STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045302	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INNISFREE HEALTH AND REHAB, LLC	301 SOUTH 24TH STREET ROGERS, AR 72758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a visibly soiled brief was not visible from the hallway to promote dignity for one (Resident #45) of 19 (Residents #5, #7, #14, #17, #19, #20, #23, #27, #33, #38, #41, #42, #45, #50, #51, #57, #58, #163 and #164) sampled residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 37 Residents who were dependent on staff for incontinent care according to a list provided by the Director of Nursing (DON) on 7/16/2020. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. The 5-day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/2020 documented the resident scored 10 (8 - 12 indicates moderately impaired) on a Brief Interview of Mental Status (BIMS); required extensive assistance of two staff for toilet use and was frequently incontinent of bowel and bladder. a. On 07/14/2020 at 08:45AM, Resident (R) #45 was observed, from the hallway, facing the doorway with the covers down to the upper thigh. The door was open and there was no privacy curtain in the room to pull to keep from exposing the soiled brief. b. On 07/14/2020 at 10:48 AM, R #45's door was still open, and he remained uncovered and visible from hall. c. On 07/14/2020 at 10:57 AM, the Director of Nursing (DON) was asked if the door should be shut to his room and/or privacy curtain pulled when he is lying in bed with covers down exposing soiled brief. He stated, Yes. But he doesn't have a privacy curtain now. I think it is in the laundry. I'll get Maintenance to put it back up immediately.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a single use Intravenous (IV) tubing was not used to infuse two different medications in accordance with acceptable standards of practice to avoid possible cross contamination or medication interactions for 1 (Resident (R) #5) of 1 sampled resident who received IV therapy. This failed practice had the potential to affect 1 resident who received IV therapy per the list provided by the Director of Nursing (DON) on 7/15/2020 at 7:55 AM. The findings are: 1. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/07/2020 documented the resident scored 15 (13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. A physician order [REDACTED].) over 30 minutes flush with 10 cc ns prior to dose and after with dose started 06/23/2020. b. On 07/14/2020 at 9:40 AM, [MEDICATION NAME] 2 gm with 100 cc saline was infusing. On 7/14/20 at 9:54 AM, after the [MEDICATION NAME] completed infusing, Licensed Practical Nurse (LPN) #2 disconnected the tubing from the Peripherally Inserted Central Catheter (PICC) line and flushed the PICC line tubing with 10 cc saline and replaced the caps. c. On 07/14/2020 at 10:36 AM, LPN #2 mixed the [MEDICATION NAME] vial with 250 cc IV saline solution bag in the medication room. After mixing the [MEDICATION NAME] solution, she entered the resident's room, removed and discarded the empty [MEDICATION NAME] bag from the single use IV tubing, and spiked the [MEDICATION NAME] IV solution with the same single use IV tubing that was dated 7/14/2020. The Surveyor asked LPN #2 if she always uses the same tubing when infusing 2 different antibiotics at different times. She stated the pharmacist told her it was okay to use the tubing for 24 hours so they can use it on both because it was less than 24 hours old. LPN #2 was priming the IV tubing for the [MEDICATION NAME] infusion and was asked if the pharmacist had specifically said to use the same IV tubing for infusing more than one drug at different times. She stated, We can use the same tubing for 24 hours, so I used it on both because it is not been 24 hours as I changed the IV tubing this a.m. LPN #2 then connected the single use IV tubing to the PICC line in the resident's upper arm and began infusing the [MEDICATION NAME]. d. On 07/14/2020 at 11:01 AM, the DON was asked what the facilities policy was regarding reusing IV tubing to infuse 2 different medications such as [MEDICATION NAME] and [MEDICATION NAME]. He stated, The facility policy is we can reuse the same tubing for 24-hours but can use the tubing on the same medication only. We don't use the same IV tubing on 2 different medications. e. On 7/16/2020 at 11:02 AM, the IV therapy consultant pharmacist was asked if reusing the same single use IV tubing was their recommended practice for 2 separate antibiotic medications to be infused at different times. He stated, The manufacturer stated right on the package, 'Single use only.' I don't know where some nurses get the idea, they can use the same tubing for 24 hours. It states single use only.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure incontinent care was provided in a timely manner for 1 (Resident #45) of 19 (Residents (R) #5, #7, #14, #17, #19, #20, #23, #27, #33, #38, #41, #42, #45, #50, #51, #57, #58, #163 and #164) sampled residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 37 residents who were dependent on staff for incontinent care, according to a list provided by the Director of Nursing (DON) on 7/16/2020. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. The 5-day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/2020 documented scored 10 (8 - 12 indicates moderately impaired) on a Brief Interview of Mental Status (BIMS); required extensive assistance of two staff for toileting and was frequently incontinent of bowel and bladder. a. The Plan of Care documented, .The Resident has an ADL (Activities of Daily Living) self-performance deficit r/t (related to) Cerebral Infarction and Dementia .Approaches: Toilet Use .The Resident requires extensive assistance by two staff for toileting. b. On 07/14/2020 at 8:45 AM, the resident's brief was visibly wet. At 10:07 AM, Certified Nursing Assistant (CNA) #4 entered the resident's room to pick up the breakfast tray and did not provide incontinent care. At 10:48 AM, the resident remained visibly soiled with urine. CNA #4 was asked when was the last time she checked Resident #45 for incontinence and/or provided incontinent care. She stated, I checked and changed him at 6:00 AM and checked him again at 8:00 but have not checked him since then. At this time she checked him and told him that she needed to change his brief. As she began providing incontinent care she was asked if he was wet with urine. She said, Oh, yes he is. This surveyor did not check the resident's brief herself. 2. The Check and Change Program Policy and Procedure received by the Director of Nursing (DON) on 7/14/2020 at 11:03 AM documented, Goal: Maintain the resident in a clean and dry state to aid in preventing complications of incontinence by checking and changing the resident at regular intervals. Procedure: Resident to use incontinent brief/pull ups/pads and will be checked at least every two hours and as needed for incontinent episodes .Peri-care provided after each incontinent episode .Document/Review: Document incontinent status q (every) shift .Care Plan should reflect Check and Change Program with every 2 hour checks/care .
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045302	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INNISFREE HEALTH AND REHAB, LLC	301 SOUTH 24TH STREET ROGERS, AR 72758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to provide an ongoing program of activities designed to meet the individualized needs of 1 (Resident #45) of 17 (Resident #1, #4, #5, #19, #23, #25, #26, #27, #33, #38, #40, #42, #45, #49, #51, #58, and #164) sampled residents who had self-directed activities. This failed practice had the potential to affect 48 residents who had self-directed activities according to a list provided by the Activities Director on 7/16/2020. The findings are: a. Resident #45 had [DIAGNOSES REDACTED]. The 5-day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/2020 documented the resident scored 10 (8-12 indicates moderately impaired) on a Brief Interview of Mental Status (BIMS); and the interview for daily and activity preferences documented, it is very important to have books, newspapers and magazines to read; to listen to music; be around animal and pets, keep up with the news,; do things with groups of people; go outside to get fresh air when weather is good and to participate in religious services or practices. b. The Plan of Care updated on 6/5/2020 documented, .Problem: Res. (Resident) at risk for alteration in psychosocial well being r/t (related to) restrictions to visitation d/t (due to) COVID-19 .Approaches: Encourage alternate communication with visitors; monitor for psychosocial changes; observe and report any changes in mental status caused by situational stressors; provide opportunities for expression feelings r/t situational stressors. Problem: D/T Droplet isolation per COVID-19 guidelines. The resident is at risk for decreased activity participation and/or social interaction. Approaches: ensure that the activities the resident is attending are compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed, compatible with individual needs and abilities and are age appropriate. c. On 07/13/2020 at 10:50 AM, the resident was sitting up in his wheelchair looking around with his call light in his hand. The lights were off, room dim, the blinds were closed, and the television (TV) was on a cartoon station. He was asked if he liked the channel his tv was turned to and he said, No. They are silly. d. On 07/14/2020 at 09:55 AM, the resident was lying in his bed with the lights off, room dim, the blinds were closed, and there was no tv or radio on. The resident was asked about his activity preferences and if the facility attempted to honor his activity preferences. He stated, The facility does not provide me with books, magazines, or newspaper nor have music for me to listen to. He went on to say that he sometimes keeps up with news by watching TV when they turn it on for him. e. On 7/14/2020 at 11:30 AM, a box containing two books were observed lying in a chair at the end of his bed against the wall under the TV. The room was dark, the blinds were pulled, and the TV not on. (The box of books was not in his reach.) f. On 07/15/2020 at 10:16 AM, the Activity Director was asked what type of activities does she provide R #45? She stated, Me and my assistant provide him with word search and adult coloring books. She was then asked who did his Activity Assessment Preference and she stated she did. She was asked if those were the activities he told her he liked to do. She then stated, He also talks to his wife often. She was then asked if she was aware that he said that it was very important to him to keep up with the news and have books, magazines, and newspapers to read. She tated, Yes. She was then asked how the Certified Nurses Assistants (CNAs) were made aware of his activity preferences and she stated, Usually those things are included on their closet care plans. I'll check and see if that is included on his.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the correct oxygen flow rate for 1 (Resident #51) and a Continuous Positive Airway Pressure ([MEDICAL CONDITION]) mask was cleaned, dried, and stored and he oxygen concentrator humidifier water container was changed for 1 (Resident #25) in a timely manner to avoid possible pathogen contamination or risk of infection for 2 (Resident #25 and #51) of 11 sampled residents (Residents #5, #7, #14, #19, #20, #25, #26, #33, #40, #51 and #57). This failed practice had the potential to affect 22 residents that use oxygen or [MEDICAL CONDITION] per the list given by the Director of Nursing (DON) on 07/15/2020 at 10:41 AM. 1. Resident #51 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] documented the resident was alert and oriented, usually understands, is understood, and received oxygen therapy in the last 7 days. a. The Care Plan documented, The resident has [DIAGNOSES REDACTED]. Date Initiated: 10/17/2017 . OXYGEN SETTINGS: O2 night and day via nasal cannula @ (at) 2 L/M (liters/minute), Humidified . b. A physician's orders [REDACTED].@ (at) 2L (liters) continuous per nasal cannula (n/c) every day and night shift related to acute and chronic [MEDICAL CONDITION]. c. On 07/13/2020 at 1:06 PM, Resident #51 was sitting in his wheelchair in his room. The resident had O2 (Oxygen) via (by way of) n/c at 3 l/m (liters/minute). d. On 7/14/2020 at 8:30 a.m., the resident was up in his wheelchair in his room. The O2 was set at 2.5 LPM (liters per minute) via NC. e. On 07/16/2020 at 9:24 AM, the Director of Nursing was asked, Who provides ongoing monitoring of oxygen concentrators including the flow rate setting? He stated, The nurse is to check the oxygen settings every morning during medication pass. Really anytime the nurse enters the room, they should check the flow rate. He was asked, Does the resident change the settings himself? He stated, Sometimes he does. 2. Resident #25 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/19/2020 documented The resident scored 9 (8 - 12 indicates cognitively impaired) on a Brief Interview of Mental Status (BIMS); and required set up/oversite with staff of one for eating, locomotion on and off unit, and extensive 1 person staff assistance for bathing. a. A physician's orders [REDACTED]. A physician's orders [REDACTED]. Clean mask and tubing daily per cleaning directions in documents. Clean humidifier tank daily per cleaning directions in documents and fill with distilled water nightly at bedtime related to OBSTRUCTIVE SLEEP APNEA . b. The care plan documented, Resident has Sleep Apnea and requires C-pap at night. Date Initiated: 11/29/2019 C-PAP SETTINGS: Mode: Auto; Pressure: 9cm H2O; Ramp time: 20 minutes. Date Initiated: 11/29/2019 Clean mask and tubing per cleaning instructions in documents. Clean humidifier tank daily per cleaning directions in documents and fill with distilled water nightly. Report to Physician any refusal or difficulty with C-PAP use. Resident manages C-PAP application at night and removal in the morning. c. On 7/13/2020 at 10:38 AM and 12:32 PM, Resident #25 was lying in bed. There was an oxygen concentrator with a humidified water container dated 6/17/20 sitting at the bedside. The oxygen tubing was dated 7/13/2020. A [MEDICAL CONDITION] mask was attached to the oxygen tubing and [MEDICAL CONDITION] machine with the mask open to air on the bedside table. d. On 7/13/2020 at 12:36 PM, the resident's sister (roommate and Power of Attorney) was asked about the oxygen and [MEDICAL CONDITION]. The sister/roommate stated, She uses the oxygen every night and puts on with assistance and takes off the mask with [MEDICAL CONDITION] in the morning. The Surveyor asked who cleans and stores the mask, and the sister/roommate stated, The facility did it about a week ago when I asked them to, other than that, no one unless I ask. The Surveyor asked if the mask is usually stored on the tabletop. The resident didn't respond, but the sister/roommate stated, Yes. I thought those were supposed to be cleaned every so often, that is why I asked them to clean it. She (resident) takes off the mask in the mornings and lays it on the table there. That is usually where it stays. The Surveyor asked if there was a plastic bag or container that the mask was stored in. The sister denied it having a storage bag. e. On 7/14/2020 at 9:09 AM, the [MEDICAL CONDITION] mask was in a plastic bag dated 7/13/2020. The humidified water container on the oxygen concentrator remained dated 6/17/2020. f. On 7/14/2020 at 9:17 AM, Licensed Practical Nurse (LPN) #1 was shown the oxygen humidified water container on the oxygen concentrator with the 6/17/20 date. She stated, They must have missed this one. It should have been changed. I will see to it right now. Usually night shift changes the oxygen and tubing/humidifier, but we also do if we notice that it is due. g. On 7/14/2020 at 1:09 PM, the Director of Nursing was asked about the facility policy regarding the [MEDICAL CONDITION] masks storage and cleaning, and the humidified water container change frequency to decrease risk of pathogen or bacteria growth leading to possible infection. He stated, The mask is to be cleaned and put in plastic bag or container for storage after drying every night. Oxygen tubing is to be changed weekly with humidification bottle of water if used. h. On 7/15/2020 at 7:49 AM, the Director of Nursing provided the facility policy and procedure on Trilogy/[MEDICAL CONDITION]/ Equipment Cleaning Instructions which documented, . Disassemble the Patient Circuit as follows: Disconnect tubing from machine . Remove mask straps from mask .Set mask straps aside (They are to be cleaned weekly or if visibly soiled per daily cleaning directions) . 3. Place mask into a clean basin lined with clean paper towels. Allow to air dry. 4. Once dry obtain a clean plastic bag, write date and time on plastic bag, reassemble and place the dated clean plastic bag over mask and store next to machine .
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a single use Intravenous (IV) tubing was not used to infuse two different medications in accordance with acceptable standards of practice to avoid possible cross contamination or medication interactions for 1 (Resident (R) #5) of 1 sampled residents who received IV therapy. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045302	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INNISFREE HEALTH AND REHAB, LLC	301 SOUTH 24TH STREET ROGERS, AR 72758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) failed practice had the potential to affect 1 resident who received IV therapy per the list provided by the Director of Nursing (DON) on 7/15/2020 at 7:55 AM. The findings are: 1. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/07/2020 documented the resident scored 15 (13 - 1 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. A physician order [REDACTED].)) over 30 minutes flush with 10 cc ns prior to dose and after with dose started 06/23/2020. b. On 07/14/2020 at 9:40 AM, [MEDICATION NAME] 2 gm with 100 cc saline was infusing. On 7/14/20 at 9:54 AM, after the [MEDICATION NAME] completed infusing, Licensed Practical Nurse (LPN) #2 disconnected the tubing from the Peripherally Inserted Central Catheter (PICC) line and flushed the PICC line tubing with 10 cc saline & (and) replaced the caps. c. On 07/14/2020 at 10:36 AM, LPN #2 mixed the [MEDICATION NAME] vial with 250 cc IV saline solution bag in the medication room. After mixing the [MEDICATION NAME] solution, she entered the resident's room, removed and discarded the empty [MEDICATION NAME] bag from the single use IV tubing, and spiked the [MEDICATION NAME] IV solution with the same single use IV tubing that was dated 7/14/2020. The Surveyor asked LPN #2 if she always uses the same tubing when infusing 2 different antibiotics at different times. She stated the pharmacist told her it was okay to use the tubing for 24 hours so they can use it on both because it was less than 24 hours old. LPN #2 was priming the IV tubing for the [MEDICATION NAME] infusion and was asked if the pharmacist had specifically said to use the same IV tubing for infusing more than one drug at different times. She stated, We can use the same tubing for 24 hours, so I used it on both because it is not been 24 hours as I changed the IV tubing this a.m. LPN #2 then connected the single use IV tubing to the PICC line in the resident's upper arm and began infusing the [MEDICATION NAME]. d. On 07/14/2020 at 11:01 AM, the DON was asked what the facilities policy was regarding reusing IV tubing to infuse 2 different medications such as [MEDICATION NAME] and [MEDICATION NAME]. He stated, The facility policy is we can reuse the same tubing for 24-hours but can use the tubing on the same medication only. We don't use the same IV tubing on 2 different medications. e. On 07/16/2020 at 11:02 AM, the IV therapy consultant pharmacist was asked if reusing the same single use IV tubing was their recommended practice for 2 separate antibiotic medications to be infused at different times. He stated, The manufacturer stated right on the package, 'Single use only.' I don't know where some nurses get the idea, they can use the same tubing for 24 hours. It states single use only. f. This is a significant medication error based on the category of the medications- antibiotics and the risk of incompatibility of mixing 2 separate antibiotics in same IV tubing.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **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.** Based on observation, record review, and interview, the facility failed to ensure the planned, written menu was followed for residents who had orders for pureed diet for 1 of 1 meal observed. This failed practice had the potential to affect 5 residents who had physicians orders for pureed diet according to the list provided by the Director of Nursing (DON) on 07/16/2020. The findings are: 1. On 07/13/2020 at 12:00 PM, Dietary Aid #2 spooned fruit into bowls to be served for lunch. When preparing the pureed dessert, the Dietary Aid stated, I don't want to ruin good fruit, so they are getting vanilla pudding. 2. On 07/13/2020 at 12:05 PM, the Dietary Manager was asked, Is pudding on the menu for pureed diet? She stated, No. She was asked, Should pureed diet receive the same dessert? She stated, Yes. 3. On 07/13/2020 at 12:15 PM, the facility's Spring / Summer 2020 menu for the noon meal documented for all residents to have fruit cup for dessert. The residents on pureed diet received vanilla pudding.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure that meals were not left in resident rooms while asleep or in the shower allowing them to not be served at temperatures that were acceptable to the resident, to improve palatability and to encourage good nutritional intake for two (Residents (R) #45, and #20) of 23 (Resident #1, #5, #7, #17, #19, #20, #23, #25, #26, #27, #28, #33, #38, #40, #42, #45, #49, #50, #51, #58, #60, #163, and #164) sampled residents who ate meals in their rooms. This failed practice had the potential to affect 54 Residents who ate meals in their rooms according to a list provided by the Director of Nursing (DON) on 7/17/2020. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. The 5-day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/2020 documented the resident scored (10 (8-12 indicates moderately impaired) on a Brief Interview of Mental Status (BIMS); and was independent with one physical assist with eating. a. On 07/14/2020 at 8:45 AM, the resident's breakfast tray was uncovered and untouched, in the dark room, by the resident whom was lying in his bed with his eyes closed. The blinds were pulled and the television (TV) was off in the room. b. On 7/14/2020 at 8:50 AM, Certified Nursing Assistant (CNA) # 3 picked up the tray and was asked, as she was leaving his room with his untouched breakfast, how much did he eat and drink. She stated, Nothing. He refused but sometimes when he wakes up he's not happy and refuses. She was then asked if she offered him a new tray or something else or encourage him to eat and drink. She said, No. c. On 07/15/20 at 08:07 AM, R #45's door was shut. The Surveyor knocked on the door and heard Resident Care come from the shut bathroom door. Just inside the bedroom door, next to the wall entering into his bathroom was his over the bed table (OBT) with his breakfast tray on top of it; again, it was untouched. CNA #3 was in his bathroom assisting him with his shower and was asked how long his breakfast tray had been sitting here. She stated, I think they brought it about 15 - 20 (minutes) ago. She was then asked if they left it when he was in there with her. She stated, Yes. I'm giving him his shower. d. On 7/17/2020 at 8:30 AM, the DON was asked if his staff should leave his breakfast tray in his room when he is asleep or while he is in the bathroom taking a shower. He stated, No. They shouldn't. I'll make sure he gets another tray. 2. Resident # 20 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/12/2020 which documented was severely impaired cognitive decision making skills according to a Staff Assessment for mental Status (SAMS); and required extensive assistance of 2 staff for toileting and transfers and extensive assistance of 1 staff for bed mobility, locomotion on or off unit, dressing, hygiene and limited assistance of 1 staff for eating; had impaired range of motion one side upper extremity and 2 sides lower extremities. a. On 07/15/2020 at 07:50 AM, Resident #20 was observed sitting in her wheelchair in the main dining room at a table by herself feeding herself scrambled egg with her fingers. On her tray (with plate guard) was scrambled eggs, bread, and a banana with a 1/4 of it brown and mussy and a bowl of hot cereal and a juice glass of orange liquid and a juice glass of clear liquid. The Surveyor asked her if she liked bananas and she mumbled and shook her head up and down indicating yes. She was asked if her banana was too bruised to eat and she again mumbled and shook her head up and down indicating yes. Unnamed staff were within hearing and aware of resident response but did not offer another banana. The staff did bring her extra eggs which she ate. b. On 7/15/2020 at 8:20 AM, the DON was asked to look at her banana she left untouched on her plate and he stated, That looks bad. He then asked her if she would like another banana and she shook her head up and down indicating yes. He went to get her another banana cut it into and she immediately started eating the banana.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review, and interview, the facility failed to ensure food was labeled and dated after being opened; the kitchen floors were kept clean, and the can opener was clean, to minimize the risk of food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 63 residents who received meals from the kitchen as documented on the Resident Census and Condition of Residents form provided by the Administrator on 7/13/2020. The findings are: 1. On 7/13/2020 at 10:58 A.M., the following observations were made in the kitchen: In the dry food storage: a Chocolate Cake Mix was open with the top rolled down and put in box. The box was not labeled or dated. A 4 pound bag of sugar that was open and rolled down with no label or date, and on a shelf by the door in a container was a half bag of pasta with no label or date. 2. On 07/13/2020 at 11:15 AM, In the refrigerator, there were two-gallon pitchers. One pitcher was half full of a brown substance that the Dietary Manager identified as nectar thickened tea. The Dietary Manager was asked, Should the pitcher be labeled to identify what is in the pitcher and use by date? She stated, Yes. I will do that now. The surveyor asked, What is in the other container? She stated, Nectar thicken water, I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045302	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INNISFREE HEALTH AND REHAB, LLC	301 SOUTH 24TH STREET ROGERS, AR 72758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) will date it now. 3. On 07/13/2020 at 11:17 AM, the surveyor observed an open loaf of Cinnamon bread with no label or date, a package of hamburger buns with 6 buns left with no label or date, and there were two packages of open corn tortillas with no label or date. The Dietary Manager took them and stated they belonged to a cook that had the day off and placed them in the trash. 4. On 07/13/2020 at 11:20 AM, there was a spray bottle with no label or date sitting on the prep table. The Dietary Manager was asked, What is in this bottle? She stated, Peroxide. We clean with it. The Dietary Manager was asked, Should it be on the prep table? She stated, No. The Dietary Manager was asked, Should it be labeled and dated? She stated, Yes. 5. On 07/13/2020 at 11:30 AM, there was a bag of carrot shreds and purple cabbage shreds that were located in the refrigerator with no label or date. 6. On 07/13/2020 at 11:38 AM, Dietary Aid #1 went to the refrigerator and removed 4% (percent) curd cottage cheese. The container was already opened, and Dietary Aid #1 scooped two bowls of cottage cheese. Dietary Aid #1 was asked, Was the container open? She stated, Yes. I think it was opened this morning. Dietary Aid #1 was asked, Is it labeled? She stated, No. 7. On 07/13/2020 at 11:42 AM, the Dietary Manager went to refrigerator and retrieved lettuce leaves, shredded carrots and shredded cabbage. The Dietary Manager was asked, Is there date on the carrots when they were opened? She stated, No. But we got them last week. The Dietary Manager was asked, Should there be a date on the carrots and cabbage? She stated, Yes. I guess it came off. I will re-label them both. 8. On 07/13/2020 at 11:50 AM, the Dietary Manager used an ice scoop that was uncovered in a pan by the ice machine. 9. On 07/13/2020 at 11:55 AM, the Dietary Manager reached up on the top shelf to retrieve two-gallon pitchers. When reaching up to get them, she placed her fingers of both of her hands inside of the lids and brought them down. She reached up and got the pitchers down. She took one pitcher over to the ice machine and got an ice scoop that was in a pan. The scoop was uncovered, and she proceeded to place ice in the pitcher. She put water in the pitcher then placed the lid (the lid was not cleaned after she placed fingers inside lid) on the pitcher. She then poured water in glasses. 10. On 07/13/2020 at 12:00 PM, there was a can opener with black substance built up on the blade. A photograph of the can opener was taken at this time.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure hand sanitizer or hand washing was used during wound care to prevent potential wound contamination of pathogens and subsequent infectious disease for 1 (Resident #5) of 1 sampled resident. This failed practice had the potential to affect 2 residents that required wound care at the facility per the list given by the Director of Nursing (DON) on 7/15/2020 at 10:41 AM. The facility also failed to ensure staff followed contact isolation precautions, including the consistent, appropriate use of Personal Protective Equipment (PPE), cleaning of equipment and supplies after use in an isolation room and proper handling of used throw away food trays for 1 (Resident #164) of 2 (Residents #163 and #164) sampled residents who had physician orders [REDACTED]. These failed practices had the potential to affect 63 residents who resided in the facility, as documented on lists provided by the Administrator on 7/13/2020 at 11:58 AM. The findings are: 1. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/07/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required total dependence of 2 staff for bed mobility, transfers, dressing, toileting and total dependence of one staff for eating, personal hygiene, bathing, and locomotion. a. A physician order [REDACTED]. Right Gluteus and left gluteus every day shift every Mon (Monday) Wound Center Will Provide Treatment dated 06/01/2020. b. On 07/15/2020 at 9:04 AM, Licensed Practical Nurse (LPN) #1, provided wound care to changed [DEVICE] dressing on left and right buttock dressing. She removed the dressing to the right buttock/hip area, and proceeded to cleanse with saline in wounds with sterile wooden cotton tip applicator, and periwound. She dried with gauze and applied [MEDICATION NAME] skin prep, then clear skin drape wafer was applied. She changed her gloves 3 times, but did not hand sanitize or do handwashing between dirty and clean or changing of gloves. She cut a wound size circular area in wafer for wound sponge and packing. LPN #1 used 3 fingers and wood tip applicator to pack sponge into wound tunneling and open areas then covered with wafer. LPN #1 removed her gloves but did not sanitize or wash her hands. She left the room and opened the hallway door to obtain dry draw sheet and returned to room without hand sanitizing. She placed new gloves on, rolled the resident to the other side, positioned her, placed dry draw sheet, and went into bathroom and washed her hands stating, between the hip wounds. LPN #1 donned gloves, and removed the soiled dressing from the left hip, but did not wash her hands or sanitize them. She continued to clean the area with saline and dried with 4 x (by) 4 gauze. She changed gloves, but did not sanitize, and placed the drape dressing strips and began packing the wounds with the sponge using 3 fingers to hold the base of the sponge at the wound and the wooden cotton tip applicator to pack the wound, then applied the clear drape dressing. She changed gloves multiple times in the process of wound care, but did not hand wash or sanitize between the soiled dressing and the clean wound care and packing of the wound. c. On 7/15/2020 at 10:02 AM, the treatment nurse, LPN #1 was asked if she usually uses hand sanitizer or hand washing between glove changes and wound care including going from dirty to clean area or leaving the room for supplies. She stated, I have the hand sanitizer on my cart. I know I should have used the sanitizer between glove changes. I just forgot. I don't know why; I usually use the sanitizer every time I change my gloves. d. On 7/15/2020 at 10:09 AM, the DON was asked, What is the practice at this facility regarding hand sanitizing or washing between glove changes and dirty and clean or leaving the room during care? He stated, Gloves should be changed whenever you go from dirty to clean and hand sanitizer is to be used at every glove change. Gloves should be changed if you have to leave the room and hand sanitizer used or handwashing to help prevent cross contamination/infections. e. The Dressing Change Using Aseptic Technique Policy and Procedure provided by the DON on 7/16/2020 at 7:35 AM documented, Procedure: 1. Wash hands . 6. Don gloves. 7. Remove soiled dressing and discard in plastic bag. 8. Discard dirty gloves in plastic bag. 9. Apply alcohol gel and reapply gloves . 2. Resident #164 had a [DIAGNOSES REDACTED]. a. The most current Care Plan dated documented, total assist with activities of daily living. Resident is in 14-day contact isolation, due to admission and no test results for COVID. b. On 07/15/2020 at 09:55 AM, Certified Nursing Assistant (CNA) #1 was observed leaving isolation room with yellow gown, gloves and mask. In the CNA's hand was a meal tray. The CNA was observed walking down the hallway, approximately 28 feet (ft), to a room labeled Tub / Shower room. The CNA punched in a code on the door with gloved hands and entered the room. The CNA exited the room with gloves still on. She went back to the resident's room and doffed PPE and exited the room. c. On 07/15/2020 at 10:00 AM, CNA #1 and CNA #2 went into the room with a Hoyer lift. The CNAs were in the room with the Hoyer lift for 5 minutes when the door opened and CNA #2 walked out of the resident's door pushing the lift in front of her. CNA #2 changed she her mask, and the surveyor asked, How did you clean the lift? She stated, Oh, I cleaned it before when I had it on 200 hall. CNA #2 was asked, Were you in an isolation room? She stated, Yes. She was asked, Did you clean the lift before you brought it out of the room? She stated, No. The Assistant Administrator instructed CNA #2 to get Cavi-wipes and clean Hoyer lift before moving it any further. d. On 07/15/2020 at 10:05 AM, the Assistant Administrator was asked, Should the CNAs leave the room with PPE on? She stated, No. She was asked, Is there a way for them to throw away the isolation trash in the rooms? After looking in room she stated, No. They don't have big trash cans in the rooms. She was asked, Should they take a lift in the room and bring it out before cleaning it? She stated, No. e. On 07/16/2020 at 10:29 AM, the Director of Nursing was asked, Have the CNAs been trained on Personal Protective Equipment and Proper disinfection of equipment? He stated, Yes. On hire and yearly. He was asked, Should a CNA walk out of an isolation room with personal protective equipment on? He stated, No. He was asked, Should equipment be brought out of an isolation room without being disinfected? He stated, No. f. The Infection Control Policy documented, .Standard precautions shall be used when caring for residents at times regardless of their suspected or confirmed infection status . g. The Isolation Precautions documented, . If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident . h. On 07/16/2020 at 10:56 AM, the Director of Nursing was asked, If they bring the lift out of the room is it contaminating the floor? He stated, Yes. 3. On 07/13/2020 at 12:14 PM, Dietary Employee #3 entered the back door of the kitchen without a mask or hair net. The employee walked into the dry storage (approximately 6-8 foot from the back door). As she entered the kitchen area the Dietary Manager (working at the prep table) hollered out to her to get her hair net on. When ask who screened her before she entered the back door to the kitchen: she stated, What do you mean? The surveyor then asked her again who checked you in to screen for COVID? She stated, I did. The surveyor asked her to step out the back door (after she put her mask and hair net on) and show the Surveyor where the screening station she used was. We walked out the back door into a hallway and just across from the employee break lounge there was a screening station set up with a digital laser thermometer, alcohol-based hand sanitizer and a log. Dietary Employee #3 signed in just below another employee. When asked who usually checks her in, she stated, I do. The Director of Nursing arrived at the screening station approximately 5 minutes later and was asked if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045302	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INNISFREE HEALTH AND REHAB, LLC	**301 SOUTH 24TH STREET ROGERS, AR 72758**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) the Dietary employees usually enter the back door of the kitchen and screen themselves. He stated, No. They usually let the Dietary Manager know and she checks them in or they call the house phone and someone comes back here and checks them in, they are not ever supposed to check themselves in.