

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

PRINTED: 09/18/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/05/2006</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OZARK HEALTH NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 HIGHWAY 65 SOUTH</b> <b>CLINTON, AR 72031</b>
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F 000	INITIAL COMMENTS  Complaint #11970 was unsubstantiated  Complaint # 11930 was unsubstantiated.	F 000		
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview, the facility failed to ensure the abuse/neglect prohibition policies and procedures were developed to include training related to appropriate interventions to deal with aggression and/or catastrophic reactions of residents, how staff should report their knowledge related to allegations without fear of reprisal, how to recognize signs of burnout, frustration and stress that may lead to abuse, in areas of prevention have procedures to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur to include analysis of features of the physical environment that may make abuse and/or neglect more likely to occur and in reponse to occurrences, analyze to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. This failed practice had the potential to affect 90 cognitively impaired residents in the facility as identified on a resident roster provided by the Administrator on 8/31/06. The findings are:	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 226	Continued From page 1  1. The Policy and Procedure titled, Reporting Resident Abuse, Neglect, Unusual Occurrences, and Misappropriation of Resident Property documented, "...  2. All Employees will receive training during new employee orientation. All employees will be given a copy of the abuse-reporting policies and procedures and sign a statement that the policies and procedures have been received and understood. Annual in-services will be held on reporting suspected abuse, neglect or misappropriation of resident property.  3. All Employees are responsible for reporting any suspicion of abuse, neglect, injury of unknown origin, misappropriation of resident property or involuntary seclusion.  4. When any situation that is considered to abuse, neglect, injuries of unknown origin, misappropriation of resident property or involuntary seclusion is brought to the attention of any employee, that employee should report it promptly to the charge nurse on the floor.  5. The charge nurse then reports the situation to the nursing home administrator, director of Social Services of their designees.  6. The charge nurse will assess the situation to determine if any emergency treatment is needed.  7. The charge nurse will ensure that any potential for further harm is eliminated...  8. Suspected abuse, neglect, or misappropriation of resident property will be reported to the local	F 226			

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F 226	Continued From page 2 law enforcement agency by the facility.  9. Suspected, alleged, or witnessed occurrences of abuse, neglect, misappropriation of resident property or exploitation of a resident will be reported to the Office of Long Term Care..."  2. The facilities Policy and Procedure did not address the training related to appropriate interventions to deal with aggression and/or catastrophic reactions of residents, how staff should report their knowledge related to allegations without fear of reprisal, how to recognize signs of burnout, frustration and stress that may lead to abuse and in areas of prevention have procedures to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur to include analysis of features of the physical environment that may make abuse and/or neglect more likely to occur.	F 226			
F 324 SS=E	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:  Based on observation, interview, and record review, the facility failed to ensure that the personal alarms were in place for 2 (Resident #2 and #4) of 2 case mix residents (#2 and #4) who had a Physician order for a personal alarm. This failed practice had the potential to affect 31 residents in the facility who had Physician orders for personal alarms as identified on a list provided	F 324			

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F 324	Continued From page 3 by the Director of Nurses on 9/5/06. The findings are:  1. Resident #2 had diagnoses of Alzheimer's Disease, Osteoporosis and Insomnia. The Quarterly Minimum Data Set (MDS) dated 7/19/06 documented the resident had moderately impaired cognitive skills for daily decision making, had short-term and long-term memory loss and had fallen in the past 30 days and 31-180 days.  a. A physician's order dated 6/26/06 documented, "Body alarm while in bed to remind resident not to get up unassisted." and a physician's order dated 6/14/06 documented, "Check body alarm Q [every] shift while in bed - to start when alarm becomes available."  b. The Medication Administration Record (MAR) dated 8/1/06 through 8/31/06 documented, "Check body alarm Q shift while in bed...". Nurse initials were not documented for the 7-3 shift on 8/01/06, 17, 18 and the 31, there were no nurse initials for the 3-11 shift for 8/05/06, 18 and 29, and there were no nurse initials for the 11-7 shift for 8/04/06, 05, 11, 12, 17, 18, 19, and the 29th for the month of August.  c. On 8/31/06 at 2:50 p.m. and 4:21 p.m., on 9/1/06 at 9:02 a.m., 10:07 a.m. and 3:25 p.m., a bed alarm was on the bedside table not connected to the resident. The resident was in bed at this time.  d. On 9/1/06 at 10:07 a.m., when asked what measures were in place to prevent the resident from falling when in bed, Certified Nurse Aide (CNA) #1 stated, "[the resident] tries to get out of bed and puts her legs over the side rails...a mat	F 324			

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F 324	<p>Continued From page 4</p> <p>on the floor, side rails up and padded to prevent this." CNA #1 did not mention the intervention for the resident to have a personal alarm while in bed. The personal alarm was lying on the bedside table. Resident in bed at this time.</p> <p>2. Resident #4 had diagnoses of Vertigo and Osteoporosis. The Quarterly MDS dated 7/26/06 documented the resident had moderately impaired cognitive skills for daily decision making, had short-term and long-term memory problems, and had no falls within the past 30 days.</p> <p>a. The plan of care dated 7/26/06 documented, "at risk for falls ..."hx [history] of fall with fx [fracture]."</p> <p>b. On 9/1/06 at 9:00 a.m., at 10:01 a.m., and at 1:43 p.m., a sensor mat on the floor by the resident's bed did not alarm when stepped on. The control was in the "off" position. The resident was in the bed at the time of each observation.</p> <p>c. On 9/1/06 after completing record review of the residents clinical record, no documentation in the plan of care for the mat sensor alarm was found.</p> <p>d. On 9/1/06 at 1:45 p.m. the Assistant Director of Nursing (ADON) was asked how long had the resident had the bed and sensor alarm, the ADON stated, "As long as I've been here, since June 13 of this year." Licensed Practical Nurse #1 stated, "I know she's had them since May." When asked how the alarms were monitored, the ADON stated, "Rounds by the nurse." When asked if the CNA's were responsible for the alarms in any way, the ADON stated, "CNA's can hook them up."</p>	F 324			