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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A263	A. BUILDING ______ B. WING ______	C **04/26/2006**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OZARK HEALTH NURSING CENTER	**2500 HIGHWAY 65 SOUTH CLINTON, AR 72031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Complaint #11649 was substantiated (all or in part) with deficiencies cited at F309, F318 and F490.	F 000		
F 309 SS=K	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #11649 was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure that resuscitative measures were provided for 1 (Resident #1) of 1 case mix residents who had not formulated an advance directive and had documentation requesting Cardio-pulmonary resuscitation (CPR) be performed in the event of a life-threatening condition. This failed practice resulted in immediate jeopardy which caused or could have caused serious harm, injury or death to Resident #1, who was found without vital signs and was not provided CPR. The failed practice had the potential to affect 41 residents who did not have advance directives or physician orders authorizing the facility to place them on "Do not Resuscitate (DNR)" status as documented on a Resident List provided by the Director of Nursing on 4/25/06 at	F 309		

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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7:05 p.m. The facility was notified of the immediate jeopardy condition on 4/25/06 at 4:14 p.m. The findings are:

1. Resident #1 had diagnoses of Congestive Heart Failure, Aortic Stenosis, Arrhythmias and Hypertension. He was admitted to the facility on 4/5/06, transferred to the hospital on 4/11/06 and re-admitted to the facility on 4/15/06 with a diagnosis of Renal Insufficiency.

a. An "Advance Directive Acknowledgement" form dated 4/5/06 documented "I have not executed an advanced directive."

b. A "Consent to Withhold Cardio-Pulmonary Resuscitation (CPR)" form dated 4/5/06 documented: "In the event of a life-threatening condition I do not consent to withholding of cardio-pulmonary resuscitation (CPR)." This document was signed by the son of Resident #1 and witnessed by two members of the facility staff.

c. There were no Physician orders to withhold resuscitation measures.

d. Nurse's Notes dated 4/15/06 at 11:50 p.m. documented: "Res [resident] found [without] VS [vital signs] at 11:35 [p.m.]. Contacted MD [Medical Doctor], family [son], contacted DON. Attempted to contact Administrator-no answer. Contacted funeral home."

e. Nurse's Notes dated 4/15/06 at 12:15 a.m. documented: "Res[ident] pronounced deceased by Coroner. Picked up and sent to Funeral Home." There was no documentation CPR had been initiated after the resident was found without

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vital signs.

f. On 4/25/06 at 1:45 p.m., LPN [Licensed Practical Nurse] #1 stated: [4/15/06 at 11:35 p.m.] [Resident #1] "was ashen, face and neck, he was cool and his torso, arms and legs were warm. I checked his carotid and at wrist for pulse and listened with a stethoscope. I left the C.N.A. [Certified Nursing Assistant #1] in room and saw a C.N.A. in the hallway and told her to get the other LPN's. I went on and got his chart. They [two LPN's] came quickly. All of us went into the room. [LPN #2] checked for vital signs and couldn't find any either. [LPN #3] looked at his chart and said he's a full code. We did not do CPR. My training told me to but [LPN #2] said he's done gone and [LPN #3] made no comment. They told me to go ahead and follow the notification protocol." She further stated: "I made a major mistake, I should have started CPR no matter what anyone said."

g. On 4/25/06 at 4:40 p.m., C.N.A. #1 stated: [4/15/06 at 11:30 p.m.] "I checked his pulse, felt for him breathing and got [LPN #1]. [LPN #1] came to the room immediately. She checked him. I stayed in the room with her. [LPN #2] showed up." CNA #1 was asked if anyone started CPR. He responded: "No".

h. On 4/25/06 at 5:25 p.m., LPN #2 stated: [4/15/06 at 11:35 p.m.] "A C.N.A. screamed that [LPN #1] needs a nurse...[LPN #3] was behind me and I went into his room. Two aides were in the room trying to get vital signs. [LPN #1] was not in the room. Just the two aides. She was getting the chart." When LPN #2 was asked if she did an assessment of the resident, she stated: "I just took a pulse." When LPN #2 was asked if she

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knew or was told the code status of the resident, she stated "No, [LPN #1] did not tell me. I asked [LPN #3] what do you think, unresponsive with no pulse. [LPN #3] said he was gone. I just assumed he was DNR on Comfort Care." When LPN #2 was asked what should have been the procedure, she stated: "We should have checked the chart and done CPR and tried to do everything."

i. On 4/25/06 at 5:45 p.m., LPN #3 stated: [4/15/06 at 11:35 p.m.] "I went to the room of Resident #1. When I got down there it was obvious that he was dead. He was cooler than a normal person." She stated that LPN #1 did not know his code status, she told LPN #1 that it was in the front of the chart. LPN #3 stated that LPN #1 said he had an advance directive. When LPN #3 was asked what should have been the procedure, she stated: "We should have started CPR I suppose. I guess we should have tried to resuscitate. The man was obviously dead."

2. On 4/25/06 at 3:34 a.m., the Director of Nursing was asked what interventions had ensued relative to the three nurses involved in the decision not to provide cardiopulmonary resuscitation to Resident #1 on 4/15/06. She stated: "I haven't talked to [LPN #2] or [LPN #3]. I talked to [LPN #1] and I told her that she should have done CPR, called the physician and sent the resident to the ER (Emergency Room).

3. As of 4/25/06 at 3:45 p.m. the facility did not have a Cardiopulmonary Resuscitation Policy or Procedure available for review.

a. On 4/25/06 at 3:34 p.m., the Director of Nursing. stated "We do not have a code policy [cardiopulmonary resuscitation policy]."

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b. As of 4/25/06 at 5:45 p.m., the facility did not have a mechanism to assure identification of each individual resident's code status:

(1) On 4/25/06 at 5:25 p.m., LPN #2 was asked to review the chart of Resident #6 [chosen at random] to determine if he was or was not a DNR. She looked back and forth in the chart and stated "I don't know, I don't see it in here."

(2) On 4/25/06 at 5:45 p.m., LPN #3 was asked to review Resident #6's chart to determine if he was or was not a DNR. The LPN found the Advanced Directive which was signed by his POA (Power of Attorney) and indicated his request for a DNR status. His Physician's orders did not document a DNR status. She stated "He has executed an Advanced Directive. I would think this would say if he didn't want CPR [the LPN then shrugged, indicating she did not know how else to respond]."

3. The immediate jeopardy was removed on 4/25/06 at 8:00 p.m., and the scope and severity reduced to an E when the facility implemented the following:

a. As of 4/25/06 at 7:05 p.m., all the residents charts were audited to determine code status. They will be audited every 6 months by Medical records. Medical Records will implement a system consisting of color coded laminated paper that will be placed in the front of each chart to denote code status as listed below. Social Services will continue to identify code status on all new residents during the admission process. Social Service will give the code status to Medical Records the floor nurse upon admission. Medical Records will color code each new residents chart.

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Medical Records will audit each chart each month with all new orders.

Color Code- Red - DNR

Green - Full Code

The DON/Designee will place a matching color coded sticker (as listed Above) on their bed, equipment, and dining table for each resident to designate their code status. Upon room, equipment, or dining table change, the Activity Director will monitor the color code on all changes.

b. As of 4/25/06 at 6:55 p.m., before shift change, the DON/designee in-serviced all current licensed nurses on code status policy and procedure, including determining code status, full or DNR, and implementing CPR per American Heart Association guidelines. Any Professional licensed nurses on leave, off day, or vacation will be in-serviced upon their return to work.

* Establish unresponsiveness

* Direct co-worker to call for help

* Open airway

* If breathing is absent/inadequate, give 2 slow breathes to cause chest to rise

* Check Carotid pulse and other signs of circulation

* If no signs, start chest compressions (ratio 15-2)

* Continue CPR until arriving at ER

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F 309	Continued From page 6 * Notify physician/family/DON/Administrator * Chart and document If resident is a DNR, see Death of Resident protocol. (attached) On 4/26/06 at 8:30 a.m., licensed staff working were in-serviced on the color coded dots signifying full code or DNR status of residents. c. As of 4/25/06, all new employees will be inserviced by DON/designee during OHNC orientation process/before first shift and will sign code status policy and procedure, including Death of Resident. d. The Administrator will ensure that these systems and in-services are implemented and repeated until professional nursing staff is compliant with the knowledge of action to be taken for each code status on each resident during their shift. Color coded stickers will be monitored for accuracy daily for 3 weeks, then 3 times a week for a month, then every 3 months by the Administrator/designee.	F 309		
F 318 SS=E	483.25(e)(2) RANGE OF MOTION 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.	F 318		

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This REQUIREMENT is not met as evidenced by:

Complaint #11649 was substantiated (all or in part) in these findings.

Based on record review and interview the facility failed to ensure that restorative care was performed as ordered/recommended for 3 (Residents #4, #5 and #6) of 3 (Resident's #4, #5 and #6) case mix residents. This failed practice had the potential to affect 62 residents in the facility that were identified with limitations in Range of Motion on the facility roster matrix received from the Assistant Administrator on 4/24/06 at 3:35 p.m. The findings are:

1. On 4/26/06 at 10:15 a.m., Restorative Aide #1 (RNA #1), who worked the South hall, was asked why was there blanks on the Restorative sheets or "R"s documented. She stated: "Because when I am working on the floor I can't do restorative. Use to, they had us put "R"s in the blanks when we were on the floors. Now they tell us not to put anything in the blanks when we work the floors. When asked if anyone did the restorative when she worked the floor, she stated: " Not that I know of." When asked when she was not at work or on vacation who took her place the RNA stated "[Name of other RNA] is suppose to, but she can't do mine and hers too. I was on vacation the [April] 12th thru the 18th, worked the floor the [April] 18th to the 20th and was not here on the 21st."

A sheet of lined notebook type paper was in the south hall Restorative book and was copied on 4/25/06 at 1:43 p.m. The sheet documented that the RNA worked the floor on the following days:

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F 318	Continued From page 8 [March 2006] 3rd, 6th, 8th thru 10th, 13th, 15th thru 17th, 20th and 22nd thru 24th. [April 2006] 18th thru 4/20/06. 2. Resident #4 had diagnoses of History of Falls with injury, Cerebral Vascular Accident with Left Side Weakness, Legally Blind, Depressive State, Quadruple Coronary Bypass and Restless Leg Syndrome. A Minimum Data Set (MDS) dated 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance in transfers and ambulation in room, required total assistance when on or off unit, had unsteady gait and had limited range of motion in arm, hand, leg and foot. a. The Plan of care documented a problem dated 2/15/06 of ADL (Activities of Daily Living) Function Rehab (Rehabilitation) Potential with a goal of (Resident #4) will obtain her optimal function level this quarter. b. The Restorative Record dated 3/01/2006 thru 3/31/2006 documented a restorative order dated 2/16/06 "Range of Motion (ROM) exercises to (L) [Left] elbow. Don't lift with (L) arm." March 3rd, 6th, 8th thru 13th, 15th thru 26th had no documentation that the resident received ROM to the Left elbow. March 27th thru 31st had an "R" documented. c. The Restorative Record dated 4/01/2006 thru 4/30/2006 documented a restorative order dated 3/17/06 "Range of Motion (ROM) exercises to (L) [Left] elbow. Don't lift with (L) arm." April 1st and 2nd had no documentation that ROM was provided, April 3rd and 4th documented an "H" (Hospital), 5th had no documentation, 6th and 7th had an "H" documented, 8th and 9th had no	F 318		

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documentation, 10th and 11th had an "R" documented, 12th, 13th, and 14th had no documentation, 15th and 16th were Xed out, 17th thru 21st had no documentation, 22nd and 23rd were Xed out, and the 24th had an "R" documented.

3. Resident #5 had diagnoses of Peripheral Neuropathy, Depressive Disorder, Compression Fracture Lumbar 1 and Degenerative Disc Disease Lumbar 2 and 3. An MDS dated 2/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making, independent in activities of daily living, had limited ROM in both hands and had an unsteady gait.

a. The Restorative Record dated 3/1/06 thru 3/31/06 documented an order dated 1/11/06 of Restorative care for ambulation and maintenance exercises if cooperative. There was no documentation on the Restorative record for March the 3rd, 6th, 8th thru 10th, 13th, 15th thru 17th, 20th, 22nd thru 24th. On March 1st, 2nd, 7th, 14th, 21st and 27th thru 1st an "R" was documented.

b. The Restorative Record dated 4/1/06 thru 4/30/06 documented the same order as stated above. There was no documentation that restorative services were provided on April 1st, 2nd, and the 21st. April 3rd thru the 20th there was an "H" documented.

4. Resident #6 had diagnoses of Cerebral Vascular Accident, Rheumatoid Arthritis and Depression. An MDS dated 3/29/06 documented the resident was moderately impaired in cognitive skills for daily decision making, was independent

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F 318	Continued From page 10 in activities of daily living and was unsteady in the test for standing balance. The Restorative Record dated 4/1/2006 thru 4/30/2006 documented an order dated 9/15/03: "May participate in Restorative program and/or exercise class PRN as tolerated." There was no documentation April 1st thru 3rd, 5th, 12th, and 17th thru 21st. There were "R"s documented on April 4th, 6th, 7th, 10, 11th, and 24th. A non-dated hand written order of Amb (Ambulate) PRN had the same missing documentation and the documented "R"s on the same days.	F 318		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #11649 was substantiated (all or in part) in these findings. Based on record review and interview, Nursing Administration failed to ensure policies and procedures were developed and implemented regarding Cardio-pulmonary Resuscitation (CPR) and failed to develop or implement a method to ensure each resident's code status was clearly documented and readily available. The failed practice resulted in the facility's failure to ensure that resuscitative measures were provided for 1 of 1 (Resident #1) case mix resident who had not formulated an advance directive and had	F 490		

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documentation requesting Cardio-pulmonary resuscitation (CPR) be performed in the event of a life-threatening condition. This failed practice resulted in immediate jeopardy which caused or could have caused serious harm, injury or death to Resident #1, who was found without vital signs and was not provided CPR. The failed practice had the potential to affect 41 residents who did not have advance directives or physician orders authorizing the facility to place them on "Do not Resuscitate (DNR)" status as documented on a Resident List provided by the Director of Nursing on 4/25/06 at 7:05 p.m. The facility was notified of the immediate jeopardy condition on 4/25/06 at 4:14 p.m. The findings are:

1. Resident #1 had diagnoses of Congestive Heart Failure, Aortic Stenosis, Arrhythmias and Hypertension. He was admitted to the facility on 4/5/06, transferred to the hospital on 4/11/06 and re-admitted to the facility on 4/15/06 with a diagnosis of Renal Insufficiency.

a. An "Advance Directive Acknowledgement" form dated 4/5/06 documented "I have not executed an advanced directive."

b. A "Consent to Withhold Cardio-Pulmonary Resuscitation (CPR)" form dated 4/5/06 documented: "In the event of a life-threatening condition I do not consent to withholding of cardio-pulmonary resuscitation (CPR)." This document was signed by the son of Resident #1 and witnessed by two members of the facility staff.

c. There were no Physician orders to withhold resuscitation measures.

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d. Nurse's Notes dated 4/15/06 at 11:50 p.m. documented: "Res [resident] found [without] VS [vital signs] at 11:35 [p.m.]. Contacted MD [Medical Doctor], family [son], contacted DON. Attempted to contact Administrator-no answer. Contacted funeral home."

e. Nurse's Notes dated 4/15/06 at 12:15 a.m. documented: "Res[ident] pronounced deceased by Coroner. Picked up and sent to Funeral Home." There was no documentation CPR had been initiated after the resident was found without vital signs.

f. On 4/25/06 at 1:45 p.m., LPN [Licensed Practical Nurse] #1 stated: [4/15/06 at 11:35 p.m.] [Resident #1] "was ashen, face and neck, he was cool and his torso, arms and legs were warm. I checked his carotid and at wrist for pulse and listened with a stethoscope. I left the C.N.A. [Certified Nursing Assistant #1] in room and saw a C.N.A. in the hallway and told her to get the other LPN's. I went on and got his chart. They [two LPN's] came quickly. All of us went into the room. [LPN #2] checked for vital signs and couldn't find any either. [LPN #3] looked at his chart and said he's a full code. We did not do CPR. My training told me to but [LPN #2] said he's done gone and [LPN #3] made no comment. They told me to go ahead and follow the notification protocol." She further stated: "I made a major mistake, I should have started CPR no matter what anyone said."

g. On 4/25/06 at 4:40 p.m., C.N.A. #1 stated: [4/15/06 at 11:30 p.m.] "I checked his pulse, felt for him breathing and got [LPN #1]. [LPN #1] came to the room immediately. She checked him. I stayed in the room with her. [LPN #2] showed

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OZARK HEALTH NURSING CENTER	**2500 HIGHWAY 65 SOUTH CLINTON, AR 72031**

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up." CNA #1 was asked if anyone started CPR. He responded: "No."

h. On 4/25/06 at 5:25 p.m., LPN #2 stated: [4/15/06 at 11:35 p.m.] "A C.N.A. screamed that [LPN #1] needs a nurse...[LPN #3] was behind me and I went into his room. Two aides were in the room trying to get vital signs. [LPN #1] was not in the room. Just the two aides. She was getting the chart." When LPN #2 was asked if she did an assessment of the resident, she stated: "I just took a pulse." When LPN #2 was asked if she knew or was told the code status of the resident, she stated "No, [LPN #1] did not tell me. I asked [LPN #3] what do you think, unresponsive with no pulse. [LPN #3] said he was gone. I just assumed he was DNR on Comfort Care." When LPN #2 was asked what should have been the procedure, she stated: "We should have checked the chart and done CPR and tried to do everything."

i. On 4/25/06 at 5:45 p.m., LPN #3 stated: [4/15/06 at 11:35 p.m.] "I went to the room of [Resident #1]. When I got down there it was obvious that he was dead. He was cooler than a normal person." She stated that LPN #1 did not know his code status, she told LPN #1 that it was in the front of the chart. LPN #3 stated that LPN #1 said he had an advance directive. When LPN #3 was asked what should have been the procedure, she stated: "We should have started CPR I suppose. I guess we should have tried to resuscitate. The man was obviously dead."

2. On 4/25/06 at 3:34 a.m., the Director of Nursing was asked what interventions had ensued relative to the three nurses involved in the decision not to provide cardiopulmonary resuscitation to Resident #1 on 4/15/06. She

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stated: "I haven't talked to [LPN #2] or [LPN #3]. I talked to [LPN #1] and I told her that she should have done CPR, called the physician and sent the resident to the ER (Emergency Room)."

3. As of 4/25/06 at 3:45 p.m., the facility did not have a Cardiopulmonary Resuscitation Policy or Procedure available for review.

a. On 4/25/06 at 3:34 p.m., the Director of Nursing stated "We do not have a code policy [cardiopulmonary resuscitation policy]."

b. As of 4/25/06 at 5:45 p.m., the facility did not have a mechanism to assure identification of each individual resident's code status:

(1) On 4/25/06 at 5:25 p.m., LPN #2 was asked to review the chart of Resident #6 [chosen at random] to determine if he was or was not a DNR. She looked back and forth in the chart and stated "I don't know; I don't see it in here."

(2) On 4/25/06 at 5:45 p.m., LPN #3 was asked to reviewed Resident #6's chart to determine if he was or was not a DNR. The LPN found the Advanced Directive which was signed by his POA (Power of Attorney) and indicated his request for a DNR status. His Physician orders did not document a DNR status. She stated, "He has executed an Advanced Directive. I would think this would say if he didn't want CPR [the LPN then shrugged indicating she did not know how else to respond]."

4. The immediate jeopardy was removed on 4/25/06 at 8:00 p.m., and the scope and severity reduced to an E when the facility implemented the

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F 490	Continued From page 15 following: a. As of 4/25/06 at 7:05 p.m., all the residents charts were audited to determine code status. They will be audited every 6 months by Medical records. Medical Records will implement a system consisting of color coded laminated paper that will be placed in the front of each chart to denote code status as listed below. Social Services will continue to identify code status on all new residents during the admission process. Social Service will give the code status to Medical Records the floor nurse upon admission. Medical Records will color code each new residents chart. Medical Records will audit each chart each month with all new orders. Color Code- Red - DNR Green - Full Code The DON/Designee will place a matching color coded sticker (as listed Above) on their bed, equipment, and dining table for each resident to designate their code status. Upon room, equipment, or dining table change, the Activity Director will monitor the color code on all changes. b. As of 4/25/06 at 6:55 p.m., before shift change, the DON/designee inserviced all current licensed nurses on code status policy and procedure, including determining code status, full or DNR, and implementing CPR per American Heart Association guidelines. Any Professional licensed nurses on leave, off day, or vacation will be in-serviced upon their return to work. * Establish unresponsiveness	F 490		

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* Direct co-worker to call for help

* Open airway

* If breathing is absent/inadequate, give 2 slow breathes to cause chest to rise

* Check Carotid pulse and other signs of circulation

* If no signs, start chest compressions (ratio 15-2)

* Continue CPR until arriving at ER

* Notify physician/family/DON/Administrator

* Chart and document

If resident is a DNR, see Death of Resident protocol. (attached)

On 4/26/06 at 8:30 a.m., licensed staff working were in-serviced on the color coded dots signifying full code or DNR status of residents.

c. As of 4/25/06, all new employees will be inserviced by DON/designee during OHNC orientation process/before first shift and will sign code status policy and procedure, including Death of Resident.

d. The Administrator will ensure that these systems and in-services are implemented and repeated until professional nursing staff is compliant with the knowledge of action to be taken for each code status on each resident during their shift. Color coded stickers will be monitored for accuracy daily for 3 weeks, then 3

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F 490	Continued From page 17 times a week for a month, then every 3 months by the Administrator/designee.	F 490		