

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

PRINTED: 10/29/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045207</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>OJACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD CAMDEN, AR 71701</b>	
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F 221 SS=D	<p><b>483.13(a) PHYSICAL RESTRAINTS</b></p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a pre-restraint assessment was completed prior to the use of a restraint to determine the medical necessity for 1 (Residents #13) of 4 (Resident #1, #6, #8, and #13) case mix residents who used a physical restraint. This failed practice had the potential to affect 10 residents who used a physical restraint as documented on the Resident Census and Conditions of Residents form dated 10/13/08. The findings are:</p> <p>Resident #13 had diagnoses of Alzheimer's Disease and Parkinson's Disease. The Minimum Data Set (MDS) dated 9/23/08 documented the resident was severely impaired in cognitive skills for daily decision making and did not use a trunk restraint.</p> <p>a. A physician order dated 10/1/08 documented, "May use lap buddy while in wheelchair."</p> <p>b. On 10/14/08 at 8:50 a.m. and 10/14/08 at 12:50 p.m., the resident was sitting in a wheelchair with a lap buddy in place.</p> <p>c. On 10/15/08 at 2:16 p.m., the MDS Coordinator was asked if there was a pre-restraint assessment done on the resident and she stated, "No."</p>	F 221		

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 309 SS=D	<p><b>483.25 QUALITY OF CARE</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure an indwelling catheter was secured with a positioning device to prevent the potential for trauma to the urinary meatus and gloves were changed after cleaning the rectal area and before providing incontinent care for 1 (Resident #12) of 2 (Resident #7 and #12) case mix residents who had an indwelling urinary catheter. This failed practice had the potential to affect 7 residents who had an indwelling urinary catheter as documented on the Residents Census and Conditions of Residents form dated 10/13/08. The findings are:</p> <p>Resident #12 had diagnoses of Cerebrovascular Disease, Peripheral Vascular Disease, and Rehabilitation. The Quarterly Minimum Data Set (MDS) dated 9/4/08 documented the resident was moderately impaired in cognitive skills for daily decision making and had an indwelling catheter.</p> <p>a. On 10/15/08 at 9:55 a.m., Certified Nursing Assistant (CNA) #8 removed the resident's pants to provide incontinent and catheter care. There was no leg band or other device to secure the catheter to prevent the potential of the catheter being pulled taut. CNA #8 provided pericare to the</p>	F 309		

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F 309	Continued From page 2 resident's rectal area and did not change gloves or wash hands. With the same gloves on the CNA picked up a clean disposable wipe and wiped from the urinary meatus down the catheter. The resident was turned during care and the catheter was pulled tight and the resident grimaced when the catheter was pulled. CNA #8 picked up the catheter bag and handed the bag to the Licensed Practical Nurse (LPN) #4.	F 309		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING  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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the penis and scrotum were cleaned during incontinent care for 1 (Resident #5) and a clean incontinent brief was applied after incontinent care was completed for 1 (Resident #10) of 16 case mix residents (Resident #1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18 and 19) who were incontinent. The facility failed to ensure nail care was provided for 5 (Resident #3, #5, #7, #10, and #12) of 13 case mix residents (Resident #1-#13) who were dependent or required assistance from staff with nail care. This failed practice had the potential to affect 73 residents in the facility who were incontinent of bowel or bladder and 110 residents who required assistance with nail care as per a list given by the Assistant Director of Nursing on 10/16/08. The findings are:	F 312		

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F 312	<p>Continued From page 3</p> <p>1. The facility's Policy for Nail Care documented "Essential Points: The nursing staff will provide observation and care of nails for all residents weekly and as needed."</p> <p>2. Resident #5 had a diagnosis of Alzheimer's Disease. The Quarterly MDS (Minimum Data Set) dated 9/18/08 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder, and required total staff performance for toileting, hygiene, and bathing.</p> <p>a. The plan of care dated 12/31/07 documented, "Nail care during bath, trim prn (as needed)."</p> <p>b. On 10/13/08 at 3:30 p.m., and 1/14/08 at 10:15 a.m., the resident's fingernails were long, approximately 1/4 inch over the tips of the fingers, uneven, and had a dark substance underneath the resident's nails.</p> <p>c. On 10/13/08 at 3:30 p.m., CNA (Certified Nursing Assistant) # 2 and 3 provided incontinent urine. CNA #2 wiped down both groin areas, but did not cleanse the resident's penis. After the resident was turned to his right side, CNA #3 wiped down both buttocks, and down across the resident's rectum 2 times. The resident's scrotum was not cleansed.</p> <p>3. Resident #10 had a diagnosis of Cerebral Vascular Accident. The Quarterly MDS dated 9/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making, and required total staff performance for activities of daily living.</p> <p>a. On 10/14/08 at 10:33 a.m., and 10/15/08 at</p>	F 312			

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F 312	<p>Continued From page 4</p> <p>10:25 a.m. and 12:00 p.m., the resident's fingernails were long, approximately 1/4 inch over the tips of the fingers, and uneven and there was a dark substance underneath the nails of the resident's right hand.</p> <p>b. On 10/14/08 at 10:33 a.m., the resident was incontinent of urine. CNA #1 rolled the resident to his left side and placed a clean incontinent brief underneath him. The resident was turned onto his back, on top of the clean brief, incontinent care was given, turned on his left side, incontinent care given to his rectal/buttock areas, turned on his back onto the same incontinent brief again, and then the incontinent brief was fastened.</p> <p>4. Resident # 3 had diagnoses of Congestive Heart Failure and Bilateral Stage 4 Heel Decubitus Ulcers. The 30 Day Medicare Minimum Data Set dated 9/19/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, and totally dependent on staff for personal hygiene and bathing.</p> <p>On 10/14/08 at 9:30 a.m., 10:25 a.m., 10:55 a.m., and 12:55 p.m. and on 10/15/08 at 9:25 a.m., there was brown material under the resident's fingernails and the fingernails extended past the finger tips of the 3rd, 4th and 5th fingers of both hands.</p> <p>5. Resident #7 had diagnoses of Diabetes Mellitus Type 2 and Hypoglycemic Coma. The Quarterly MDS dated 7/29/08 documented the resident was severely impaired in cognitive skills for daily decision-making and totally dependent on staff for personal hygiene.</p> <p>a. A Care Plan dated 7/29/08 documented on</p>	F 312		

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F 312	<p>Continued From page 5</p> <p>page 8, "Problem Onset... ADL's (activities of daily living): Resident is total care with all ADL's... Nail care during bath, trim as needed..."</p> <p>b. On 10/13/08 at 1:15 p.m., the resident's fingernails on both hands were long and dirty.</p> <p>c. On 10/14/08 at 8:25 a.m., the resident's fingernails on the both hands were long and on the right hand there was a black substance underneath the nails.</p> <p>d. On 10/14/08 at 11:25 a.m. Certified Nursing Assistant (CNA) #7 provided oral care to the resident but not cleaned the fingernails. The resident's fingernails on both hands were dirty.</p> <p>e. On 10/15/08 at 8:55 a.m. and 11:35 a.m., the resident's fingernails were long and dirty.</p> <p>6. Resident #12 had diagnoses of Cerebrovascular Disease, Peripheral Vascular Disease, and Rehabilitation. The Quarterly MDS dated 9/4/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on staff for personal hygiene.</p> <p>On 10/13/08 at 11:53 a.m. and 10/14/08 at 8:22 a.m., the resident's fingernails were long and pressing into the palm of the hand.</p> <p>7. On 10/15/08 at 2:50 p.m., the Director of Nursing (DON) was asked who did resident nail care. The DON stated, "We have a restorative aide." The DON was asked who was to do nail care on the diabetic residents and the DON stated, "For the diabetes and circulatory impaired resident, restorative." The DON was asked how</p>	F 312		

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F 312	Continued From page 6 often nails were to be cleaned and the DON stated, "Every time they get a bath. The bath days they are suppose to clean." The DON was then asked if CNA's can do nail cleaning and the DON stated, "They can use orange sticks and emery boards but not aggressive."	F 312		
F 315 SS=D	483.25(d) URINARY INCONTINENCE  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the same area of the cloth and a back to front motion was not used during incontinent care for 1 (Resident #1) of 10 case mix residents (Resident #1-#3 #5-#10 #13) who were incontinent. This failed practice had the potential to affect 73 residents who were incontinent of bowel or bladder as per a list given by the Assistant Director of Nursing on 10/16/08. The findings are:  Resident #1 had diagnoses of Urinary Tract Infection and Hypertension. The Minimum Data Set (MDS) dated 8/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent for toilet use with 2 persons to physical assist.	F 315		

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F 315	Continued From page 7  a. On 10/14/08 at 11:50 a.m., Certified Nursing Assistant (CNA) #5 and CNA #8 provided incontinent care. The resident's mons pubis was washed across one time then with the same area of the cloth wiped across the same area again, the right groin was washed using a downward stroke then this was repeated once more using the same area of the cloth, the left groin was washed downward one time, then again using the same area of the towel. The resident was positioned on the side and had a moderate amount of loose stool, the rectal area was washed downward toward the vaginal area.  b. The facility's Incontinent Resident Care Policy #9 documented, "Remove the fecal material from the resident's buttocks area using toilet tissue. Always work from "front to back."	F 315			
F 318 SS=D	483.25(e)(2) RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a positioning device was used to prevent the potential for further decline in the range of motion (ROM) for 1 (Resident #12) of 2 (Residents #7, and #12) case mix residents who had contractures. This failed practice had the potential to affect 37	F 318			

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F 318	Continued From page 8 residents who had contractures as documented on the Resident Census and Conditions of Residents form dated 10/13/08. The findings are:  Resident #12 had diagnoses of Cerebrovascular Disease, Peripheral Vascular Disease, and Rehabilitation. The Quarterly Minimum Data Set (MDS) dated 9/4/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had limited range of motion to one hand with full loss of voluntary movement and no splint or brace assistance.  a. On 10/13/08 at 11:53 a.m., 10/14/08 at 8:22 a.m., and 10/15/08 at 9:10 a.m. the resident's right hand was contracted with the fingers in a grasp-like position and there was no handroll or positioning device in place.  b. On 10/14/08 at 10:25 a.m., the resident's right hand was contracted and the fingers were resting on the palm of the hand and there was no handroll or positioning device in place.  c. On 10/15/08 at 10:07 a.m., CNA (Certified Nursing Assistant) #8 asked the resident if he wanted a handroll in the right hand. The resident nodded in an up and down motion with his head yes.  d. On 10/15/08 at 1:10 p.m., the Director of Nursing was asked if the resident received restorative therapy or splints and the DON stated, "No, [other resident] does but not him"	F 318			
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube	F 322			

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F 322	<p>Continued From page 9</p> <p>receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure the head of the bed was not lowered while formula was infusing through the feeding tube for 1 (Resident #10) and placement of the feeding tube was checked by auscultation and aspiration for 1 (Resident #7) of 4 case mix residents (Resident #7, #10, #11, and #12) who had a feeding tube. These failed practices had the potential to affect 8 residents who had a feeding tube as documented on the Resident Census and Conditions of Residents form dated 10/13/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #10 had a diagnosis of Dysphagia. The Quarterly MDS (Minimum Data Set) dated 9/2/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required total staff performance for activities of daily living and had a feeding tube. <ol style="list-style-type: none"> <li>a. A physician order dated Glytrol 60 cc (cubic centimeters) per hour and flush G (gastrostomy tube) with 50 cc of water prior to feedings and medications.</li> <li>b. On 10/14/08 at 10:33 a.m., the head of the resident's bed was flat, and the resident's feeding was infusing at 60 cc (centimeters) an hour and CNA (Certified Nursing Assistant) #1 provided incontinent care. At 10:45 a.m., CNA #1</li> </ol> </li> </ol>	F 322		

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F 322	<p>Continued From page 10</p> <p>completed incontinent care. LPN (Licensed Practical Nurse) #2 entered the room, turned the feeding pump off, and disconnected the feeding tube so the resident could be transferred.</p> <p>A sign posted above the resident's bed documented, "HOB (head of bed) [up] at all times."</p> <p>c. On 10/14/08 at 2:30 p.m., the DON (Director of Nursing) was asked what the CNAs should do for a resident with a feeding pump before care and the DON stated, "They should get a nurse to turn the feeding pump off so they can lower the head of the bed. The pump shouldn't ever be running if the head of bed is down."</p> <p>2. Resident #7 had diagnoses of Dysphagia, Gastrostomy, Diabetes Mellitus Type 2, and Hypoglycemic Coma. The Quarterly MDS dated 7/29/08 documented the resident was severely impaired in cognitive skills for daily decision-making and had a feeding tube.</p> <p>a. A Care Plan dated 7/29/08 documented on page 7, "...Problem Onset:2/1/2008... Feeding tube... Approaches... Check NGT (nasogastric tube) prior to meds/feedings/flushes per A/A (aspiration and auscultation) to ensure proper placement of tube..."</p> <p>b. On 10/14/08 at 11:32 a.m., Licensed Practical Nurse (LPN) #2 disconnected the gastrostomy feeding tube from the feeding line and inserted a 60cc (cubic centimeter) syringe, aspirated and stated, "They don't like to check her tube with air cause she had a whole lot of trouble, just aspirate." No stomach contents were aspirated into the syringe. The LPN then flushed the</p>	F 322			

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F 322	Continued From page 11 feeding tube with 100cc of water and reconnected the feeding to the pump. The LPN did not check placement with auscultation per stethoscope.  c. As of 10/14/05, there was no documentation on the physician orders or physician progress notes that auscultation should not be performed prior to giving flushes or formula through the gastrostomy tube.  d. On 10/15/08 at 11:55 a.m., the Director of Nursing (DON) was asked if placement was to be checked with air and auscultation. The DON stated, "We have some doctors that feel like putting air and checking for residual shouldn't have to be done. That doesn't mean we don't." The DON was asked if residents with gastrostomy tubes were to have placement checked and the DON stated, "Yes, auscultation and aspiration that's our policy."	F 322		
F 323 SS=E	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 and interview the facility failed to ensure hazardous chemicals and supplies were secured, floor fans had guard covers and scissors were stored out of reach of cognitively impaired residents. The facility failed to ensure eating utensils were not bent for 1 of 1	F 323		

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F 323	Continued From page 12 case mix resident (Resident #13) who received a bent fork during a meal. These failed practices had the potential to affect 45 residents who were mobile and cognitively impaired as identified by Director of Nurses on 10/16/08, and 114 residents who received meals from the kitchen according to the Resident Census and Conditions of Residents form dated 10/13/08. The findings are:  1. On 10/15/08 at 3:05 p.m., the door to the Central Bath Room located between the 700 and 800 Halls was unlocked. There were 3 cabinets containing supplies that were unlocked and contained the following potential hazards:  a. Nine nail clippers.  b. One 5 ounce Gentle Plus Deodorant spray can and four 3.5 ounce deodorant bottles that documented warning, "Intentional misuse by deliberately ...inhaling the contents can be fatal."  c. Eleven 1.5 ounce bottles of Medi-Pa Anti-Perspirant under warning, "If swallowed get medical help or contact a Poison Control Center immediately."  d. One 4 ounce Provon Perineal wash with a documented warning, "If swallowed call physician or poison control."  e. Two disposable razors.  f. Eight 8 ounce bottles of Provon Lotion with a documented warning on the Material Safety Data Sheet (MSDS) of, "Ingestion: Contact a physician or Poison Control Center."	F 323			

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F 323	<p>Continued From page 13</p> <p>g. One 14 ounce uncovered jar without a lid of Eucerin Aquaphor ointment with a warning of "If swallowed get medical help or contact a poison control right away."</p> <p>h. Three uncovered containers of 1 gallon bottles of Derma Cen Apra Care Shampoo/Body Wash with an that MSDS that documented a warning of "If swallowed: ...get medical attention... always get medical attention when product is swallowed, or when symptoms are significant or persist."</p> <p>i. One 32 ounce spray bottle of Husky Disinfecting Cleaner with approximately 2 ounces remaining with an MSDS warning of "Emergency and First Aid Procedures: Eye Contact: Get Medical Attention... Ingestion: Get immediate medical attention."</p> <p>j. One 1 gallon bottle of Invacare Disinfectant with an MSDS warning of "Inhalation of mists may cause irritation to nose, throat and mucous membranes; pulmonary edema, tissue and chemical burns... severity depends on degree of exposure... corrosive... Ingestion; Harmful or fatal if swallowed... may cause nausea, vomiting and gastrointestinal irritation, swelling of larynx, respiratory distress, skeletal muscle paralysis, circulatory shock and convulsions... corrosive."</p> <p>2. On 10/15/08 at 3:50 p.m., there was an 8 ounce spray can of WD-40 lying on the bedside table in Resident Room 610 B. The WD-40 documented under Breathing Hazard, "Deliberate or direct inhalation of vapors or spray mist may be harmful or fatal."</p> <p>3. Resident #13 had diagnoses of Alzheimer's Disease and Parkinson's Disease. The Minimum</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>Data Set dated 9/23/08 documented the resident was severely impaired in cognitive skills for daily decision making and totally dependent for eating with one person physical assist.</p> <p>On 10/14/08 at 12:50 p.m. the resident was eating lunch in the dining room and was feeding herself. The metal fork that the resident was eating with was bent. The first prong of the fork pointed upward, the second prong downward and the first and second prongs were separated from the others leaving a space between the prongs. The resident had constant shaking of the head and hands.</p> <p>4. On 10/13/08 at 1:00 p.m., there was a fan in Resident Room 507 with no front guard cover on it exposing the blades.</p> <p>5. On 10/13/08 the following observations were made:</p> <p>a. At 11:56 a.m., in Resident Room 305A there was a 12 ounce bottle of Provon periwash on the top of the nightstand. The bottle was full and was labeled, "CAUTION: KEEP OUT OF EYES. In case of accidental contact DO NOT RUB EYES. Flush eyes thoroughly with water. If condition worsens or irritation persists, call a physician. If swallowed, consult a physician or poison control center."</p> <p>b. At 1:32 p.m., in Resident Room 401A there was a pair of scissors with pointed metal blades approximately 4 inches long lying on the table next to the television. There was a cognitively impaired resident propelling herself in the hallway outside of this room. The Director of Nursing present on rounds stated, "She normally keeps</p>	F 323			

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F 323	Continued From page 15	F 323		
F 328	these locked up."			
SS=D	483.25(k) SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure the masks for nebulizer updraft were clean to prevent the potential for infections for 1 (Resident #7) of 6 (Resident #1, #3, #7, #10, #11, and #15) case mix residents who required nebulizer updraft treatments. These failed practices had the potential to affect 6 residents in the facility with nebulizer updraft treatments as documented on a list provided by the Director of Nursing on 10/16/08. The findings are:  Resident #7 had diagnoses of Pneumonitis, Aphagia, Diabetes Mellitus Type 2, and Hypoglycemic Coma. The Quarterly Minimum Data Set (MDS) dated 7/29/08 documented the resident was severely impaired in cognitive skills for daily decision-making and received respiratory therapy.  a. On 10/14/08 at 10:50 a.m., the resident's	F 328		

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F 328	<p>Continued From page 16</p> <p>nebulizer machine fell off of the overbed table and onto the floor during care by Certified Nursing Assistant (CNA) #7 and Licensed Practical Nurse (LPN) #3. The cover came off of the machine and the nebulizer mask tubing was partially out of the plastic bag and on the floor.</p> <p>b. On 10/14/08 at 11:25 a.m., LPN #2 entered the resident's room, picked up the nebulizer machine, mask and tubing, with cover and placed the nebulizer dated 10/8/08 on the overbed table. LPN #2 then left the resident's room.</p> <p>c. On 10/14/08 at 11:37 a.m., LPN #2 picked up the nebulizer tubing and placed the tubing back into the plastic bag, put the bag inside the nebulizer machine storage area, closed the outside cover to the machine over the tubing. The LPN then left the room.</p> <p>d. On 10/14/08 at 1:15 p.m., the nebulizer mask dated 10/8/08 was over the resident's nose and mouth. LPN #2 was seated in the resident's room during the respiratory treatment. The mask had not been changed to a new mask prior to administering the resident's respiratory treatment.</p> <p>e. On 10/14/08 at 1:20 p.m., LPN #2 finished the nebulizer treatment and placed the mask and tubing into a plastic bag and then into the nebulizer machine, closed the lid, and left the room. The LPN did not rinse or clean the equipment prior to storing it.</p> <p>f. On 10/15/08 at 11:35 a.m., LPN #3 was asked if a nebulizer mask, tubing and machine should be used after it had fallen on the floor. The LPN stated, "No." The LPN was asked to remove the mask from the nebulizer machine. LPN #3 was</p>	F 328			

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F 328	Continued From page 17 asked what the date was on the nebulizer mask when she removed the mask from the machine. The LPN stated, "10/8/08."	F 328			
F 329 SS=E	<b>483.25(I) UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to ensure a dosage reduction was attempted for a proton pump inhibitor (PPI) or there was written justification for the continued use of the PPI for 2 (Resident #1 and #10) of 4 case mix residents (Resident #1 #7 #10 and #11) who received	F 329			

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F 329	<p>Continued From page 18</p> <p>PPI's. This failed practice had the potential to affect 38 residents who received PPI's as per the Assistant Director of Nursing on 10/16/08. The findings are:</p> <p>1. Resident #1 had a diagnosis of Esophageal Reflux. The Minimum Data Set (MDS) dated 8/20/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A physician order dated 1/17/08 documented, "Prilosec 20 mg (milligrams) PO (by mouth) QD (every day)."</p> <p>b. A Pharmacist's Consult To Physician Letter dated 5/28/08 documented, "Please review the diagnosis and the resident's current status to determine the continued need for a proton pump inhibitor. Manufacturer's do not recommend for use over 12-16 weeks. CMS (Centers for Medicare and Medicaid Services) regulations require evaluation of PPI's after 12 weeks of use. May we discontinue the Prilosec 20 mg"</p> <p>At the bottom of the form was checked "No changes are to be made at this time" and was signed by the physician on 6/6/08.</p> <p>c. As of 10/15/08, there was no documentation in the clinical record as to why the medication was continued and there was no risk versus benefit justification for the continuation of the medication beyond the manufacturer's recommendations.</p> <p>d. The Lexi-Comp's Drug Reference Handbook-The Geriatric Dosage Handbook page 1139 documented, "GERD (Gastroesophageal Reflux Disease): Oral, 20 mg/day for up to 4 weeks."</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>2. Resident #10 had a diagnosis of GERD (Gastroesophageal Reflux Disease). The MDS dated 8/22/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on staff for all activities of daily living.</p> <p>a. A physician order dated 4/14/08 documented, "Percid 30 mg (milligrams)," PGT (per Gastrostomy tube), Q (every), day."</p> <p>b. The April 14, 2008 through October 2008 (MAR) Medication Administration Record documented the Percid was administered as ordered.</p> <p>c. The Lexi-Comp's Drug Information Handbook for Nursing, 8th edition copyright 2007 documented on pages 708 and 709, "Lansoprazole, U.S. Brand name Percid, Percid Solu Tab in the section for Pharmacologic Category "Proton Pump Inhibitor" and Use, "Short term (4-8 weeks) treatment of active duodenal ulcers; maintenance treatment of healed duodenal ulcers... Short term treatment of symptomatic GERD..."</p> <p>d. As of 10/15/08, there was no documentation in the clinical record in the progress notes, nurse's notes, or pharmacist consultant notes of a medical symptom for the continued use of Percid, a Proton Pump Inhibitor.</p> <p>3. On 10/16/08 at 8:50 a.m., the DON (Director of Nursing) was asked if there was any clinical information for the continued use of the Percid and Prilosec for these residents. At 2:30 p.m. the DON stated, "I did not find any other</p>	F 329		

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F 329	Continued From page 20 information..."	F 329			
F 333 SS=E	<p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure medication patches were applied as ordered for 1 (Resident #25) of 2 case mix residents (Resident #17 and 25) who received medicated patches. This failed practice had the potential to affect 14 residents who received medicated patches according to the Director of Nurses on 10/28/08. The findings are:</p> <p>Resident #25 had a diagnosis of Non-psychotic Brain Syndrome. The Quarterly Minimum Data Set dated 9/16/08 documented the resident was moderately impaired in cognitive skills for daily decision making, easily distracted and mental function varied over the course of the day</p> <p>a. A physician order dated 10/2/08 documented Exelon 4.6 mg (milligram) patch every day times 78 days, then increase to 9.5 mg daily.</p> <p>b. On 10/16/08 at 7:56 a.m., a patch dated 10/12/08 was removed from the resident by LPN (Licensed Practical Nurse) #1.</p> <p>c. The October 2008 Medication Administration Record documented the patch was administered daily from 10/2/08 through 10/16/08 a total of 15 times.</p> <p>d. On 10/16/08, the box of 28 patches received</p>	F 333			

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F 333	Continued From page 21 from the physician on 10/2/08 contained 16 patches. Fifteen patches should have been applied and 13 patches should remain for administration. The 16 patches still remaining indicated that no patch was administered on 10/13/08, 10/14/08 and 10/15/08.  e. This was a significant medication error due to the resident's condition and frequency of the error.	F 333			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the Pharmacy Consultant reported the use of Prevacid beyond the recommended guidelines for 1 (Resident #10) of 3 case mix residents (Resident #1, #7, and #10) who received proton pump inhibitors. This failed practice had the potential to affect 38 residents who received Proton Pump Inhibitors as documented by the ADON (Assistant Director of Nursing) on 10/16/08. The findings are:  Resident #10 had a diagnosis of GERD (Gastroesophageal Reflux Disease). The MDS	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045207</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/16/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD CAMDEN, AR 71701</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 428	Continued From page 22 dated 8/22/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on staff for all activities of daily living.  a. A physician order dated 4/14/08 documented, "Prevacid 30 mg (milligrams)," PGT (per Gastrostomy tube), Q (every), day."  b. The April 14, 2008 through October 2008 (MAR) Medication Administration Record documented the Prevacid was administered as ordered.  c. The Lexi-Comp's Drug Information Handbook for Nursing, 8th edition copyright 2007 documented on pages 708 and 709, "Lansoprazole, U.S. Brand name Prevacid, Prevacid Solu Tab in the section for Pharmacologic Category "Proton Pump Inhibitor" and Use, "Short term (4-8 weeks) treatment of active duodenal ulcers; maintenance treatment of healed duodenal ulcers... Short term treatment of symptomatic GERD..."  d. As of 10/15/08, there were no Pharmacy Consultant Drug Regimen Review forms from 4/30/08 to 9/30/07 that identified that the resident received Prevacid since 4/14/08.	F 428			
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION  The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.  This REQUIREMENT is not met as evidenced	F 444			

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NAME OF PROVIDER OR SUPPLIER  <b>OUACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD CAMDEN, AR 71701</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 444	<p>Continued From page 23</p> <p>by:</p> <p>Based on observation and record review, the facility failed to ensure staff washed their hands after providing incontinent care and before performing other tasks for 3 (Resident #5, 7 and 12) of 10 case mix residents (Resident #1-#3 #5-#10 #13) who were incontinent. This failed practice had the potential to affect 73 residents who were incontinent of bowel or bladder according to a list given by the Assistant Director of Nursing on 10/16/08. The findings are:</p> <ol style="list-style-type: none"> <li>1. The facility's policy and procedure "Handwashing and Hand Hygiene-All Staff" documented "...6. After touching excretions (feces, urine, or material soiled with them...9. Before and after changing an incontinent resident..."</li> <li>2. Resident #5 had a diagnosis of Alzheimer's Disease. The Quarterly MDS (Minimum Data Set) dated 9/18/08 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder, and required total staff performance for toileting, hygiene, and bathing.</li> </ol> <p>On 10/13/08 at 3:30 p.m., CNA (Certified Nursing Assistant) #2 and 3 provided incontinent care. After cleaning the rectal area of feces CNA #3 applied Lantiseptic cream to the resident's buttocks and rectal area without changing her gloves or washing her hands.</p> <ol style="list-style-type: none"> <li>3. Resident #7 had diagnoses of Gastrostomy, Diabetes Mellitus Type 2, and Hypoglycemic Coma. The Quarterly MDS dated 7/29/08 documented the resident was severely impaired in cognitive skills for daily decision-making and</li> </ol>	F 444			

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NAME OF PROVIDER OR SUPPLIER  <b>OUACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD CAMDEN, AR 71701</b>		
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F 444	Continued From page 24 totally dependent on staff for all activities of daily living.  On 10/14/08 at 10:35 a.m. through 11:15 a.m. Certified Nursing Assistant (CNA) #7 provided pericare and cleansed the rectum. The CNA did not wash or sanitize her hands after the care. At 11:15 a.m., CNA #7 removed her gloves, left the resident's room and walked to the clean linen cart. The CNA lifted the cover of the cart and then replaced it and returned to the resident's room.  4. Resident #12 had diagnoses of Cerebrovascular Disease, Peripheral Vascular Disease, and Rehabilitation. The Quarterly MDS dated 9/4/08 documented the resident was moderately impaired in cognitive skills for daily decision making, was incontinent of bowel and had an indwelling catheter.  On 10/15/08 at 9:55 a.m., CNA #8 provided pericare. The CNA had worn the same pair of gloves throughout the care. The resident's rectal area was wiped multiple times followed by the CNA touching the clean draw sheet, the resident's arms and hands, the resident's catheter and catheter bag, and side rails of the bed. The CNA did not change gloves during the care and did not remove the gloves and wash the her hands prior to touching the sheet.	F 444			
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502			

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NAME OF PROVIDER OR SUPPLIER  <b>OUACHITA NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 COUNTRY CLUB ROAD CAMDEN, AR 71701</b>		
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F 502	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure stool for occult blood, Ova and Parasite and C (Clostridium) difficile toxin was obtained as ordered for 1 (Resident #2) of 14 (Resident # 1- #14) case-mix residents who had laboratory tests ordered. This failed practice had the potential to affect 83 residents who had orders for laboratory tests as identified by Director of Nurses on 10/16/08. The findings are:</p> <p>Resident #2 had diagnoses of Insulin Dependent Diabetes Mellitus, Chronic Ischemic Heart Disease, Alzheimer's Disease, Hypertension, Anxiety and Depression. The 30 Day Medicare Minimum Data Set dated 9/24/08 documented the resident was moderately impaired in cognitive skills for daily decision-making and required total assistance of staff for mobility, toilet use, and personal hygiene.</p> <p>a. A Physician Telephone Order dated 9/17/08 documented, "stool for occult blood, Ova and Parasite and C. difficile toxin (due to loose stools)."</p> <p>b. As of 10/15/08, there was no documentation in the clinical record of laboratory results for this test.</p> <p>c. On 10/14/08 at 5:15 p.m., Registered Nurse (RN) #1 was asked, "Was there a stool specimen obtained and sent to the laboratory on 9/17/08?" RN #1 stated, "I don't see that the stool specimen was obtained."</p>	F 502			