| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **045390** | A. BUILDING _____ B. WING _____ | **07/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ENCORE HEALTHCARE AND REHABILITATION OF WEST LITTL** | **12111 HINSON RD LITTLE ROCK, AR 72212** |

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 0659<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide care by qualified persons according to each resident's written plan of care.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 021) and Complaint # (AR 119) were substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed and medications were administered for 1 (Resident #9) of 18 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18) case mix residents who had physician's orders for medication administration. This failed practice had the potential to affect 76 residents who had physician's orders for medication administration, according to a statement provided by the Registered Nurse Consultant on 7/16/2020 at 1:47 p.m. The findings are: Resident #9 had [DIAGNOSES REDACTED]. The 5-Day Medicare Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and received as needed (PRN) and scheduled pain medications. a. A Physician's Order dated 5/6/2020 documented, .[MEDICATION NAME] 300 mg (milligrams) capsule . give 3 caps (capsules) (to equal) 900 mg PO (by mouth) Q (every) Day TID (three times daily) . b. A Physician's Order dated 5/6/2020 documented, .Duloxetine HCL ([MEDICATION NAME]) DR (Delayed Release) 30 mg cap (capsule) . Give one cap PO (by mouth) Q (every) Day BID (twice daily) . c. A Physician's Order dated 5/26/2020 documented, .[MEDICATION NAME] Hcl ([MEDICATION NAME]) 5 mg (milligrams) tablet Q (every) 12 hrs (hours) . d. A Physician's Order dated 5/26/2020 documented, .[MEDICATION NAME] 10 mg (milligrams) tablet one tab PO (by mouth) Q (every) Day . e. The Medication Administration Record [REDACTED]. f. On 7/9/2020 at 10:00 a.m., the resident was lying in bed. He was asked if he had any problems with getting his medications on the weekends. He stated, It's hit and miss. I guess it depends on who the nurse is. He was asked, When was the last time this happened? He stated, This past weekend. He was asked if he remembered some of the medications he did not get. He stated, My [MEDICATION NAME]. I know they have a lot to do, but my pain meds (medications) are wearing off by that time, and it's hard when I don't get them at the time it is prescribed. g. On 7/9/2020 at 11:01 a.m., Licensed Practical Nurse (LPN) #2 was asked when she came to work Monday morning (7/6/2020), if she noticed if some of the medications that should have been given over this past weekend were still in the medication bubble pack card. She stated, I don't really know. She was asked if the medications were to be punched out by date. She stated, Yes, except for the narcotics. She was asked to pull a medication card out of her cart for review. A medication card for a medication scheduled to be administered at 8:00 a.m. for Resident #9 was checked. The pharmacy label on the medication card documented, .[MEDICATION NAME] 300 mg . Take 3 capsules (900 mg) by mouth 3 times a day . The 3 capsules were still present in the 8:00 a.m. bubble for 7/4/2020 and for 7/5/2020. A second 8:00 a.m. medication card for Resident #9 was checked. The pharmacy label on the medication card documented, .[MEDICATION NAME] 10 mg . Take 1 tablet by mouth once daily . The tablet was still present in the 8:00 a.m. bubble for 7/5/2020. A third 8:00 a.m. medication card for Resident #9 was checked. The pharmacy label on the medication card documented, .Duloxetine DR (Delayed Release) 30 mg . Take 1 capsule by mouth twice a day . The capsule was still present in the 8:00 a.m. bubble for 7/5/2020. A fourth medication card for Resident #9 was checked. The pharmacy label on the medication card documented, .[MEDICATION NAME] 5 mg . Take 1 tablet by mouth every 12 hours . The narcotic log for the medication documented, .[MEDICATION NAME] 5 mg . Take one tab (tablet) BID (twice daily) . The information contained in the narcotic log which documented the date and time the medication was administered documented, .7/3/2020 (administered at) 8:00 a.m. .1 (one tablet) . 7/3/2020 (administered at) 8:00 p.m. . 1 (one tablet) . 7/4/2020 (administered at) 8:20 p.m. . 1 (one tablet) . 7/5/2020 (administered at) 2400 (12:00 a.m.) 1 (one tablet) . 7/5/0 (administered at) 8:00 a.m. .1 (one tablet) . 7/5/2020 (administered at) 8:00 p.m. .1 (one tablet) . The documentation in the narcotic log indicated the morning dose of [MEDICATION NAME] was not administered as ordered. h. As of 7/10/2020 at 3:00 p.m., the nurse who was responsible for administering the medications to this resident was not available for interview. i. On 7/19/2020 at 6:06 p.m., the Director of Nursing (DON) was asked if she was aware of a resident getting their medications 5 to 6 hours late on several occasions, or if the same resident missed their pain medication on or about 7/14/2020. She stated, I know exactly what you're talking about. (Resident #9) did not receive his [MEDICATION NAME] on 7/14/20, I believe. The narcotic was on the 300 Hall Medication Cart instead of the 100 Hall Medication Cart. Plus, it was a brand-new nurse. The [MEDICATION NAME] was the only medication he did not receive timely that day. j. As of 7/19/2020 at 6:30 p.m., the Medication Administration Record [REDACTED]. One tab (tablet) by mouth Q (every) 12 HRS (hours) at 0600 (6:00 a.m.) and 1800 (6:00 p.m.) . The MAR indicated [REDACTED]. k. As of 7/19/2020, the Narcotic Log page for the resident's [MEDICATION NAME] 5 mg documented, .7/14/2020 . 9:00 p.m. .1 (one tablet administered) . The Narcotic Log contained no documentation to indicate the [MEDICATION NAME] was administered at 6:00 a.m. on 7/14/2020. l. The facility policy titled General Guidelines Policy and Procedure for Medication Administration provided by the Administrator on 7/19/2020 documented, .Policy . Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Medications are administered in accordance with written orders of the prescriber . |
| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 021) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure treatment and services were provided to promote healing and prevent potential infection by failing to ensure dressings were in place and covering the wounds for 3 (Residents #2, #5, and #11) of 3 case mix residents who had pressure ulcers. This failed practice had the potential to affect 6 residents who had pressure ulcers, according to a list provided by the Registered Nurse Consultant on 7/10/2020 at 11:55 a.m. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date (ARD) of 5/28/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS), required extensive two-plus person assistance for bed mobility, and was at risk for developing pressure ulcers. a. A Braden Risk Assessment Report dated 6/15/2020 documented the resident's risk score was 16 which indicated a mild risk for pressure ulcers. b. The Care Plan dated 7/2/2020 documented, .I have impaired skin integrity to my sacrum . excoriation / irritation . Observe my skin when providing routine care . I need wound care as ordered by my physician . Monitor for changes in my skin status that may indicate worsening of my wound and notify the physician . c. A physician's orders [REDACTED].Clean open area to Left Coccyx area with wound cleaner, pat dry, apply thin coat of Med-A-Honey . Cover with dry dressing Q (every) day and PRN (as needed) . d. A physician's orders [REDACTED].Clean open area to Right Upper Coccyx area with wound cleaner, pat dry, apply thin coat of Med-A-Honey . Cover with dry dressing Q day and PRN . e. A physician's orders [REDACTED].Clean open area to Right Lower Coccyx area with wound cleaner, pat dry, apply thin coat of Med-A-Honey . Cover with dry dressing Q day and PRN . f. The Treatment Administration Record (TAR) dated July 2020 documented the nurse's initials on 7/4/2020 to indicate the resident's treatments were administered as ordered. As of 7/6/2020 at 11:00 a.m., the TAR contained no nurse's initials to indicate the administration of the treatment of [REDACTED]. g. On 7/6/2020 at 11:03 a.m., the resident was lying in bed. Certified Nursing Assistant (CNA) #2 was asked to position the resident so the |

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

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| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>resident's dressing would be visible. The CNA positioned the resident on her left side. No dressing was visible over the resident's wounds. There were numerous Stage 2 open areas to the resident's bilateral buttocks and the area was covered in feces. The CNA was asked if the areas were supposed to be covered with a dressing. She stated, I think so. 2. Resident #11 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/15/2020 documented the resident scored 4 (0-7 indicates severely impaired) on a BIMS, required extensive two-plus person assistance for bed mobility, and was at risk for developing pressure ulcers. a. The Braden Risk Assessment Report dated 3/26/2020 documented the resident scored an 18 which indicates a mild risk for developing pressure ulcers. b. The Care Plan dated 6/25/2020 documented, .I have impaired skin integrity to my coccyx . Stage 2 pressure ulcer . I need wound care as ordered by my physician . c. A physician's orders [REDACTED].Cleanse Stage 2 pressure ulcer to coccyx 1 cm (centimeter) (by) 1 cm (by) 0.1 cm with wound cleanser, apply [MEDICATION NAME], cover with foam dressing every day and PRN (as needed) . d. The TAR dated July 2020 did not contain nurse's initials for Saturday 7/4/2020 or Sunday 7/5/2020 to indicate the treatments had been administered on those dates. e. On 7/6/2020 at 11:26 a.m., the resident was lying in bed. CNA #1 was asked to position the resident so the dressing would be visible. She positioned the resident on her right side. A Stage 2 open area, approximately 1 cm by 1 cm by 0.1 cm was visible to the coccyx area. There was no dressing visible. The CNA was asked if the wound was supposed to be covered with a dressing. She stated, Yes. f. On 7/9/2020 at 2:14 p.m., Registered Nurse (RN) #2 was asked if she worked the previous weekend on 7/4/2020 and 7/5/2020. She stated, Yes, I worked this past weekend. She was asked if she performed the treatments in the facility. She stated, I did the treatments on the 200 Hall. I didn't do them on the other halls. She was asked why she didn't do the treatments on the other halls. She stated, Usually the nurses do their own treatments. (Director of Nursing (DON)) let me know she wanted me to try and help. I went to each nurse and asked what they needed done and the one who got back with me was the nurse on 200 Hall. g. The facility policy titled Wound Care provided by the Administrator on 7/9/2020 documented, .Any resident identified with a wound / skin concern will have a treatment in place to assist with healing of the wound/skin concern. Treatment order will be entered in the physician orders [REDACTED]. Treatment Nurse or designee will perform wound care / skin care as ordered by the physician per the eTAR (electronic Treatment Administration Record) .<br><br>3. Resident #5 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 5/14/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; required extensive two-plus person assistance for bed mobility; had an indwelling catheter, was always incontinent of bowel, was at risk for the development of pressure ulcers, and had one stage 3 pressure ulcer. a. A physician's orders [REDACTED].Off-Loading Boots to Bilateral Feet as tolerated . Monitor every shift . b. A physician's orders [REDACTED].Clean unstageable to Right Great Toe with WC (Wound Cleanser) . Apply [MEDICATION NAME] Cream 1% . Cover with dry drsg (dressing) . Change Q (every) day and PRN (As needed) . c. A Care Plan dated 5/21/2020 documented, .I have impaired skin integrity to my right great toe . Unstageable pressure ulcer . Place my pressure-reducing device / product on bed / chair as appropriate . Observe my skin when providing routine care . I need wound care as ordered by my physician . Monitor for changes in my skin status that may indicate worsening of my wound and notify the physician . d. On 7/6/2020 at 11:00 a.m., Resident #5 was lying in bed. Licensed Practical Nurse (LPN) #2 was standing at the Medication Cart outside of the resident's room. LPN #2 was asked if the Surveyor could observe the resident's lower extremities. LPN #2 entered the resident's room and pulled back the resident's bed clothing. Podus boots were in place to the resident's bilateral feet. LPN #2 loosened the resident's podus boot to the resident's right foot. A wound was visible to the resident's right great toe. There was no dressing in place. LPN #2 was asked if a dressing should be in place. She stated, Yes. e. The Treatment Administration Record (TAR) dated July 2020 documented, .Clean Unstageable to Right Great Toe with WC (wound cleanser) . Apply [MEDICATION NAME] Cream 1% . Cover with dry drsg (dressing) . Change Q (every) Day and PRN (as needed) . Time Code 8:00 a.m. . As of 7/6/2020 at 11:30 a.m., the Treatment Administration Record contained no nurse's signature / initials to indicate the administration of the treatment on 7/5/2020. |
| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 072) and Complaint # (AR 077) were substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure there was adequate visibility through a window in the door to the Secured Unit to prevent potential accidents for 1 (Resident #17) of 1 sampled resident who was at risk for falls on the secured unit. The failed practice resulted in actual harm for Resident #17 who was struck by a door by an employee resulting in a humeral condyle fracture, and had the potential to cause more than minimal harm for 11 residents who resided on the Secured Unit, according to a list provided by the Nurse Consultant on 7/14/2020 at 11:53 a.m. The Administrator was notified of the Actual Harm situation on 7/14/2020 at 11:53 a.m. The findings are: a. Resident #17 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 4/9/2020 documented the resident scored 0 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, required limited one person physical assistance for bed mobility; required limited one person physical assistance for transfer; was independent for walking in room per setup help only; was independent for walking in corridor per setup help only; was independent for locomotion on unit per setup help only; was independent for locomotion off unit per setup help only; required extensive one person physical assistance for dressing, toilet use, and personal hygiene; and had no falls since prior assessment. b. A Care Plan with a revised date of 6/22/2020 documented, .I have a fracture to my left elbow . Administer my medications as ordered . Order for sling as tolerated to LUE (Left Upper Extremity) . F/U (Follow-up) with ortho dr. (Orthopedic Doctor) in one week . 7/1/2019 . I am at risk for falls r/t (related to) wandering and unsteady gait . Refer me for Therapy screen as appropriate . 6/1/2020 . In-service staff on being careful when entering the retreat area . 6/22/2020 . X-ray to left elbow . elbow is fractured . c. A Nurses Note dated 6/1/2020 at 9:28 a.m. documented, .At 1415 (2:15 p.m.) the resident was hit by the door of the unit as it was opened causing her to stagger a few steps backwards and land on her butt. The CNA (Certified Nursing Assistant) working on the unit was entering the locked door w/ (with) supplies and didn't see her through the window d/t (due to) resident crouching down . Res (Resident) paces up and down the hall all day and often pauses and rests at the end with the doors just out of sight from the other side if you're looking through the windows on either door. Res. witnessed staggering back and falling to the ground by CNA that was entering the unit. Assessed by myself and Day Shift Nurse. No injuries noted or c/o (Complaints Of) pain. Cont. (Continued) amb (Ambulating) w/o (without) difficulty after assisting off of the ground. Res. had amb (ambulated) to the end of the hall and was in the Dining Room by the time I left the unit and came back w/ (with) a v/s (vital sign) machine. No visible limp or change in gait noted. BP (Blood Pressure) 113/67, P (Pulse) 76, R (Respirations) 18, T (Temperature) 96.8. APN (Advanced Nurse Practitioner) notified @ (at) 1437 (2:37 p.m.) and no new orders rcv'd (received). DON (Director of Nursing) @ facility and made aware @ 1449 (2:49 p.m.). Res.'s (Resident's) son called @ 1620 (4:20 p.m.) and msg (message) left to call facility. Res.'s daughter called and notified of incident @ 1623 (4:23 p.m.) and appreciative for notifying her . d. A Resident Incident Report dated 6/1/2020 at 4:49 p.m. documented, .Narrative of incident and description of injuries .At 1415 (2:15 p.m.) the resident was hit by the door of the unit as it was opened causing her to stagger a few steps backwards and land on her butt. Res. (Resident) Witnessed staggering back and falling to the ground by CNA that was entering. Assessed by myself and Day Shift nurse. No injuries noted or c/o (complaint of) pain. Cont. (continued to) amb. (ambulate) w/o (without) difficulty after assisting off the ground . Immediate Post-Incident Action . Had staff in-service reminding them to use caution and pause and look through the windows prior to opening the door and entering the unit . e. A facility In-Service Form dated 6/1/2020 documented, .When entering the retreat be careful and cautious of the residents behind the door . f. A facility Resident Incident Report dated 6/20/2020 at 10:33 a.m. documented, .Narrative of incident and description of injuries . Resident was walking near the door in the hallway when a CNA was walking into the door. Resident was hit by the door, falling to the floor on her left side. Resident was able to ambulate on her own away from the door. Some swelling and decreased movement in her left forearm . Immediate Actions Taken . Resident was moved to a safer area, assessed for injuries. DON (Director of Nursing) and APN (Advanced Practice Nurse) notified. Vital signs taken and pain medication given . Immediate Post-Incident Action . Asked CNAs to be more cautious when entering doors on the 200 Hall . Narrative of Investigation . Resident was behind entry doors on retreat entry. She is small stature and difficult to see when she is |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>standing by door. Staff entered in the door and resident fell on her left side. She had swelling to her left forearm and facial grimacing when movement was noted. Initial x-ray showed no injury however the following day resident had increased swelling and new x-ray was done to elbow showing fracture. She was sent to ER (emergency room ) for eval (evaluation). She has order for sling to left arm. Today she is showing signs of increased difficulty walking. New x-ray was ordered and PT (Physical Therapy) to screen . g. A Nurses Note dated 6/20/2020 at 3:07 p.m. documented, .Resident was walking in the hallway on 200 (Hall) near the door. As a CNA entered, resident was hit by the door causing her to fall onto her left side. Some swelling and decreased movement in her left forearm. Vitals (vital signs) stable, pt. (patient) still able to ambulate as before. X-Ray ordered for left forearm and Tylenol given for pain . h. A Fall Risk assessment dated [DATE] documented, .Total Score (Total Score of 10 or above represents High Risk) . Grand Total . 11 . i. A (Radiology) x-ray digital image dated 6/20/2020 documented, .Forearm Left (2V (views)) AP (anteroposterior), LAT (lateral) .Findings . Views of the left forearm show bony architecture to be Osteopenic. No definite bone or soft tissue abnormality is seen . Impression . No acute injury . j. A physician's orders [REDACTED].Mon (Monday) Sling LUE (Left Upper Extremity) as tolerated . k. A Nurses Note dated 6/22/2020 at 6:35 p.m. documented, .Rad. tech (Radiology Technician) @ (at) facility to x-ray L (left) elbow around 3pm (3:00 p.m.). Report rcv'd (Received) @ 1547 (3:47 p.m.) . Acute Lateral Humeral Condyle Avulsion Fx (fracture). APN (Advanced Practice Nurse) @ facility and copy of report given. V.O. (Verbal order) rcv'd @ 550 (3:50 p.m.) to send to ER (emergency room ) of family's choice . Daughter called @ 1601 (4:01 p.m.) and notified of fx (fracture) and stated she wanted res. (resident) sent to (Hospital) ER (emergency room ). MEMS (Metropolitan Emergency Medical Service) called, and transport requested @ 1607 (4:07 p.m.). Report called to ER @ 1610 (4:10 p.m.) .Nurse stated they're on diversion d/t (due to) no open rooms and a full waiting room and that they may not accept. MEMS @ facility @ 1625 (4:25 p.m.) and left @ 1628 (4:28 p.m.) . l. A (Radiology) Digital x-ray dated 6/22/2020 documented, .Elbow Left (2V) (2 Views) AP (Anteroposterior) LAT (Lateral) .Findings . Frontal and lateral views left elbow submitted. No prior studies. Acute Lateral Humeral Condyle Avulsion Fracture. Lateral view is oblique, cannot assess for joint effusion. The Unotrochlear and Radiocapilellar joints are with mild [MEDICAL CONDITION] changes. Osteopenia . Impression . Acute Lateral Humeral Condyle Avulsion Fracture . m. A Nurses Note dated 6/22/2020 at 6:49 p.m. documented, .Report rcv'd from RN (Registered Nurse) (at) (Hospital) ER (emergency room ) (at) 1840 (6:40 p.m.) . Fx (fracture) verified to L (left) elbow. Will be in sling. Wear as tol (tolerated). Rx (Prescription) for [MEDICATION NAME] and will need to f/u (follow-up) w/ (with) ortho (Orthopedics). Res. (Resident) coming back by MEMS (Metropolitan Emergency Medical System). APN (Advanced Practice Nurse) notified and given okay to send Rx (prescription) to pharmacy and give as directed . n. An Advanced Practice Registered Nurse (APRN) Progress Note dated 6/26/2020 documented, .Today she is being seen following a Fall. Has left elbow pain with limited movement. She cannot complain but limited or no movement obvious. 6/22/2020 X-ray . Acute Lateral Condyle Avulsion Fracture . Assessment / Plan . 1. Closed Fracture of Condyle of Humerus . Send to ortho (Orthopedic Doctor) for further eval (evaluation) . o. A (Radiology) Digital Image dated 7/2/2020 documented, .Pelvis (1 to 2V (one to two views) AP (anteroposterior) . Impression . No acute abnormality . p. On 7/13/2020 at 10:10 a.m., Resident #17 was sitting in a wheelchair in the Day Room with her feet flat on the floor. There was no assistive devices or sling on the resident's left arm. q. On 7/13/2020 at 11:45 a.m., Resident #17 was propelling herself down the hallway returning from taking a shower. The resident's left arm was resting in her lap and no assistive device was in place. r. On 7/13/2020 at 11:48 a.m., a sign hanging on the outside and inside of the door of the Retreat Unit documented, .Retreat . Please be cautious when opening this door for everyone's safety . Thank You . s. On 7/13/2020 at 3:36 p.m., Registered Nurse (RN) #1 was asked if he was familiar with (Resident #17). He stated, Yes. He was asked if he remembered an incident involving the resident. He stated, Yes. The resident was knocked down by the door when a staff member came through it. The resident got up and walked. She did not have any injuries. t. On 7/14/2020 at 1:56 p.m., Certified Nursing Assistant (CNA) #4 was asked if she was familiar with (Resident #17). She stated, Yes. I remember the resident falling at the beginning of June (June 2020). I was bringing supplies to the hall. I am tall and could still not see through the little window. The resident was crouched behind the door. I did see the resident fall. I bumped the resident with the door. The nurse was at the beginning of the hall and came to look at resident. We had an in-service to make sure we look through the window. I do not know who did the fall at the end of June (June 2020). After the second fall, I do not know why the resident was not walking. She had pain in her hip. u. On 7/14/2020 at 2:15 p.m., the Director of Nursing (DON) was asked if she was familiar with (Resident #17). She stated, Yes. The incident that happened towards the end of June (June 2020) happened on a weekend. I instructed the weekend staff to be cautious when entering the unit and to distract residents away from the doors. From June 22nd (6/22/2020) through June 25th (6/25/2020) the resident was not ambulating. The resident had hip pain post fall, but we had the staff keep her occupied and away from the doors. A Nurse does stay on the hall during meal service. We did an in-service on being cautious when entering the unit. v. On 7/14/2020 at 3:47p.m., RN #2 was asked if she was familiar with (Resident #17). She stated, Yes. She stated she does remember the resident falling. She stated, The resident would pace the hallway. She is short and she would get down behind the door. The CNA did not see the resident when she opened the door. I am the RN Supervisor and was not on the hall at the time of the incident. (RN #3) told me of the incident. I did assess the resident and did the Incident Report. The resident was non-verbal, she not moving her left arm as much, and she was holding her arm. An x-ray was ordered. (RN #3) called the doctor. The rest of the shift I checked on the resident frequently. I tried to get her vital signs, but I couldn't get them. The resident would not allow it. The resident continued to wander. We did finally have the resident sit in the office and was able to give her pain medication and she allowed the x-ray to be done. I was not there when the x-ray results came back. I did tell the DON of the incident. She told me to tell the CNAs to be more cautious when entering the unit. There was a sign on the door going in and coming out alerting us to be cautious. w. On 7/15/2020 at 10:10 a.m., CNA #5 was asked if she was familiar with (Resident #17). She stated, I have worked the Retreat Unit since starting here. I am familiar with (Resident #17). The resident had a fall about a month ago. The resident was ambulating well. She would stand up and would constantly walk up and down the hallway. The resident never sat in any activities. The resident would stop for a few minutes, rub her hands together, and would then continue to walk. The resident would stand by the doors. I was on the hall on the day of the incident. It was me and another aide (Certified Nursing Assistant). We were pushing residents to the Dining Room. I did not witness the fall. I heard someone saying a faint 'Hey, hey'. I then saw resident on the floor behind the doors. The resident will stand in the corner behind the doors. I do not remember who came through the doors. We went to get the nurse. The nurse assessed the resident. The resident started limping and was rubbing her arm. The resident's arm was swollen. We did get the resident to go to the MDS (Minimum Data Set) office for her x-ray to be done. The resident has been in a wheelchair ever since the fall. We are always being told to watch the door when we enter the Unit and to be careful. We have had a repeat in-service since the fall to be cautious when entering the Unit. There has been a sign on the door instructing us to be careful when entering the Unit. This sign has been there since the Retreat Hall was started. The resident is now more stationary. She is now in a wheelchair. x. On 7/15/2020 at 10:31 a.m., CNA #6, was asked if she was familiar with (Resident #17). She stated, Yes. I work on the Retreat Unit 80% of the time. The resident was ambulatory prior to her fall. She does now walk a few times. The last time that she walked she was a little clumsy. The resident used to pace constantly. The fall happened 2 to 3 weeks ago. I can't remember if I was here on the day of the fall. I am only aware of the resident having one fall. The shower aide pushed the door open and the resident fell backwards. There has been a sign on the door ever since the doors were closed making it into a Retreat Unit. We have had a few in-services telling us to be careful when we open the doors to the Unit. y. On 7/15/2020 at 11:21 a.m., CNA #7 was asked if she was familiar with (Resident #17). She stated, Yes. The resident was a walker, walked up and down the hall. I know that resident would stand behind the doors. The resident would walk to the door, stand there for a while, then turn around, and repeat the same behavior. She's always had that behavior. Walking and wandering. I am not aware of the resident falling at the beginning of June (June 2020). I am aware of the fall towards the end of June (June 2020). I was pushing the hall trays onto the Unit. I could not see through the glass. I couldn't see anyone back there, even if I looked through the glass. I could not see resident. She was in the corner by the door. I did look through the door window before I opened it. The door hit the resident as I was pushing the cart (tray cart) onto the Unit. I had one hand on the cart and one hand on the door. It was a cart full of trays. As I pushed the door, it hit the resident. I got the nurse. She was on the hall and she checked her out. Later we had an in-service. It was before the end of the shift that day, to be cautious when going through the door. I did write a statement and the Staffing Coordinator, she educated me on how to open the doors real slow. About six months ago they put out an in-service when the doors were first locked to be careful when we go through the doors. I was pushing the (tray) cart and holding the door at the same time. The door tapped the resident and she lost her balance and fell . I saw the resident as I was entering but |

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| | 045390 | A. BUILDING _____ B. WING _____ | 07/22/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| ENCORE HEALTHCARE AND REHABILITATION OF WEST LITTL | 12111 HINSON RD LITTLE ROCK, AR 72212 |

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) |
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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 3)<br>she was already falling. I had my back turned as I was going through the doors. There was a nurse right there close to the door. She was passing meds (medications). There has been a sign on the doors for a long time, more than a month, telling us to be careful when we open the doors. z. On 7/15/2020 at 1:38 p.m., RN #3 was asked if she was familiar with (Resident #17). She stated, Yes. I am usually assigned to the 200 Hall and a few residents on the 300 Hall. I do remember one Saturday that the resident fell and sustained a fracture to her elbow. The resident was behind the door. The CNA did not see resident behind the door and knocked her down. I was not on the Unit at the time of the incident. I was passing meds (medications) on the 300 Hall. The CNA came and told me about the fall. I did assess the resident and an x-ray was ordered of her arm. If an in-service was done about the incident, I know nothing about it. I have worked on the Unit since April (April 2020). There has been a sign on the door instructing us to be cautious when going through the doors ever since I have been working the Unit. I know nothing about the fall earlier in June (June 2020). The resident did use to pace up and down the hallway and would stand behind the door. The staff are aware of the sign on the door. I always practice caution when entering the Unit. |
| F 0726<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 077) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure staff was knowledgeable on how to properly insert a hypodermoclysis device for 1 (Resident #15) of 2 (Residents #15 and #14) case mix residents who had a hypodermoclysis device inserted in the past 30 days. This failed practice had the potential to affect 2 residents who had a hypodermoclysis device in the past 30 days, according to a list provided by the Director of Nursing on 7/14/2020 at 10:30 a.m. The findings are: Resident #15 had [DIAGNOSES REDACTED]. a. The Care Plan dated 6/10/2020 documented the resident required set up help for meals, had a [MEDICAL CONDITION], and had a urinary catheter. b. Lab results dated 6/15/2020 documented the resident's sodium level as 134 (normal results are 136-145), chloride as 91 (normal results are 98-107), Creatinine 1.4 (normal results are 0.7-1.3), and Hematocrit 40.5 (normal results are 41-51). c. A physician's orders [REDACTED].Normal Saline 0.9 . 1 liter via Klysis at 75 ml/hr (milliliters per hour) . d. A Nurse's Note dated 6/17/2020 at 6:38 a.m. and signed by Licensed Practical Nurse (LPN) #3 documented, .Resident is refusing food and fluids. Called (APRN) (Advanced Practice Registered Nurse) to notify of resident's situation. N.O. (New order) to start Normal Saline 0.9 1 liter via Klysis at 75 ml/hr (milliliters per hour). Klysis in right hip area. Resident received it well. No complaints noted . e. A Nurse's Note dated 6/17/2020 at 11:56 a.m. and signed by LPN #5 documented, .Order clarified by (APRN). Sodium Chloride 0.9%, 1000 ml. (milliliters) . Infuse 1 liter via hypodermoclysis at 75 ml/hr (milliliters per hour) r/t (related to) dehydration. Clysis currently infusing at 75 cc/hr (cubic centimeters per hour). Clysis tubing replaced twice r/t (related to) drip not observed . f. On 7/13/2020 at 3:15 p.m., LPN #5 was asked about her Nurse's Note dated 6/17/2020. She stated, I remember when I got here, I was actually training another nurse that day. We were rounding. We went to make sure it was infusing, and it wasn't dripping. We tried moving the site around and it still wouldn't drip. I replaced the tubing, got a drip, then it wasn't dripping again, and I replaced the tubing again, and that was that. Then I think it was the next shift. She was asked if she heard anything else after that as to why it wasn't working. She stated, I think when I came back, the nurse said it quit dripping again and she had to change it. She was asked if she had ever been trained on how to use clysis. She stated, I think I had that at another facility. I'm more comfortable with those than a regular IV (Intravenous). She was asked if she remembered any training on clysis since she had started at the facility. She stated, Not that I can recall. But I am IV certified. That's not a requirement. That's just something I have. g. On 7/13/2020 at 3:33 p.m., Registered Nurse (RN) #1 was asked about the resident's clysis the evening of 6/17/2020. He stated, Those 2 little needles .each one had a rubber type sheath over it. I don't think the sheath is rounded or closed at the end. I think it is like barely longer than the actual needle and has a little tiny hole in it. But we rolled the resident over and those were still on the needles. That's why it wouldn't run the fluid in. RN #1 was asked if the resident received any fluids at all via the hypodermoclysis during the day shift or evening shift that day. He stated, Not that I know of. I started a regular IV on him at the end of the shift so he could get some fluids. h. On 7/14/2020 at 11:15 a.m., LPN #3 was asked if she remembered (Resident #15). She stated, I do. She was asked if she remembered the resident having an order for [REDACTED]. I called the doctor because it seemed like every day I would ask if he had been drinking. On one particular morning, I kept trying to figure out how much output he had. I called the APN (Advanced Practice Nurse) and told her what was going on. She ordered clysis and I had never done that before, and I explained that to them. The other nurse explained to me what to do. It was me and another nurse. But for some reason it didn't work. The other nurse was (LPN #4). (LPN #4) said she had done plenty of clysis before. I had never heard of it before going to work there. I didn't know anything about it. She told me as she was walking thru the steps, and said you put it in the fatty part. She put the clear cover over it and set it to 75 ml/hour (milliliters per hour), but it didn't work. When I got back to work, it still was on the same amount. And that was after 2 shifts. (RN #1) was there working, so we rolled him over. We found that it was another clysis that had been put in him from when I did it. There was another order given. She had put it in, and it didn't work for them either. She was asked about the needles for the clysis device. She stated, Ok. The little plastic things on the needle part of it was still on, so those people that started that one didn't know that either. We took that off and we started an actual IV. I asked (LPN #4) if she knew the plastic things were on the needle and she said she didn't know that. And I said how could you not know that if you had done so many. She got mad. She said it wasn't her patient, so it didn't matter to her. Well it did matter because she was teaching me how to do that. They are like 2 little bitty plastic caps that's on the needles. You have to pull those off in order for it to work. They cover the needle until you're ready to use it. The actual clysis is inside a plastic container, and when you take it out you have to pull those off. What happened is that it didn't actually go into his skin. Those plastic caps were still on there, so it never went in him. It didn't puncture the skin. The morning nurse came in and was like, 'Yeah, we got an order', but I was telling her that it didn't work for them either. She was asked if she had ever been trained on clysis. She stated, No. She was asked who she told that she had never done one before. She stated I told (LPN #4) (night nurse). I told the APN. I didn't even know what it was. I even had to call the APN back because she's foreign and I didn't understand what she said. I was very angry behind that. Whatever skill it is, you need to teach me how to do it. If I make a mistake, you need to tell me how to fix it. I asked (LPN #4) and she said 'it ain't got nothing to do with me, it ain't my patient.' I was like, yeah it was my patient, but you were teaching me how to do it. She was asked if anyone instructed her on how to properly perform the procedure so it would not happen again. She stated, In that facility, I learned that they're not too big on stuff like that. They don't tell you, 'Hey I'm sorry this happened. I want to make sure this doesn't happen again.' You do what you do and that's it. i. On 7/14/2020 at 1:45 p.m., the DON was asked if she knew anything about why the clysis procedure didn't work for (Resident #15). She stated, I don't know anything about why it didn't run. It was explained to the DON that the plastic tips were left on the needles. She stated, No one reported that to me. If they had, I would have educated the nurses. Those things are so easy to put in. I spoke with (LPN #3) and she said she had never done one, and I told her another nurse had done them before, and that she could help her. When I talked to her later, she said they got it in, and everything went fine so that's all I knew about it. She was asked if the nurses had been trained on how to do clysis. She stated, Most of the nurses that are here now were trained prior to me coming. (LPN #3) was new. When I interviewed her, I told her we did a lot of IV and clysis to avoid hospitalization s. She told me she knew how to do that stuff because of her experience. j. A Licensed Nursing Competency Form date 2/12/1010 provided by the Director of Nursing (DON) on 7/14/2020 at 3:00 p.m. documented LPN #4 was competent in providing hypodermoclysis therapy. At this time, the DON was asked about a Competency form for (LPN #3). She stated (LPN #3) had not worked at the facility long enough to complete the Competency Form and never returned her paperwork. k. The facility policy titled Hypodermoclysis provided by the Director of Nursing on 7/14/2020 documented, .Purpose . To provide the resident hydration via continuous subcutaneous access . Procedure . Cleanse insertion site following policies for vascular device site care. Prepare subcutaneous device for insertion. Grasp skin between thumb and forefinger . Lift up into a small mound and insert device at a 45-degree angle . |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 014), Complaint # (AR 021), Complaint # (AR 027), Complaint # (AR 044), and Complaint # (AR 064) were substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed |

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| | **045390** | A. BUILDING _____ B. WING _____ | **07/22/2020** |

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|---|---|
| **ENCORE HEALTHCARE AND REHABILITATION OF WEST LITTL** | **12111 HINSON RD LITTLE ROCK, AR 72212** |

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 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 4)<br>to ensure proper infection control procedures were followed to prevent the potential spread of infectious disease and COVID-19 for 1 (Resident #9) of 2 (Residents #9 and #18) case mix residents who were in quarantine. This failed practice had the potential to affect all 76 residents who resided in the facility, according to a list provided by the Administrator on 7/17/2020 at 11:05 a.m. The findings are: 1. Resident #9 had [DIAGNOSES REDACTED]. The 5-Day Medicare Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). 2. Resident #18 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 5/28/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS. a. On 7/14/2020 at 12:40 p.m., the surveyor approached Resident #9's room. A sign was on the door of the resident's room. The sign documented, .Respiratory Droplet / Contact Precautions . All who enter this room must adhere to respiratory droplet and contact precaution protocols . Wash hands. Wear eye protection, gown, mask, and gloves. Dispose of all protective gear in designated waste area. Wash hands . A supply bin containing Personal Protective Equipment (PPE) was outside of the resident's room. Resident #9 was lying in bed. The resident was expressing his dissatisfaction with having to be in quarantine due to going out to the emergency room (ER) last night. He stated, They want me in quarantine, but they put me back in my old room with my roommate, and now my roommate is in quarantine too. While speaking with Resident #9, a staff member, Certified Nursing Assistant (CNA) #3, entered the room with the resident's meal tray and placed the tray on the over-the-bed table. CNA #3 had on a blue disposable gown, a mask, but no gloves. CNA #3 placed the tray on the resident's bedside table and exited the resident's quarantine room without removing the gown and without washing her hands. b. On 7/14/2020 at 1:45 p.m., the Director of Nursing (DON) was asked about the guidelines for the facility's quarantine rooms. She stated, They are still to wear all of their PPE, and a mask, and when they're done, they can hang them (gowns) in the room and then throw those gowns out at the end of the day. If they're soiled, they throw them away immediately. She was asked about staff delivering a meal tray. She stated, Any time they enter the room, they should wear full PPE and wash their hands when they leave. She was asked why (Resident #9) was placed back in his room with his roommate, (Resident #18). She stated, I wasn't aware he came back early this morning and they had put him in that room with his roommate, so now he is quarantined also. The DON was told about the staff member who delivered a meal tray to (Resident #9). She stated, She should have had on gloves. And she should not have worn the PPE out of the room. She should have hung the gown up in the room to use later . c. The facility's policy titled Arkansas COVID-19 Outbreak Policy provided by the Administrator on 7/14/2020 documented, .Purpose . To minimize exposure and infection of the Coronavirus (COVID-19) within the facility when there is a suspected or known case of COVID-19 . The facility will post a sign 'Respiratory Droplet Precautions' on the Resident's door indicating Droplet Precautions are to be utilized in addition to Standard Precautions . The Resident with known or suspected COVID-19 will be placed in a single-person room with the door closed . d. The facility's policy titled COVID-19 provided by the DON on 7/14/2020 documented, .Residents admitted or readmitted to the facility without a COVID-19 test will be placed in isolation and treated as suspected COVID-19 until a negative test is received or 14 days from admit . |