| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045337 | A. BUILDING _____ B. WING _____ | 09/04/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **HEATHER MANOR NURSING AND REHABILITATION CENTER** | **400 WEST 23RD STREET HOPE, AR 71801** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0558<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Reasonably accommodate the needs and preferences of each resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure call lights were within reach of the resident for 3 (Residents #247, #80, and #81) sampled residents who were dependent on staff for activities of daily living (ADLs). This failed practice had the potential to affect 9 residents who were dependent on staff for ADLs, according to a list provided by the Director of Nursing (DON) on 9/3/2020 at 3:20 p.m. The findings are: 1. Resident #247 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS) and required extensive two-person assistance for bed mobility, transfer, toilet use, and dressing. a. The Care Plan dated 5/23/18 documented, .The resident to use bell to call for assistance . The resident has [DIAGNOSES REDACTED]. b. On 8/31/2020 at 2:30 p.m., the resident's call light was tied to the bed rail and hanging near the floor. c. On 9/1/2020 at 2:00 p.m., the resident's call light was hanging near the floor. The resident was asked, Can you reach your call light if you needed help? She stated, Oh, yes. She looked around on her bed and could not find the call light. d. On 9/1/2020 at 2:30 p.m., Certified Nursing Assistant (CNA) #1 was asked, Should the call light be within the resident's reach? She stated, Yes. e. On 9/1/2020 at 2:40 p.m., CNA #2 was asked, Should the call light be within the resident's reach? She stated, Yes. f. On 9/1/2020 at 2:45 p.m., Licensed Practical Nurse (LPN) #1 was asked, Should the call light be within the resident's reach? She stated, Yes. g. On 9/1/2020 at 2:50 p.m., the Director of Nursing (DON) was asked, Should the call light be within the resident's reach? She stated, Yes.<br><br>2. Resident #81 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 8/5/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), was dependent for transfers, toilet use, and dressing; and required extensive assistance for bed mobility, eating, and personal hygiene. a. On 9/1/2020 at 9:08 a.m., Resident #81 was in his room sitting in a geriatric chair that was reclined. His chair was positioned next to the closet length wise in the room with the resident's head towards the window and feet pointed towards the door to the room. The resident's call light was attached to the bottom of his side rail on the left side of his bed which was approximately 6 feet from the resident. b. On 9/2/2020 at 2:10 p.m., Resident #81 was lying in bed. His call light was located on the floor under the bed. 3. Resident #80 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 8/5/2020 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance for transfers; required limited assistance for toilet use, dressing, and personal hygiene; and was occasionally incontinent of bladder. a. The Care Plan with a revised date of 7/3/2020 documented, .Moderate risk for fall . The resident needs a safe environment with even floors free from spills and / or clutter . Adequate, glare-free light . A working and reachable call light . b. On 8/31/2020 at 11:05 a.m., Resident #80 was lying in bed. Her call light was wrapped around the bottom of the side rail close to the floor. c. On 9/1/2020 at 8:20 a.m., the resident was walking back to her bed from the bathroom. She was crying. She sat down on the bed. The call light was at the bottom of the side rail. The resident was asked, Why are you crying? She stated, My left hand hurts. She was asked, Do you want me to get the nurse? She stated, Yes. The LPN was notified and responded. d. On 9/1/2020 at 1:50 p.m., Resident #80 was sitting in bed. Her call light remained attached to the bottom of her side rail close to the floor. The resident was asked, Can you reach your call light? She looked around the bed for it and stated, It's somewhere around here. e. On 9/2/2020 at 10:50 a.m., the Director of Nursing (DON) was asked, Should the resident's call light be within reach? She stated, Yes. Anything could happen. The resident may need to go to the bathroom. The resident may need something. The resident could fall. |
| F 0655<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure a Baseline Care Plan was developed within 48 hours after admission to include the minimum information necessary to provide for the resident's care needs, to promote continuity of care and minimize the potential for adverse events for 1 (Resident #197) of 2 (Residents #197 and #347) sampled residents who were admitted in the last 30 days. This failed practice had the potential to affect 6 residents who were admitted within the last 30 days, according to the list provided by the Director of Nursing on 8/31/2020. The findings are: 1. Resident #197 had [DIAGNOSES REDACTED]. The resident was admitted on [DATE] and the 5-Day Admission Minimum Data Set was in progress. a. As of 9/2/2020 at 9:24 p.m., the resident's clinical record contained one entry on the Care Plan which was related to possible discharge after Therapy. There was not a Baseline Care Plan for the resident. b. A Baseline Care Plan dated 9/3/2020 documented the resident required setup for eating, one-person assistance for personal hygiene, toilet use, dressing, bathing, bed mobility, transfers, walking, and locomotion; and had fallen at home prior to admission to the hospital. A Nursing Readmit form dated 8/28/20 documented the resident scored 15 (13-15 indicated cognitively intact) per staff assessment. c. On 9/3/2020 at 8:52 a.m., Licensed Practical Nurse #4 was asked how staff knew how to take care of the resident. He stated, There should be a Closet Care Plan. d. On 9/3/2020 at 9:20 a.m., the Director of Nursing (DON) provided a copy of a document titled Closet Care Plan which documented, .Oriented (times) 2 to 3 . Able to pick out clothes . Speech clear . Hard of hearing . Glasses . Diet / Eating .Reg (Regular) Diet .Shower days 7 to 3 (7:00 a.m. to 3:00 p.m.) daily . Transfers . Assist of 1 . Toileting assistance . Liquids Regular . Ambulation with staff assistance . e. On 9/3/2020 at 10:45 a.m., Minimum Data Set (MDS) Coordinator #1 was asked if a Baseline Care Plan had been done for the resident. She looked in the computer and stated, No, it was not done. f. On 9/3/2020 at 3:00 p.m., the Director of Nursing (DON) was asked if a Care Plan with basic care needs should be completed within 48 hours after admission for a new resident. She stated, Yes. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure a Comprehensive Care Plan was developed and implemented to identify care and services required for 4 (Residents #19. #30, #4, and #247) sampled residents whose care Plans were reviewed and required assistance with activities of daily living. This failed practice had the potential to affect 97 residents who required asssitance with activities of daily living, according to the Resident Census and Conditions of Residents form dated 8/31/2020. The findings are: 1. Resident #19 had [DIAGNOSES REDACTED]. The Quarterly |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>Minimum Data Set with an Assessment Reference Date documented the resident scored 10 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status; required extensive one person assistance with bed mobility; was totally dependent with two person assistance for transfer; was totally dependent with one person assistance for toilet use; had an indwelling urinary catheter; had an ostomy; and had functional limitation in range of motion of both sides of the lower extremities.<br>a. On 8/31/2020 at 11:30 a.m., Resident #19 was sitting in a Geri-chair in her room. The facial hair on her chin was over one-half inch long. Certified Nursing Assistant #1 removed the resident's socks and the skin on the resident's feet was extremely dry and flakey. (The Surveyor took a photograph of the resident's facial hair and feet at this time.) b. As of 9/3/2020 at 10:05 a.m., the resident's Care Plan contained no documentation to indicate the resident's requirements / needs related to activities of daily living. 2. Resident #30 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 6/16/2020 documented the resident scored 4 (0-7 indicates severe impairment) on a Brief Interview for Mental Status; required extensive one person assistance with toilet use and personal hygiene; required limited one person assistance with bed mobility and transfer; and was always incontinent of bladder and of bowel. a. As of 9/3/2020 at 10:10 a.m., the resident's Care Plan contained no documentation to indicate the resident's requirements / needs related to activities of daily living. 3. Resident #4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 8/20/2020 documented the resident scored 9 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status; required extensive one person assistance with toilet use and personal hygiene; required limited one person assistance with bed mobility and transfer; and was always incontinent of bladder and of bowel. a. As of 9/3/2020 at 10:15 a.m., the resident's Care Plan contained no documentation to indicate the resident's requirements / needs related to activities of daily living. 4. Resident #247 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 6/30/2020 documented the resident was severely impaired in cognitive skills for daily decision making skills per a Staff Assessment for Mental Status; required extensive one person assistance with bed mobility, transfer, and personal hygiene; was totally dependent with one person assistance with toilet use; and was always incontinent of bladder and of bowel. a. On 8/31/2020 at 11:39 a.m., Resident #247's fingernails were jagged and dirty. The resident's toenails extended past the tip of the great toe by greater than one-fourth inch. (The Surveyor took a photograph of the resident's fingernails and toenails at this time.) b. As of 9/3/2020 at 10:20 a.m., the resident's Care Plan contained no documentation to indicate the resident's requirements / needs related to activities of daily living. 5. On 9/3/2020 at 3:00 p.m., the Long-Term Care Minimum Data Set (MDS) Coordinator was asked, Should a resident have a section on their Care Plan that covers Activities of Daily Living, such as bathing, personal hygiene, oral care, nail care and toileting, or protective boots to keep a resident's feet floating? She stated, Well, yes, of course. She was asked, Do you review the Care Plans on a regular basis? She stated, Yes. She was asked, Would you look at a couple of charts and show me where the documentation is? She stated, Sure. The MDS Coordinator looked at the above resident's clinical records. She was unable to locate documentation for the above issues. |
| F 0677<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure necessary care and services were provided to maintain grooming, and personal and oral hygiene for 3 (Residents #247, #19, and #67) of 3 sampled residents who required assistance for shaving, nail care, and oral care. This failed practice had the potential to affect 97 residents who required assistance with shaving, nail care, and/or oral care, according to the list provided by the Director of Nursing (DON) on 9/2/2020 at 1:00 p.m. The findings are: 1. Resident #247 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/2020 documented the resident was severely impaired in cognitive skills for daily decision making skills per a Staff Assessment for Mental Status (SAMS) and required extensive two-person assistance for bed mobility, transfer, and toilet use. a. On 8/31/2020 at 11:39 a.m., Resident #247's fingernails were jagged and dirty. The resident's toenails extended past the tip of the great toe by greater than one-fourth inch. (The Surveyor took a photograph of the resident's fingernails and toenails at this time.) 2. Resident #19 had [DIAGNOSES REDACTED]. The Quarterly Minimum Date Set (MDS) with an ARD of 6/8/2020 documented the resident scored 10 (8-12 indicates moderate impairment) on a Brief Mental Assessment (BIMS) and required extensive two-person assistance to total dependence for mobility, grooming, bathing, transfer and toilet use. a. On 8/31/2020 at 11:30 a.m., Resident #19 was sitting in a Geri-chair in her room. The facial hair on her chin was over one-half inch long. Certified Nursing Assistant #1 removed the resident's socks and the skin on the resident's feet was extremely dry and flakey. (The Surveyor took a photograph of the resident's facial hair and feet at this time.) b. On 8/31/2020 at 11:35 a.m., the resident was asked, Does having the whiskers on your chin and really dry feet bother you? The resident stated, Yes. The resident stated she didn't feel her best with whiskers on her face. c. On 8/31/2020 at 11:45 a.m., the Director of Nursing (DON) was asked, How often should nail care be done? She stated, Every 2 weeks and as needed (PRN). She was asked, Should a resident's nails be allowed to get this long or be dirty? She stated, No. She was asked, Should a resident's facial hair be allowed to get in this condition? She stated, No. I will get this taken care of this afternoon. She was asked for a facility policy for nail care. The DON stated the facility did not have a policy for nail care.<br><br>3. Resident #67 had [DIAGNOSES REDACTED]. The Annual MDS with ARD of 7/2/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS) and required extensive one-person assistance for bed mobility, transfers, toilet use, dressing, and personal hygiene. a. The Care Plan with a revised date of 5/5/2020 documented, .The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited mobility . Bathing / Showering . Check nail length and trim and clean on bath day and as necessary . Report any changes to the nurses . b. On 8/31/2020 at 11:51 a.m., Resident #67 was sitting in the Day / Dining Room in her wheelchair. The resident's fingernails on her left hand and right hand had a brown substance under them and were jagged in appearance. c. On 9/1/2020 at 11:50 a.m., Resident #67 was sitting up in the Day / Dining Room in a wheelchair. Her fingernails on both hands had a brown substance under them and were jagged in appearance. d. On 9/2/2020 at 10:30 a.m., the Director of Nursing (DON) was asked, How often should nail care be done? She stated, It should be done PRN (as needed) or at least weekly. |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was properly stored in a bag or closed container, and the humidifier bottle was not sitting on the floor when not in use, to prevent potential cross contamination that could result in respiratory infection; and, the facility failed to ensure oxygen was administered at the flow rate ordered by the physician to prevent potential complications for 4 (Resident #13, #16, #30, and #40) of 4 sampled residents who had physician's orders [REDACTED]. Resident #13 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/3/2020 documented the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required supervision with eating; required limited assistance with locomotion; required extensive assistance with bed mobility, dressing, toilet use, personal hygiene, and bathing; was totally dependent with transfers; had no shortness of breath; and did not require oxygen therapy. a. The physician's orders [REDACTED]. Oxygen at 2 L (liters) . b. On 8/31/2020 at 12:04 p.m., the resident was in his room. He was wearing an oxygen nasal cannula. The oxygen concentrator gauge / oxygen flow rate was set on 3.5 liters per minute. The oxygen tubing was dated 8/31/2020. c. On 9/1/2020 at 10:12 a.m., the resident was lying in bed with a fall mat at the bedside. The resident was receiving oxygen per nasal cannula with the oxygen flow rate set at 3.5 liters per minute. d. On 9/2/2020 at 10:39 a.m., Licensed Practical Nurse (LPN) #1 was asked to look at the resident's gauge on the oxygen concentrator. She was asked what it was set on. She stated, 3 Liters per minute. The oxygen flow rate reading on the gauge was between 3 and 4. She was asked to look at it carefully and was asked what it was set on. She stated, It's jumping. She adjusted it 3. She was asked if she would look and see what his current order was. She stated, (Resident) is on 2 liters per minute. I am going to have to turn his down. She was asked, Who is responsible for checking that the oxygen is infusing at the ordered rate? She stated, Sometimes I check it when I give them their medicine. She stated night shift (11:00 p.m. to 7:00 a.m.) changes the tubing on Mondays, and they should check to see if it is set correctly. e. On 9/2/2020 at 10:42 a.m., the Director of |

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| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>Nursing (DON) was asked, Who is responsible for ensuring the oxygen is administered per the physician's orders [REDACTED]. She was asked, How often do they check it? She stated, At least every shift. She was asked, Could (Resident #13) change the settings? She stated, No, he couldn't. 2. Resident #40 had a [DIAGNOSES REDACTED]. a. On 8/31/2020 at 2:06 p.m., the resident was in his room. The oxygen concentrator was on and the flow rate was set at 4.5 liters per minute. The oxygen cannula was lying on the bed and was not on the resident. b. On 9/1/2020 at 10:48 a.m., the resident's oxygen concentrator flow rate was set at 4 liters per minute. c. On 9/2/2020 at 10:39 a.m., LPN #1 was asked to look at the resident's oxygen. She stated, It's too high. 4.5 (liters per minute). She told the resident that the oxygen did not need to be that high. She turned the oxygen flow rate down to 2 liters per minute. She was asked to verify the resident's physician's orders [REDACTED]. 3. Resident #30 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/2020 documented the resident scored 4 (0-7 indicates severe impairment) on a Brief Interview for Mental Status; required extensive assistance with activities of daily living; had no shortness of breath; and required oxygen therapy. a. On 8/31/2020 at 11:14 a.m., the resident was at the bedside and the oxygen cannula was on the floor behind the oxygen concentrator. There was no bag or closed container visible. The resident's oxygen concentrator was turned on. (The Surveyor took a photograph of the oxygen tubing at this time.) b. On 8/31/2020 at 1:00 p.m., the resident's oxygen tubing was on the floor. (The Surveyor took a photograph of the oxygen tubing at this time.) c. On 8/31/2020 at 2:30 p.m., the resident was sitting on her bed with an oxygen nasal cannula in place. LPN #1 was asked, Did you put the resident's oxygen back on her? She stated, Yes. She was asked, Did you change the tubing? She stated, No. She was asked, You put the oxygen nasal cannula on her from the floor? She stated, No. She had it on her head. I can go change it if you want. The Surveyor instructed her to check with her Director of Nursing (DON). d. On 9/1/2020 at 2:36 p.m., the resident was out of her room. Her oxygen tubing was found lying across her bedside table. The oxygen concentrator was running / on. There was no bag or closed container to place the oxygen tubing in. (The Surveyor took a photograph of the oxygen tubing at this time.) e. On 9/2/2020 at 11:00 a.m., the DON was asked for a facility policy for Oxygen or Oxygen Tubing. The DON stated the facility did not have a policy on Oxygen or Oxygen tubing. The DON was asked, How should oxygen tubing be stored when not in use? She stated, Tubing should be stored in a clear plastic bag with the date on it. She was asked, Should oxygen tubing be left on the floor? She stated, No. She was asked, Should tubing that was found on the floor be put back on a resident or changed? She stated, It should be changed. That tubing from the floor should never be placed back on a resident.<br><br>4. Resident #16 had [DIAGNOSES REDACTED]. A Significant Change MDS with an ARD of 6/5/2020 documented the resident scored 3 (0-7 indicates severely impaired) on a BIMS; required extensive assistance with transferring; required limited assistance with toilet use, dressing and personal hygiene; had no shortness of breath; and did not require oxygen therapy. a. A Care Plan with a revised date of 6/18/2020 documented, .Has O2 (oxygen) therapy r/t (related to) [MEDICAL CONDITIONS] . Oxygen Settings . O2 via nasal cannula (at) 2 LPM (liters per minute) . Humidified air . b. A physician's orders [REDACTED].Oxygen as needed for SOB (Shortness of Breath) at 2 LPM (Liters Per Minute) . c. On 8/31/2020 at 11:10 a.m., the resident had an oxygen concentrator in her room with the flow rate set at 2 liters per nasal canula. The humidifier bottle (dated 8/17/2020) was connected to the oxygen concentrator. The nasal canula tubing and a zip lock bag dated 8/30/2020 were lying on top of the floor mat by the resident's bed. d. On 8/31/2020 at 2:24 p.m., the humidifier bottle (dated 8/17/2020) was connected to the oxygen concentrator. The resident's nasal cannula tubing was lying partially on the floor and partially on the floor mat next to the resident's bed. e. On 9/1/20 at 8:29 a.m., the resident's oxygen concentrator humidifier bottle (dated 8/17/2020) was sitting on the floor next to the oxygen concentrator. The resident's nasal canula tubing was lying on the fall mat with a zip lock bag dated 8/30/2020 lying on top of the nasal canula tubing. f. On 9/2/2020 at 8:55 a.m., the resident's oxygen humidifier bottle (dated 8/17/2020) was sitting on the floor mat by the resident's bed. The nasal cannula tubing attached to the humidifier bottle was in a zip lock bag dated 8/30/2020 on the bedside chest. g. On 9/2/2020 at 10:40 a.m., the Director of Nursing (DON) was asked, How often is the humidifier bottle and nasal canula tubing changed out? She stated, The tubing is changed Sunday night to Monday morning weekly. The humidifier bottle is changed out weekly unless it needs to be changed more often. h. On 9/4/2020 at 9:10 a.m., the DON was asked, Should the humidifier bottle that is connected to the oxygen concentrator and nasal canula tubing be sitting on the floor? She stated, No. The DON was asked, Should a zip lock bag that has been lying on the floor be reused to hold a nasal canula tubing? She stated, It should be changed. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure bottles of [MEDICATION NAME] Nasal Spray were stored in an upright position in the Medication Cart for 4 residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 11 residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 97 residents who received medications, according to a list provided by the Administrator on 9/4/2020. The findings are: 1. On 9/2/2020 at 1:15 p.m., the 100 Hall, 400 Hall, and 600 Hall Medication Carts and two Medication Rooms were checked with Licensed Practical Nurse (LPN) #5 and LPN #3. The 100 Hall Medication Cart contained a bottle of [MEDICATION NAME] AC 1% with a delivery date of 7/27/2020. LPN #5 stated, I think that she (the resident) is through with that. He looked at the resident's physician's orders [REDACTED]. The 600 Hall Medication Cart contained 3 bottles of [MEDICATION NAME] Nasal Spray which were stored in the top drawer of the Medication Cart. The 3 bottles of [MEDICATION NAME] Nasal Spray were bagged and lying flat in the Medication Cart. LPN #3 was asked, How should [MEDICATION NAME] Nasal Spray be stored? She stated, Well, they come in bags, but other shifts throw them away. a. On 9/2/2020 at 1:20 p.m., the narcotic medications were checked with LPN #1. The Pharmacy Label on one medication card containing [MEDICATION NAME] 5/325 milligrams (mg) for sampled Resident #67 indicated the medication was dispensed from the pharmacy on 7/25/2019 and had an expiration date of 7/24/2020. The Narcotic Log Book documented the medication had been administered. There were 46 pills remaining in the card. The Pharmacy Label on another medication card containing [MEDICATION NAME] 10/325 mg indicated the medication expiration date was 8/28/2020. A medication card containing [MEDICATION NAME] 110 mg capsules for Resident #67 had an expiration date of 3/10/2020. The medication card contained 15 capsules for administration. All of these medications were ordered as PRN, to be given as needed. b. The manufacturer's insert for the [MEDICATION NAME] provided by the Director of Nursing (DON) on 9/2/2020 at 134 p.m. documented, .How do I store . Store upright with the cap on . c. On 9/3/2020 at 3:00 p.m., the DON was asked, How often do you pick up discontinued or expired narcotics? She stated, It depends. The nurses usually call me. She was asked, Should expired medications be given to residents? She stated, No. The DON was asked to provide a facility policy for the removal of discontinued medications from the Medication Carts. As of 9/3/2020 at 8:00 p.m., no policy had been provided. d. On 9/3/2020 at 8:24 p.m., the Medication Administration Record [REDACTED]. |
| F 0803<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.**<br><br>Based on observation, record review, and interview, the facility failed to ensure pureed, alternative, and mechanical soft meals were prepared and served according to the approved, planned, written menu signed by the Dietitian, to meet the nutritional needs of the residents who received a pureed diet for 1 of 1 meal observed from 1 of 1 kitchen. This failed practice had the potential to affect 15 residents who received a pureed diet, 17 residents who received alternative meat, and 26 residents who received mechanical soft diets, according to the list provided by the Food Service Supervisor dated 9/1/2020 at 2:23 p.m. The findings are: 1. On 8/31/2020 at 12:20 p.m., the facility's Spring / Summer 2020 Menu for the lunch meal documented residents who received a pureed diet were to receive one #16 scoop (2 ounces) of a pureed dinner roll, 2 ounces of gravy for all diets, and 3 ounces of alternate meat (roast turkey) or 5 ounces of pork chop. 2. On 8/31/2020 at 12:45 p.m., the following observations were made during the lunch meal service for the residents who received |

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|---|---|---|---|
| | 045337 | A. BUILDING _____ B. WING _____ | 09/04/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| HEATHER MANOR NURSING AND REHABILITATION CENTER | 400 WEST 23RD STREET HOPE, AR 71801 |

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| F 0803<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 3)<br>pureed diets and the residents who requested alternative meat: a. On 8/31/2020 at 12:45 p.m., there was no bread prepared or served to the residents who received a pureed diet for the lunch meal. 3. On 8/31/2020 at 12:48 p.m., the facility recipe for Roast Turkey documented residents were to receive a portion size of 3 ounces. The recipe for gravy documented residents were to receive a 2-ounce portion of gravy. a. On 8/31/2020 at 12:50 p.m., residents who received roast turkey as an alternative meat were served a small slice of roast turkey, instead of 3 ounces as specified on the recipe book. There was no gravy served to the residents with their meal. b. On 8/31/20 at 1:33 p.m., Dietary Employee #4 was asked to weigh the amount of sliced turkey which had been portioned on a plate to serve to the resident. Dietary Employee #4 weighed the portion of sliced turkey and the portion weighed 2 ounces instead of the 3-ounce portion specified on the recipe book. c. On 8/31/20 at 1:43 p.m., Dietary Employee #4 was asked to weigh the amount of ground smothered pork chop portioned in a bowl to serve to the resident. Dietary Employee #4 weighed the portion of pork chop and the portion weighed 1.3/4 ounce instead of 5 ounces as specified on the menu. On 9/1/2020 at 1:45 p.m., Dietary Employee #4 was asked, What was the reason a small portion of meat was served to the resident? She stated, We were running out. |
| F 0805<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.**<br><br>Based on observation and interview, the facility failed to ensure pureed food items were blended to smooth, lump-free consistency to minimize the risk of choking or other complications and improve palatability for residents who required a pureed diet for 2 of 2 meals observed. This failed practice had the potential to affect 15 residents who received pureed diets, according to the list provided by Dietary Employee #1 on 9/1/2020 at 2:23 p.m. The findings are: 1. On 8/31/2020 at 12:12 p.m., Dietary Employee #3 pureed smothered pork chops and poured the mixture into a pan. Dietary Employee #3 covered the pan of pureed smothered pork chops with foil and placed it in a pan of hot water on the stove. The consistency of the pureed smothered pork chops was not smooth and there were pieces of pork chops visible in the mixture. 2. On 8/31/2020 at 1:34 p.m., Dietary Employee #3 was asked to describe the texture of the pureed meat served to the residents who received pureed diets for the lunch meal. She stated, It was not smooth. Dietary Employee #1 stated, It was lumpy. 3. On 8/31/2020 at 1:40 p.m., Certified Nursing Assistant #1 was assisting a resident in the Dining Room with her meal. She was asked to describe the texture of the food served to the residents who received pureed diets. She stated, It was thick and soft. 4. On 9/1/2020 at 8:06 a.m., the pureed sausage served to the residents who received pureed diets was not smooth. There were pieces of sausage visible in the mixture. The pureed oatmeal was runny. Certified Nursing Assistant #2 was assisting a resident with her breakfast meal in the Dining Room. She was asked to describe the texture of the pureed sausage served to the residents who received pureed diets. She stated, The pureed sausage was not smooth. It is gritty, like oatmeal. 5. On 9/1/2020 at 8:09 a.m., Certified Nursing Assistant #3 was assisting with the meal and was asked to describe the texture of the pureed sausage and pureed oatmeal served to the residents who received pureed diets. She stated, The pureed sausage it's clumpy and the pureed oatmeal is watery. 6. On 9/1/2020 at 8:13 a.m., Dietary Employee #3 and #4 were asked to describe the consistency of the oatmeal served to the residents who received pureed diets for breakfast. They stated, It is a little thin, like liquid. 7. On 9/1/2020 at 8:14 a.m., Dietary Employee #1 tasted the pureed sausage and stated, It has little lumps of sausage in it. Dietary Employee #1 asked Dietary Employee #3 and Dietary Employee #4 to taste it and feel the texture in their mouths. They tasted it and felt the texture in their mouth and stated, It was not smooth. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to ensure food items stored in the refrigerator were covered or sealed to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; failed to ensure Dietary Staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; failed to ensure expired food items were promptly removed / discarded by the expiration or use by dates prevent potential for food bone illness; failed to ensure ice machines and ice scoop holder were maintained in clean and sanitary condition to prevent contamination of residents' beverages. These failed practices had the potential to affect 96 residents who received meals from the kitchen (Total census: 97), according to a list provided by the Food Service Supervisor on [DATE] at 1:30 p.m. The findings are: 1. On [DATE] at 10:43 a.m., the ice machine in the kitchen had yellow residue on the panel. There was black residue on the inside body of the ice machine. Dietary Employee #1 was asked to wipe the black residue in the ice machine with a tissue. She wiped the black residue and the black residue easily transferred to the tissue. Dietary Employee #1 was asked, Who uses the ice from the machine and how often do you clean the ice machine? She stated, We clean it every day. We use it in the kitchen to fill beverages served to the residents at mealtime. 2. On [DATE] at 10:45 a.m., the following observations were made in the storage room in the kitchen: a. On [DATE] at 10:45 a.m., one opened box of cornstarch was stored on a shelf in the storage room. The box of cornstarch was not sealed. b. On [DATE] at 10:46 a.m., 9 boxes of baking soda were stored on a shelf in the storage room. The expiration date on the boxes of baking soda was [DATE]. c. On [DATE] at 10:52 a.m., an open box of cream cheese was stored on a shelf in the refrigerator. The box of cream cheese was not sealed. 3. On [DATE] at 10:53 a.m., the following observations were made in the walk-in freezer: a. On [DATE] at 10:53 a.m., one open box of grilled chicken was stored on the shelf in the walk-in freezer. The box of grilled chicken was not sealed. b. On [DATE] at 10:54 a.m., one open box of cube beef steak was stored on a shelf in the walk-in freezer. The box was not sealed. c. On [DATE] at 10:55 a.m., one open box of diced turkey was stored on a shelf in the walk-in freezer. The box of turkey was not sealed. d. On [DATE] at 10:56 a.m., one open box of crescent rolls was stored on a shelf in the walk-in freezer. The box of crescent rolls was not sealed. e. On [DATE] at 11:08 a.m., the ice machine in the Dining Room had black residue on the panel. The ice scoop holder on the right side of the ice machine in the Dining Room had water in the container, and there were pieces of a white flaky substance at the bottom of the scoop holder. The ice scoop that was being stored in the scoop holder was in direct contact with the residue. Dietary Employee #1 was asked to describe the contents within the ice scoop holder. She stated, I don't know what they are. They are white food crumbs. We clean it every day. The CNAs (Certified Nursing Assistants) use it for the water pitchers in the residents' rooms. f. On [DATE] at 11:10 a.m., one open box of pancake mix was stored on a shelf in the storage room. The box of pancake mix was not sealed. g. On [DATE] at 12:03 p.m., Dietary Employee #3 took out lids from the storage room and placed them on the cart. Without washing her hands, she picked up glasses by their rims and placed them on the cart. She scooped ice cubes in the glasses and poured beverages to be served to the residents with their lunch meal. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure multi-resident use blood glucose meters were cleaned and disinfected after each resident use according to manufacturer's instructions to decrease the potential for the spread of infection for 2 (Residents #72 and #89) of 2 sampled residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 4 residents who had physician's orders [REDACTED]. The findings are: 1. Resident # 72 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/30/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). 2. Resident # 89 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 8/12/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS. 3. On 9/2/2020 at 11:40 a.m., Licensed Practical Nurse (LPN) #3 sanitized her hands, put on gloves, and placed medication in a plastic medication cup. She picked up a blood glucose meter that was on the top of the Medication Cart. LPN #3 entered Resident #72's room and administered the medication in the plastic medication cup to the resident. LPN #3 cleaned the resident's finger with an alcohol pad, and after allowing the area to dry, performed the blood glucose check. LPN #3 exited the room and placed the blood glucose meter on the Medication Cart. LPN #3 removed her gloves, sanitized her hands, and put on new gloves. LPN #3 removed an alcohol pad from a drawer in the Medication Cart, cleaned the blood glucose meter with the alcohol pad, and placed the blood glucose meter in a drawer of the Medication Cart. LPN #3 removed her gloves, sanitized her hands, and put on new gloves. 4. On 9/2/2020 at 12:00 |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 4)<br>p.m., LPN #3 removed the blood glucose meter from the drawer in the Medication Cart. She removed an alcohol pad from the Medication Cart and cleaned the blood glucose meter. LPN #3 removed her gloves, sanitized her hands, put on new gloves, and placed medication into a plastic medication cup. LPN #3 entered Resident #89's room and administered the oral medication. LPN #3 cleaned the resident's finger with an alcohol pad, and after allowing the area time to dry, performed the blood glucose check. LPN #3 exited the resident's room, cleaned the blood glucose meter with an alcohol pad, and placed it into a drawer in the Medication Cart. LPN #3 removed her gloves, sanitized her hands, and put on new gloves. 5. On 9/4/2020 at 9:05 a.m., the DON was asked, What should the blood glucose meter be cleaned with? She stated, (Name) wipes or bleach wipes. 6. A facility policy titled Glucometer, Cleaning Of provided by the Director of Nursing on 9/3/2020 at 3:30 p.m. documented, .Procedure . 1. Glucometer should be cleaned after each usage using an approved cleaning product . |
| F 0947<br><br>**Level of harm -** Potential for minimal harm<br><br>**Residents Affected -** Many | **Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure Certified Nursing Assistants were provided with the required in-service training, to include Dementia care, to ensure they were prepared and competent with the skills required to meet the needs of the residents who had a [DIAGNOSES REDACTED]. This failed practice had the potential to affect 57 residents who had a [DIAGNOSES REDACTED]. On 9/2/2020 at 11:06 a.m., a review of the facility in-services for the last 12 months was conducted. The last documented in-service for Dementia was conducted on 7/8/2019. 2. On 9/2/20 at approximately 3:00 p.m., the Director of Nursing (DON) was asked, How often should in-services for Dementia be conducted? She stated, Yearly. I will get it done this month. |