4/6/06</p> <p>5. On 4/5/06 at 2:20 p.m., the Nursing Scheduler</p>	F 226			

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F 226	Continued From page 6 stated: "The Director of Administrative Services determines when the new employees have abuse training." She was asked if she could find documentation of abuse training for the 2 NAs. The Nursing Scheduler stated: "New employees are put on the floor for awhile before they receive orientation where they would get abuse training. Orientation is determined by the Human Resource office of the hospital." 6. On 4/5/06 at 2:35 p.m., Human Resource staff employee #1 stated orientation was done monthly on the 3rd Thursday and that abuse training was included in the monthly orientation. 7. On 4/6/06 at 9:15 a.m., the Director of Administrative Services stated they had changed the orientation of new employees from weekly to monthly; this started on 3/23/06.	F 226			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure incontinent care was provided in a manner (front to back	F 315			

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F 315	Continued From page 7 technique) to prevent possible urinary track infections for 1 (Resident #4) of 5 (Residents #1 thru #5) case mix residents who were incontinent and required staff assistance with incontinence care. This failed practice had the potential to affect 68 residents who required incontinent care by staff, according to the facility Roster Matrix dated 4/3/06. The findings are: Resident #4 had diagnoses of Alzheimer's Disease, Hypertension and Congestive Heart Failure. The Annual Minimum Data Set dated 1/12/06 documented the resident was incontinent of bowel and bladder and was dependent on staff for assistance with toileting and hygiene. a. On 4/4/06 at 1:00 p.m., Certified Nursing Assistant (CNA) #1 was performing incontinent care, with the resident positioned on her back. The CNA removed a soiled brief and sprayed No-rinse foam cleanser on a disposable washcloth, spread the resident's legs and wiped from the perineal area to the vulva (back to front). b. The Policy and Procedure for Perineal Care, provided by the Director of Nursing on 4/6/06, documented in section 11d. "Use one gloved hand to stabilize the labia, with other hand wash from front to back."	F 315			
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:	F 324			

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F 324	<p>Continued From page 8</p> <p>Complaint #11571 was substantiated (all or in part) in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure that an intervention to prevent injury was implemented for 1 (Resident #2) of 5 (Residents #1 thru #5) case-mix residents. This failed practice had the potential to affect all 107 residents in the facility, according to the Administrator on 4/3/06. The findings are:</p> <p>Resident # 2 had diagnoses of Cerebrovascular Accident with Left Paralysis, Seizure Disorder and Degenerative Joint Disease. The Significant Change Minimum Data Set dated 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision-making and was totally dependent for all Activities of Daily Living (ADL).</p> <p>a. On 4/3/06 at 11:22 a.m., the resident had a bruise to the area left of her eyebrow, measuring approximately 1 centimeters (cm) by 2 cm; it was dark purple in color.</p> <p>b. On 4/3/06 at 11:22 a.m. and at 2:45 p.m., the resident's side rails were up and had no padding.</p> <p>c. On 4/4/06 at 3:10 p.m., Certified Nursing Assistants (CNA) #2, who provided care for the resident, stated that the resident could not move her body on her own. The CNA stated that the resident could move her head and arms at will.</p> <p>d. On 4/4/06 at 3:15 p.m., CNA #1, who provided care for the resident, stated that the resident could not move her body, just her head and arms.</p>	F 324			

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F 324	Continued From page 9 e. An Occurrence Form dated 3/29/06 documented the hospice CNA reported a bruise to the left eyebrow of the resident. f. An Occurrence Form, dated 03/29/06, documented the system modification that need to be made to prevent recurrences was "Get padded siderails to prevent future occurrences."	F 324			
F 328 SS=D	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 and record review the facility failed to ensure updraft equipment were maintained in a clean, sanitary manner to prevent the potential for contamination for 1 (Resident #2) of 3 (Residents #1, #2 and #4) case-mix residents assessed for the use of updraft treatments. This failed practice had the potential to affect 22 residents in the facility that received updraft treatments, according to a list provided by the facility on 4/5/06. The findings are: Resident #2 had diagnoses of Cerebrovascular Accident with Left Paralysis, Seizure Disorder and	F 328			

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F 328	Continued From page 10 Pneumonia. The Significant Change Minimum Data Set (MDS) dated 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision-making, was totally dependent for all Activities of Daily Living and received oxygen therapy. On 4/4/06 at 10:00 a.m., the resident's updraft nebulizer machine was sitting in a recliner on the right side of the bed, with the tubing for the mask attached to the nebulizer and the mask lying on the floor under the bed.	F 328			
F 441 SS=D	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 corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that infection control practices were followed to prevent the potential for contamination and possible cross-contamination for 1 (Resident #2) of 3 (Resident #2, #4, and #5) case mix residents who received wound care. This failed practice had the potential to affect 68 residents who required wound care, as documented on a list provided by	F 441			

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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 441	<p>Continued From page 11 the facility dated 4/5/06. The findings are:</p> <p>Resident #2 had diagnoses of Cerebrovascular Accident with Left Paralysis, Seizure Disorder and Pneumonia. The Significant Change Minimum Data Set (MDS) dated 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision-making and was totally dependent for all Activities of Daily Living (ADL).</p> <p>a. On 4/4/06 at 10:00 a.m., Licensed Practical Nurse (LPN) #1, during wound care to the resident's right heel, removed the existing dressing with her gloved hands. Then, without changing her gloves, the LPN cleaned the wound with wound cleanser and applied a clean non-stick pad to the wound. The dressing was secured with paper tape.</p> <p>During wound care to the resident's right heel, the multi-use wound cleanser and paper tape were lying on the bed.</p> <p>The LPN left the resident's bedside to give attention to the roommate.</p> <p>b. The Dressing Change Procedures, provided on 4/5/06, documented that after removing soiled dressings, the nurse will discard the dressing and the gloves...and then put on clean gloves.</p>	F 441			