

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

PRINTED: 05/23/2006
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 R-C 05/11/2006
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 312 SS=E	<p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure all areas of the perineum and/or anal/buttock areas were cleansed to maintain personal hygiene for 2 (Residents #9 and #17) of 16 (Residents #1 through #16) case-mix residents who were incontinent of bowel and/or bladder. This failed practice had the potential to affect 68 residents that were incontinent of bowel and/or bladder, according to the Roster/Sample Matrix received from the Administrator 5/9/06 at 1:30 p.m. The findings are:</p> <p>1. Resident #9 had diagnoses of Cerebral Vascular Accident (CVA), History of Pneumonia with Rhonchi and Wheezing and Moderate Oropharyngeal Dysphagia. A Significant Change Minimum Data Set (MDS) 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent for personal hygiene, incontinent of bowel and bladder and required oxygen therapy.</p>	F 312		

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 312	<p>Continued From page 1</p> <p>a. A Care Plan dated 2/17/06 and updated 5/3/06 documented, "Problem ... At risk for decline in ADL's due to degenerative arthritis...Approaches Turn and reposition every [every 2 hours] keep [Resident #9] clean, dry and odor free..."</p> <p>b. On 5/10/06 at 2:20 p.m., Certified Nursing Assistant (CNA) #5 and CNA #6 provided incontinent care, after the resident had been incontinent of urine. The resident held her legs tightly together and would not open them.</p> <p>CNA #5 took a sheet of wet wipes and swiped the resident's left groin area and left the sheet of wipes between the resident's legs. The CNA then swiped the resident's right groin area and left the wipes between the resident's legs. The CNA then swiped the mons pubis downward and left that wet wipe between the resident's legs.</p> <p>The resident was turned onto her right side where the CNA removed the 3 wipes from between the resident's legs. The CNA did not spread the labia for cleansing.</p> <p>2. Resident #17 had diagnoses of Congestive Heart Failure and Alzheimer's Disease. The Annual MDS dated 4/5/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent on staff for toilet use and personal hygiene and was frequently incontinent of bowel and bladder.</p> <p>a. The Care Plan dated 4/14/06 documented, "Problem... Incontinent of bladder (daily but some control present), related to: dementia [with confusion], diuretic therapy, Alzheimer's disease, depression [with anxiety]... Incontinent of bladder. Check [every] 2 hours. Peri care with each</p>	F 312			

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F 312	Continued From page 2 episode. Provide incontinent care following each episode." b. On 5/10/06 at 2:50 p.m., the resident was incontinent of a large amount of loose stool; when the resident's disposable brief was removed, stool covered the entire mons pubis. The resident held her legs tightly together and refused to open them. CNA #5 took a sheet of wet wipes and swiped the resident's left groin area and left the sheet of wipes between the resident's legs. The CNA then swiped the resident's right groin area and left the wipes between the resident's legs. The CNA swiped the mons pubis downward and left that wipe between the resident's legs. The resident was turned onto her right side where the CNA removed the 3 wipes from between her legs. The CNA did not spread the labia for cleansing. The CNA then swiped the rectal area 3 times, but did not cleanse the buttocks or perineal area. 3. On 5/11/06 Registered Nurse #1 stated, " When giving peri care to women the labia should be separated in order to clean the vagina. They have been in-serviced on this."	F 312			
{F 441} SS=E	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	{F 441}			

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{F 441}	<p>Continued From page 3</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Rewritten Deficiency</p> <p>Based on observation, record review and interview, the facility failed to ensure that staff washed their hands before and after providing incontinent care and handling soiled linen for 3 (Residents #2, #9 and #17) of 11 (Residents #2, #4 thru #10, #12, #13 and #16 thru #18) case-mix residents that were incontinent of bowel and/or bladder. The facility also failed to ensure the ice scoop was kept in a closed container to prevent possible contamination when passing ice to residents. These failed practices had the potential to affect 54 residents on the South East and South West Hall, according to a list provided by the facility on 5/11/06 at 1:55 p.m. The findings are:</p> <p>1. Resident #2 had diagnoses of Chronic Obstructive Pulmonary Disease and Dementia. A Physician "History and Physical" dated 5/4/06 documented the resident had difficulty breathing, was confused and disoriented and incontinent of urine at times.</p> <p>On 5/10/06 at 1:50 p.m., the resident was seated on the bedside commode having a bowel movement (BM). When the resident was finished Certified Nurse Assistant (CNA) #4 applied latex gloves and assisted the resident to stand. After</p>	{F 441}			

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{F 441}	<p>Continued From page 4</p> <p>providing incontinent care, the CNA pulled up the resident's disposable brief and then pulled up his pants.</p> <p>The CNA then assisted the resident to transfer to his recliner, without removing the soiled gloves. The CNA placed a clothing protector around the resident's neck, placed the resident's oxygen tubing around the resident's ears, placed the canula into the resident's nares and then removed his gloves.</p> <p>2. Resident #9 (Room 830) had diagnoses of Cerebral Vascular Accident (CVA), History of Pneumonia with Ronchi and Wheezing and Moderate Oropharyngeal Dysphagia. A Significant Change MDS 2/15/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent for all activities of daily living (ADL), totally incontinent of bowel and bladder and required oxygen therapy.</p> <p>a. The Care Plan dated 2/17/06 and updated 5/3/06 documented, "Problem... At risk for decline in ADL's due to Degenerative Arthritis. . . Approaches turn and reposition [every 2 hours] keep [Resident #9] clean, dry, and odor free."</p> <p>b. On 5/10/06 at 2:20 p.m., Certified Nursing Assistant (CNA) #5 and CNA #6 provided incontinent care, after the resident had been incontinent of urine.</p> <p>After providing the incontinent care and handling the soiled linen, CNA #5 raised the resident's side-rails, covered the resident with a sheet, placed the oxygen tubing around the resident's ears and then placed the oxygen canula in the</p>	{F 441}			

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{F 441}	<p>Continued From page 5</p> <p>resident's nares. CNA #5 and CNA #6 then removed their soiled gloves.</p> <p>CNA #6 assisted CNA #5 in turning and repositioning the resident during incontinent care. With a gloved hand, CNA #6 removed the urine soaked bed protector and assisted CNA #5 in placing a clean bed protector under the resident.</p> <p>CNA #6 then removed his gloves, but did not wash his hands, before going into the hall; the CNA lifted the top off the trash and soiled linen containers and disposed of the bags.</p> <p>The CNA then got a drink of water from the fountain in the hall and walked to the Nurse's Station, where the CNA leaned on the counter top and then walked down the hall into the Day Room. CNA #6 then continued down the hall and entered Resident Room 826. The CNA straightened the covers on Bed A and left the room and returned to Resident #9's room.</p> <p>The CNA asked a nurse in Resident #9's room what he could do to assist him/her and then went to the Nurse's Station to retrieve a Telfa bandage for the nurse and returned to Resident #9's room and handed it to nurse.</p> <p>The CNA then stood at foot of bed, took the blanket from a chair, unfolded it over the resident and pulled the resident up in bed. The CNA then rolled a Hoyer lift out of the resident's room, down the hall and into Resident Room 878, without ever washing his/her hands.</p> <p>3. Resident #17 (Room 726) had diagnoses of Replacement of Joint Hip-partial-total, Alzheimer's Disease and Chronic Diarrhea. An</p>	{F 441}			

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{F 441}	<p>Continued From page 6</p> <p>Annual MDS dated 4/5/06 documented the resident had moderately impaired cognitive skills for daily decision-making, was totally dependent on staff for toilet use and personal hygiene, frequently incontinent of bowel and bladder and had a urinary tract infection in the last 30 days.</p> <p>On 5/10/06 at 2:50 p.m., CNA #6 walked down the hall to Resident Room 726, where he entered to assist CNA #5 with incontinent care for Resident #17.</p> <p>CNA #6 applied gloves without washing his hands. The CNA then left the room, went down the hall to the clean linen cart, got an incontinent pad and returned to Room 726. The CNA then changed his right glove, left the room again to look in the clean linen cart and stated, "I'm going to have to find someplace to wash my hands." The CNA then continued down the hall, retrieved a gait belt and returned to Resident Room 726.</p> <p>CNA #6 then removed his gloves, put on clean gloves and assisted CNA #5 with changing linens and providing incontinent care for Resident #17. CNA #6 took the resident's dirty linens to the soiled linen container in the hall, removed the top and disposed of the bag.</p> <p>CNA #5 provided incontinent care for Resident #17, who had been incontinent of bowel. The CNA did not wash her hands before putting on gloves.</p> <p>After the incontinent care was complete, CNA #5 straightened the resident's clean gown and attempted to poke the resident's hair under the resident's hair net, without removing the soiled gloves.</p>	{F 441}			

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{F 441}	Continued From page 7 4. On 5/11/06 at 11:05 a.m., Registered Nurse (RN) #1 stated, "The CNA's have been in-serviced on washing their hands. They should wash their hands after providing care with each resident and after coming in contact with any body fluid." 5. The facility policy and procedure for "UNIVERSAL PRECAUTIONS," documented, "GUIDELINES ...The following are guidelines to follow when using universal precautions. 1. Wash hands: ...Before and after giving care to a patient ...After contact with body fluids ...After removing gloves..." 6. On 5/10/06 at 2:10 p.m., CNA #3 was passing ice to residents at the end of the 800 hall in Resident Rooms 810 thru 814. The CNA reached into the cooler of ice with her gloved hand, picked up the ice scoop and shoveled ice into a resident's water pitcher.	{F 441}			