

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

PRINTED: 11/24/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/13/2008
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 314} SS=E	<p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that staff informed the LPN and/or Treatment nurse when a wound dressing needed to be replaced for 1 (Resident #4), and wound care was provided as per physician orders for 1 (Resident #7) of 4 (Resident # 1, #4, #7, and #8) case mix residents with pressure sores. The failed practices had the potential to affect 20 residents in the facility who had pressure sores as documented on the list provided by the Director of Nursing on 11/6/08. The findings are:</p> <p>1. Resident # 4 had diagnoses of Dementia with Behavior (End Stage), Decubitus Ulcer, Non-Insulin Dependent Diabetes Mellitus and Infection (wound). A Quarterly Minimum Data Set (MDS) dated 7/18/08 documented the resident had severely impaired cognitive skills for daily decision-making, was totally dependent on staff for activities requiring two-person assistance with transfers/mobility, had inadequate control of bladder and bowel with multiple daily episodes all</p>	{F 314}		10/25/08

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 314}	Continued From page 1 or most of the time, and had one Stage II pressure ulcer, and skin tears. a. A care plan dated 4/23/08 documented, "Check q (every) 2 hrs (hours) and prn (as needed). Provide incontinent care following each episode. Keep [resident's name] clean, dry and odor free. Maintain dignity." b. A treatment ordered dated 10/23/08 documented, "Clean and rinse Stage II to sacrum with NS (normal saline), pat dry, apply Allanderm T ointment to periwound tissue, apply Panafil to wound bed, cover with Polymem foam pad. Then border gauze dressing qd (every day) until healed." c. On 11/4/08 at 9:06 a.m., after the breakfast meal, CNA (Certified Nursing Assistant) #1 and CNA #2 transferred the resident from a gerichair to the bed using an electric lift. The residents brief was removed. The resident had a decubitus ulcer on the coccyx approximately the size of a quarter. The edges were white, the center was beefy red with a small white spot in the center approximately 1/2 inch in diameter. CNA #1 and CNA#2 stated they were aware the resident had a pressure ulcer and there should have been a dressing. Both stated they would inform the charge nurse when they finished incontinent care. d. On 11/4/08 at 2:00 p.m., the Treatment Nurse, LPN (Licensed Practical Nurse) #1, was asked if the CNA's had relayed any information regarding the resident's dressing not being in place at the time they had provided incontinent care this morning at approximately 9:06 a.m.. The LPN stated she was not informed and discovered the wound had been left exposed when she went into	{F 314}			

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{F 314}	<p>Continued From page 2</p> <p>the resident ' s room to do the dressing change shortly before lunch approximately around 12:00 p.m.</p> <p>e. On 11/5/08 at 9:00 a.m., CNA #3 and CNA #4 transferred the resident using an electric lift from a geri-chair to the bed. The resident ' s incontinent brief was removed. It was slightly saturated with urine; no feces noted. The decubitus ulcer was not covered with a dressing. The edges were white, the wound bed was beefy red with a small white area in the center, approximately the size of a quarter. Both CNA's stated they were aware there should have been a dressing on the pressure ulcer and they would inform the nurse when they completed incontinent care. Both CNA's stated this was the first time they had performed incontinent care on the resident that morning. The CNA ' s notified the Treatment Nurse.</p> <p>f. On 11/6/08 at 9:40 a.m., the resident was taken to the outpatient wound clinic for a scheduled appointment. Upon examination the resident's dressing was taped on the top and two sides but open at the bottom and the wound was exposed. The dressing was dated 11/5/08 and had the Community Nurse's initials (LPN #1) on it.</p> <p>g. On 11/6/08 at 10:15 a.m., the wound care physician was asked to clarify if the wound was a Stage II or a Stage III and he stated, "Stage II does not involve muscle tissue; Stage III involves muscle tissue. ... since there is no damage to the muscle I have staged it as a Stage II. You could stage it as a III if you want, though." The wound care nurse, LPN #2, measured the wound, prior to sharps debridement by the physician, and documented 1.3 cm (centimeters) x 0.6 cm x 0.2</p>	{F 314}			

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{F 314}	Continued From page 3 cm on the chart. h. On 11/6/08 at 9:50 a.m., LPN #2 was asked if she was aware of any times when the resident did not have a dressing on the wound. The LPN stated the resident had frequently, in the past, come to the wound center without a dressing covering the wound. i. On 11/6/08 at 11:15 a.m., the physician was asked if he was aware of other times when the resident did not have a dressing on the wound. The physician stated, "We have been working on this wound for a long time, now. We have occasionally had her come down here without a dressing on the wound." 2. Resident # 7 had a diagnosis of Decubitus Ulcer. The Quarterly MDS dated 7/31/08 documented the resident had moderately impaired cognitive skills for daily decision making, was totally dependent of staff for bed mobility and transfers, and had 2 stage II pressure ulcers. a. A Physician Telephone Order dated 10/31/08 documented, "Clean wound to coccyx and right (R) buttock with normal saline (NS), apply 1/2 calazyme ointment (oint) and 1/2 zinc oint. to peri wounds. Apply Prisma to all wound beds. Change every day (QD) and as needed (PRN). b. The Treatment Record for 11/1/08 thru 11/30/08 documented, "10/31/08 cleanse stage II to coccyx and R buttock with NS. Apply 1/2 calazyme 1/2 zinc oint to peri wounds. Prisma to wound bed, cover with dry dressing. Change QD and PRN.	{F 314}			

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{F 314}	<p>Continued From page 4</p> <p>c. On 11/4/08 at 9:12 a.m., (CNA) #3 and #4 performed incontinent care for the resident. The residents brief was marked 11/4 and 5A (11/4/08 5:00 a.m.). While the CNA ' s were performing incontinent care there were 2 pressure ulcers observed. One pressure ulcer was located on the residents coccyx and one on the right buttock. There were no dressings on either pressure ulcer. The pressure ulcer on the right buttock was bleeding. CNA #4 stated that the pressure ulcer on the right buttock was, bleeding there was no dressing on it now. " It normally has a dressing." After performing the incontinent care CNA #4 applied a skin protectant ointment over the resident's buttock and coccyx. The ointment was applied over the pressure ulcers.</p> <p>At 9:55 a.m., the resident was transferred, without a dressing over the pressure ulcers, to a shower chair and taken to the shower room.</p> <p>d. On 11/4/08 at 10:20 a.m., CNA #4 pushed the resident in a shower chair back to the resident's room. A brief with the time 10:09 written on it was fastened around the resident's upper legs. The brief did not cover the resident's pressure ulcers. The pressure ulcer on the resident's buttock was exposed and the resident sat on the shower chair until 10:43 a.m. without a dressing covering the pressure ulcers. At 10:43 a.m. the resident was transferred to bed by Nursing Assistant #4 and Licensed Practical Nurse (LPN) #3.</p> <p>e. On 11/4/08 at 10:50 a.m., LPN #3, the community nurse for the hall that the resident resided on, performed the treatment for the resident's pressure ulcers. There were no dressings on the resident's pressure ulcers before the treatment began. The LPN cleansed</p>	{F 314}			

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{F 314}	Continued From page 5 the pressure ulcers with wound cleanser, not normal saline as ordered. The LPN then applied the 1/2 calazyme, 1/2 zinc ointment over the pressure ulcers. The LPN did not apply any Prisma to the wound beds as ordered. The LPN then applied a dressing over the pressure ulcer on the buttock. There was no dressing put over the pressure ulcer on the coccyx.	{F 314}			
{F 323} SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure staff followed the facility ' s policy for applying the body personal alarm to prevent the potential for falls for 1 (Resident # 10) of 4 (Resident #8, 9, 10, and 11) case mix residents who required a personal alarm, and for 1(Resident #7) of 2 (Resident #3 and #7) case mix residents who required padded	{F 323}		10/25/08	

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{F 323}	Continued From page 6 side rails. The failed practices had the potential to affect 27 residents in the facility care planned for personal alarms and 3 residents in the facility care planned for padded side rails as documented on a list provided by the Director of Nursing on 11/7/08 at 10:40 a.m. The findings are: 1. Resident #10 had a diagnosis of Dementia With Behavioral Disturbances. The Annual Minimum Data Set (MDS) dated 10/17/08 documented the resident had moderately impaired cognitive skills for daily decision making, required extensive assistance for transfers, had fallen in the past 30 days, and in past 31- 180 days. a. The Standard Fall Intervention Care Plan dated documented, "Dates of falls: 9/9/08, 9/27/08, 10/28 ...[and had circled] ... Body alarm while in bed 9/9 ... Body alarm while in W/C (wheel chair)." b. An Occurrence/ Analysis Report dated 10/28/08 documented, "Housekeeping heard resident yelling in day room. Went to look. Found resident lying in floor next to wheelchair. ... Briefly describe any follow up actions required: Reinstruct staff to lay resident (R) down in bed or recliner after meals. Resident leans over to take shoes on and off a lot. Has body alarm on." c. On 11/4/08 at 8:35 a.m., the resident was in a wheelchair in the dining room. The personal alarm was not clipped to the resident. The clip was fastened to the alarm box, hanging on the resident's wheelchair. d. On 11/4/08 at 8:52 a.m., the resident was in a	{F 323}			

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{F 323}	Continued From page 7 wheelchair in the day room. The personal alarm was not clipped to the resident. The clip was fastened to the alarm box hanging on the resident's wheelchair. e. On 11/4/08 at 9:59 a.m., the resident was in a wheelchair in the day room. The personal alarm was not clipped to the resident. The clip was fastened to the alarm box hanging on the resident's wheelchair. The resident had not been put in bed or the recliner since breakfast. f. On 11/4/08 at 11:10 a.m., the resident was sitting in a recliner. The personal alarm was clipped to the resident's shirt, but the alarm box was sitting on top of a night stand. The alarm box was not secured to anything. g. On 11/4/08 at 2:35 p.m., the resident was in bed. The alarm was clipped to the resident's shirt, but the alarm box was sitting on top of the mattress of the bed. The alarm box was not secured to anything. h. On 11/5/08 at 9:55 a.m., the resident was sitting in a recliner. The personal alarm was clipped to the resident's shirt, but the alarm box was sitting on top of a night stand. The alarm box was not secured to anything. j. On 11/6/08 at 9:30 a.m., the resident was in bed. Nursing Assistant #4 looked at the Resident Care Guide on the inside of the resident's closet door and took the alarm off the resident. The Resident Care Guide documented, " Special equip (equipement) Alarm(s) Body alarm w/w [wheel chair] . The document did not indicate an alarm was to be used while the resident was in bed.	{F 323}			

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{F 323}	Continued From page 8 1). On 11/6/08 at 2:15 p.m., the Director of Nursing was asked when was the resident suppose to have the alarm on. The Director of Nursing stated, "I know [Resident # 10] is suppose to have it on in the wheelchair." The Director of Nursing looked at the Resident Care Guide and stated,"Body alarm on wheelchair, that is what the CNAs are suppose to go on." The Director of Nursing also stated that Licensed Practical Nurse (LPN) # 5 updated both the care plans and the care guides. 2). On 11/6/08 at 2:30 p.m., LPN # 5 was asked when was the resident suppose to have the personal alarm on. The LPN looked at the Care Guide in the resident's room and stated,"Body alarm in wheelchair." The LPN was then notified of the discrepancy between the Care Plan and Care Guide. The LPN stated, "I take the Care Plan and update the Care Guide." k. On 11/6/08 at 2:00 p.m., Nursing Assistant #3 was asked when the personal alarm was supposed to be used for the resident. The Nursing Assistant stated, "Suppose to have it on in bed or when out." The Nursing Assistant was asked if the resident was supposed to have it on while sitting in the recliner. The Nursing Assistant stated, "Suppose to have it on when in the recliner." l. On 11/6/08 at 2:15 p.m., Certified Nursing Assistant (CNA) #5 was asked when was the resident supposed to have the personal alarm on. The CNA stated, "Says on the chart to put it on when up in the wheelchair." m. On 11/7/08 at 10:45 a.m., the Director of	{F 323}			

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{F 323}	Continued From page 9 Nursing provided the Policy and Procedure concerning resident alarms. The Policy and Procedure documented, "Secure alarm to wheelchair, chair or bed." 2. Resident # 7 had diagnoses of Debility and Diabetes Mellitus, Adult On Set. The Quarterly Minimum Data Set (MDS) dated 7/31/08 documented the resident had moderately impaired cognitive skills for daily decision making. a. An Occurrence/ Analysis Report dated 10/13/08 documented, "Skin tear (s/t) noted to left (L) inner elbow ... briefly describe any follow up actions required: Resident refuses geri sleeves. Add padded side rails." b. An Occurrence/ Analysis Report dated 10/13/08 documented, "ST (skin tear) noted on left (L) elbow, cleaned with normal saline (NS) and applied dry dressing. Patient (Pt) may have rubbed against rail ... Pad side rails." c. On 11/5/08 at 9:20 a.m., the resident was laying in bed. The side rails were up X 2. The side rails were not padded at this time. There were no staff in the room. A sign above the head of the resident documented, "[Residents Name] needs side rail pads on the bed at all times to prevent skin tears and bruising."	{F 323}			