

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

PRINTED: 06/29/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04A263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>06/22/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>OZARK HEALTH NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 HIGHWAY 65 SOUTH CLINTON, AR 72031</b>		
(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 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>Rewritten Deficiency</p> <p>Based on observation, record review and interview, the facility failed to ensure that all areas of the perineum were cleansed to maintain good personal hygiene for 3 (Residents #11, #13 and #14) of 13 (Residents #2, #3 and #5 through #14) case mix residents who were incontinent of bowel and bladder. This failed practice had the potential to affect 104 residents in the facility who were incontinent of bowel and bladder, according to a list provided by the Administrator on 6/22/06. The findings are:</p> <p>1. Resident #11 had a diagnosis of Organic Brain Syndrome with Anxiety. An Annual Minimum Data Set (MDS) dated 6/14/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total care in all activities of daily living and was incontinent of bowel and bladder.</p> <p>a. The Care Plan dated 7/13/05 documented, "Problem: At risk for skin breakdown related to incontinence of bowel and bladder, severely impaired mobility, HX (history) of pressure ulcer."</p> <p>b. On 6/20/06 at 10:06 a.m., Certified Nursing</p>	{F 312}		5/29/06	

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>Assistant (CNA) #1 and Nursing Assistant (NA) #9 were observed at the bedside. The resident's buttocks were on the edge of an upright Geri-chair and the resident's pants were pulled down below her knees. A clear plastic bag was on the bed that contained a soiled brief and wet wipes. CNA #1 placed a new brief between the residents thighs.</p> <p>CNA #1 and NA #9 performed a 2-person under-arm lift of the resident and held the resident in an upright position; the resident's legs were drawn up. There was incontinent bowel movement in the seat of the Geri chair.</p> <p>CNA #1 and NA #9 held the resident upright under the arms, as CNA #1 wiped the incontinent BM from the seat of the Geri chair with a wet wipe and then used a wet wipe to wipe the resident's anal area of incontinent bowel movement one time.</p> <p>A brief was applied to the resident and the resident's pants were pulled up. There was no vaginal/labia care provided and the resident was not positioned to view the perineum or the rectal/buttocks area to provide complete incontinent care.</p> <p>When asked if the resident's brief was wet when removed and what care was provided, CNA #1 stated, "Yes, she was wet and we wiped her in the front while she was in the Geri chair."</p> <p>When asked, "How were you taught to provide incontinent care? CNA #1 stated, "What you saw us do is how we were taught to do it."</p> <p>When asked, "How were you taught to provide</p>	{F 312}			

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{F 312}	<p>Continued From page 2</p> <p>incontinent care? NA #2 stated, "I have been here 3 days. I took my clinicals here. This was how I was taught to do it."</p> <p>c. On 6/20/06 at 12:30 p.m., when asked, How do you know how incontinent care is provided on the floor? LPN #1 charge nurse stated, "I watch them. I haven't seen them do it improperly in quite some time."</p> <p>2. Resident #13 had diagnoses of Diabetes, Pernicious Anemia and Congestive Heart Failure. A Significant Change MDS dated 5/3/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent on two staff members for personal hygiene and incontinent of bowel and bladder.</p> <p>a. The Plan of Care dated 5/3/06 documented, "Problem-Risk for skin breakdown secondary to impaired to impaired immobility and incontinuity of bowel and bladder, Hx (history) of pressure ulcers, IDDM (diabetes), obesity and Wt. (weight) loss...Approaches-Check Q (every) 2 hrs. (hours). provide incontinent care following each episode. Keep resident clean, dry and odor free.</p> <p>b. On 6/21/06 at 11/05 a.m., CNA #7 and CNA #8 rolled the head of the resident's bed down; CNA #8 then wiped the resident's left groin area using a front to back motion and then cleaned the surface of the resident's labia. The CNA did not separate the resident's labia, clean the resident's right groin areas or the abdominal fold.</p> <p>The CNAs then rolled the resident to her right side and CNA #8 cleaned the resident of incontinent bowel movement and cleaned the</p>	{F 312}			

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{F 312}	<p>Continued From page 3</p> <p>buttocks. The CNAs did not dry any areas of the resident's skin.</p> <p>3. Resident #14 had diagnoses of Organic Brain Syndrome, Cerebral Vascular Accident and Dementia. An Annual MDS dated 4/12/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent on staff for toilet use, personal hygiene and bathing and was incontinent of bowel and bladder.</p> <p>a. The Resident Plan of Care dated 4/12/06 documented a problem of, "Incontinent Of Bowel and Bladder Secondary To CVA, OBS, Dementia." Approaches "Incontinent Of Bowel And Bladder. Check Q (every) 2 HRS (hours). Peri Care with each episode. Provide Incontinent Care following Each Episode. Keep [Resident #14] clean, dry, and odor free."</p> <p>b. On 6/19/06 at 1:40 p.m., CNA #3 and CNA #4 performed incontinent care for the resident as the resident sat on the bathroom commode.</p> <p>CNA #4 stated that the resident's brief was wet with urine; a brief was in a plastic bag. CNA #3 and CNA #4 assisted the resident up off the commode to a standing position. CNA #4 stood by to steady the resident. CNA #3 then cleansed the resident's rectal area and buttock with a front to back motion with wipes and a clean brief was then applied.</p> <p>The resident's labia was not spread apart and cleansed and the mons pubis was not cleansed during the procedure.</p> <p>4. The facility policy and procedure entitled</p>	{F 312}			

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{F 312}	<p>Continued From page 4</p> <p>"Perineal Care" documented: "Purpose - 1. To cleanse the perineum. 2. To prevent infection and odor...."Procedure - ...9. Instruct resident to raise hips while bed protector is placed underneath resident. 10. Offer bedpan to resident. 11. Position bath blanket so only the area between legs is exposed. Female perineal care - a. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed... d. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back. Rinse and pat dry with towel. If periwash solution is used, place resident on bedpan and pour solution 5 inches above the perineum and over vulva until it runs back into the bedpan. Dry, remove from bed pan, and position resident on back. 12. Turn resident away from you. Use new washcloth and wash around anus. Rinse area and dry. 13. Help position resident onto back. 14. Remove protective pad under buttocks, remove gloves."</p> <p>5. On 6/21/06 at 4:00 p.m., the Director Of Nursing (DON) was asked how she expected incontinent care to be done if the resident was on a bathroom commode. The DON stated that they could do peri care if the resident was on the toilet, but that it could be harder, depending on the resident. The DON stated that a female resident should be cleansed from front to back, to cleanse the front peri area and the buttock.</p> <p>The DON stated that if a resident received incontinent care while in bed that all the equipment needed, the gloves, the wipes and briefs should be gathered. Privacy should be provided. The dirty brief should be removed. The front should be cleansed, the labia should be</p>	{F 312}			

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{F 312}	Continued From page 5 open and cleansed well. The resident should be turned to cleanse the buttock. Clean any other areas as needed.	{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 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:  Rewritten Deficiency.  Based on observation, record review and interview the facility failed to ensure that wet under pads were kept off of the floor, wheel chair trays were cleaned after being on the floor, gloves were changed after cleaning bowel incontinence, Geri chairs were cleaned after being soiled with bowel incontinence, staff washed their hands after handling soiled linen and trash after incontinent care for 3 (Residents #10, #11, and #13) of 11 (Residents #2, #3, #5, #7 thru #14) case mix residents who were incontinent of bowel and/or bladder. This failed practice had the potential to affect 104 residents who were incontinent of bowel and/or bladder, as documented on a list received from the Administrator on 6/21/06. The findings are:	{F 441}		5/29/06	

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{F 441}	<p>Continued From page 6</p> <p>1. Resident #11 had a diagnosis of Organic Brain Syndrome with Anxiety. An Annual Minimum Data Set (MDS) dated 6/14/06 documented the resident was severely impaired in cognitive skills for daily decision making, totally dependent on the physical assistance of 2-plus staff persons for transfers, totally dependent on the physical assistance of one staff person for personal hygiene and incontinent of bowel and bladder.</p> <p>a. On 6/20/06 at 10:06 a.m., Certified Nursing Assistant (CNA) #1 and Nursing Assistant (NA) #9 were observed during incontinent care; both Aides donned gloves. CNA #1 and NA #9 performed a 2-person under-arm lift of the resident and held the resident in an upright position; the Geri chair had incontinent bowel movement in the seat of the chair. CNA #1 used a wet wipe to wipe the bowel movement one time from the chair seat. No further cleansing of the chair was provided.</p> <p>Upon completion of the incontinent care, NA #9 did not change gloves; the NA used the same gloves to place the oxygen nasal cannula in the resident's nose.</p> <p>b. On 6/21/06 at 9:55 a.m., CNA #10 and NA #11 were observed during incontinent care; both Aides donned gloves. During the procedure, NA #11 left the room wearing the gloves and then returned to the room wearing the same gloves and continued the incontinent care procedure.</p> <p>At 10:00 a.m., on completion of the incontinent care, CNA #10 did not change gloves. CNA #10 used the same gloves to place the oxygen nasal cannula in the resident's nose.</p>	{F 441}			

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{F 441}	<p>Continued From page 7</p> <p>CNA #10 then removed the glove from the right hand and used the left gloved hand to pick up the soiled linen bag. The CNA used the right bare hand to raise the resident's side rail, place the pad to the side rail, place the call light then move the Geri chair.</p> <p>CNA #10 left the room without washing her hands or using a hand cleanser. The CNA lifted the lid on the soiled linen cart and disposed of the plastic bag, removed the glove from the left hand and closed the lid using the bare right hand, placed both hands on her hips then entered a non case mix resident room.</p> <p>2. Resident #10 had diagnoses of Cerebral Artery Occlusion, Diabetes and Cancer of the Urethra. An MDS dated 6/4/06 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance of one staff member for personal hygiene and was incontinent of bowel and bladder.</p> <p>a. On 6/20/06 at 10:45 a.m., CNA #4 and CNA #5 were completing incontinent care for the resident; CNA #4 timed and dated the resident's clean incontinent brief. CNA #5 placed the brief that was wet with urine on the floor, then after dressing the resident, the CNA placed the wet brief in a plastic bag.</p> <p>b. On 6/20/06 at 12:25 p.m., CNA #4 and CNA #6 assisted the resident to a wheelchair and then picked up the wheelchair tray from the floor and placed it on the resident's chair, without cleaning the tray. CNA #4 then transported the resident to the dining room, removed the tray from the resident's wheelchair and placed it on the floor,</p>	{F 441}			

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{F 441}	<p>Continued From page 8 leaned against the wall.</p> <p>c. On 6/21/06 at 4:20 p.m., when asked what she expected from her staff when equipment had been placed on floor, the Director of Nursing replied, "Always clean properly before using, placing on the resident."</p> <p>3. Resident #13 had diagnoses of Diabetes, Pernicious Anemia and Congestive Heart Failure. An MDS dated 5/3/06 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent on two staff members for personal hygiene and incontinent of bowel and bladder.</p> <p>a. The resident's Plan of Care dated 5/3/06 documented, "Problems-Risk for skin breakdown secondary to impaired immobility and incontinency of bowel and bladder, Hx (history) of pressure ulcers, IDDM (Insulin Dependent Diabetes Mellitus), obesity and Wt. (weight) loss...Approaches-Check Q (every) 2 hrs (Hours). Provide incontinent care following each episode. Keep resident clean dry and odor free."</p> <p>b. On 6/21/06 at 11:05 a.m. CNA #7 and CNA # 8 provided incontinent care for resident. CNA #8 then disposed of the plastic bag that contained the soiled linen and the plastic bag that contained the soiled brief and wipes in a container in the hallway and returned to the resident's room. The CNA did not wash her hands before leaving the resident's room or upon re-entry to the resident's room, at which time CNA #8 assisted in adjusting the resident's position without washing her hands.</p> <p>CNA #7 left the resident's room without washing her hands re-entered the resident's room with a</p>	{F 441}			

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{F 441}	Continued From page 9 clean incontinent pad from the linen cart. CNA #7 then assisted CNA #8 to place the incontinent pad under the resident, without washing her hands.	{F 441}			