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 |
|---|---|---|---|
| | 045414 | A. BUILDING ____ B. WING ____ | C 06/17/2008 |

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

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| F 000 | INITIAL COMMENTS<br><br>Complaint #13575 was substantiated, all or in part, with deficiency cited at F498. | F 000 | | |
| F 323 SS=J | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure adequate supervision was provided to prevent resident elopement from facility as evidenced by the facility failure to ensure 4 of 6 exit doors were either monitored or equipped with "Secure Guard" alarm system that would lock door when wandering residents approached, the failure to ensure the "Secure Guard" system was checked as documented on the care plan, and a plan for prevention of reoccurrence of elopement (i.e. investigate causal factors of elopement, revise care plan, retrain staff) was implemented for 1 case mix resident (Resident #5) that was identified at risk for elopement. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Resident #5 and had the potential to affect 11 residents who wore a "Secure Care Tester" device to alarm the staff of the residents attempt for elopement according to a list provided by the Director of Nursing on 6/17/08 at 11:00 a.m. The facility was informed of the Immediate | F 323 | | |

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 323 | Continued From page 1<br>Jeopardy condition on 6/17/08 at 2:30 p.m. The findings are:<br><br>1. Resident #5 had diagnoses of Dementia with Behaviors and Alzheimer. The Minimum Data Set dated 3/24/08 documented the resident was moderately impaired in cognitive skills for daily decision-making; had no behavioral symptoms; was independent in transfers and locomotion in the corridor and on and off the unit; no functional limitations in range of motion; and fell in the past 31-180 days.<br><br>a. Physician's Orders dated 9/29/05 documented, "May use elopement bracelet. Check q (every) shift for placement."<br><br>b. The Risk of Elopement Assessment dated 3/19/08 documented a history of "exhibited wandering behavior in the last 60 days when up" with a frequency of qd (every day). Past history of leaving facility, increased confusion in the evening, history of pushing on exit door handles and makes statements such as 'I'm going home, how do I get out of here and have to catch the bus'." Mobility was documented as "ambulates independently". The evaluation documented, "resident monitoring bracelet applied, door alarms and care plan completed and reviewed."<br><br>c. The Plan of Care dated 3/19/08 documented a problem of "at risk for elopement" with interventions to "evaluate patterns of attempts to elope... provide with secure care band to wear continually. This will lock doors and sound alarm if [Resident #5] attempts to leave the nursing home without supervision, follow elopement protocol if [Resident #5] leaves the facility unsupervised; observe closely to ensure | F 323 | | |

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| F 323 | Continued From page 2 | F 323 | | |

resident's safety especially around exit doors, check placement of wanderguard bracelet each shift and check secure care system daily to ensure doors are operating properly." The Plan of Care documented an intervention dated 6/11/08 of "Wears two [secure care] bracelets d/t (due to) knows how to manipulate bracelet to open doors. Has hx of prying [bracelets] off ankles."

1) On 6/17/08 at 10:30 a.m., the Administrator, Director of Nursing, Maintenance Director and Surveyor assessed the facility exit doors. Two doors have the Secure Care Alarm System (Northeast and Southeast). The remaining doors at North Day Room, South Day Room, Small Dining Room, Large Dining Room, Northwest and Southwest have an alarm system which was not affected by the Secure Care bracelet and alarm only when an individual exits or opens the given door.

2) The Secure Care Tester form documented the resident's Secure Care bracelet was not checked on 6/1/08 through 6/4/08, 6/7/08 through 6/10/08 or 6/15/08 through 6/16/08. The form was designed to document daily checks of the Secure Care Alarm System.

3) Certified Nursing Assistant (CNA) #1 in a witness statement dated 6/15/08 documented, "I was lunch seating on couch by front door the door alarm on North Hall went off, it was [Resident #5] trying to get out she turned around and left, that [was] the last I saw of her..."

d. The Nurse's Notes dated 6/15/08 at 8:45 p.m. and signed by LPN #1 documented, "Door alarm went off at the Nurse's Station. C.N.A.

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| F 323 | Continued From page 3<br>approached desk to check alarm box. C.N.A. asked this nurse 'what zone is alarm in?'. This nurse told C.N.A. to check court yard doors and door at left of dining room. C.N.A. checked court yard doors and resident was not there. This nurse immediately locked cart and went out dining room doors to the left. C.N.A. went around to back of nursing home and nurse went around front of building and searched for resident. All halls and bathrooms were searched."<br><br>Licensed Practical Nurse [LPN] #1 in a witness statement dated 6/15/08 documented, "At approximately 2045 (8:45 p.m.) I was passing medications [and] had started an updraft on a resident. I did not hear the alarm due to noise of updraft. Upon exiting room I heard the alarm. CNA [#2] heard alarm after leaving a room. [CNA #2] asked 'What zone is the alarm in?' I told her the alarm went to the courtyard and doors to [left] of dining room..."<br><br>e. The Nurse's Notes dated 6/15/08 at 9:00 p.m. documented, "This nurse then called 911. The police stated they had found resident at a street behind Wal-mart and resident had fallen and had abrasions. The police department called ER (Emergency Room) at [Hospital] and transferred resident by ambulance to ER. Upon assessment, ER nurse reported abrasion to resident's nose and fx (fracture) to R (right) little finger as noted. R (resident) returned from ER back to NH (Nursing Home) at 2240 (10:40 p.m.). A & O (alert and oriented), verbal. Order to resume all NH meds. Consult [with] [Physician] in a.m. Leave hand splint in place until [Physician] sees patient. Administrator was notified of occurrence. [Physician] was notified. [Director of Nursing] was notified. Daughter aware. C.N.A.'s helped | F 323 | | |

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| F 323 | Continued From page 4<br>[with] search. In bed resting. VS (vital signs) 114/64, 20, 84, 98.1."<br><br>f. The [Local Police Department's] Investigative Information dated 6/15/08 documented: "On 6/15/08 at approximately 8:50 p.m., [Local Citizen] reported to the Sheriff's office dispatch that an elderly woman was walking on [Street approximately .6 mile from Nursing Home] and fell and appeared to be lost and confused. Sheriff's office then dispatched city police officer to the scene to assist. Upon my arrival, I saw [Local Citizen] holding upright in the sitting position a confused and somewhat dazed [Resident #5]. [Resident #5] had abrasions on her nose and right side cheek area from where she had fell on the asphalt. I advised the Sheriff's office dispatch that the woman appeared to have come from the nursing home because she was wearing some kind of a security bracelet on her right wrist. The Sheriff's office dispatch confirmed that the nursing home had just called and reported her missing and it was probably their missing person. [Ambulance Service] was dispatched to the scene to check [Resident #5's] condition and then transported her back to the [Nursing Home]."<br><br>g. The Emergency Room Physician documented, "6/18/08... Noted to have facial and right knee abrasions with some mild swelling of R (right) hand."<br><br>h. The Radiology Report dated 6/15/08 documented an impression of "Mildly comminuted, mildly displaced fractures through the proximal half of the right 5th phalanx."<br><br>i. The Suspected Elopement Procedure (to be | F 323 | | |

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| F 323 | Continued From page 5<br>implemented if a resident is discovered missing) documented, "Supervisor in charge at time of incident will initiate the Missing Resident/Post Elopement Form. Implement plan for prevention of reoccurrence (i.e. revise care plan, retrain staff). Begin investigation as to the causal factor of elopement, summarize findings and new interventions and send to state officials within 5 days if applicable (ADM/DNS [Administrator/Director of Nursing Service] to perform)."<br><br>1) As of 6/16/08 at 4:00 p.m., the care plan was not revised to address the resident's elopement on 6/15/08.<br><br>2) On 6/17/08 at 10:00 a.m., the Director of Nursing stated that following the incident of elopement of Resident #5 on 6/15/08, "The nurses have spoken and instructed the night shift C.N.A.'s to round more frequently at a minimum of every hour on that resident. There probably is no documentation." She stated that there was no documentation of those directives or the implementation of the rounds for Resident #5. The Director of Nursing stated that inservices relative to elopement were "started at 6:00 a.m. this morning (6/17/08)." She further stated that the doors of the facility were assessed for appropriate operation "yesterday (6/16/08) at about 10:30 a.m." The Director of Nursing stated that there was no documentation nightly as required post testing assurance of the application of the Secure Care Bracelets on multiple occasions on the South Hall during June of 2008 [five residents one of which was Resident #5]. The Director of Nursing stated that the Missing Resident/Post Elopement Form was not available for review because it was not initiated. She | F 323 | | |

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| F 323 | Continued From page 6<br>further stated that there was no policy/procedure for the Secure Care system.<br><br>j. On 6/16/08 at 12:48 p.m. and 3:01 p.m. and on 6/17/08 at 9:15 a.m., 11:17 a.m. and 3:02 p.m., the resident was observed with a Secure Care bracelet on right wrist.<br><br>2. The Immediate Jeopardy was removed on 6/17/08 at 4:23 p.m. and the scope and severity lowered to "G" when the facility implemented the following Plan of Removal:<br><br>a. As of June 17, 2008 at 0630 in-servicing began on the Elopement Policy. All in-servicing will be performed by June 18, 2008 at 2355. No employee will be allowed to work until they have been in-serviced.<br><br>b. Secure Care Alarm Bracelet checks for placement and activation will be done on each 11-7 shift by the professional nursing staff. The DON/Designee will monitor daily and document compliance.<br><br>c. The doors with the Secure Care Alarm System and all exit doors will be checked day by the Maintenance Director/Designee for appropriate mechanical functionality. The Administrator/Designee will review/monitor on a weekly basis, and document compliance.<br><br>d. In this facility we have eight sets of doors. Two sets have the Secure Care Alarm System on them, North East and South East which lead outside of the Nursing Home. The remaining six sets of doors, one set at North Day Room, South Day Room, Small and Large Dining Room which is the door [Resident #5] exited the building, | F 323 | | |

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| F 323 | Continued From page 7<br>North West and South West have alarms. Temporarily June 17, 2008, 3:40 p.m., a staff member will be posted at the North West, South West, and Large dining room doors, with the sole responsibility of guarding the doors to ensure residents that are elopement risk do not exit the building. Random monitoring of the door security by personnel will be conducted three times within each 24 hour period, and at least once each shift by the Administrator/Designee. Compliance will be documented. This will be continued until the Secure Care Alarm system on the remaining doors is in place.<br><br>e. Approval from facility CEO (Chief Executive Officer) has been obtained to purchase the Secure Care Alarm System for the remaining six sets of doors. Secure Care Alarm Company has been contacted as of June 17, 2008 at 1515 and will be here within the week to begin installation of the alarm systems on the remaining sex sets of doors." | F 323 | | |
| F 498 SS=J | 483.75(f) PROFICIENCY OF NURSE AIDES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #13575 was substantiated, all or in part, in these findings.<br><br>Based on observation, record review and interview, the facility failed to ensure that nurse aides were able to demonstrate competency in | F 498 | Past noncompliance: no plan of correction required. | |

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skills and techniques necessary to care for residents' needs as evidenced by leaving the side rails down while obtaining incontinent care supplies for 1 (Resident #1) of case mix resident who was totally dependent on staff for Activities of Daily Living. This failed practice resulted in Past Immediate Jeopardy which caused or could have caused serious harm, injury or death for Resident #1 and had the potential to affect 101 residents who had physician orders for side rails according to a list provided by the Director of Nursing on 6/17/08 at 2:00 p.m. The facility was informed of the Past Immediate Jeopardy on 6/17/08 at 2:30 p.m. The findings are:

1. Resident #1 had diagnoses of Dementia with Behavior Disturbance, Alzheimer's Disease, Osteoarthritis and Osteopenia. The Minimum Data Set dated 4/21/08 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for activities of daily living, partial loss of functional range of motion on one side of arms and hands and full loss of functional range of motion of legs and feet.

a. The Plan of Care dated 4/16/08 documented a problem of "at risk for falls or injury related to dementia and impaired mobility secondary to Alzheimer's" with an intervention to use full side rails times two up when in bed to promote safety and prevent injury.

b. The facility's Fall Risk Assessment and Post Fall Assessment dated 4/21/08 documented a total score of "13". The document included the statement, "If total is 12 or greater, the resident is considered to be at high risk for falls and placed on the Fall Prevention Program immediately."

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c. Nurse's Notes dated 5/30/08 at 3:00 documented, "In room changing other R (Resident). CNA (Certified Nursing Assistant) putting [Resident #1] to bed. CNA. stepped away from bed to closet and left side rail down. This nurse heard R hit the floor. No obvious injuries. Small bruise on L (left) upper shoulder. No c/o (complaints) pain. No s/s (signs or symptoms) of pain during assessment. Family at facility for visit. Family requested Xray of L (left) shoulder and L hip. Dr. (Physician) agreed. VS (vital signs) 140/72, 112, 20."

c. The Radiology Reports dated 5/30/08 documented impressions of "Fracture of the left femoral neck, Osteopenia" and "Left 7th rib fracture".

d. The Emergency Room Physician Report dated 5/30/08 documented "recent fx (fracture) left hip and 7th L (left) rib".

e. On 6/17/08 at 1:11 p.m., the Director of Nursing stated there were "no inservices prior to 5/30/08 regarding side rail safety. Inservices were conducted after the fact."

f. Employee Disciplinary Report dated 5/30/08 and signed by supervisor documented CNA #3 was suspended for three working days for "substandard work, violation of safety rules, carelessness and violation of company rules of conduct" with a notation of "CNA did not follow policy and procedure. Performed two person transfer by herself. Did not put up side rail when stepping away from bedside. [Resident #1] fell out of bed..." CNA signed the report 6/6/08.

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1) A typed statement by the DON documented than on 5/31/08 at 7:00 a.m., CNA #3 was instructed to "never leave resident's bedside without making sure resident was safe."

2) On 6/17/08 at 12:50 p.m., CNA #3 (Certified Nursing Assistant #3) stated that on 5/30/08 "I left the right siderail down. I had her on the left side. She had never moved before. I left the side rail down to get a diaper from the closet just a few feet, 4-5 feet away. The Treatment Nurse was also in the room. She was at the roommate's bedside. [Resident #1] fell out of bed. I was suspended three days, had a written counseling and was inserviced on siderail safety."

3) On 6/17/08 at 2:24 p.m., CNA #1 stated that on 5/30/08 "I knew the side rail should have been pulled up for [Resident #1's] safety."`

g. The facility's Proper Use of Side Rail Policy was revised May 2008 to address documentation of less restrictive devices being unsuccessful, completion of the Side Rail assessment Form, obtaining a physician's order for the side rails, obtaining consent, incorporating the use of side rails in the care plan and ensuring the safety of the resident. Inservices regarding Transfers, Lift Procedures, Bed Rails, Gait Belts were completed for all nursing staff on 6/2/08. Physician orders indicated that physicians who had residents with side rail orders were clarified when necessary by 6/16/08 (45 residents).

h. On 6/3/08 the Plan of Care was revised to include an intervention of "SR's (side rails) up when in bed."

i. On 6/12/08 Physician's Orders documented,

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| F 498 | Continued From page 11<br>"Full SR (side rails) up x (times) 2 to define boundaries".<br><br>j. On 6/16/08 at 2:50 p.m. and 6/17/08 at 2:57 p.m., the resident was in bed with full side rails up. | F 498 | | |